V I C T O R I A

Auditor-General
of Victoria

SPECIAL REPORT No. 43

PROTECTING VICTORIA'S CHILDREN

The role of the Department of Human Services

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The President
The Speaker

Parliament House
Melbourne Vic. 3002

Sir

Under the provisions of section 16 of the *Audit Act* 1994, I transmit the Auditor-General's Special Report No. 43, *"Protecting Victoria's Children: The role of the Department of Human Services"*.

Yours faithfully

C.A. BARAGWANATH
Auditor-General

Contents

Foreword

Community concern for the protection of children in this State has increased in recent years in response to an intense media focus and a growing community awareness of child abuse and neglect.

A number of government entities make a significant contribution to the protection of children in Victoria, including the Department of Human Services (formerly the Department of Health and Community Services), Victoria Police and the Children's Court. The protection of children is also dependent upon the services provided by many non-government welfare agencies.

In recent years, the child protection system has experienced a number of major changes including the transfer, in 1992, of primary responsibility for the protection of children to the Department of Human Services and the introduction in 1993 of mandatory reporting. During this time, resources available for the provision of child protection services have been severely stretched in coping with very large increases in notifications of abuse and neglect, coupled with a high turnover of protective services staff.

This Report deals with the important responsibilities of the Department of Human Services in the subject area, the role of Victoria Police and its relationship with the Department, and the adequacy of placement and support arrangements (including services provided by non-government agencies) for children and their families in the State.

I see my audit of child protection services as making an important contribution towards assisting the Department of Human Services and the Department of Justice in overcoming the existing serious impediments to effectively protecting and providing the necessary support to the children of this State.

The emerging significance from a national viewpoint to ensuring effective protection of children from abuse and neglect was reinforced by an agreement reached between Australian and State Governments in April 1996 on a National Strategy To Combat Child Abuse. At the time of their agreement, the Federal and State Ministers stated that:

> *"The national priority of community services Ministers is now indisputably on protecting the most vulnerable members of Australian society - our children."*

I hope that the issues addressed in my Report will assist Victoria to maximise the value of its contribution to such an important national strategy.

C.A. BARAGWANATH
Auditor-General

Part 1

Executive summary

Part 1.1

Overall audit conclusion

1.1.1 Protective services in Victoria are provided to children and families by the Department of Human Services. The Department endeavours to assist families, where protective concerns have been identified, to allow children to remain safely at home. Where this aim cannot be achieved, children are removed from home and provided with a range of accommodation and support services either by the Government or from non-government service providers funded by the Government.

1.1.2 Following increasing public awareness of child abuse and neglect, together with the introduction of mandatory reporting in Victoria late in 1993, the Department was confronted with a huge task in coping with a very large increase in notifications of child abuse, in conjunction with providing support services and accommodation for a greater number of children requiring protection who could no longer live at home.

1.1.3 The Department has made strenuous efforts to reshape its workforce and resources to meet the extremely challenging demands placed on it over the past 3 years. This action has been aimed at alleviating the burden carried by its workforce that has been severely stretched in terms of workloads, poor working conditions relative to tasks demanded, high stress levels and continuing public criticism. The Department has been fortunate that, despite these pressures, most of its protective services workforce have a strong work ethic and dedication to undertaking a very difficult, but essential task.

1.1.4 This Report identifies many significant weaknesses in key elements of the Department's protective services, which have adversely impacted on its ability to effectively address the protective concerns of children. These weaknesses include:

- poor investigation of notifications, including the closure of many cases which warranted further investigation;
- ineffective case management, particularly in terms of low quality draft case plans presented to the Children's Court and shortcomings in final case plans;
- placements of children which are inappropriate to meet their needs;
- the absence of a cohesive working relationship with Victoria Police in adequately protecting children, particularly adolescents;
- failure to cater for the long-term needs of many children in the care of the State;

- a lack of psychiatric services and therapeutic treatment for severely disturbed children and young people; and
- excessive delays in finalising and reporting to the Parliament on inquiries into the deaths of children requiring protection.

1.1.5 Until such time as the weaknesses in the existing child protection system, such as those outlined above, are adequately addressed, audit cannot conclude that the Department is achieving maximum effectiveness in protecting and providing the necessary support for the children of Victoria. The major priority for the Department is to achieve, through workforce planning strategies, a higher professional status for protection workers, improved conditions of employment, increased experience levels and greater stability in the workforce. Such action would help the Department to raise the level of expertise and the quality of outcomes for such critical steps as the notification/intake phase, investigations and case management.

1.1.6 In addition, the Department needs to build on the strong contributions made by foster families towards caring for children who may otherwise be placed in facility-based care.

1.1.7 Following the provision of additional annual funding from the Government of $9.4 million since July 1994, the Department has been progressively addressing the multiple problems facing it and has introduced many worthwhile initiatives and projects, such as the redevelopment of placement and support services, in order to further improve its capacity to protect and care for Victoria's children. Of particular public benefit was the introduction of the After Hours Service, whereby notifications of suspected child abuse can be promptly responded to outside of normal hours by teams of highly skilled protection workers located throughout the State.

1.1.8 The Department has initiated strategies, as part of a national strategy, to prevent child abuse and neglect. In this regard, unless effective preventative measures are able to be introduced, the continuing burden of managing a high level of notifications will further aggravate the workload pressures on the Department.

1.1.9 While the development of performance indicators for measuring the effectiveness of child protection services is at a preliminary stage Australia-wide, the Department needs to address critical deficiencies in its management information and, in turn, upgrade the quality of its performance measurement and reporting practices. In effect, the ultimate effectiveness of the child protection system can only be measured in terms of whether State intrusion in a family has produced a better outcome for children. The Department does not attempt to measure such outcomes, including where children have left State care.

1.1.10 It is acknowledged that certain audit recommendations may involve additional resources to achieve better quality outcomes for children. However, considerable scope exists for the Department to make more cost-effective and efficient use of its existing resources, especially in areas such as the high levels of renotifications and the need for more effective case management.

1.1.11 Audit accepts that, in some instances, the Department's ability to address the issues outlined in this Report has been restricted by the huge demands placed upon its workforce. It is also recognised that, in line with experiences elsewhere in Australia and overseas, the provision of protective services to children is an extremely difficult responsibility and measuring the impact of such services on children's lives constitutes a major challenge. Nevertheless, the opportunity exists now for the Department to build on its recent initiatives with a view to efficiently and effectively managing what should be a respected professional workforce dedicated to making Victoria's child protection system the benchmark against which other systems throughout Australia can compare their performance.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

Introduction of mandatory reporting early in 1993 reflected the high priority attached to protecting Victorian children at risk. The Department accepts audit's findings that the dramatic increase in workload as a result of mandatory reporting placed child protection services under enormous pressure and that required standards of performance were not able to be met in all cases. The Department also welcomes audit's acknowledgment that since July 1994 it has been progressively addressing problems and has introduced many worthwhile initiatives and projects to further improve its capacity to protect and care for Victoria's children at risk, many of these initiatives and projects are detailed in the body of the Report. Audit's conclusion that the program has stabilised since the latter part of 1995 accords with the Department's assessment.

The Department is working through the Council of Australian Governments to refine national benchmark standards of performance of child protection services. These will ensure national accountability of programs performance into the future.

Audit's comprehensive 2 year review of child protection services is of assistance to the Department in identifying priorities for further action and establishing future directions. Key initiatives planned or already commenced include:

- *development of a workforce master place to enhance staff retention;*
- *continued placement and support service redevelopment with increased emphasis on placement diversion, greater support to home-based care and residential care providers;*
- *enhanced reimbursement provisions to foster carers through allocation of an additional $4.2 million;*
- *enhanced child and adolescent psychiatric treatment services through the allocation of an additional $8 million;*
- *strengthened intake processes and piloting of a differentiated response to notifications;*
- *piloting of an assessment review process with Victoria Police and extension of current joint training programs;*
- *implementation of the findings of research into multiple placements; and*
- *implementation of a child centred-family focused case management approach.*

Detailed implementation plans are being developed to ensure further improvement to services in line with identified audit priorities.

Part 1.2

Summary of major audit findings

NOTIFICATION AND INVESTIGATION OF CHILD ABUSE *Page 31*

- The introduction of Mandatory Reporting in Victoria placed significant workload pressures on the Department of Human Services (DHS), which were accentuated by an initial under-estimation of resourcing requirements.

  Paras 4.17 to 4.22

- Under the circumstances it faced in 1993 and 1994 with minimal planning for mandatory reporting and an environment of budget constraints, DHS has endeavoured to reshape its workforce and resources to meet the extremely challenging demands placed upon it.

  Paras 4.23 to 4.28

- DHS should assess the efficiency and effectiveness of the implementation of mandatory reporting and use the results to assist in the development of new strategies to further enhance the State's ability to combat child abuse.

  Paras 4.29 to 4.54

- Given that decisions made at the notification/intake phase can have a serious and lasting impact on the future lives of children and their families, DHS needs to determine, on a Statewide basis, the underlying reasons for the significant variations between regions in the proportion of notifications subsequently investigated.

  Paras 4.55 to 4.64

- Several factors were identified by audit as impacting on the quality of the notification/intake phase including:
  - the use of inexperienced workers on intake duties;
  - the incidence of inappropriate and malicious notifications; and
  - the closure of up to 20 per cent of cases in some regions, despite the existence of circumstances warranting further investigation;

  Paras 4.65 to 4.96

NOTIFICATION AND INVESTIGATION OF CHILD ABUSE - *continued* **Page 31**

- Given that, in many instances, cases are closed by DHS although welfare concerns are evident, the desirability of DHS having specific legislative responsibility to refer cases exhibiting such concerns to welfare agencies warrants early research.

  Paras 4.97 to 4.103

- The latest data produced by DHS shows that 32 per cent of all notifications of suspected child abuse or neglect received during 1993-94 were renotifications of either earlier or new protective concerns.

  Paras 4.104 to 4.107

- Given the high level of renotifications, DHS should allocate higher priority to analysing their underlying causes, with a view to ensuring, in the best interests of the child, that protective concerns are always addressed at the earliest possible point in time.

  Paras 4.108 to 4.117

- While the number of substantiated cases of child abuse in Victoria, as a proportion of investigations, is the highest in Australia, substantiated cases as a proportion of notifications, is one of the lowest, which could indicate that a significant level of child abuse occurring in Victoria has not been subject to investigation.

  Paras 4.119 to 4.123

- During 1994-95, 92 per cent of cases requiring investigation were commenced by DHS within its standard of 7 calendar days compared with 89 per cent in 1993-94.

  Para. 4.126

- Weaknesses existed in relation to the depth and calibre of investigations by DHS of suspected child abuse and in the evaluation of the risk of significant harm to children.

  Paras 4.130 to 4.145

- To its credit, DHS has initiated action to address deficiencies in its investigation procedures in some critical areas including cases involving adolescents and high risk infants.

  Paras 4.146 to 4.147

CASE MANAGEMENT *Page 79*

- Draft case plans presented to the Children's Court by DHS were often of poor quality and lacked the necessary detail to effectively address the protective concerns and welfare needs of the child.

  Paras 5.8 to 5.15

- DHS needs to take urgent action aimed at addressing the major shortcomings of final case plans.

  Paras 5.16 to 5.22

- Several factors are contributing to ineffective case management by DHS including:
  - high workload levels and turnover of case workers;
  - delays in the allocation to workers of cases, even though protective concerns for the child had already been confirmed by the Children's Court;
  - an inadequate emphasis on the provision of counselling and therapy services to the child and its family;
  - the breaching of Protection Orders by parents; and
  - the adequacy of security over information within the CASIS information system.

  Paras 5.23 to 5.63

- The closure of cases coinciding with the expiry of Protection Orders should not occur until such time as DHS is satisfied that the child can live safely and case plan goals have been met.

  Paras 5.80 to 5.86

- There is a need for DHS to refocus its case management emphasis from investigations, placement of children and subsequent reliance on welfare agencies for family support services, to a more practice-oriented strategy which provides for greater personal involvement by its case workers with children and families.

  Paras 5.87 to 5.90

SUPPORT SERVICES AND SHORT-TERM PLACEMENTS *Page 105*

- There were several shortcomings in the planning and early implementation of the Department's major restructuring of placement and support services, in that:
  - there was a lack of documentary evidence to justify the move from residential care to home-based care;
  - inadequate attention was directed to service quality when assessing system capacity;
  - placement and support resources were not allocated across regions on an equitable basis; and
  - delays had occurred in the implementation of output-based funding.

  Paras 6.27 to 6.54

- Significant budgetary reductions were applied to the placement and support system in 1993-94 and 1994-95, at a time when system service demands escalated sharply as a consequence of increased public awareness of child abuse as well as the introduction of mandatory reporting.

  Paras 6.55 to 6.62

- Following a submission by DHS, the Government allocated an additional amount of $4.5 million in 1995-96 for placement and support to be used to establish an extra 242 placements in the system.

  Paras 6.63 to 6.65

- Between December 1992 and June 1995, the number of children in formal reception care more than doubled, with regions operating at well above formal reception capacity, resulting in children having to be located into inappropriate placements which added further to their trauma.

  Paras 6.73 to 6.86

- Preventable harm has been done to children as an indirect result of policies or programs designed to provide care and protection. In other words, *"system abuse"* of children has occurred in Victoria.

  Paras 6.87 to 6.119

- Rather than serving as temporary arrangements, reception placements are assuming a longer-term nature, extending beyond 6 months for many children. Subsequent removal of a child from the placement, where emotional bonds may have been formed with the carer, can add further to the trauma and instability already experienced by the child from the earlier removal from its family.

  Paras 6.120 to 6.124

- Foster families carry a significant financial burden in their provision of home-based care to children and prospective families need to be willing to take on such a burden.

  Paras 6.131 to 6.139

- Against the background of a pressing need to increase remuneration rates and introduce other measures designed to financially support foster families, the Government has recently announced a funding increase of $4.2 million for such families.

  Paras 6.137 to 6.138

SUPPORT SERVICES AND SHORT-TERM PLACEMENTS - *continued* **Page 105**

- There would be merit in establishing a joint working party involving DHS and representatives from the non-government sector to examine the feasibility of an accreditation system in Victoria covering service providers in the child welfare industry**.**

  Paras 6.145 to 6.150

- DHS has taken a positive initiative in establishing a specialist support unit which is intended to develop means for improving the range and quality of support services which focus on strengthening families and avoiding the need to place children away from home.

  Paras 6.165 to 6.166

- There are 6 principal programs that deliver support services to children and young people in the child protection system in relation to specialist requirements.

  Para, 6.139

- The Families First Program is an effective service to families in crisis that could be enhanced to ensure that a range of family programs are available, offering varying levels of intensity to suit the needs of individual families.

  Paras 6.180 to 6.188

- DHS and the non-government service providers need to reach agreement on the principles underlying service agreements, particularly in relation to the expected service and quality management standards**.**

  Paras 6.214 to 6.221

- The inadequacies of the Key Information Data System have reduced the Department's ability to monitor the quality and efficiency of the placement and support network in a timely and effective manner.

  Paras 6.223 to 6.231

RELATIONSHIP BETWEEN VICTORIA POLICE AND THE DEPARTMENT OF HUMAN SERVICES **Page 165**

- The protocol arrangements between Victoria Police and DHS, revised in 1994 following mandatory reporting, need to be formalised without further delay with a view to improving relations and enhancing co-operation and professionalism in both agencies in the paramount interests of the children involved.

  Paras 7.10 to 7.16

- It will be important that the results of the current review by Victoria Police of community policing provide the Community Policing Squads with a strong future direction in their role in child protection.

  Paras 7.17 to 7.21

RELATIONSHIP BETWEEN VICTORIA POLICE AND THE DEPARTMENT OF HUMAN SERVICES - *continued* **Page 165**

- Many problems are impeding a cohesive working relationship between Victoria Police and DHS and, in turn, limiting the capacity of both parties to adequately protect children.

  Paras 7.22 to 7.44

- Victoria Police and DHS need to adopt an integrated approach in developing strategies to deal with children in care frequenting streets.

  Paras 7.45 to 7.54

- Given the benefits of the limited joint training in child protection issues which has occurred to date between DHS protection workers and Victoria Police, both parties should reach agreement on a joint Statewide professional development program.

  Paras 7.55 to 7.57

- The combination of the respective skills of both DHS and Victoria Police in specialist teams would be more effective in substantiating sexual abuse.

  Paras 7.58 to 7.65

- Information is not routinely maintained by Victoria Police on sexual abuse cases substantiated by DHS and referred for Police investigation, and on the extent to which successful prosecutions occur in such cases.

  Paras 7.66 to 7.74

- The following factors are clearly impeding the ability of DHS and Victoria Police to prove sexual abuse:
  - restrictions within the legislation which are seen by Victoria Police as giving rise to an imbalance of justice in favour of the alleged offender to the detriment of the child;
  - low standards of investigation and a need for a co-ordinated joint approach by the parties;
  - lack of facilities for video taping interviews; and
  - incomplete intelligence information.

  Paras 7.75 to 7.122

- The Government's action in establishing the Victorian Institute of Forensic Medicine and addressing what was seen as a crisis in the provision of forensic medical services in the State was a positive initiative.

  Paras 7.123 to 7.128

CHILDREN UNDER THE CARE OF THE STATE *Page 201*

- The further closure of family group homes should be deferred until it can be demonstrated that other viable options are available to cater for the needs of children coming under the care of the State, and in particular, sibling groups.

  Paras 8.21 to 8.25

- There are several avenues available to DHS to minimise the effects on the future wellbeing and the adverse development of children coming into the care of the State who are placed in rostered units, from influence of the behaviour of other children in these units.

  Paras 8.26 to 8.36

- The impact of children remaining in facility-based care for extended periods can be extremely damaging to a child in the longer-term, leading to criminal behaviour, substance abuse, poor education, long-term psychological damage and diminished employment prospects.

  Paras 8.40 to 8.49

- The many concerns expressed by foster parents and foster care agencies, in terms of support received from DHS on problems experienced in caring for children under the care of the State, need to be carefully addressed by DHS.

  Paras 8.52 to 8.62

- More emphasis needs to be placed by DHS on promoting the *lead tenant* form of placement involving an adult acting, in effect, as a role model for often severely disturbed adolescents.

  Paras 8.74 to 8.79

- There would be merit in DHS undertaking research into the outcomes of independent living arrangements for adolescents to establish whether such arrangements had been made before the adolescents had exhibited adequate self-reliance and responsibility, particularly younger adolescents.

  Paras 8.80 to 8.85

- Around 26 per cent of children under the care of State for more than 3 years were not living in a permanent care arrangement and audit considered that time had run out for many of these children as to their ability to successfully blend into society as adults.

  Para. 8.95

- Judging by the incidence of multiple placements and the large number of children under State care still in short-term placements after 3 years, the legislative intention to assist children in achieving stable and secure living arrangements is largely not being achieved.

  Paras 8.87 to 8.99

- Secure welfare facilities, which are meant to provide an immediate response and a limited strategy for dealing with a crisis period in a child's life, have been inappropriately used on a longer-term basis for a significant number of children who are among the most severely disturbed in the care of the State.

  Paras 8.100 to 8.114

- There is a need to provide sufficient psychiatric beds within the hospital system specifically for children and adolescents, with priority access given to children under the care of the State.

  Paras 8.117 to 8.125

CHILDREN UNDER THE CARE OF THE STATE *- continued* **Page 201**

- The Department has a clear obligation to make a concerted effort to provide security in the lives of a large number of children in its care through the active promotion of permanent care arrangements within the community.

  Paras 8.126 to 8.139

- In some instances, the rights of children to be placed in a secure, nurturing and caring environment have been jeopardised by repeated attempts by DHS to return children to families that have not demonstrated a willingness to rehabilitate their lives and are highly unlikely to accept parenting responsibilities.

  Paras 8.140 to 8.154

- More effort needs to be applied by DHS in seeking Permanent Care Orders for children in long-term foster care.

  Paras 8.160 to 8.168

- The following factors should be addressed in terms of enhancing the education of children in State care:
  - the impact of multiple placements on children's education;
  - the soundness of relationships between schools and case managers; and
  - the lack of liaison between DHS and the Department of Education in regard to suspension, expulsion and exclusion of children from schools.

  Paras 8.180 to 8.197

- DHS has an obligation to provide detailed guidance to case workers on how the educational needs of these children can be met.

  Paras 8.198 to 8.204

- The problems associated with children in State care regularly absconding from placements need to be further addressed by DHS.

  Paras 8.219 to 8.230

- While extremely valuable initiatives have been taken by the Government in addressing the issue of youth homelessness, there is also a need to research the factors that lead to children in State care becoming homeless.

  Paras 8.231 to 8.243

- The high incidence of criminal behaviour of children in the care of the State, and the likelihood of it continuing after children leave such care, is of serious community concern and warrants research as to causes and prevention strategies.

  Paras 8.244 to 8.251

- DHS should examine the demand for, and type of, after care arrangements and support, including financial support, that should be provided by the State in relation to adolescents leaving care.

  Paras 8.254 to 8.264

QUALITY OF STRATEGIC MANAGEMENT Page 275

- Given the importance of its responsibilities for the protection of children, DHS should upgrade, as a matter of urgency, its strategic planning framework for child protection services.

  Paras 9.3 to 9.10

- With the increasing emphasis by the Victorian Government on measurement of outputs and outcomes and, at the national level, on comparisons of performance between States, DHS should develop a structured performance monitoring and measurement framework for child protection services and, in turn, establish a sounder basis for reporting to the Parliament and community on the extent to which its management strategies have resulted in maximising protection and care for children in Victoria.

  Paras 9.11 to 9.22

HUMAN RESOURCE MANAGEMENT Page 291

- The major human resource challenge now facing DHS is to achieve, through implementation of appropriate workforce planning strategies, a higher professional status for protection workers and increased experience levels accompanied by greater stability within the workforce.

  Paras 10.11 to 10.41

- DHS needs to address a number of key factors such as staff proficiency, resource availability, and adequate performance of other parts of the overall system including prevention if it is to achieve optimum utilisation of its existing workforce.

  Paras 10.16 to 10.41

- Initiatives which DHS could consider to further enhance the capacity of its protective services workforce include:
  - identifying ways to attract back experienced and capable ex-staff, even for short-term periods;
  - emphasising to staff, through training, appraisals and supervision, the key notions of efficiency, effectiveness and quality; and
  - introducing training on best practices derived from studies of current work methods.

  Paras 10.42 to 10.49

- DHS should introduce a performance-based classification and salary structure for its protective services workforce.

  Paras 10.54 to 10.61

- Improving the quality of teamwork, both within its protective services teams and in their relationships with external parties, should be a key development imperative for DHS.

  Paras 10.70 to 10.76

HUMAN RESOURCE MANAGEMENT *- continued* *Page 291*

- There are a number of opportunities available to DHS to further build on the sound progress it has made in the provision of training to workers within protective services.

  Paras 10.77 to 10.82

- There would be merit in DHS undertaking a wide-ranging assessment of work practices in its protective services.

  Paras 10.99 to 10.105

DEATHS OF CHILDREN UNDER PROTECTION *Page 317*

- An excessively long time is taken by DHS to complete and report to the Parliament on inquiries into deaths of children who are under the care of protective services or subject to investigation of protective concerns.

  Paras 11.22 to 11.25

- DHS has responded effectively to address weaknesses in its case management procedures identified in inquiries into child deaths.

  Paras 11.30 to 11.34

- It is expected that the newly established Victorian Child Death Review Committee will raise the standard and timeliness of inquiries into and reporting on child deaths.

  Paras 11.39 to 11.42

APPEALS AND COMPLAINTS *Page 331*

- While parents' complaints on the actions of protection workers raised formally with central DHS management were adequately followed-up, there was a need for DHS to strengthen the procedures in place within regions for the handling of complaints.

  Paras 12.17 to 12.25

- Scope exists to improve the credibility and accessibility of processes followed in regions for the review of appeals by parties against case planning decisions of DHS.

  Paras 12.26 to 12.30

- DHS should establish a framework which enables children and young people under its care and protection to voice their opinions and concerns, without prejudice or fear of retribution, to achieve the best outcomes for their care.

  Paras 12.47 to 12.54

PREVENTION AND EARLY INTERVENTION *Page 347*

- While there has been significant expenditure by a number of government agencies on measures to help prevent child abuse and neglect, there is now a need to evaluate the effectiveness of such measures within the framework of the National Prevention Strategy.

  Paras 13.7 to 13.19

- The effectiveness of the various primary care services provided by DHS in helping to prevent child abuse and neglect would be further enhanced by a more definitive focus by such services on prevention.

  Paras 13.20 to 13.63

- DHS has initiated a number of pilot projects aimed at reducing the number of notifications primarily involving welfare concerns to enable resources to be directed to higher risk protective issues.

  Paras 13.70 to 13.75

Part 2

The nature and importance of child protection

CONCEPT OF PROTECTION AND THE RIGHTS OF INDIVIDUALS

2.1 Throughout history, civilised communities have provided for the safeguarding of the rights of individuals, through the promulgation of a significant body of law, and for the protection of those members of society who, for various reasons, are unable to protect themselves. Special attention therefore, has been focused upon the elderly, the sick, the physically disabled, and children because of their reduced capacity to protect and care for themselves. The extent to which a nation has displayed compassion for, and protection of, these special or needy groups is often used as a major benchmark to measure the quality of life of its citizens and the degree of social progress and values of these nations.

RIGHTS OF CHILDREN

2.2 In November 1989, the United Nations adopted *"The Convention On The Rights Of The Child"*; Australia is a signatory to this Convention.

2.3 The Convention recalls that, in the Universal Declaration of Human Rights, the United Nations proclaimed that childhood is entitled to special care and assistance because of its vulnerability by reason of its physical and mental immaturity. Rights of children specifically identified in the Convention include the right to survival and development, to a name and nationality, a right to live with the parents, a right to protection from abuse and neglect (Article 19), and a right to the highest attainable standard of health and medical care.

PRIMARY ROLE AND RESPONSIBILITY OF THE FAMILY

2.4 The Convention also recognises that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding. It also identifies the family as the fundamental group of society and the natural environment for the growth and wellbeing of its members, particularly children.

2.5 In acknowledging the special place of the family in the lives of children, the Convention gives recognition to the responsibilities, rights and duties of parents and the extended family and guardians in providing appropriate direction and guidance to the child and in ensuring that the best interests of the child will be their primary concern. The family, therefore, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

ROLE OF GOVERNMENT

2.6 While placing special emphasis on the primary caring and protective responsibility of the family, the Convention on the Rights of the Child also reaffirms the role of governments, welfare institutions, courts of law, administrative authorities etc., and the need for legal, mental and physical protection of the child where its family is unwilling or unable to do so. Article 19 of the Convention, in particular, requires that the State shall protect the child from all forms of maltreatment by parents or others responsible for the care of the child and establish appropriate social programs for the prevention of abuse and the treatment of victims.

VIOLATION OF CHILDREN'S RIGHTS THROUGH CHILD ABUSE

Definition of child abuse

2.7 Child abuse is the maltreatment of children or the violation of their rights through the deliberate infliction of physical, emotional or sexual harm on the child. Not all actions which result in the maltreatment of children however will invoke protective intervention by the authorities as the legislation (in Victoria) requires that there must be a likelihood of significant harm to the child and the parents are unwilling or unable to protect the child. In essence, therefore, if the parent/s are protective of children, the protective services mandate does not allow for protective intervention to occur.

2.8 The Department of Human Services (DHS) has defined the following 4 major types of abuse.

CHART 2A
TYPES OF CHILD ABUSE

Physical abuse involves any non-accidental injury to a child by a parent or care-giver. The injury may take the form of bruises, cuts, burns or fractures.

Sexual abuse occurs when an adult or someone bigger and/or older than the child uses power or authority over the child to involve the child in sexual activity. Physical force is sometimes involved. Child sexual abuse involves a wide range of sexual activity. It may include fondling of the child's genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or other object, or exposure of the child to pornography.

Emotional abuse occurs when a child is repeatedly rejected or frightened by threats. This may involve name-calling, being put down or continual coldness from the parent or care-giver to the extent that it affects the child's physical and emotional growth and development.

Neglect is the failure to provide the child with the basic necessities of life, such as food, clothing, shelter and supervision, to the extent that the child's health and development are at risk.

Source: *"Reporting Child Abuse - Training Package"*, Victorian Department of Human Services.

2.9 Child abuse occurs every day in our community when children are bruised, beaten, burned, sexually exploited, rejected, starved, abandoned, belittled and humiliated.

Extent of child abuse

2.10 The National Child Protection Council stated that, in Australia, the numbers of children reported and confirmed abused have continued to increase over the years. This could be due to a greater community awareness rather than an increase in occurrence of child abuse. Educative and legislative changes e.g. the introduction in 1993 of mandatory reporting in Victoria, also mean that professionals are becoming more adept at recognising child abuse with resultant higher notification rates, while members of the community are identifying and responding to the issues of child abuse more frequently. In Victoria, during 1993-94, 6 116 cases of child abuse were substantiated compared with 7 326 for the 1994-95 year, representing a 19 per cent increase in the latter year.

2.11 It should be remembered that the extent to which child abuse occurs is not known. What is known is the extent to which it is reported to authorities. Statistics compiled by authorities, therefore, are only indicative of reported or substantiated abuse but not of the overall occurrence of child abuse.

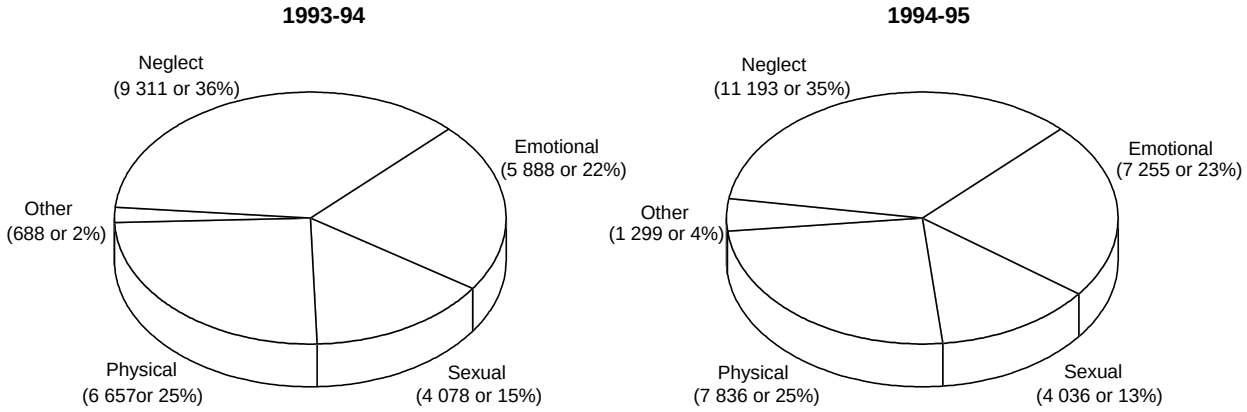
2.12 While the introduction of mandatory reporting has served to ensure the establishment of a momentum, in this State, in terms of arousing the public's awareness and involvement in child protection issues, there exists the need to take advantage of this trend to continue progress towards the achievement of even greater levels of awareness and reporting of child abuse. In essence, the community cannot assume that the increase in the number of reports of child abuse will necessarily lead to a significant decrease in the number of children at risk, nor that mandatory reporting is the most effective way to protect children from abuse. It is one means of broadening the community's net for capturing notifications of suspected child abuse and, as a consequence, significant administrative mechanisms are subsequently required to process and distil the many notifications to eventually highlight those children which are actually at risk of significant harm. This activity is very resource-intensive and, as is shown in this Report, not foolproof, in that some children at risk will inevitably fall through the net.

2.13 It is maintained by some, therefore, that it is just as appropriate to allocate available finite resources towards the adoption and extension of primary care services such as preventative community education and family support, as it is to maintain the mandatory reporting framework. Clearly, there is a need to strike a fine balance between the need to ensure all cases of abuse are appropriately reported and as much as possible is done to ensure that abuse never eventuates in the first instance.

Frequency of each type of child abuse

2.14 During 1994-95, DHS received 31 619 notifications of suspected child abuse. This figure compares with 26 622 notifications for 1993-94 and represents an increase of 4 997 notifications, or 19 per cent. The extent of the 4 types of abuse notified during the 2 years is shown in Chart 2B.

CHART 2B
TYPES OF SUSPECTED CHILD ABUSE NOTIFIED TO DHS



Source: Protective Services Annual Statistical Report 1993-94 and 1994-95, DHS.

2.15 Of the abuse notifications that have been substantiated, both men and women about equally commit physical abuse, emotional abuse and neglect. These types of abuse are commonly perpetrated by the parent that spends the most time with the child. Perpetrators of substantiated child sexual abuse, however, are overwhelmingly male (98 per cent) and the victims are generally females (77 per cent), although among those reported, many boys are also sexually abused (23 per cent). It should be also noted that some consider that female perpetrators of sexual abuse are under-reported.

2.16 The Australian Institute of Criminology stated in its publication *Trends and Issues No. 53, March 1996*, that one in twelve homicides in Australia involves a child under the age of 15, that children under the age of 1 are the most vulnerable and that child abuse is often the forerunner of child homicide incidents. In fact, for those under one year of age, the number of deaths by homicide equals or exceeds the number of deaths caused through motor vehicle traffic accidents, accidental poisonings, falls or drownings.

Factors that cause persons to abuse children

2.17 Child abuse occurs across all socioeconomic, religious and ethnic groups. No one single cause, or even small number of common causes, can be linked to the perpetration of all child abuse. However, it is possible to discern some common characteristics of family situations which often work in combination to exacerbate individual risk factors and comprise a combination of different elements which lead people to abuse children. These factors have been identified by The National Child Protection Council and include personal factors, family factors and community influences.

Personal factors

2.18 Child abuse, as currently reported, is often perpetrated by persons with low levels of parenting skills. This deficiency may also be exacerbated by problems with coping, self-control and low levels of self-esteem. Persons who abuse children often face serious marital problems, may have attained a lower level of academic achievement and possess a general deficiency in interpersonal skills. Some child abusers may have a background of violence in their family or may have been themselves subjected to abuse. Specific events such as unwanted, early or premature pregnancies, occurrence of physical or mental illness and poor ability of parents to relate to their children can markedly increase the likelihood of child abuse.

Family factors

2.19 Family factors which often feature in child abuse include situations of social stress and social isolation, particularly with respect to certain religious and ethnic groups, poverty, unemployment and inadequate housing. Confronted with these family environments, parents often resort to drug and/or alcohol abuse and, faced with a lack of necessary support networks to assist them to overcome their difficulties, eventually take their frustrations out on their children.

2.20 While adults are generally responsible for the abuse of children, certain inherent characteristics prevalent in some children act in tandem with adult factors and are likely to provoke or increase the likelihood of child abuse. These characteristics may include the emotional or behavioural temperament of individual children, their age, physical development or impairment, any psychological or emotional deficiencies and their demands and level of reliance on parents.

Community factors

2.21 The above analysis can be extended to indicate that low income (as evidenced by pension/benefit affiliation and lack of home ownership) family breakdown (as evidenced by sole parenthood and high mobility) and an acceptance of violence (as evidenced by domestic violence) are structural factors connected with child abuse. While the causal mechanisms of child abuse are still unclear, it appears that poor economic conditions and a community climate which accepts violent behaviour provide a framework in which adverse family and personal factors are more difficult to remedy.

IMPACT OF CHILD ABUSE ON THE CHILD, THE FAMILY AND THE COMMUNITY

2.22 Clearly, the greatest impact of child abuse is on the abused child. Recent research indicates that the immediate effects of child physical abuse can be devastating to the child and can result in mental and social retardation, brain damage or even death. In recent years, Victorians have been constantly and graphically reminded of the horrific consequences of child abuse by media emphasis on certain high profile child death cases.

2.23 While, in certain instances, child abuse can be stopped and the effects on the child addressed by early detection, timely intervention and expert treatment, the long-term consequences can be just as devastating. These consequences can include mental illness, violent tendencies and aggressive behaviour, difficulty in establishing lasting relationships and interacting with other members of the community. Distrust of others, lack of self-esteem, self-destructive behaviour such as mutilation and suicide, substance and alcohol abuse, and perpetration of crime are also common consequences of abuse. Some child abusers were themselves abused as children and have grown up in violent family environments. To these individuals, child abuse and family violence can become an accepted way of life although it does not necessarily mean that they will abuse their children.

2.24 It was previously mentioned that child abuse commonly occurs in families which, for many and varied reasons, find themselves, and their individual members, under significant levels of stress. In the majority of cases, it is possible for support and services to be provided to these families so that existing stresses can be effectively reduced to levels which significantly reduce the risks to the children without the removal of the children from the family environment. These are the more fortunate families. In some instances, however, the abused children leave the family environment to face life homeless, without adequate support, accommodation, education and safety.

2.25 Family units, and individual members of the family, are often unable to recover from the negative impacts of child abuse and to overcome the destructive effects of stresses which negatively influence the family environment, notwithstanding the provision of significant levels of servicing and support. In the most severe of cases, there exists little option but to remove the abused child from the care and custody of the family and for the State to undertake the responsibilities of parents.

2.26 While the costs, in a non-financial sense, to the abused individual will usually be extreme, the community eventually meets the financial costs of the rehabilitation and treatment of abused children and their families through the intervention of government entities such as DHS or through the implementation of government welfare and health and correctional programs. It has consequently been necessary, in Victoria, and throughout the Western World, for the establishment of sophisticated infrastructures of government and non-government entities to deal with the phenomena of child abuse and neglect. This Report deals with the operation of such child protection infrastructures in Victoria.

Part 3

Conduct of the audit

IMPETUS FOR AUDIT

3.1 The decision to conduct an examination of the provision of child protection services in Victoria, as a performance audit on behalf of the Parliament and community, was principally prompted by a growing awareness within the community of the importance of protecting children from abuse and neglect. It was also deemed desirable to assess the impact of the introduction in Victoria of mandatory reporting by certain professional groups of suspected child abuse or neglect.

3.2 A performance audit in this subject area was endorsed by the Public Accounts and Estimates Committee of the Parliament following consultation by the Auditor-General with the Committee on annual performance audit planning, as required by the *Audit Act* 1994.

AUDIT OBJECTIVES

3.3 The overall objective of the audit was to assess the effectiveness of the provision of child protection services to the Victorian public by government and private sector service providers engaged under service agreements with government, and the level of efficiency and economy achieved in the management and delivery of such services.

3.4 In particular, the audit sought to determine whether:

- the needs of Victorian children requiring protection are satisfied with due regard to their dignity and their rights;
- the service infrastructure and resources dedicated to the protection of children in the State are effectively organised and co-ordinated to ensure that child protection services are provided promptly, efficiently and equitably; and
- funding of child protection services is adequate, administered efficiently and provides maximum benefit to the children of the State.

SCOPE OF THE AUDIT

3.5 In the preliminary planning for this audit, it became evident that the issues in child protection were highly significant and very wide ranging and that, in addition to the important role of the Department of Human Services, many other entities play a critical and integral role in the protection of children in the State and the provision of pertinent welfare services.

3.6 It was considered, that, in order to maximise the value of the audit to the Parliament, the broader community and the Government, the scope of the audit should be expanded to encompass the activities of other important entities which participate in the child protection process. These entities included the Children's Court, Victoria Police, and non-government agencies which provide a variety of support and services to protected children and their families.

3.7 The audit was performed in accordance with Australian Auditing Standards applicable to performance audits and accordingly included such tests and other procedures considered necessary in the circumstances.

INPUT TO THE AUDIT BY MANY ORGANISATIONS AND INDIVIDUALS

3.8 The widespread public interest in child protection issues suggested to audit that it would be appropriate for any individuals or organisations which may wish to contribute to the issues to be given an opportunity to do so. Consequently, a notice was placed in selected, but widely circulated newspapers in Melbourne, Geelong, Ballarat, Bendigo and Gippsland, inviting submissions to the audit team. Comments subsequently provided in these submissions were carefully considered for inclusion in the audit programs. Overall, more than 100 submissions were received from various groups and individuals including mandated notifiers, practitioners, welfare organisations, trade unions and individuals. In addition, the audit team travelled around the State to take verbal comments from individuals who were, for a variety of reasons, unable to provide written submissions.

SPECIALIST ADVICE OBTAINED BY AUDIT

3.9 Specialist advice on selected areas covered by the audit was provided to the audit team by Professor Jan Carter of Deakin Human Services Australia, Deakin University and Dr Dorothy Scott of the School of Social Work at the University of Melbourne.

3.10 In addition, reference was made by audit to a number of other professionals in the child protection arena, in the following areas:

- the judiciary;
- social welfare;
- the legal profession;
- child psychologists;
- law enforcement; and
- forensic medicine.

ASSISTANCE PROVIDED TO AUDIT

3.11 The management and staff of the Department of Human Services provided significant support and assistance to audit. Assistance was also provided by Victoria Police and the many groups and individuals mentioned in the preceding paragraphs.

3.12 Audit wishes to acknowledge the contribution that this assistance made to the conduct of the audit and the preparation of material for this Report.

Part 4

Notification and investigation of child abuse

OVERVIEW

4.1 The child protection system acts in response to reports, or *notifications*, of knowledge or suspicions of child abuse or neglect. Notifications traditionally come from members of the public, family and friends of the children, and a range of professionals such as teachers and nurses who have frequent contact with children.

4.2 One of the most significant influences on child protection activities in recent years was the introduction of *mandatory reporting* in November 1993, which placed legislative requirements on medical practitioners, nurses, police and, more recently, teachers, from July 1994, to report suspected serious physical or sexual abuse of children. This legislation, in conjunction with an increased public awareness of child abuse, resulted in significant increases in notifications not only from mandated notifiers, but also from the general community. Other significant developments in child protection, in recent years, have included the implementation of the Children and Young Persons Act, completed in 1992, and the introduction of the single track - welfare-based child protection system in February 1992.

4.3 The audit established that the Department of Human Services (DHS) was largely unprepared for the introduction of mandatory reporting and substantially underestimated the projected increase in notifications, calculated at 8 per cent. Notifications subsequently rose by 38 per cent in the first year and have risen steadily since.

4.4 DHS adopted a range of strategies to address the resourcing problems arising from the need to investigate the large increase in notifications which warranted further inquiry. These strategies were assisted by additional funding from the Government of $9.4 million a year since mid 1994, and have enabled the child protection services to stabilise since the latter part of 1995.

4.5 Notwithstanding the commendable effort of DHS in restructuring its services so as to better address child protection in Victoria, including the provision of accommodation and support to children in care, there remains a number of areas where further improvements are warranted, including:

- In focusing investigations only on those notifications where risks to children are seen as more serious, the ratio of initial investigations to notifications has dropped to 49 per cent in 1994-95, as compared with 57 per cent in 1993-94. Although this level represents the extent to which existing resources of DHS can undertake investigations, audit considered from its review of notifications that up to 20 per cent of notifications should have been investigated further instead of being closed;
- The incidence of re-notifications of suspected abuse was around 32 per cent of all notifications in 1993-94. This high incidence of re-notifications was a reflection on cases that should have been investigated further in the first instance;
- A limited number of mandated professionals are adopting particular strategies to avoid making notifications direct to DHS in a timely manner;

OVERVIEW - *continued*

- Improved liaison between DHS and the Department of Education is warranted to address concerns arising from mandatory reporting by teachers;
- There was scope for improvement in the general standard of investigations undertaken by protection workers, as evidenced by the poor planning, documentation, conduct of investigations and lack of a risk-based methodology; and
- More attention needs to be given to addressing welfare concerns in families detected from notifications that did not warrant investigation for child abuse, but which could lead to serious situations in the future.

4.6 In summary, the introduction of mandatory reporting in conjunction with increased community awareness of child abuse and neglect has led to constantly increasing levels of notifications to DHS, thereby absorbing a large amount of resources. Notification and investigation of child abuse will not prevent the incidence of child abuse occurring in the community, but highlights the urgent need for governments both at a State and National level to develop prevention strategies to address the various factors that can eventually lead to a reduction of children being abused and neglected in Victoria.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department notes audit's conclusion that the injection of an additional $20.4 million with Child Protection Services since 1994 has meant the program has stabilised since the latter part of 1995.

The Department continues to monitor program performance rigorously and undertakes action to address identified shortcomings. Action currently in train to improve the quality of investigations involves the Initial Decision Making Audit Project, the Impact of Mandatory Reporting Research and the production of Protecting Children manuals including "Responding to High Risk" and "Risk Assessment" guidelines.

Further work is also under way to determine the reasons for renotifications. Comparative data produced by the Council of Australian Governments (COAG) show that Victoria recorded a re-substantiation rate of 4 per cent in comparison with NSW 11 per cent and Queensland 16.4 per cent. In 1994-95, COAG data also indicates that Victoria's rate of substantiated child abuse is above the national average, second only to New South Wales.

Audit's failure to examine the Department's response to after hours notifications and investigations received through the Central and Rural After Hours Child Protection Service is particularly disappointing, as 19 per cent of all notifications and 21 per cent of all investigations are managed by this service. This omission seriously undermines audit's findings. Since March 1989, Victoria has had the most specialised and accessible after hours service in the country. This service has received notable acclaim, including from Justice Fogarty in his 1993 Report, and gives Victoria a 24 hour, 7 days a week child protection response.

In referring to the level of experience in this area within the workforce currently, audit takes a lowest common denominator approach and ignores the broader level of experience and skill that exists within the child protection workforce at large. Similarly, audit ignores efforts by the Department to attract more experienced staff into the child protection workforce by increasing the SOC-1 and SOC-2 ratio to 50-50. This has enabled the program to attract a number of experienced staff, and is also a measure intended to assist in the greater retention of experienced child protection staff.

It is of concern that in making several suggestions and recommendations for service improvements in this Report, audit makes no significant effort to cost these either in terms of resources required, relative efficiency, or impact upon families. The Department is taking steps to improve service outcomes for clients, along some of the lines suggested by audit in this Report, within the resources currently available and the spirit of the existing legislation.

BACKGROUND

4.7 The *Children and Young Persons Act* 1989 provides that a child is in need of protection if:

- it has been abandoned, the parents cannot be found and no other suitable person is willing and able to care for the child;
- the parents are dead or incapacitated;
- the child has suffered, or is likely to suffer, significant harm as a result of physical or sexual abuse and the parents are unlikely to protect it from future harm;
- it has suffered or is likely to suffer emotional or psychological harm; or
- its physical development or health has been or is likely to be significantly harmed by neglect.

4.8 The Act designates DHS and Victoria Police as protective interveners where a child is seen to be in need of protection. A *notification* arises when any person witnesses child abuse or believes on reasonable grounds that a child is in need of protection and these agencies are informed accordingly. Where abuse of a criminal nature such as serious physical assault or sexual abuse is believed to have occurred, in accordance with government policy, the agency receiving the notification must advise the other agency, with DHS pursuing the grounds for protection and Victoria Police undertaking the criminal investigation.

4.9 While members of the community often notify DHS of cases of suspected child abuse, the legislation specifically identifies a number of professions whose members, are designated as mandated notifiers and are required to report to DHS instances where they have a reasonable belief that either sexual or physical abuse of a child may have occurred. This process, known as *mandatory reporting*, was announced by the Government in March 1993 and became operational in November 1993. To date, medical practitioners, members of Victoria Police and nurses (from 4 November 1993) and teachers (from 18 July 1994) have been mandated.

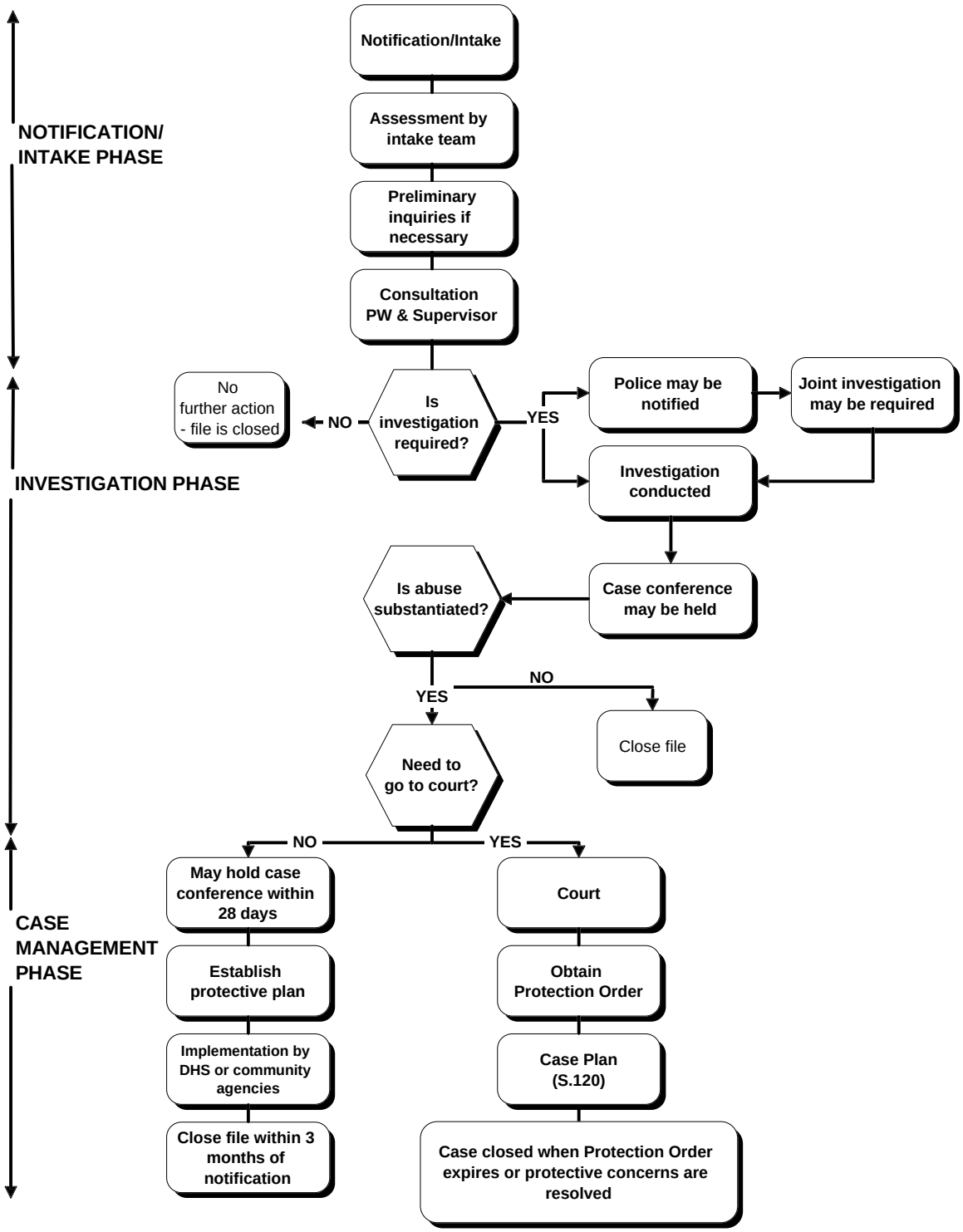
4.10 The majority of notifications are made by family members, friends, neighbours and other non-mandated persons, comprising around 59 per cent of all notification in 1994-95 (73 per cent, 1993-94). The remainder of notifications come from mandated professionals, mainly from Victoria Police and teachers and the level of mandated notifications is gradually increasing.

4.11 Upon accepting notifications, the protective services duty officers within DHS discuss the substance of each notification with their supervisors and decisions are made as to whether preliminary inquiries should be made in order to obtain additional corroborative information about the existence or otherwise of suspected protective concerns. These preliminary activities are commonly referred to as the *notification/intake phase* of the child protection process. Depending on the outcome of these inquiries in terms of whether the risk of suspected significant harm is minimal or otherwise, the case will either proceed to *investigation*, usually within 7 calendar days, or be closed with no further action taken. In the case of serious allegations, a decision may be made to proceed immediately to an investigation and possible removal of the child from its family, especially where the child is seen to be in immediate danger.

4.12 Of the 31 600 notifications received during 1994-95, around 15 600 or 49 per cent were investigated, while the remaining 16 000 or 51 per cent were closed.

4.13 Chart 4A illustrates the overall child protection process within DHS which can be divided into 3 major phases, namely, the Notification/Intake phase, the Investigation phase and the Case Management phase.

CHART 4A
CHILD PROTECTION PROCESS WITHIN DHS



4.14 While the Children and Young Persons Act requires that notifications be investigated where there are reasonable grounds to believe that child abuse has occurred, it also emphasises a need to minimise intervention into a family and to give the widest possible protection and assistance to the family. The quality of decision-making in the notification/intake phase is therefore critical in terms of focusing only on those notifications where intervention is warranted.

4.15 Where the investigation substantiates that abuse has occurred and the child is assessed to be at risk, DHS will endeavour to address the protective concerns through strengthening the capacity of the family to protect the child by the provision of welfare and support services, usually by referring the family to a non-government welfare agency.

4.16 It is only where a child is not considered safe within a family, even with the provision of supports, that DHS will intervene, remove a child and apply for a Protection Order from the Children's Court. Even where the child has been removed and a Protection Order granted, DHS will continue to work with the family, where possible, through the provision of support services with a view to attempting re-unification of the child with its parents when it is considered safe for the child to return home.

INTRODUCTION OF MANDATORY REPORTING

Impact of mandatory reporting on notifications to DHS

4.17 In February 1989, Mr Justice Fogarty, in a report on Victoria's child protection system entitled *Protective Services for Children in Victoria* recommended that the then existing dual track system, whereby child protection investigations were conducted by both Victoria Police and DHS, be terminated and that over a 3 year period commencing from 1989 the prime responsibility for child protection services be transferred to a welfare-based system within DHS. The recommendation was accepted by the Government and the transfer of responsibility was completed in March 1992. However, the transfer was not accompanied by a commensurate shift of resources to enhance the capacity of DHS to absorb the additional workload by assuming responsibilities for child protection activities previously undertaken by Victoria Police. This meant that by the time the Government introduced mandatory reporting in November 1993, in response to intense community debate following several highly publicised deaths of children from child abuse, DHS was already under significant workload pressure.

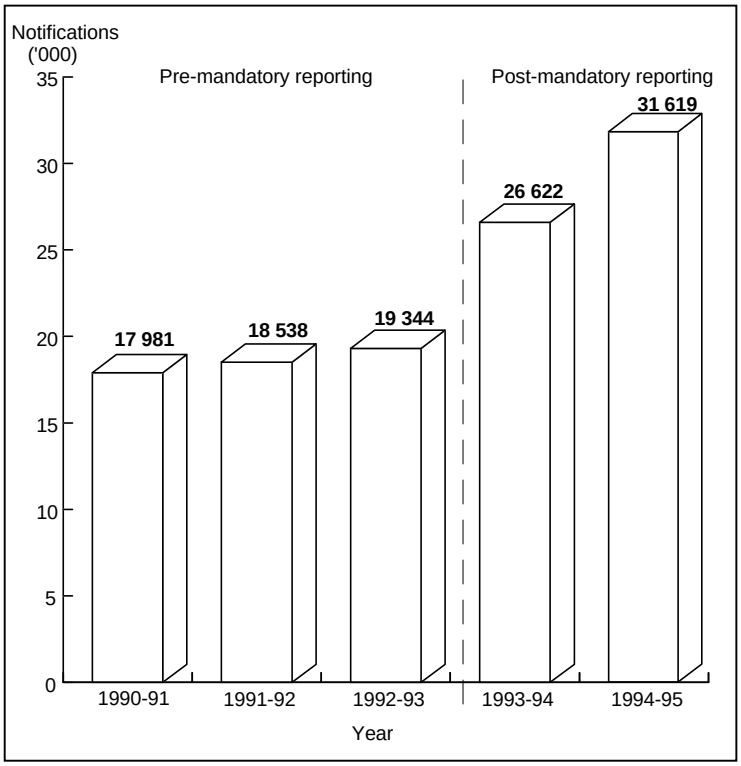
4.18 In August 1993, in preparation for the introduction of mandatory reporting, DHS estimated that the rate of increase in notifications of suspected child abuse was likely to be in the order of 1 520 notifications a year, representing an expected 8 per cent increase. Based on the projected increase of 8 per cent, additional program funding of only $1.8 million in 1993-94 was **requested**, notwithstanding that the introduction of mandatory reporting in other States in Australia had experienced average increases in notifications of around 20 per cent a year.

4.19 The Department agreed that significant underestimations of likely notification numbers did occur. The impact of this situation can be best summarised from a report of March 1994, prepared by DHS which identified:

- That monthly increases in notifications reached a peak in December 1993 (79 per cent), with some moderation in the rates of increase in January 1994 (39 per cent), February (45 per cent) and March (42 per cent);
- Significant increases in reporting by mandated notifiers from November 1993 to March 1994, of 221 per cent by nurses, 164 per cent by doctors, albeit from a small base, and 38 per cent by police officers. Of added interest was an increase in notifications of 57 per cent by teachers, who had not at the time been mandated;
- An initial increase in the contribution to total notifications by professionals from 21 per cent of the total in 1992-93 to 26 per cent in January 1994 subsequent to their mandating in November 1993. (This percentage of total notifications has since increased to 41 per cent in June 1994-95 mainly due to the mandating of teachers.); and
- Extreme variations among regions in numbers of notifications, with Eastern Metropolitan reporting an overall decrease and Western Metropolitan a 156 per cent increase, Loddon Mallee 112 per cent increase and Southern a 78 per cent increase.

4.20 Chart 4B shows the notifications received by DHS between 1990-91 to 1994-95.

CHART 4B
NOTIFICATIONS RECEIVED BY DHS
FROM 1990-91 TO 1994-95



Source: Department of Human Services.

4.21 Chart 4B shows that in 1993-94, during which mandatory reporting was introduced, an additional 7 278 notifications, representing an increase of 38 per cent were received by DHS and a further 19 per cent increase in 1994-95. The sustained increase in notifications impacted severely on the capacity of protective services to respond.

4.22 **The introduction of mandatory reporting in Victoria placed significant workload pressures on DHS, which were accentuated by an initial underestimation of resourcing requirements.**

Action taken by DHS in response to increasing workload

4.23 Faced with an environment of significant financial constraints on public spending, spiralling notification levels, a severely strained workforce often under intense public scrutiny and media attention, DHS in 1994, adopted several strategies to increase service capacity to meet the growth in workload, including:

- internal redeployment of $1.8 million during 1993-94 to protective services;
- the internal transfer of protective workers from long-term case management to the notification/intake phase to assist in reducing the backlog of notifications awaiting investigation;
- securing an amount of $1.85 million in March 1994 from the Community Support Fund to employ an additional 62 child protection workers while longer-term strategies could be finalised;
- further education of mandated professionals, in an effort to minimise the occurrence of inaccurate notifications;
- redevelopment of placement and support services (separate detailed audit comment on this redevelopment over 2 years from June 1993 is contained in Part 6 of this Report); and
- the conduct of a detailed *Workload Review* in order to re-engineer protective services.

4.24 Despite the above actions, DHS continued to experience difficulty in meeting demands. In an internal report entitled *"Impact of mandatory reporting on protective services"* issued in June 1994, advice was provided to management that 14 per cent of notifications were not capable of being investigated within 5 working days, the performance standard set by the Department. In addition, at any point in time, 7 per cent of children under Protection Orders were not supervised by case workers, as a consequence of transferring long-term case workers to the notification/intake phase. The report also found that *"... a significant number of cases referred for investigation had not received adequate follow-up because of the pressure to respond to new notifications. Backlogs in assessments were developing and the quality of the protective response was seriously compromised"*.

4.25 On the basis of the June 1994 report, DHS decided that any further reduction in quality standards could not be supported, as the risks associated with this would be substantial. In particular, the risk of death or serious injury to a child would be likely to increase if standards were further reduced. The Government recognised the difficulties experienced by DHS and in 1994-95 allocated to the Department an increase of $9.4 million in funding for child protection services, which absorbed the earlier increase of $1.85 million, **with the net increase of $7.5 million** anticipated to enable DHS to process an additional 23 per cent of notifications. For 1995-96, this amount was included in the child protection base budget of DHS, thereby maintaining the 1994-95 funding levels.

4.26 A further $5.9 million was also approved for distribution from the Community Support Fund in 1995-96 to fund, over a 3 year period, a range of pilot projects designed to support families in crisis. While this funding is not directly applicable to child protection activities, DHS envisaged that the projects will be beneficial in terms of the prevention of child abuse.

4.27 The additional annual funding of $9.4 million, representing a percentage increase in budget of around 30 per cent since July 1994, has made a significant contribution to the operational capacity of protective services, including:

- an enhanced capability to commence investigations on a more timely basis (within 7 calendar days of notification) through the employment of additional protective workers, supervisors and managers;
- the appointment of administrative support officers and case support workers, to assist protective workers and enable them to give greater concentration to field work in protective services;
- the transfer back to long-term case management of various protective workers that had previously been redeployed to intake teams to assist in alleviating investigation backlogs; and
- an enhanced capacity to provide induction training to recently recruited staff and ongoing training to existing workers.

4.28 **Under the circumstances it faced in 1993 and 1994 with minimal planning for mandatory reporting and an environment of budget constraints, DHS has endeavoured to reshape its workforce and resources to meet the extremely challenging demands placed upon it. These actions were aimed at alleviating the burden carried by its workforce which has been severely stretched in terms of workloads, working conditions, a high stress environment and, at times, public criticism. DHS has been fortunate that despite these factors, most of its child protection workforce have a strong work ethic and commitment to undertaking an extremely difficult task.**

Weaknesses in the operation of mandatory reporting

Strategies employed by mandated notifiers to circumvent mandatory reporting requirements

4.29 From examination of case files and discussions held with welfare agencies, protective workers and mandated notifiers, audit became aware that some notifiers adopted strategies to avoid their obligations under mandatory reporting.

4.30 Instances were identified where mandated notifiers had reported concerns to welfare agencies rather than DHS. The agencies subsequently conducted their own inquiries and, if protective concerns were found, it then became the responsibility of agencies rather than the mandated professionals to report the abuse to DHS. This allowed the mandated notifier to avoid the necessity to make a direct notification to DHS, and also reduced the potential for conflict between the mandated notifier and the child and family. Some protective workers advised audit that they supported this approach as the assessments made by welfare agencies acted as a screening process and consequently only higher risk cases would be eventually notified to protective services. Acceptance of the practice also reduces the level of notifications which may require investigation.

4.31 Audit considers that allowing this practice to continue creates a potential risk to the child, as the agency staff are generally not skilled in child abuse investigations. Even if skilled staff are available or abuse or neglect are obvious, the agency may not be able to conduct inquiries for some time, if at all, due to its other responsibilities. Further, the welfare agency has no specific legislative authority to carry out inquiries in order to assess notifications and, more importantly, in cases of possible sexual or serious physical abuse, the alleged perpetrator may be alerted to the fact that an investigation by DHS and possibly Victoria Police is likely to take place in the near future and commence concealing the abuse, for example by intimidating the child.

4.32 A second strategy adopted by mandated notifiers in the education area is for a school or teacher to make a notification at the end of a day or last day of a week, so that DHS is unable to conduct the interview on the premises. The notifier anticipates that by the next working day protective services will have responded and conducted inquiries without a need for an interview on campus. Additionally, this strategy was seen by the notifier as saving the child some potential embarrassment or unwanted publicity on campus and avoiding possible identification of the notifier to the parents. In audit opinion, a specific disadvantage of this strategy is that the delaying of notifications can lead to further abuse of a child. In addition, notwithstanding the importance of protecting the confidentiality of the notifier and the privacy of the child, DHS has a preference for on-campus interviews because the environment is neutral for the child and, at the same time, familiar.

4.33 Discussions with protective workers and representatives of the teaching profession led audit to conclude that the adoption of the above strategy by teachers can largely be attributed to a negative image of protection workers in terms of the manner in which inquiries may be conducted. There was also a lack of a consultative mechanism for teachers to seek advice from DHS prior to making a formal notification.

4.34 The above situation suggests that there is scope for an improved relationship between schools and DHS through measures by the parties such as:

- negotiating revised protocol arrangements whereby visits to schools by protection workers are accepted as necessary but are conducted in a discreet and unobtrusive manner by prior arrangement with schools;
- teachers, as mandated notifiers, becoming fully conversant and accepting the difficult role that protection workers must perform in acting quickly on suspected child abuse; and
- provision by DHS of a consultancy or advice service to mandated notifiers, whereby the merits of notifications could be discussed prior to DHS accepting a notification.

4.35 **It became clear to audit that DHS was not in a position to assess the extent of avoidance of responsibilities by mandated notifiers or whether corrective action is warranted as comprehensive data on the incidence of avoidance is not maintained.**

Lack of responsiveness, feedback and communications with notifiers

4.36 The DHS Policy Advice and Practice Manual requires workers to advise notifiers of the outcomes of notifications. In discussions with mandated notifiers and other professional groups, audit was frequently advised that feedback on the outcomes of notifications to DHS was not conveyed back to the notifier, leaving the impression that no action had been taken. Such feedback from DHS is seen as particularly important in instances where a professional, such as a doctor, is working with a child or a family and knowledge of the details of the protective intervention by DHS would be relevant to the effective treatment of the patient.

4.37 Professionals interviewed by audit indicated that a decision to make a notification requires a lot of thought as to the justification and likely impact of such an action. The absence of effective feedback can significantly diminish the confidence of both mandated and other professionals in the child protection system and encourages a reluctance by professionals to make notifications in the future, if they cannot be assured of action taken.

4.38 DHS acknowledged the problem but advised audit that workload pressures and difficulties often experienced in making contact with notifiers precluded workers from always providing feedback to notifiers. However, DHS has not sought to identify the extent of this problem and determine the most effective approach from a risk management viewpoint.

4.39 **The ongoing effectiveness of the mandatory reporting system depends on maintaining the confidence of mandated notifiers and other professionals in the system. It is therefore important that DHS reinforces to workers the importance of promptly advising notifiers, wherever practical, of the outcomes of notifications, with due regard to the privacy of families involved, and institutes suitable risk management procedures for the provision of feedback.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  A consultancy service is provided by child protection through the intake system on many of the notifications on which no further action is taken. A significant number of notifications which do not proceed to an investigation are managed within the community who seek advice from protective services. The Department has already promulgated a practice instruction in relation to feedback to notifiers .

Concerns expressed by schools

4.40 Discussions between audit and professional groups within the primary and secondary school system disclosed a large number of concerns with respect to Mandatory Reporting, including:

- teachers making notifications becoming unintentionally, but readily identified and subsequently subject to threats from irate and abusive parents;
- difficulties experienced by teachers and schools in identifying the responsible worker in case of need for further communications;
- responsibility for monitoring of children subject to notification was often placed back to schools or teachers;
- lack of courtesy and respect for the school environment when protection workers entered school premises;
- an absence of ongoing training in mandatory reporting; and
- need for more instruction to teachers on detecting potential abuse, assessing disclosures made by children and the level of evidence necessary prior to making a notification.

4.41 It was not possible for audit to gauge the extent to which the above concerns existed. However, given that these problems were extensively repeated to audit in submissions and discussions with staff employed by State and private schools, it became apparent that the issues were of considerable importance and needed to be addressed by the various parties.

4.42 **Audit considered that greater liaison was necessary between senior representatives of both DHS, and the private and State school systems in order to communicate concerns and develop solutions, possibly through ongoing development of protocol arrangements and addressing training requirements for teachers as mandated notifiers.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department considers that the issues documented as "Concerns Expressed by the Education Sector" are anecdotal, subjective and overstated. Nonetheless, the Department has initiated with DSE a joint review of the existing protocol, and is committed to developing more effective working arrangements with the education sector, which includes resolution of disputes at the local level.

  The Department is concerned at the practices by professionals as reported by audit and will seek to address these through case specific reviews, redevelopment of working agreements and protocols, and professional education initiatives. To support the introduction of mandatory reporting, the Department has offered professional education through the Protection and Care Branch to 3 751 health, welfare and education professionals. The Department continues to promote a range of training programs to the DSE and other professionals, programs which receive high praise through attendee evaluations. The Department continues to liaise with peak bodies and other departments about the most appropriate methods for ongoing professional development on child abuse issues.

Effectiveness of mandatory reporting

4.43 On 10 March 1993, the Minister for Community Services issued a *Statement on Child Protection* which communicated the Government's intention to legislate for the introduction of mandatory reporting in Victoria. The Minister stated that the proposed legislation *"... will not stop child abuse. No Government can guarantee to prevent it. But we must act to reduce and minimise the tragedy of abuse. We must address how we, as a Government and as a community can effectively protect our children from abuse and when it does occur, we must have a system in place that will identify it quickly and reliably".*

4.44 The introduction of mandatory reporting in Victoria was seen by the Government as a key initiative of its commitment to improve child protection services.

4.45 At the time, the Minister announced the establishment of an advisory group made up of representatives from the mandated professionals and the non-government child-based welfare network. It was indicated that this group would meet on a regular basis with the Minister and provide a forum for discussion on the impact of mandatory reporting.

4.46 The group, known as the Mandatory Reporting Consultative Committee, met on a quarterly basis over the period March 1994 to November 1995 and considered a broad range of issues including:

- access to professional education on mandatory reporting in rural areas;
- capacity of protective services to deal with the impact of mandatory reporting;
- sharing by DHS of information, particularly about the outcome of a notification, with the professional who notified the matter;
- child abuse prevention strategies;
- failure by mandated professionals to notify;

- what happens to the large percentage of notifications that are not investigated; and
- future funding of child protection etc.

4.47 While the Committee discussed a number of important issues and provided valuable feedback to the Minister on the mandated notifiers' views on those issues, it did not perform any specific work on the effectiveness of mandatory reporting in assisting the State in combating child abuse.

4.48 In view of the importance placed upon mandatory reporting by the Government and of community support and expectations, audit envisaged that DHS, prior to the introduction of mandatory reporting, would have developed a range of specific objectives and performance indicators aimed at measuring:

- the extent to which mandatory reporting identifies child abuse quickly and reliably;
- the efficiency and effectiveness of the Department's implementation of mandatory reporting; and
- the impact of mandatory reporting on the overall ability of the State to protect children.

4.49 In addition, given the large commitment of public funds to mandatory reporting there would be an expectation that DHS would provide accountability to Parliament through its annual report for the use of these funds including key achievements of mandatory reporting.

4.50 Audit inquiries determined that DHS had not established performance indicators to assess the effectiveness of mandatory reporting prior to its introduction and, at the date of completion of the audit, such indicators had still not been developed. It is acknowledged that during the early stages of implementation of mandatory reporting, DHS was fully occupied in dealing with the significant increases in the numbers of notifications and a consequential need for additional investigations. However, given that mandatory reporting was first introduced in 1993, there would be an expectation that mechanisms to be used for periodically measuring the effectiveness of mandatory reporting should have been established by now.

4.51 Audit has now formed the view that, although mandatory reporting should not be viewed as a panacea for dealing with child abuse and neglect in the community, its introduction has served to highlight the responsibility of the general public and the legal obligation of mandated groups to report suspected cases of abuse to the appropriate authorities. The community response to this social problem has been abundantly evidenced in the significant increases in notifications since the introduction of mandatory reporting. Audit also considers that mandatory reporting has created a greater awareness within the community that child abuse and neglect are unacceptable and should be decisively acted upon.

4.52 Notwithstanding the community response, whether mandatory reporting has actually led to a sustained reduction in the number of children seriously harmed from abuse within the family is highly unlikely, as evidenced by the ongoing annual increases in the number of notifications and substantiations of child abuse. The likelihood of child abuse continuing is also manifested in the many instances of chronic welfare concerns detected by DHS which also continue to increase in number and, while not representing actual abuse, border on abuse. Factors which raise doubts as to the effectiveness to date of mandatory reporting are detailed below:

- Notifications of abuse are continuing to increase annually. If mandatory reporting was successful there would be an expectation that it would act as a deterrent to further abuse and therefore notifications would begin to stabilise;
- Although substantiations of abuse have increased following the introduction of mandatory reporting, the rate of increase has been considerably less than the overall rate of increase in notifications;
- The capability of DHS to fully cope with mandatory reporting remains doubtful, in that Victoria now has the lowest rate of investigations as a proportion of notifications in Australia and one of the lowest substantiation rates as a proportion of notifications; and
- The high proportion of re-notifications which suggests that in some cases notifications should have been investigated in the first instance.

4.53 **It is primarily through effective prevention strategies, including better community and parent education, early intervention with families experiencing difficulties and improved public access to primary care, which recently have been given stronger emphasis by governments, that child abuse can be reduced.**

4.54 **In audit opinion, it would be of benefit to DHS and the State if a set of objectives and relevant performance measures consistent with and emanating from the Government's stated objectives for mandatory reporting are developed. These objectives and performance indicators should measure the efficiency and effectiveness of the implementation and management of mandatory reporting and should be used by the Department to develop new strategies, if necessary, to further enhance the State's ability to combat child abuse.**

MANAGEMENT OF NOTIFICATIONS OF CHILD ABUSE AND NEGLECT BY DHS REGIONS

4.55 The notification/intake phase is the most critical phase of the child protection process which largely determines the success or failure of the subsequent phases. Based upon the information provided by the notifier, in conjunction with further inquiries by the intake team member, decisions are made on whether:

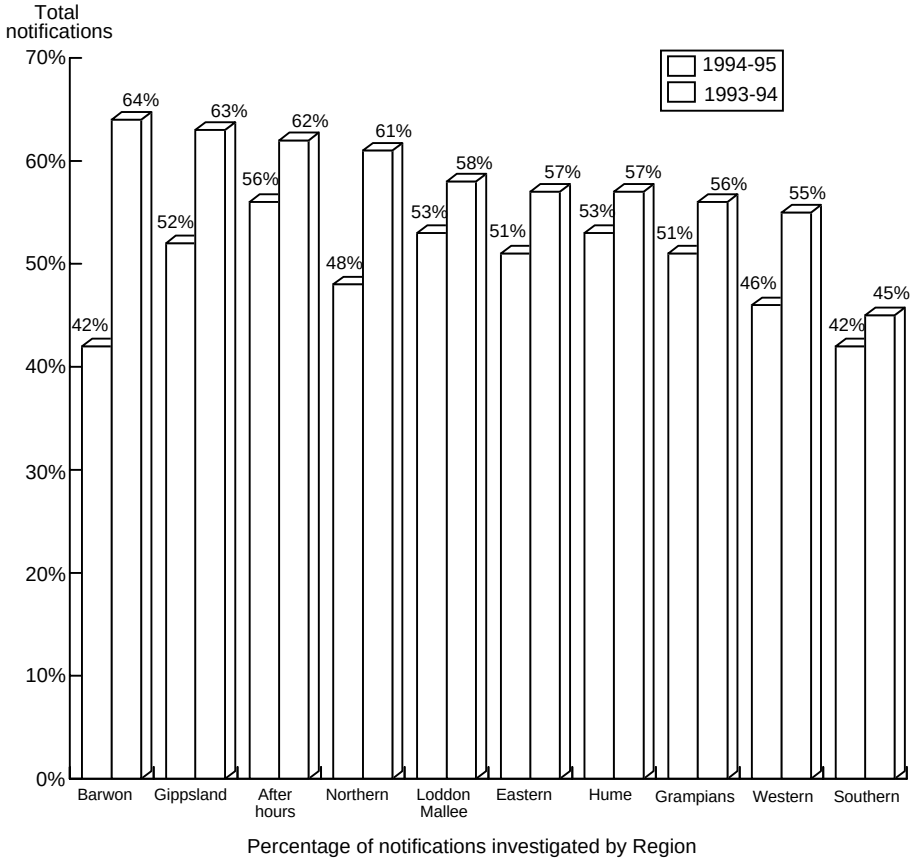
- sufficient concerns exist to warrant initial investigation of the notification; or
- some abuse may have occurred but further action is not warranted as the child is not at significant risk, or the child's safety needs have been met, possibly through the provision of services by an agency to the family; or
- abuse is not evident.

4.56 The impact of decisions made at the notification/intake phase can have a serious and lasting impact on the future lives of children and their families. Accordingly, the quality of decision-making based on available information is of crucial importance to the child protection system as a whole in terms of its ultimate effectiveness.

Significant variations between regions in percentage of notifications investigated

4.57 Chart 4C compares notifications received by DHS regions for the 1993-94 and 1994-95 years and discloses significant variations between regions with respect to the levels of investigations.

CHART 4C
REGIONAL COMPARISON OF NOTIFICATIONS
INVESTIGATED FOR THE YEARS 1993-94 AND 1994-95



Source: DHS Protective Services - Annual Statistical Report 1994-95.

4.58 Significant variations also occurred between years as evidenced by Gippsland Region which was able to undertake 1 418 investigations in 1993-94 or 63 per cent of total notifications. In 1994-95, the region conducted 1 352 investigations representing 5 per cent less investigations than the previous year. However, as a percentage of total notifications in 1994-95 this was only 52 per cent. Across the State, the investigation rate dropped from 57 per cent in 1993-94 to 49 per cent in 1994-95.

4.59 Audit also established that there were significant variations within regions between various offices in the regions. Table 4D provides one such example.

TABLE 4D
EXAMPLE OF SIGNIFICANT VARIATIONS BETWEEN OFFICES OF ONE REGION

Month and year	*Regional notifications*	*Percentage investigated*	*Office*		
			A	*B*	*C*
August 1994	476	44.3	49.0	58.0	38.0
September 1994	409	44.7	58.0	49.0	30.0
October 1994	427	41.2	51.0	48.0	38.0

4.60 Audit was informed by protective workers that reasons for significant variations between and within regions included:

- Varying levels of experience of intake teams;
- Absence of a uniform definition across regions of what constitutes an investigation. For example, one region may define a visit to a creche by a protective worker to clarify certain protective concerns as a component of the notification/intake phase, whereas another region might classify such activity as an element of the investigation phase;
- Inequitable distribution of resources to handle the different volumes of notifications in the various regions. The number of notifications proceeding to investigation in many instances is resource-driven; and
- Different intake models used by the individual regions which can lead to variations in decision-making. Examples of different intake models in place are:
    - In some regions, intake teams comprised the more experienced protection workers, whereas in other regions, teams consisted of mainly recently recruited staff on the basis that intake activities provided valuable experience for new recruits;
    - The intake worker receiving the notification in certain regions is also responsible for conducting preliminary inquiries from sources outside the child's immediate family in order to make informed decisions on the notifications. In other regions, preliminary inquiries are made by other members of intake teams;
    - Some regions regularly rotate members of intake teams while other regions allow protection workers to specialise in intake duties for an extended period of time; and
    - Certain regions had a common reception point for all incoming notifications. Other regions had intake reception facilities within all offices.

4.61 All of the above factors can affect the manner in which notifications are evaluated and the quality of preliminary inquiries conducted, and can lead to varying levels of efficiency, effectiveness and cost. The wide diversity of service models used can ultimately impact upon the level of investigations conducted and the addressing of protective concerns. In audit opinion, the quality of intake processes is also a factor contributing to the high level of re-notifications (commented on in later paragraphs in this Part of the Report), which in 1993-94 represented 32 per cent of all notifications in that year (the latest information available from DHS).

4.62 DHS has been aware of the large variations between regions in investigation levels, following the *Workload Review* in July 1994. The findings of that review prompted a further DHS review of a selection of case files in an effort to establish reasons for the large variations. Although the results of the second review, produced in April 1995, disclosed many deficiencies in the handling of notifications and investigations, the review did not address the underlying reasons for the large variations across the State. In effect, a comprehensive and systematic analysis is yet to be performed by DHS to specifically identify the factors influencing variations between regions, offices within regions and between years.

4.63 Audit accepts that regions need to display flexibility and initiative in their operations with a view to achieving optimum results. Notwithstanding this factor, it was apparent to audit that the existence across regions of various intake models in conjunction with other variables such as experience levels of intake teams, resourcing capabilities and varying definitions as to what constitutes an investigation, is having a marked impact upon the levels and quality of investigations. This latter point is elaborated on in subsequent paragraphs of this Part of the Report.

4.64 **There is a need for DHS to determine, on a Statewide basis, underlying reasons for the significant variations in the capacity of regions to undertake investigations. In addition, DHS needs to take responsibility for the development and implementation of a common intake model based on the experiences over many years of the various regions.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department has already undertaken significant work to refine the Intake Models across the State and further refinement to these models is underway. Nonetheless it needs to be recognised that differences in case practice across regions can be related to population trends, availability of other resources and services. Regions are provided with monthly statistical reports to analyse and compare their practice to Statewide trends.

EFFECTIVENESS OF THE NOTIFICATION/INTAKE PHASE OF PROTECTIVE SERVICES

4.65 In view of the variations between regions in the levels of notifications proceeding to investigation and the different service models in operation, audit sought to determine the impact of the different practices on the quality of the notification/intake phase.

4.66 In undertaking this element of the audit, extensive reference was made to the DHS Protective Services Policy Advice and Practice Manual. In some instances, reference was also made on a strictly confidential basis to external professionals, including specialists engaged to assist the audit team. In addition, in accordance with normal audit practice, detailed discussions were held with individual case workers and supervisors to discuss and confirm audit findings.

4.67 Recurring factors identified by audit as impacting on the quality of the notification/intake phase are listed below and commented upon in the succeeding paragraphs:

- inexperienced workers on intake duties and inadequate handling of initial telephone contacts from notifiers;
- incidence of inappropriate and malicious notifications;
- notifications where further investigation was warranted;
- impact of poor notification/intake decisions on subsequent phases; and
- need for referral of family welfare concerns identified from notifications.

Inexperienced workers on intake duties and inadequate handling of initial telephone contacts from notifiers

4.68 As previously mentioned, the notification/intake phase is the most critical phase in the child protection process. A poor initial assessment of a notification may lead to a decision not to conduct an investigation even though protective concerns may have been present, potentially allowing the child to remain at risk. Conversely, to investigate all notifications would represent an inefficient use of resources and an unnecessary intrusion in many family lives.

4.69 Protection workers indicated to audit that, although statistics have not been compiled in respect of cases closed due to insufficient information being given by the notifier, a major factor influencing assessments of notifications was that notifiers often do not provide sufficient quality evidence or identifying details with respect to children, such as the names, ages or addresses of children concerned and, more importantly, the exact nature of protective concerns and supporting evidence. A typical telephone notification can be of limited duration and disclosure value, particularly if the caller wishes to remain anonymous.

4.70 Protection workers stressed to audit that without specific identification of the children at risk and an accurate outline of specific protective concerns, there is little choice other than not to proceed further.

4.71 In view of the apprehensiveness of many notifiers and their concern to remain anonymous, it is essential that the intake officer be highly trained in communication and interviewing skills to obtain sufficient quality information in order to make a reasonably informed decision on whether further inquiries should be made, immediate action is required, concerns are welfare-based or the notification does not warrant further action.

4.72 Various staff, particularly senior protective workers and supervisors, informed audit that a cause of some notifications resulting in no further action was the use of inexperienced protective workers to take incoming notifications. As previously referred, it is a strategy of some regions to utilise inexperienced officers for intake duty in order to gain experience. The workers expressed the view that intake duty work should not be undertaken by base-grade protective workers because of their limited experience and competency.

4.73 Use of the more experienced protection workers on intake duty, as is occurring in some regions, can also lead to efficiencies in that, apart from the ability to solicit more information from which to make decisions, improved use of resources can occur in that investigations are better targeted to those notifications where children appear to be at serious risk.

4.74 Apart from the quality of the intake assessment process, reliance is also placed upon general telephone receptionists in the various regions to handle initial telephone contacts from notifiers These receptionists must be able to distinguish those calls involving potential notifications from all other incoming telephone calls and to refer them to intake duty officers. In one region, audit established that around 6 per cent of incoming calls which were responded to in general terms by receptionists actually involved protective concerns but had not been referred to intake workers.

4.75 **DHS has not established minimum experience levels or basic competencies for intake workers. In view of the critical importance of the intake function, DHS needs to develop minimum experience and competency standards to be achieved prior to assigning protective workers to intake duty work. DHS also has an obligation to ensure that receptionists in regions are sufficiently trained to be able to identify and refer calls involving protective concerns.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department has commenced the application of competency-based training and performance assessment and is currently developing a pilot Traineeship program for new protective workers which aims to develop and consolidate core competencies prior to the full exercise of service functions. This will build upon current strategies where staff receive intensive induction training and ongoing staff development.

Incidence of inappropriate and malicious notifications

4.76 In a high proportion of notifications where no further action was taken, DHS establishes, quite correctly, that there is no valid basis for any action, whether of a welfare or protective nature. Typically, such notifications involve unfounded concerns by notifiers, vindictive calls possibly associated with marital disputes involving custody of a child, and notifications which did not provide sufficient details to allow or justify the case to be pursued.

4.77 As previously mentioned, 51 per cent of notifications in 1994-95 were assessed as not warranting investigation. These notifications absorb significant protective services resources which would be more productively employed in other child protection activities. Discussions by audit with protective services supervisors and managers disclosed that, until recently, no effort had been spent in researching the major contributing causes to notifications not warranting further action.

4.78 In addition to notifications that do not justify investigation, many departmental staff expressed concern to audit with respect to the level of vindictive calls, particularly from persons involved in custody disputes in the Family Court. Allegations of sexual and/or physical abuse of children can be made in the Family Court in the hope that the Court will award custody to the accusing parent.

4.79 The Crime Prevention Committee of Parliament, in its May 1995 report *"Combating Child Sexual Assault - An Integrated Model"*, recommended that: *"... a new criminal offence: that of wilfully making a false and malicious complaint of the sexual assault of a child, be created"*. Although the Committee acknowledged the seriousness of malicious notifications, audit considers that further research needs to be conducted by DHS to determine the extent of the problem and the potential for any introduction of punitive measures to detrimentally impact on willingness to notify, before considering any further action.

4.80 There are also many unnecessary notifications which are not malicious in intent but which absorb protective resources. Unnecessary notifications usually arise where a person may have a suspicion of abuse occurring without any evidence to support such a suspicion. Any actions that could be taken by DHS to reduce levels of unnecessary notifications without discouraging well-meaning notifiers would be of benefit in enabling resources to be used more productively and effectively.

4.81 **Research is warranted into the extent of, and the major contributing factors to, malicious and unnecessary notifications with the aim of formulating strategies to reduce their occurrence.**

Notifications where further investigation was warranted

4.82 Audit's review of case files revealed the often poor standard of files and the lack of documentation justifying decisions on whether notifications should proceed to investigation. The file review took into account information contained on hard copy files, such as Court Orders, correspondence, special reports from professionals, draft and final case plans, as well as case information contained on the computerised Client and Services Information System (CASIS).

4.83 DHS and its predecessor bodies have been dealing with the protection and welfare of children for probably the best part of this century. Audit would have expected that a common file structure would have been established, whereby apart from case management issues, key elements of the notification/intake phase such as justification for decisions, evaluations of risks and discussions with the respective supervisors on strategies would have been systematically documented and placed in key sections within a file.

4.84 Following examination of a selection (within 2 regions) of cases which were closed without further action, audit agreed that the Department's decision was appropriate in around 80 per cent of these cases. However, in the remaining 20 per cent of files, audit considered that further investigation was warranted due to the following factors:

- Some files contained either no documentation or inadequate documentation of decisions reached between supervisors and intake workers as to the risks identified from notifications, reasons as to whether or not notifications should proceed to investigation, or whether a family or child was in need of support services;
- Although information provided by notifiers was on files, the files invariably did not contain an assessment of that information by the intake duty officer;
- Risks to the child, including an assessment of the level of risk, were often not recorded. DHS has developed standard documentation as to risk evaluation but this was rarely used by protection workers; and
- There was minimal evidence of advice or assistance, including referrals to support services being provided to children and families identified in the intake process.

4.85 The specific issues disclosed in the 20 per cent of files which, in audit opinion, warranted further investigation, included:

- Cases which were closed inconclusively without proper assessment of the protective concerns. In such cases, the responsibility for monitoring risks was passed back to the notifier, relying on the notifier to re-notify if concerns persisted. This may not occur despite concerns continuing as notifiers can be inhibited from re-notifying if the first notification is not followed-up, particularly if there has been no feedback to the notifier;
- Cases where more inquiry was warranted to corroborate the evidence but the file had been closed;
- Cases where protective workers were apparently unwilling to make direct contact with children and families, with a strong preference for telephone contact with third parties, which obviously does not give a practical and visual knowledge of a situation. In certain instances, the inconclusive and contradictory nature of the evidence obtained through preliminary telephone inquiries from third parties indicated that a home visit was clearly necessary but was not undertaken. The following example, drawn from cases examined by audit, provides a practical illustration of these issues;

In October 1994, a notification was received from a professional expressing concern for the safety of 2 children, between 2 and 4 years of age, seen wandering the streets near their residence unsupervised. In view of the age of the children involved, the intake worker recommended that a home visit take place as soon as practicable. In November, a telephone call was made by DHS to the primary school attended by a 6 year old child of the same family. The school principal's response indicated no concerns about the child and that there were no indications that the mother was neglectful of the child. The response also indicated that the principal was not aware of any concerns about the children not being supervised at home. Based on this information, DHS concluded that the concerns expressed in the notification were likely to be a one-off incident and since the school was monitoring the child attending school no further action was taken.

.....

In audit opinion, the Department failed to adequately address the real risk factors which were that the children were roaming the streets unsupervised and at risk. The inquiries made of the school were not directly related to the children in question and their risk exposures. In audit opinion, further inquiries from local creches and child minding centres would have been appropriate, and, if inconclusive, a home visit should have been undertaken to effectively address the notified risks.

- instances where minimal action was taken in response to multiple re-notifications, preferring to wait for yet a further renotification. Although these cases were relatively few in number, the fact that there were often 3 or more notifications on the same child warranted, in audit opinion, an investigation. Audit would have expected that in most instances the more notifications received on a child, particularly where there were different notifiers, the higher the priority to investigate.

4.86 Following discussions between audit and DHS, the Department undertook its own review of case management through reviewing a selection of cases in all regions. The DHS review, the results of which were reported in April 1995, confirmed the audit findings in that the DHS report drew attention to 12 per cent of cases which had been closed as warranting no further action but should have been investigated further. Conversely, the Report also found that 46 per cent of cases investigated should not have been investigated, thus providing reinforcement to the need for first class notification/intake procedures. Some cases were closed by regional management due to workload constraints rather than practice considerations. In addition, the report disclosed inadequate assessment of risks and lack of evidence to justify decisions.

4.87 In response to audit requests, no information was provided by DHS on new strategies, arising from its review, to improve the notification/intake phase.

4.88 Audit can appreciate that, with a child protection system under extreme pressure, administrative processes such as minimum documentation standards may not feature highly. Nevertheless, audit considers that measures need to be taken by DHS to improve the quality of case files and decision-making in general through:

- developing a more appropriate file structure and minimum documentation standards;
- documenting and emphasising to supervisors their responsibilities to not only advise protection workers on individual cases, but to progressively review case files as to structure, documentation levels and justifications for decision-making; and
- institute an ongoing process of independent and regular peer review of case files against established criteria and periodically report outcomes to regional directors and head office.

4.89 **Unless evidence is available to confirm that practice standards have been adhered to and decisions are soundly based and supported by a proper risk analysis, the level of compliance with the *Children and Young Persons Act* 1989 and professional standards becomes questionable and children may remain at risk.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department has standard uniform formats for case note recording for each phase of intervention. These are accessed through CASIS, whenever a case note is recorded. Guidelines on Case Recording are currently being finalised. These will enhance case recording practice and promote decision making accountability.

The Department questions audit's methodology in its case review. While audit officers have reviewed files and held discussions with staff at a variety of locations, this has been done in an unstructured way, and failed to account for the "benefit of hindsight" factors. Findings are generalised and focus exclusively on perceived faults in a minority of cases.

The Initial Decision Making File Audit (1995) conducted by the Department in response to the Workload Review (1994) was undertaken by experienced child protection practitioners and regional managers. While one of the findings was that 12 per cent of files closed without further action required protective investigation, this was balanced against a finding that in general the investigation rate was 50 per cent higher than that judged necessary by the reviewers. Audit fails to acknowledge this related finding.

Impact of poor notification/intake decisions on subsequent phases

4.90 Audit acknowledges that, with child protection activities, decisions to investigate notifications will often be subjective and influenced by a range of factors, including experience levels of protective workers and quality of supervision, identified in earlier paragraphs of this Part of the Report. There will always be instances where unwarranted intervention in a family proves to be harmful and alternatively where, with hindsight, intervention should have occurred much earlier before child abuse became more pronounced. Many such cases were brought to the attention of audit by parents and organisations. Nevertheless, after taking these factors into account, audit considers that it is unacceptable for up to 20 per cent of cases to be closed despite warranting further investigation.

4.91 Audit contends that if notification/intake processes are of a high standard and investigations are competently conducted, then it should be expected that a lower percentage of notifications would be investigated and conversely, a high percentage of investigations would be substantiated. Failure to undertake investigations as a direct result of inadequate assessments of notifications not only leads to increased levels of re-notifications thereby absorbing more resources, but also leads to abuse not being detected. Audit acknowledges the limited ability of DHS to conduct more investigations.

4.92 Between 1993-94 and 1994-95 notifications increased by 19 per cent, from 26 622 to 31 619, respectively. However, the level of investigations undertaken Statewide only increased by 2 per cent, from 15 179 to 15 618 in that period.

4.93 Table 4E compares on a regional basis the percentage increases in notifications, and investigations and substantiations as a percentage of notifications between 1993-94 and 1994-95. The table illustrates that generally the lower the level of investigations undertaken as a percentage of notifications, the lower the level of substantiated abuse as a percentage of notifications. For example, in 1993-94 the Barwon S.W. Region investigated 64 per cent of all notifications (the highest in the State) and substantiated 28 per cent of all notifications, also the highest in the State. This performance compares very favourably with Eastern Region which investigated only 57 per cent of all notifications to the Region and also only substantiated 22 per cent of all notifications.

TABLE 4E
COMPARISON BETWEEN 1993-94 AND 1994-95
OF SUBSTANTIATED ABUSE CASES

Region	% increase in notifications 1993-94 to 1994-95	Investigations as a % of notifications 1993-94	1994-95	Changes from 1993-94 to 1994-95	Substantiations as a % of notifications 1993-94	1994-95	Changes from 1993-94 to 1994-95
Barwon S.W.	+34	64	42	-22	28	20	-8
Gippsland	+15	63	52	-11	26	20	-6
Grampians	+25	56	51	-5	23	20	-3
Hume	+23	57	53	-4	23	22	-1
Loddon Mallee	+6	58	53	-5	24	20	-4
Eastern	+15	57	51	-6	22	25	+3
Northern	+38	61	48	-12	24	24	-0
Southern	+10	45	42	-3	17	20	+3
Western	+10	54	46	-8	24	23	-1
After Hours Service	+25	62	56	-6	26	30	+4
Statewide	**+19**	**57**	**49**	**-8**	**24**	**22**	**-2**

4.94 Globally, Table 4E illustrates that between 1993-94 and 1994-95 there was an overall reduction Statewide on the level of investigations conducted within each region. The Table also illustrates that with the exception of 3 regions, the substantiation rate, as a percentage of notifications, dropped in direct relationship with the fall in investigation levels. Of the 3 regions where substantiation levels actually increased, included was also the After Hours Service, which reflected the high level of investigation skills of this staff and additional resources assigned to this Service.

4.95 Given the finite level of resources at its disposal, it is essential that maximum benefits be obtained by DHS from these resources through better focusing of investigations on those cases where there is a likelihood of abuse having occurred. This strategy, although currently adopted by DHS, is not as successful as it should be due to the often poor quality, and inappropriate actions occurring at the intake stage as referred to earlier.

4.96 **The Department needs to take responsibility at a central level for raising the quality of intake processes across the State, through actions such as employing the more experienced staff in this process, improving supervision standards and upgrading quality control and monitoring procedures. Practices, such as referring the monitoring responsibility back to notifiers instead of undertaking investigations, need to be strongly discouraged.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is committed to strengthening its intake processes and developing appropriate quality assurance measures. Initiatives which have enhanced performance of the intake function include:

  - *Production of Protecting Children manuals (including practice standards);*
  - *Production of 'Responding to High Risk' and Risk Assessment' guidelines;*
  - *Enhanced training to complement the risk assessment guidelines; and*
  - *Undertaking the Initial Decision Making Audit.*

  The Department rejects audit's assertion that notifiers are asked to monitor children's welfare inappropriately when insufficient evidence exists to support a child protection investigation. Audit fails to acknowledge that many of these notifications come from highly skilled professionals who are well placed to make further assessments of a child's situation.

Need for referral of family welfare concerns identified from notifications

4.97 The examination of case files commented on in the previous paragraphs also disclosed many instances where, although welfare concerns were evident, inquiries at the notification/intake phase indicated the child was not at risk of significant harm and thus the situation did not warrant intervention by DHS.

4.98 This situation arises largely because notifiers are required to notify on the basis of a *"belief (by the notifier) on reasonable grounds that a child was in need of protection",* and would expect intervention action by DHS. On the other hand, DHS must assess notifications on the stricter basis of *"when a child has suffered or is likely to suffer significant harm and the child's parents have not protected or are unlikely to protect the child from harm of that type"* which essentially creates an *expectation gap* from the viewpoint of notifiers.

4.99 This expectation gap between the criteria for notification as distinct from intervention represents, in many cases, welfare concerns, mainly of a severe nature, where the distinction from protective concerns is often borderline. This gap is also the source of a high degree of stress and conflict between mandated notifiers and DHS.

4.100 A notification/intake worker's responsibilities are predominantly confined to deciding, in conjunction with a supervisor, whether a protective investigation is warranted. Although an investigation is not justified, the notification may provide a clear indication of welfare concerns which, if not addressed, could escalate into protective concerns. Although most notifiers would not want involvement with a family beyond making the notification, scope does exist, especially where the notifier is a family member or a professional such as a doctor or welfare worker, for DHS to provide advice on assisting the family, through referral to another service such as a child welfare or family support service. This type of advice is provided in isolated instances rather than as a standard procedure. In some other cases, the family may already be receiving support from another welfare service, and in these instances the establishment of such a linkage is easily facilitated.

4.101 Audit acknowledges that DHS has no legislative authority to intervene in a family where notifications do not proceed beyond the preliminary inquiry stage. However, directing attention to providing support for families whenever practical, can be an effective child abuse prevention strategy, as well as a cost-effective measure in reducing subsequent re-notifications absorbing further resources. The following case extracted from a Department case file provides one such illustration:

A notification was received reporting the concerns that the functioning of certain children was effected by exposure to domestic violence, insufficient food, the filthy condition of the house and the absence of adequate supervision for the children. The mother had apparently suffered from an accident and her ability to adequately look after and protect the children was questioned. The occasional caregiver to the children also expressed similar concerns.

The protective worker advised the notifier that DHS would follow-up and may be able to link the family to a local community support agency and a domestic violence worker could also assist if the mother was willing. However, the supervisor's assessment of the urgency and level of risk was:

> *"Domestic violence is very concerning but there is insufficient information to indicate whether it is immediate. Lack of food for the children is also concerning but young boys do tend to be always hungry and the notifier describes them as healthy and energetic so they cannot be significantly deprived. Lack of supervision is also of concern, but the boys may be fairly sensible and independent if their mother is fairly helpless. Further information is needed to make a decision whether to investigate but risk is not immediate. A home visit may be required when there is more information."*

Inquiries by DHS from the children's school indicated that the school was aware of the mother's accident but held no concern for the children and undertook to monitor the children and report back to DHS if required. The protective worker concluded that the children were not at risk as they were being monitored by their teachers.

Further contact by DHS with the children's prior day carer conflicted with the school's assessment. The carer referred particularly to the children's dirty state and inadequate supervision being more due to the mother's inability to change rather than the effects of the accident.

The protective worker noted the apparent contradiction between the school and the day carer but attributed this to "a matter of different standard of value judgement in assessment of the children's situation". The worker felt that protective services involvement was not necessary due to the involvement by the school.

The case was closed with no further action.

.....

Audit formed the view that the apparent counter-reasoning provided in the above worker's risk assessment by the worker's supervisor tended to dilute the level of risk allocated to the case and indicated an unwillingness to become involved. Audit considered that, where there exist contradictions in assessments by various parties, if the protective concerns are to be effectively addressed a home visit is the only means of conclusively assessing the concerns. Additionally, the children's exposure to family violence was not addressed and the promise of support linkages for the mother were not pursued as this activity was not seen as a function of protective services. Audit expressed the view to DHS that, in this instance, the case was inconclusive and the children remained exposed to protective risks.

4.102 Provision of an effective referral service would reinforce the need for suitably skilled and experienced duty officers, with access to a current directory of services available within a region, such as doctors, primary care services, welfare agencies, child care services and other professional services. Audit established that a similar concept operates in Tasmania, whereby at the intake phase the child's needs for protection and welfare concerns for the family are assessed and addressed in tandem.

4.103 **Research is warranted in developing further the capacity of notification/intake workers and other officers undertaking preliminary notification inquiries to offer a comprehensive referral service.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is developing a pilot service through which families referred to protective services, but require a support oriented service, would receive that service without the need for more intrusive formal investigation, as referred to earlier. Interstate and international approaches to the investigation/follow-up of child abuse notifications will inform development of this strategy.

RENOTIFICATIONS

Extent of renotifications

4.104 A renotification occurs when a child who has been previously the subject of a notification is notified a second or further occasion for either the same protective concerns or with respect to new concerns. The audit of cases closed with no further action being taken detected a significant number of notifications which were renotifications.

4.105 Table 4F shows details compiled by DHS of notifications and renotifications for the 1993-94 year, which was the latest available data.

TABLE 4F
NOTIFICATIONS AND RENOTIFICATIONS, 1993-94

	Number of children	*Percentage of children*	*Number of notifications*	*Percentage of all notifications*
With one notification	17 934	83%	17 934	68%
renotifications:				
With 2 notifications	2 850	13%	5 700	21%
With 3 notifications	632	3%	1 896	7%
With 4 notifications	156	1%	624	2%
With > 4 notifications	80	0.4%	468	2%
subtotal of renotifications	*3 718*	*17%*	*8 688*	***32%***
Total	**21 652**	**100%**	**26 622**	**100%**

Source: DHS - *Protective Services - Annual Statistical Report, 1993-94.*

4.106 Table 4F indicates that 3 718 or 17 per cent of all children notified during 1993-94 were notified more than once, and that 4 per cent of all children notified were notified 3 times or more. The table also indicates that 8 688 notifications or 32 per cent of all notifications for the year were renotifications.

4.107 **Despite the value of the above data in establishing the extent of re-notifications, similar data was not produced by DHS in 1994-95. Such information should be compiled by DHS on an annual basis to assist in trend analysis and management decision-making.**

Scope for greater investigation of cases involving renotifications

4.108 A renotification, although a useful indicator of the quality of processes in the notification/intake phase, does not necessarily reflect an incorrect assessment in the first instance. The audit disclosed a number of instances in which renotifications occurred, but clearly did not involve protective concerns. For example, a concerned neighbour or family member may repeatedly provide notifications on the basis of minor concerns about cleanliness of a house, or alternatively, a parent in a Family Court custody battle may repeatedly make notifications on a child with an ulterior motive of attempting to influence custody arrangements.

4.109 Conversely, a renotification, particularly when made by a different person to the original notifier, can be an important indicator that the prior notification warranted further investigation. Further, a renotification represents an opportunity for DHS to re-assess the risks to the child and reconsider the notified protective concerns.

4.110 In many cases where children were not initially assessed to be at significant risk although some concerns existed, audit established from file examination that DHS deliberately closed files on the assumption that, if protective concerns continued, a renotification would be made.

4.111 While the above approach may reduce the necessity for investigations, the reliance by DHS on renotifications may not be soundly-based in that a renotification may not eventuate for several reasons such as:

- a mandated notifier, or other community member, having made a notification and having seen no apparent action by DHS, may not renotify on the basis of a loss of confidence in the system because the original concerns that were not investigated had not materially changed from the previous notification;
- a parent who may be abusing a child is unlikely to take the child back to the same doctor, hospital, day care centre etc. for examination;
- a welfare agency or other professional may not continue involvement with the same family; and
- a school teacher may not be adequately trained to detect subtle disclosures by a child that indicate continuing abuse, or the child's family may move to another area and the new school is unaware of the problems with respect to protective concerns.

4.112 In addition, audit established that the attention accorded to renotifications by DHS did not significantly vary from the earlier notification even where a different notifier was involved.

4.113 **DHS should allocate a higher investigation priority to renotifications, given their current high levels. Cases involving 3 or more notifications in respect of the same child should automatically justify an investigation by an experienced worker.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department accepts that it should undertake further work to examine the issue of re-notifications. However, it rejects audit's recommendation that an automatic investigation should take place when 3 or more notifications are received on the same child. It is a practice standard that "... the intake protective worker should determine at point of notification intake whether or not the child has previously received service from DHS. The intake protective worker should conduct a CASIS search to ascertain this information". This file search makes immediately available any prior information in relation to the family/child concerned and impact upon ensuing decisions and urgency considerations.

  A renotification does not automatically receive priority. Decision-making regarding further action is based on the nature of abuse, age of child, parent's capacity to protect, level of extended family support and local agency involvement, family history and background as well as prior departmental involvement.

  While not diminishing the importance of re-notifications, it is important to note that multiple notifications over a period of time may be caused by factors which may not relate to the child's wellbeing or risk level (e.g. vexatious notifiers).

  The Department is pursuing an examination of re-substantiation rates as a more accurate indicator of its performance. During 1994-95, Victoria recorded a re-substantiation rate of 4 per cent in comparison with New South Wales 11 per cent and South Australia 10 per cent.

Absence of procedures to handle renotifications

4.114 Regional staff indicated to audit that routine procedures for formal reviews of the incidence and nature of renotifications had not been established. Accordingly, DHS was not in a position to determine the extent to which renotifications indicated poor assessment at the notification/intake phase.

4.115 However, staff, including supervisors of the intake teams, did indicate to audit that renotifications are treated with a greater degree of seriousness, although the cases examined by audit did not reflect a more intense level of scrutiny. Staff also advised that renotifications are often received with respect to families generally referred to as high risk families, i.e. families classified by DHS as those that periodically leave and return to the child protection system.

4.116 **DHS should establish formal review procedures covering the incidence and nature of renotifications.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is significantly advanced in its data collection and analysis capacity and is committed to implementing measures for continuous performance improvement, including research. Examples of this include the Initial Decision Making Audit, the Protective Services Data Project and the Impact of Mandatory Reporting Research.

Overall comment on renotifications

4.117 **In audit opinion, given that the high level of renotifications received by DHS could, in some instances, represent inadequate notification/intake procedures or other system deficiencies, there was a need for:**

- **Research into the extent that renotifications are substantiated as protective concerns that should have been identified in the first instance;**
- **Research to establish the extent to which renotifications may have been avoided if serious welfare concerns within a family had been initially identified and the family directed towards support;**
- **An analysis by DHS of common reasons for renotifications, as this may indicate that mandated persons and other notifiers need further education on what constitutes a child being at risk of serious harm;**
- **Renotifications to be allocated, where possible, to protection workers other than those originally involved in order to obtain alternative independent evaluations of a situation; and**
- **Establishing, as a standard procedure, a mechanism for the protective services manager to independently review cases where more than 3 renotifications occur within a 12 month period. Audit understands that a similar requirement has recently been introduced in New Zealand.**

INVESTIGATION OF CHILD ABUSE

4.118 At the end of the notification/intake phase, a decision is made either to close a file and take no further action on the ground that protective concerns placing a child at significant risk are not present, or to investigate those cases in which significant protective concerns are identified. The investigation phase involves the process of obtaining sufficient evidence to substantiate whether abuse has occurred and if so identifying the specific supports and services needed by the family in order to overcome protective concerns.

Levels of investigation and substantiation of child abuse in Victoria

4.119 During 1994-95, DHS investigated 15 618 notifications of suspected child abuse of which 7 326, or 47 per cent, were actually substantiated. The number of cases substantiated reflected an increase from 1993-94, where of 15 179 investigations, 6 175, or 41 per cent, were substantiated. Table 4G provides relevant details of notifications, investigations and substantiated cases of abuse dealt with by DHS during 1994-95.

TABLE 4G
NOTIFICATIONS, INVESTIGATIONS AND SUBSTANTIATIONS OF CHILD ABUSE, 1994-95

	Notifications		*Investigations*		*Substantiations*	
Type of abuse	*Number*	*per cent*	*Number*	*per cent*	*Number*	*per cent*
Physical	7 836	25	4 999	32	2 125	29
Sexual	4 036	13	2 054	13	655	9
Emotional	7 255	23	3 162	20	2 247	31
Neglect	11 193	35	4 949	32	2 078	28
Other	1 299	4	454	3	221	3
Total	**31 619**	**100**	**15 618**	**100**	**7 326**	**100**

Source: DHS - *Protective Services Annual Statistical Report, 1994-95.*

4.120 Table 4H below details across-Australia comparisons between the percentages of notifications investigated and the levels of substantiated abuse both as a percentage of notifications and as a percentage of investigations. Audit acknowledges that, due to variations in terminology and practices between the States and Territories, the statistics do not represent a completely accurate comparison. Notwithstanding the different classifications as to what constitutes an investigation between the various States and Territories, the crucial figure is the proportion of notifications which are substantiated, given that the definitions of notification and substantiation are comparable Australia-wide.

TABLE 4H
AUSTRALIA-WIDE COMPARISON BETWEEN INVESTIGATIONS AND SUBSTANTIATIONS OF CHILD ABUSE AS A PERCENTAGE OF TOTAL NOTIFICATIONS: 1994-95
(percentage)

	NSW	*Vic.*	*QLD.*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Australian average*
Notifications investigated	89	49	89	98	69	99	100	76	83.6
Investigations substantiated	37	47	31	37	33	21	46	34	35.7
Notifications substantiated	***33***	***23***	***28***	***36***	***23***	***21***	***46***	***26***	***29.5***

Source: Council of Australian Governments (COAG) - Steering Committee for the Review of Commonwealth/State Service Provision.

4.121 DHS maintains that the low investigation rate and high substantiation rate of investigations reflects its current strategy of only focusing on those notifications where a child is deemed to be potentially at risk of serious harm. While, in theory, this policy is sound, it relies very heavily upon the quality of notification/intake processes, which, as commented on in previous paragraphs, are deficient with up to 20 per cent of cases that warranted further investigation closed.

4.122 Table 4H indicates that, when substantiation rates of abuse are reflected as a percentage of notifications, Victoria has one of the lowest rates in Australia at 23 per cent, well below the Australian average of 30 per cent of notifications being substantiated. In essence, while Victoria's substantiation rate of investigations is the highest in Australia, it is more selective as to the number of investigations undertaken and has the lowest investigation rate in Australia. When substantiations are compared with notifications, Victoria's low rate of 23 per cent suggests, in audit opinion, that there is a significant level of child abuse occurring in Victoria that is not being investigated and is a contributing factor to the very high levels of renotifications.

4.123 **It is acknowledged that, due to a finite level of resources available for investigations, DHS is not in a position to increase the level of investigations, nor is this necessarily warranted provided notification/intake processes reflect best practice standards and investigations are conducted in the most effective and efficient manner. In audit opinion, both the notification/intake and investigation phases warrant further improvement.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Audit makes comparisons of the investigation rates and substantiation rates across the States which is not appropriate given the significantly different counting rules and definitions used in different states.

  The Department has played the lead role in reviewing the national performance indicators for Protection and Care services by convening meetings of the States, and involving the Australian Institute of Health and Welfare (AIHW) and the Industry Commission in this review process. It is expected that the review will result in significant changes to the performance indicators and other data included in the Council of Australian Governments (COAG) auspiced report on Government Service Provision.

Need for greater consistency in measuring timeliness of investigations

4.124 The timely commencement of investigations is an essential element in the child protection process. There is a tendency of children to forget critical details about abuse as time passes, such as inability to accurately place an event or to recall the intensity of pain or suffering. Physical and forensic evidence with respect to sexual and physical abuse tends to dissipate quickly, which makes it essential that detection and documentation of this evidence occurs as close as possible to the event.

4.125 In acknowledgment of the importance of timely investigations, DHS has adopted a quantitative performance measure which requires that investigations commence within 7 calendar days of the notification.

4.126 During 1994-95, 92 per cent of cases requiring investigation were commenced within 7 calendar days compared with 89 per cent in 1993-94. Therefore, only 8 per cent of all cases deemed by DHS as requiring investigation in 1994-95 were not commenced within the 7 days benchmark. The statistics, however, need to be interpreted with caution as:

- In 1993-94, 57 per cent of the 26 622 notifications were investigated whereas this percentage dropped to 49 per cent of the 31 619 notifications received during 1994-95. In other words, DHS only undertook investigations to the extent that resources were available to conduct such investigations within a reasonable time frame; and
- There existed variations between regions in defining completion of the notification/intake phase and the commencement of the investigatory phase. For example, a region may classify a telephone call to a school to confirm the existence of protective concerns as an element of the notification/intake phase, whereas another region may classify such activity as the commencement of the investigation phase. Consequently, the latter region is able to claim it commenced its investigation at an earlier date. It was not possible for audit to determine the extent to which regional variances impacted upon the performance of DHS against its benchmark.

4.127 **For performance measures to be able to provide meaningful information to DHS on performance, the methodology adopted to developing the measures must be consistently applied across all regions. It is only through adoption and application of common parameters that low performance between regions can be identified, analysed and remedied.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The Department refutes audit's criticisms of the level of skill and experience within the workforce. These criticisms apply principally to staff who are newly appointed SOC-1s. Audit does not take into account the different levels and experience that exist within the workforce as a whole. Retention rates used by audit in the Human Resource Part of the Report indicates that in June 1995, 76 per cent of the staff had more than one year's experience in the program.

  Audit also fails to note that protective workers have tertiary qualifications in disciplines such as Social Work or Welfare Studies, and "family functioning" is a core component of such courses. Further, "family functioning" is widely covered in various training programs through the Protective Services Training Team.

Undertaking investigations

4.128 Specific emphasis was placed by audit on an assessment of the notification information to determine whether all cases that proceeded to investigation involved risks that warranted an investigation being undertaken and that the relevant families were not subjected to unwarranted intrusion and stress.

4.129 The audit examination of a number of cases chosen at random from a statistical sample disclosed that, in every instance examined, the decision to proceed to an investigation had been soundly-based on available evidence from the notification. Audit acknowledges that the substantiation rate of investigations by DHS compares favourably with all other States. However, this situation can be primarily attributed to the strategy of DHS to only investigate high risk cases where abuse is most likely to have occurred. In audit opinion, there remains scope for further improvement in the quality of investigations and, in turn, an increased substantiation rate. **Achievement by DHS of an increased substantiation rate would mean that more children could be protected and strategies developed to safeguard their future welfare and development.**

Scope for improving the quality of investigations

The need for a risk-based methodology

4.130 A fundamental element of the Department's approach to its child protection responsibilities is the evaluation of the level of risk of significant harm to children subject to notifications. The DHS Policy Advice and Practice Manual stipulates that: *"The assessment of risk to the child is an integral aspect of child protection practice, providing a base line for decision making, and is therefore relevant throughout the period of intervention by our statutory services".*

4.131 To assist protective workers in making risk assessments, the Department provides some compulsory risk assessment training as part of induction training and an advanced course at a later stage of staff development. This training is supported by the Policy and Advice Practice manual, and a range of information contained in various policy statements, research articles and bibliographies.

4.132 While the abovementioned material provides a range of reference sources in relation to risk assessment principles and investigation techniques, DHS has not yet developed and formally adopted a definitive methodology to provide guidance to its protective workers on preferred practice in risk assessment. In the absence of such a methodology, DHS cannot be assured that all investigations are undertaken on a consistent basis and in line with established quality standards. In this regard, variations in the capability of regions to substantiate abuse was reflected in the 1994-95 Statistical Report prepared by DHS which indicated, for example, that Gippsland and Loddon-Mallee regions were only able to substantiate abuse in 38 per cent of investigations undertaken, whereas Eastern and Northern Metropolitan regions were able to substantiate 50 per cent of investigations.

4.133 The case files on investigations examined by audit often contained only minimal references to risk identification such as alcohol/substance abuse by one or both parents, domestic violence, severe parental intellectual disability or undernourished children, quantification of risk level as serious, medium or low and strategies available to address protective concerns. This audit finding was corroborated by the April 1995 DHS review of notification/intake processes which found that in 31 per cent of files examined, the files did not contain adequate information on risks to the child and 67 per cent of files did not distinguish between risk levels of serious, medium and low risk.

4.134 Clearly, any decision reached based on an inconclusive evaluation of the family circumstances may not be in the best interests of the child. The level of risk identified is a crucial factor in determining whether a Protection Application is warranted or whether protective concerns could be addressed through welfare support. For example, with a child at serious risk, it is more than likely that DHS will seek a Protection Order, whereas with medium or low risk protective concerns, welfare support would be the preferable option, provided the family was willing to co-operate. Any weaknesses in the quality of the investigation could lead to the Children's Court not agreeing to a Protection Order, or DHS being advised by their lawyers not to proceed with a Protection Application due to the quality of the investigation and accompanying evidence. These matters have been extensively discussed in the Auditor-General's June 1996 Special Report No. 42 - *Protecting Victoria's Children - The Role of the Children's Court.*

4.135 Audit also considered that the inadequate attention given to risk assessment was a major factor contributing to the level of renotifications and, on isolated occasions, severe abuse being inflicted on a child subsequent to investigation.

4.136 In summary, the Department needs to progress beyond just providing training and broad guidance on risk evaluation to the adoption of a formal risk-based methodology with accompanying risk assessment principles, measurement criteria and documentation standards. The advantage of such an approach would be to undertake investigations in a more structured and consistent manner with a greater focus on identifying potential risks, consequences and action required to address protective concerns. In addition to the adoption of such a methodology, it is essential that a quality review process followed by the supervisor be of a commensurate standard, which could be relied upon in the event of external criticism subsequent to a decision not to proceed further with a case.

4.137 **Audit supports the Department's principle of applying a risk based approach to determining the level of intervention necessary in a family and assessing whether a protection application is warranted. However, this approach needs to be expanded upon through adoption of a formal methodology and an effective quality review process to enhance the quality of investigations.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The Department has developed comprehensive Risk Assessment Guidelines, including "Responding to High Risk" to provide a practical and theoretical framework for protective assessments and decision-making.

Poor documentation of investigation planning

4.138 Prior to the commencement of an investigation, a planning meeting should occur between the investigating team and the supervisor in charge of the case. These meetings are very important in terms of identifying the prior history of a family, the expected reaction of a family to intervention, interview techniques, questions to be asked and by whom, reliance on other parties such as teachers, welfare assistance available and availability of alternative placements.

4.139 While these meetings are acknowledged by protective services staff as an essential element of the investigatory process, the audit examination of files disclosed that, apart from summary entries made in supervisor diaries, there was little, if any, evidence of these meetings, the protective risks and issues discussed, and more importantly, the strategies to be adopted. As such, it was not possible for audit to evaluate the adequacy of planning with respect to investigations undertaken.

4.140 Inadequate documentation of an investigation plan could lead to misunderstanding as to action and strategies agreed upon, as well as investigations not canvassing all protective concerns and risks. Such plans are particularly relevant where joint investigations are proposed with Victoria Police in cases involving suspected sexual assault and serious physical abuse.

4.141 **The success or otherwise of investigations is strongly influenced by effective planning prior to conducting interviews with a family and related parties. In the event of DHS adopting a formal risk-based methodology when conducting investigations, the quality and documentation of the planning phase of investigations will be an important consideration.**

Depth and calibre of investigations

4.142 In order to establish whether child abuse has occurred, a thorough and expert investigation should be undertaken. The ability of protection workers to conduct effective investigations requires training in investigative techniques and evidence gathering, appropriate field experience and a minimum level of aptitude for extracting relevant disclosures and information from persons interviewed. In addition, a sound knowledge of family functioning, family norms and child development is essential. An inadequate investigation can result in an abused child remaining at further risk within the family.

4.143 While the increased rate of substantiation of investigations from 41 per cent in 1993-94 to 47 per cent in 1994-95 may be attributable to improved investigative skills, this increase also needs to be viewed in the context of the existing DHS strategy that investigations are only conducted where notification/intake teams consider that the allegations are serious enough to warrant intervention in a family by protection workers. Adoption of this strategy, as previously referred to, attempts to maximise resources through greater focusing on high risk cases.

4.144 Focusing on investigations of high risk notifications relies extensively on the quality of notification/intake processes, and carries the expectation that the low level of investigations undertaken will result in a high substantiation rate. Accordingly, investigations undertaken must be of a quality standard commensurate with this strategy. From audit examination of cases and extensive discussions with protective workers involved in investigations, the following deficiencies were found:

- Some investigations lacked depth, with questioning only involving face-to-face interviews with parents. In many instances, the parent(s) were the alleged abusers and obviously would rarely admit any wrong doing. Alternative evidence which might have been available, such as from the notifier and possibly other persons who may have had contact with the child over a period of time, such as teachers, friends, relatives, Victoria Police and other organisations was often not sought or not subjected to detailed scrutiny;
- In certain instances, investigation teams could have gained additional corroborative evidence from third parties. However, workers advised audit that, unless such evidence was likely to be conclusive, there was a reluctance to do so because of potential embarrassment to the family should the intrusion into their privacy by DHS become known to other parties;
- Records of interviews contained on files clearly indicated in many cases that not all the protective concerns identified in the planning process had been addressed at the interview;
- Protective workers assigned to investigation teams were often inexperienced and lacked a comprehensive knowledge of family functioning. As a consequence, difficulty was experienced in distinguishing between deliberate abuse leading to protective concerns and dysfunctional characteristics such as poor parenting skills, which was a welfare concern. It was relatively common for parents coming from dysfunctional families or having been previously in alternative care during their own childhood, to have only a limited knowledge of how to rear their own children; and
- Although, in general, response times to commencing investigations were satisfactory, audit did establish some isolated instances where serious allegations involving sexual or serious physical abuse were made and were not investigated until several days had elapsed. In some instances, the delays could be attributed to an inability to promptly arrange a joint investigation with Victorian Police. Further comment on this issue is contained in Part 7 of this Report.

The following case is provided as an illustration of the above findings:

A family comprising a mother and 4 children from 2 to 11 years of age were subject to notification on the following dates:

- **Notification 1**. January 1994. *Notified by a Community Policing Squad (CPS) and investigated on the basis of environmental neglect, failure to provide basic care and failure to ensure safety. The case was investigated and closed as "unsubstantiated" in February 1994.*
- **Notification 2**. April 1994. *Notification by a professional organisation. No further action taken and the case was closed.*
- **Notification 3**. May 1994. *Notification by a different person as to environmental neglect. Case investigated but unsubstantiated and was closed in June 1994.*
- **Notification 4**. August 1994. *Notification by a different professional for failure to provide adequate food and environmental neglect. File closed and no further action was taken.*
- **Notification 5**. September 1994. *Notification by a CPS for failure to provide adequate clothing and environmental neglect. On this occasion, the Victoria Police indicated a need for DHS to become involved because of the filthy state of the house, the inadequate clothing of the children, the physical health and neglect of the children, and the dirty condition they were in. When protective workers visited the residence to investigate, the house was relatively clean and the children appeared reasonably well looked after. This could have been expected, however, in view of prior involvement by the mother with investigations and the likelihood of a predicted visit by DHS subsequent to the CPS visits.*

The notifications remained unsubstantiated, despite the number of credible notifications by different persons, and the apparent ability of the parent to cover up the evidence of neglect due to advance warning of a DHS visit. There was a high degree of reliance placed upon feedback to the protective workers by the mother at interview instead of seeking to obtain alternative evidence. Claims by the mother that she suffered from HIV or Hepatitis C and required blood tests every 3 months were never confirmed with medical authorities.

The workers concluded that, in view of the mother presenting as a caring mother, committed to her children's well-being, about to access community resources in organising occasional care for the children and voluntarily participating in a parents support program aimed at enhancing parenting skills, the investigation was unsubstantiated. The workers strongly recommended that, given the number of past notifications, prior contact should be made with the school if any more notifications were received to assist in determining whether investigations were warranted.

- **Notification 6**. March 1995. *This notification disclosed the following concerns:*
  - *emotional trauma and severe neglect of the children;*
  - *the children drank alcohol when left unattended;*
  - *awareness of sexual activity of mother due to her leaving the door open when her boyfriend visited;*
  - *children inadequately dressed; and*
  - *younger children left in care of older children (11 and 9 years old).*

The protective worker summarised the previous and current involvement with the family as follows:

"DHS has received a number of notifications in the past regarding concerns in relation to the above children, however, when workers have made home visits, the mother has not allowed them to enter the house without a warrant. When workers have returned with a warrant she has cleaned up the house and no further action has been taken. Previous attempts to investigate the family have been futile because of the above reasons. The house is in an extreme mess and the Department of Housing has visited the family to inspect the place a number of times." The worker recommended that "Any further investigations with this family need to be planned and spontaneous, given reported concerns of futile attempts in the past to address issues of neglect and subsequent emotional trauma to the children." The supervisor's conclusion on this notification was that "given that the concerns raised were related to past issues with the elder child and are no longer present, and given the family support worker's close involvement with the family, no further action to be taken. The family support will report if any concerns arise in the future".

- **Notification 7**. September 1995. *The notification was effected by a person close to the family on the basis of physical violence perpetrated by the mother's live-in boyfriend upon the children.*

.....

At the completion of case discussion with DHS, audit was informed that in view of the past history of this family, and because the nature of the reported concerns have changed with the latest notification, the case was now considered to be urgent and an investigation was about to be undertaken.

4.145 Protective workers acknowledged to audit that there were inadequacies in investigations, and investigative skills of most workers required enhancement. Causes of these inadequacies were seen as:

- inexperienced workers being assigned to investigation teams under minimal supervision and instruction from experienced workers;
- access to supplementary training in investigations was seen as difficult in some regions; and
- although training courses provided were of high quality, there was a need for more supplementary training and advanced courses in such areas as:
  - investigation of sexual abuse;
  - conducting joint investigations with Victoria Police;
  - dealing with parents with psychiatric illness, severely disturbed adolescents and babies at high risk;
  - alternative investigation methods available, including the gathering of corroborative evidence; and
  - clearly distinguishing between what could be regarded as hearsay evidence and factual evidence. Although hearsay evidence is permissible in Family Division matters in the Children's Court, factual evidence, especially of a forensic nature, reinforces the ability of DHS to prove protection applications.

4.146 In discussions on the above matters, DHS advised audit of the following initiatives it had taken:

- each region had been provided with adolescent response teams to specialise in cases involving adolescents;
- guidance on investigations involving babies at high risk has now been developed;
- the first of a series of joint training programs with Victoria Police had been successfully completed; and
- additional training in investigations was to form part of a new workforce planning strategy for protective services.

4.147 **The positive approach taken by DHS to address deficiencies in investigations is acknowledged. In conjunction with the above initiatives, it is imperative that quality control processes be enhanced in order that supervisors and managers can be satisfied that high quality and comprehensive investigations are being conducted and that all protective concerns identified in planning processes have been addressed. In addition, the need for specialisation of workers conducting certain categories of investigations needs to be further considered.**

Importance of clarity of handwritten notes of interviews

4.148 In some instances, manual notes of interviews were so poorly written that they were almost indecipherable. While some of these notes were subsequently typed, or entered later into DHS's Client and Services Information System (CASIS), the initial handwritten interview notes were still of importance in some cases. This aspect was highlighted to audit by Magistrates of the Children's Court when they emphasised that it was not unusual for DHS failing to prove Protection Applications on account of original notes differing from CASIS reports, or omitting to record key evidence such as references to witnesses at interviews. Also, at Court hearings where Protection Applications are contested, handwritten notes are prime evidence and must be in a suitable form to withstand scrutiny from lawyers and Magistrates.

4.149 While audit acknowledges that circumstances at interviews will not always permit protective workers to compile comprehensive and legible notes of interviews, and that only 6 per cent of all notifications proceed to Court and, if full documentation was made in all cases to the standard that might be required as evidence, significant resources would be absorbed by this process. Conversely, however, it is necessary to emphasise such notes could be required in Court as prime evidence.

4.150 **DHS has an obligation to provide additional guidance to protective workers when conducting investigations, to endeavour to ensure that handwritten notes are in a legible form, address pertinent issues, identify clearly sources of information and cover all issues included in the planning phase.**

Inadequate record of interview with clients

4.151 In addition to the poor quality and legibility of handwritten notes, such notes were not always clear as to the question being asked, to whom the question was directed, and the exact nature of the response. In discussing these findings with protective workers, it was emphasised to audit that these workers often faced difficulties with interviews including lack of co-operation from parents, potential violence, and the often generally chaotic conditions under which some of the interviews are undertaken. In certain instances, investigation teams may be concurrently interviewing a child and the parents. Under these circumstances, it is extremely difficult to establish a communicative and co-operative relationship with the parent(s) and child, conduct a thorough interview and take adequate and accurate notes of the process at the same time. The position is further complicated in that DHS does not encourage audio taping of interviews.

4.152 Audit acknowledges this difficult operational environment and, as a consequence, the quality of note taking would not be the highest priority for workers. It is also acknowledged that a major purpose of the interview, in addition to obtaining evidence on whether abuse has occurred, is to engage the family in a discussion of its needs so that strategies can be developed to effectively address those needs. However, in view of the importance of the evidence gathering process, and the potential requirement to present evidence in Court, audit considers there is a need for improved recording of interviews.

4.153 **The Department should consider the use of audio taping to record interviews for cases particularly where risk levels are assessed as high, where there is a likelihood of a protection application being sought or where a client requests an interview to be taped. Such a step would overcome the abovementioned difficulties and ensure accurate and unassailable records of interviews.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department and Victoria Police have established a working party which will develop improved investigative techniques for police officers and protective workers. The Video Audio Taping Evidence Project (VATE) auspiced by Victoria Police is being expanded Statewide with an increased emphasis upon the Department's active involvement in the pre and post-interview process.

Inadequate emphasis placed on siblings

4.154 In cases where an investigation was conducted and more than one child existed in the family unit, it is important that the impact of the reported abuse on the physical and emotional well-being of the other children in the family is given full consideration. Where sexual abuse is established, it is relatively common for siblings also to have suffered abuse. It is also likely that children who witness abuse (if not being directly abused themselves) of a brother or sister will be psychologically affected by such events.

4.155 In a number of cases examined by audit, there was little or no evidence of consideration being given to siblings. In these circumstances, DHS was not in a position to conduct a detailed evaluation of the impact of the abuse of a child on its siblings, or determine whether abuse had also occurred to these children. In some cases, subsequent notifications were made on siblings not previously assessed.

4.156 **To be effective, an investigation must take full account of all siblings in a family and not only the child to which the notification applies.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  In December 1993, the Department gave a practice instruction to the field which was later incorporated in the Risk Assessment Policy Advice and Practice' guidelines produced in 1996. These guidelines specify that where a notified child has siblings, careful consideration must be given to whether risk factors pertain to them also. Files of past or current involvement with siblings should be read.

Part 5

Case management

OVERVIEW

5.1 The effectiveness of case management by DHS has been adversely impacted by the transfer of resources from long-term case management to assist with the processing of spiralling numbers of notifications and investigations, coupled with a shortage of experienced staff and inadequate supervision. The audit found that:

- The quality and level of detail of draft and final case plans were deficient in providing guidance to the Children's Court, and to case workers, on future welfare considerations for protected children;
- There was a need to improve the timely allocation of cases to the most suitable case worker available, although the audit disclosed that some improvement had been made in the latter part of 1995 in reducing such delays;
- While emphasis was directed to finding a suitable placement for children once a Protection Order was obtained, a similar emphasis was not placed upon the timely planning and delivery of counselling, therapeutic and other support services to families. Additionally, once links were arranged with service agencies and professionals the actual delivery of these services was often delayed because of long waiting lists;
- In some regions there is a significant level of tension between management and case workers with respect to the appropriateness of case deallocations; and
- More effort could be applied by DHS towards the early provision of support services to families and holding case conferences in order to increase the level of success of families in responding to the conditions in Protection Orders and meeting the objectives of case plans.

5.2 In addition to enhancing existing aspects of case management, audit considers that there is a need for DHS to shift its case management focus from one that overemphasises the technical and procedural elements of case management to one that places greater importance upon the human or family oriented aspects to facilitate a shift from the current system-based approach to one which is more service oriented.

BACKGROUND

5.3 After an investigation establishes that abuse or neglect has occurred, a decision is made by DHS as to the level of risk to a child and whether it is necessary to take the matter to Court. If the family agrees to co-operate with DHS, it is usual for a protective plan to be prepared by case workers and the family and child are in most cases referred to a non-government agency to manage the case and/or provide assistance according to the goals of the plan.

5.4 Where the protective issues are of a serious nature and/or the family is unco-operative, DHS will apply to the Court for a Protection Order. A draft case plan prepared by the designated case worker is normally submitted to the Court along with the Disposition Report. The protective plan prepared at the initial planning meeting with the family, normally held within 28 days of the notification, will assist in developing the draft case plan. If the protection application is accepted by the Court, a detailed case plan must be finalised within 6 weeks.

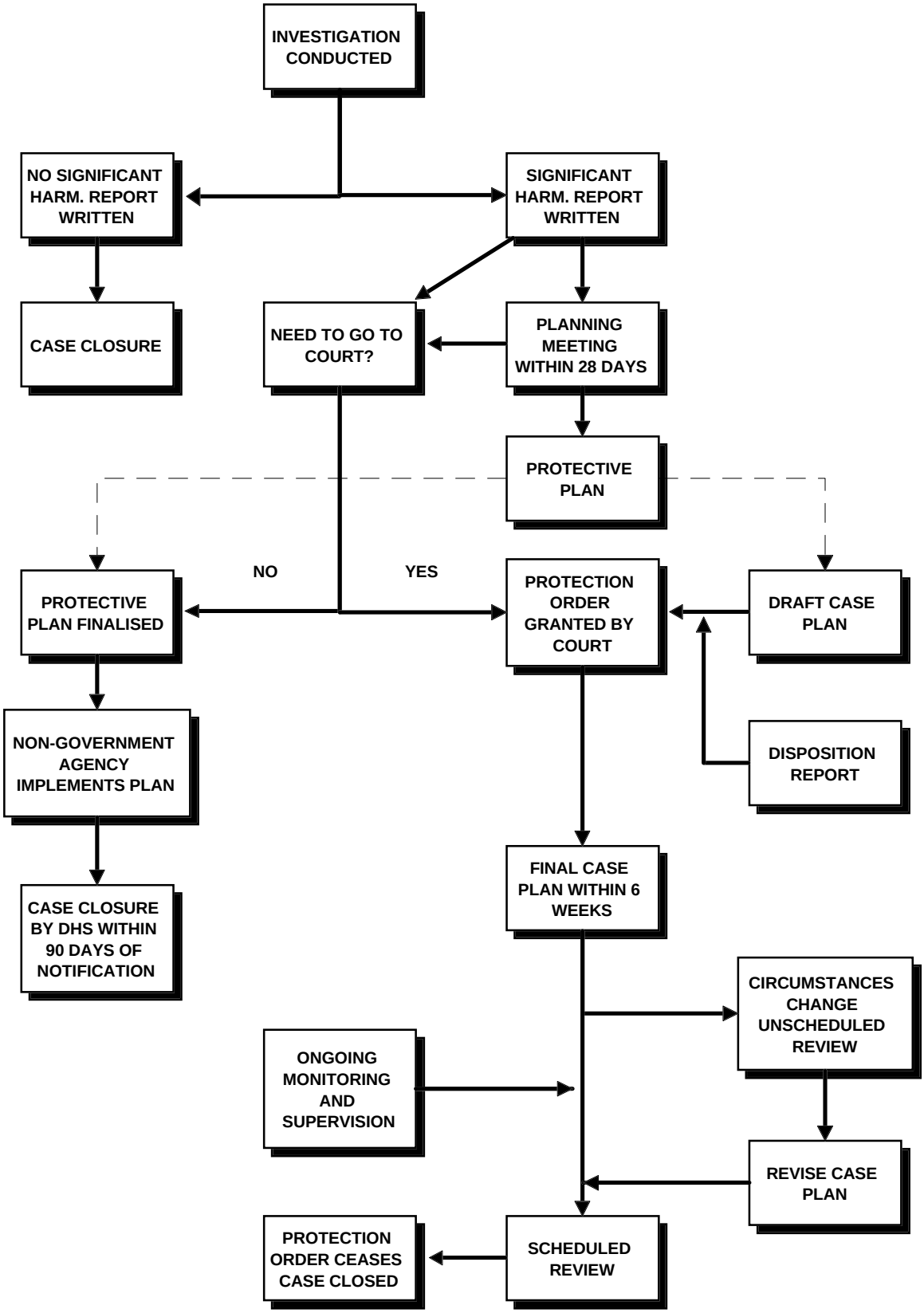
5.5 The purposes of case planning, as set out in the DHS Policy Advice and Practice Manual, are to:

- determine the specific issues that cause a child to be in need of protection and to develop goals or objectives to be met in bringing about key changes to address these concerns;
- identify those activities and tasks necessary to achieve the case plan goals so that the child can live safely and have its individual needs met;
- nominate the persons and/or agencies responsible for implementing the specific tasks and activities; and
- ensure that the intervention process is properly targeted to the protective concerns identified through the establishment of timeframes for specific tasks to be achieved.

5.6 Once DHS assumes the responsibility for care of a child, irrespective of whether the case plan is managed by DHS or delegated to an agency, it remains responsible for all costs associated with a child in alternative care, i.e. care outside the family home. These costs encompass payments to carers, usually foster families or adolescent community placements, and other costs such as education, special support, counselling and medical expenses directly attributed to a child's upbringing and development.

5.7 Chart 5A outlines the process arising from investigations leading to the development of case plans to be implemented by DHS case workers, and protective plans which, although they can be implemented by DHS, are more often the responsibility of non-government agencies assigned to work with the families. This Part of the Report focuses upon the quality of case planning, implementation of case plans and case closures, as highlighted in the chart.

CHART 5A
CASE MANAGEMENT



NEED FOR IMPROVED QUALITY OF CASE PLANNING AND MANAGEMENT

Limited usefulness of draft case plans

5.8 Where a child is deemed to be in need of protection from risk of significant harm, a case conference is normally convened by DHS before the Court hearing. Attendance at a case conference usually involves the parents and child, a senior child protection worker (being the delegated case planner, the case worker allocated to manage the interests of the child, professionals such as teachers and psychologists, welfare agency representatives, and any other persons such as relatives who are able to assist in defining the problems and solutions. The intended outcome of such meetings is a draft case plan which provides the case worker, child and family with a schedule of goals, strategies and tasks required to resolve the protective concerns and ensure the child's welfare and future development.

5.9 Draft case plans, in conjunction with Disposition Reports, are crucial documents in the Children's Court process, in that they indicate to a Magistrate the course of action planned by DHS in meeting the protective, welfare and accommodation needs of children. These documents also indicate to the Court the measures planned to address the protective concerns identified within families in order that children may be able to live safely at home. The legislation provides that a Magistrate must take these matters into account when determining a protection application.

5.10 From an examination of case files of DHS, audit considered that draft case plans presented to the Court were often of poor quality and lacked the necessary detail to effectively address the protective concerns and the child's welfare. This view was also confirmed to audit by Magistrates, pre-hearing conference convenors and other Court users. In addition, draft case plans were, on occasions, not provided to the Court, usually due to timing factors, arising from the late allocation of cases, or a family refusing to co-operate. The poor quality of draft case plans was further confirmed by Court reports such as those from the Children's Court Clinic, which often identified a range of dysfunctional factors concerning the family and child which were not addressed in draft case plans.

5.11 Draft case plans were often very broad and lacked adequate detail to provide all users (Court, child, parents, protective workers and other professionals) with sufficient insight into the plans' requirements, including the specific supports available to a family in relation to the identified protective concerns. Examples of broad goals included in draft case plans were:

- *"child to significantly reduce risk-taking and criminal behaviour";* and
- *"to ensure the physical and emotional well-being of the child".*

5.12 These broad goals were not adequately supported by specific aims, strategies, tasks, schedules for the provision of services, and identification of persons or agencies responsible for implementation of the plan goals, designed to benefit the child.

5.13 Discussions between audit and case workers established that often these broad draft plans were the best that could be achieved, given the practice whereby case workers are often not allocated a case until shortly before the Court hearing of the protection application. In these circumstances, it is difficult for the case worker to become sufficiently aware of all the facts of the case (risks, needs, family backgrounds and other characteristics) in order to be able to develop a detailed plan in time for the Court hearing.

5.14 Audit acknowledged that in circumstances where it was not possible to hold a case conference with a family prior to a Court hearing, particularly where a family was unco-operative, that the draft case plan could only be based on broad intentions. Nevertheless, this situation was seen by audit as the exception rather than normal practice and did not justify the overall poor quality of draft case plans submitted to Magistrates.

5.15 **In audit opinion, DHS needs to ensure that draft case plans submitted to Court are more specific in relation to the goals, objectives, strategies, tasks, and time frames which apply to all participants in the plan so that they can be fully aware of their commitments. The draft case plans should be developed in a manner that enables Magistrates to be satisfied that adequate strategies have been established by DHS to protect the children, develop programs to meet their welfare needs, and at the same time assist families in removing protective concerns.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The Department rejects audit's conclusion. Child protection staff work in accord with the case planning principles as enshrined in the Children and Young Persons Act and the departmental case planning process. Audit's reference to the quality of draft case plans is inaccurate. Draft case plans are intended to be a brief description of proposed departmental directions with a particular case and they comply with that purpose.

Shortcomings in final case plans

5.16 Draft case plans, once accepted by the presiding Magistrate, form the basis of the final case plans to be prepared in accordance with the legislation by DHS within 6 weeks of the Court decision, after taking into account any conditions imposed by the Court. A draft case plan of poor quality and based upon an inadequate assessment of the child and family can subsequently be translated into a final case plan incorporating the same deficiencies, particularly where there is a new case worker assigned to the case subsequent to the Court decision. Despite the crucial nature of final case plans, many of these plans differed little from the inadequate draft case plans.

5.17 An audit examination of selected case files identified major shortcomings of final case plans including:

- broad-based goals which could give rise to a variety of interpretations;
- inadequately detailed strategies to achieve the stated goals;
- minimal attention directed to consequences and risks to the child in the event of the goals not being achieved or only partly addressed;

- limited detail of specific programs, supports, services, e.g. the frequency of family attendance required at counselling sessions; and
- an absence of timelines for completion of tasks linked to the achievement of case plan goals, including timetables for case plan reviews.

5.18 In addition, audit found that some final case plans took the form of loosely developed handwritten notes.

5.19 Monitoring schedules, which could have been used by DHS to observe the child's progress or to redefine or reassess the case plan and make any necessary adjustments, were rarely utilised. There was often evidence that the child or parents were not responding to the case plan and yet DHS allowed the plan to run its full course without review or amendment even though it was evident that the goals would not be achieved. Also, in serious cases, DHS did not purposely breach the Protection Order to enable the case to again be brought before the Court.

5.20 Audit considered that the non-fulfilment of case plan goals could often be attributed to the setting of unrealistic goals by DHS. Examples were identified where evidence suggested that long-term strategies were required to adequately address the protective concerns and welfare of the child, yet the specified time limit of the protection order, on which the plan was based, did not facilitate implementation of such strategies.

5.21 Although case planning is regarded by DHS as a key element of its child protection activities, discussions with the Department disclosed that many case workers lacked experience in case planning and, in recent years, little emphasis had been placed by DHS on training in case planning. The need to focus training emphasis on case management is identified in Part 10 of this Report.

5.22 **DHS needs to take urgent action aimed at substantially improving the quality and effectiveness of final case plans. In addition, audit suggests that a program of continuous improvement be established under which the management of case plans would be subject to an ongoing internal quality assurance process, with regular reporting back to case workers and higher management.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department accepts the need for continuous improvements in areas such as case planning. A specific training and development course is offered to staff at SOC-4 level, on a twice yearly basis. In addition, case planning issues are thematically pursued in the content of various other training and development courses.

Factors impacting on the effectiveness of case management

5.23 The implementation of the case plan involves a case worker or a non-government agency contracted by DHS undertaking effective management of the child's case in order that the strategies within the case plan are actioned in a timely manner and that any emerging issues are responded to promptly to ensure the child's safety and well-being.

5.24 Case management responsibility is generally assigned to the DHS region where the child's parents reside, regardless of where the child lives. However, in the case of adolescents, where the main focus is for the adolescent to progress to living independently, the region in which the adolescent lives assumes the responsibility.

5.25 The audit identified a number of concerns associated with case management by DHS including:

- the high workload levels and turnover of case workers;
- delays in allocating cases;
- an emphasis on placement rather than services;
- the breaching of Protection Orders by parents; and
- the adequacy of security over information contained within the CASIS information system.

Implications of high workload and turnover of case workers

5.26 An issue frequently referred to by parents, agencies and case workers with whom audit had contact was the high level of staff turnover within DHS's Protection and Care Services due to resignations, transfers and promotions. The turnover results in children and their families, non-government welfare agencies and professional organisations providing services to DHS having to deal with numerous case workers.

5.27 High staff turnover is an ongoing problem in child protection services provided by governments, both within Australia and overseas. Audit acknowledges that due to the difficulty of the work and particularly the high stress levels, child protection workers commonly only remain in this line of work for up to 3 years and, in Victoria, in June 1995, the average experience level of child protection workers and senior workers was 2 years and 7 months.

5.28 High worker turnover, particularly with case workers, also had some repercussions upon the audit process, in that in endeavouring to arrange interviews with case workers, audit experienced considerable difficulty in finding case workers who accepted ownership of the cases. This problem was also highlighted to audit by Magistrates who experienced difficulties in inquiring about the background of cases from new case managers who had no previous involvement with the family and child. Case workers often emphasised to audit their limited knowledge of, or involvement in, the management of the particular cases, an issue which directly impacts upon the quality of case management.

5.29 In Part 10 of this Report, audit identifies that the turnover of child protection workers had been approximately 30 per cent in the previous 2 years. Audit found the high levels of workloads undertaken by most case workers meant at times only basic assessments of families and children were capable of being undertaken prior to supervisors assigning case responsibilities to long-term case managers. Supervisors advised audit that, due to this situation, their ability to allocate individual cases to the most suitable case workers was at times limited.

5.30 Audit received advice from welfare agencies of case workers attending meetings with parents, children and/or care-givers without any knowledge of the child and only minimal awareness of the circumstances. Agencies rely extensively on the case worker's knowledge of the child's family situation when planning the child's welfare and development.

5.31 An examination by audit of case files showed that it was common for a child to have a large number of case workers interacting in the child's care over relatively short periods. Care-givers and children commented to audit on how frustrating it became to constantly go over old ground with each new case worker. The consensus of opinion conveyed to audit by experienced protection workers was that a trusting relationship between a child and adult case worker, and between the worker and the family, could not be easily developed if the child had to describe its life, wants and needs repetitiously to various new case workers. It is relevant to indicate that in some circumstances where the State has guardianship or custody responsibilities, case workers act as defacto parents under the provisions of the *Children and Young Persons Act* 1989.

5.32 Due to the individual perceptions, backgrounds and life experiences of the various case workers, views on what needed to be undertaken to develop a plan for a child's welfare often varied considerably between successive case workers, adding a further element of uncertainty in a child's life. In one case file examined by audit, the child remarked: *"I'm sick of this, I've had 50 workers in the past year!"*. Although obviously this number was exaggerated, it illustrated the level of frustration experienced by children in care with respect to high staff turnover and their eventual inability to place trust and confidence in case workers in the knowledge that the workers may not remain.

5.33 **Both audit and DHS acknowledge that staff turnover is a contributing factor to poor case management and that solutions are difficult. Part 10 of this Report recommends that DHS undertake a major reappraisal of its past strategies and direct priority to improving the overall professional status of its child protection workforce. It also needs to address a range of management issues and improve staff working and employment conditions.**

Delays in allocating cases

5.34 Following the notification and investigation phases, cases are transferred to long-term case management teams at various stages of the case management process. Practices can vary between regions, but generally the transfer to a long-term case worker will occur prior to a Court hearing because responsibility rests with this worker to implement the final case plan inclusive of conditions imposed by the Court. Where cases are unable to be allocated to long-term case workers prior to a Court appearance, either the intake worker or the supervisor will appear in Court.

5.35 Case files are forwarded to the relevant regional office of DHS and distributed to the supervisors who, after due examination, endeavour to allocate each case to the most appropriate protective case worker. Factors taken into account in this process include the characteristics of the case, the complexity of the case plan, the risks involved, background history of any prior involvement of the family with DHS, and the workload and experience of the case workers in the team. After consideration of all these factors, the supervisor may not be in a position to allocate a case and will need to retain personal responsibility for the case.

5.36 As outlined in Part 4 of this Report, the introduction of mandatory reporting with the resultant large increases in notifications resulted in the transfer of long-term case workers to intake teams in order to assist in the processing of notifications and investigations. This strategy, while supplementing the intake teams, had the impact of reducing resources available for long-term case management. As a consequence, extended delays of between 6 to 12 weeks in the allocation of case files became common due to the unavailability of case workers.

5.37 Long-term case workers emphasised to audit that intake teams were able to manage their workloads by forwarding cases to long-term case workers, even though investigations and Court action may have been incomplete. Cases transferred to these long-term teams eventually had to be accepted irrespective of existing workloads and subsequent ability to promptly service clients. The excessive workload of long-term case managers is exacerbated by having to undertake duties normally associated with intake teams, such as completion of investigations.

5.38 Inability to promptly and appropriately allocate cases to long-term case workers has the following consequences:

- Insufficient time available prior to the Court hearing for a family to be properly assessed and the Disposition Report prepared. As previously referred to, this can mean a poor quality draft case plan providing little guidance to pre-hearing conference convenors and Magistrates as to what actions in relation to welfare and development are required in the child's best interests;
- Inadequate time prior to the Court hearing for the case worker to gain the trust and confidence of the child. This is particularly important if a child is suffering trauma from an out of home temporary placement; and
- Unallocated cases subsequent to Court appearances remain the responsibility of the supervisor until such time as a suitable long-term case worker can be found. As a consequence, some supervisors can have the direct responsibility for case loads exceeding 40 cases, a very heavy responsibility which can also mean that cases cannot be managed adequately. The Department regards 10 to 12 cases as an acceptable workload for its case workers. Delays in servicing families can result in cases initially assessed as low to medium risk subsequently escalating to the stage where a child is exposed to a high risk of significant harm.

5.39 DHS did not have a benchmark as to what was considered to be a reasonable time frame within which a case could remain unallocated. Discussions with supervisors indicated to audit that a 2 week period commencing from when the supervisors assumed responsibility for the case, would be considered an ideal time frame: one week for the supervisor to become familiar with the particulars of the case and one week to determine the allocation of the case to the most suitable case worker. Discussions with line management indicated that this time frame, while considered ideal, was not practicable under the existing high pressure environment with escalating notifications and resource limitations. In the absence of a specific DHS benchmark, audit applied a benchmark of 4 weeks for the purposes of examination. It was considered by audit, after discussions with protection workers, that it was clearly unsatisfactory if a case remained unallocated for more than 4 weeks.

5.40 Audit sought to determine the extent of the problem arising from delays and the premature allocation of files through a detailed examination in 3 metropolitan DHS regions as follows.

Northern Region

5.41 Although this region had experienced allocation problems during 1994, the situation improved quite markedly during 1995 when only a small number of cases awaited allocation for more than 4 weeks. Discussions held with regional staff indicated that, while the region had been able to promptly allocate the majority of cases, on occasions, problems had arisen as a result of the pressure to allocate cases as follows:

- individual case loads were not always seen as equitable;
- assessment of the capability of a worker to accept a new case did not always take into account the increasingly high complexity and family violence involved in many cases;
- supervisors were working excessively long hours in order to cope with workloads, particularly in relation to unallocated cases; and
- dissatisfaction among supervisors with having to constantly allocate cases to inexperienced workers.

Eastern Region

5.42 Although the percentage of unallocated cases greater than 4 weeks was 2.7 per cent, a reasonable level, similar problems to those observed in Northern Region were evident in the region.

Western Region

5.43 The audit disclosed that a number of cases at the Footscray Office had been awaiting allocation for periods of more than 4 weeks, and in some instances, significantly more than 4 weeks, although these cases were mostly of medium or low risk. However, cases which had been contracted to non-government welfare agencies were often not allocated to a departmental case worker for 2 to 3 months because of their low risk ranking by the region. As such, DHS was not in a position to undertake any meaningful monitoring of these cases. It is important that all cases contracted to agencies, even those assessed to be low risk, are adequately monitored to ensure effective management of the cases, as responsibility for the children remains with DHS. With respect to this issue, DHS advised audit that every region had recently been provided with a senior social worker with responsibility for the oversight and monitoring of contracted cases.

5.44 The review of the unallocated case load at the Moonee Ponds Office disclosed a more serious situation. Of a total workload (at the time of the audit) of 178 cases, 51 cases (29 per cent) did not have an allocated case worker for periods extending beyond 4 weeks. Of the 51 cases, around 44 per cent were assessed at medium to high risk levels. Staff at the office were extremely concerned at this situation.

5.45 The audit of individual allocation records at the Office also disclosed that the above situation had occurred regularly in the past for these cases. The primary reason for cases reverting to unallocated status during the period of a Protection Order is the turnover of caseworkers. Also, some files disclosed a history of being transferred between long-term teams, a process which provided an illusion of activity when in reality no action occurred. Since the time of the audit, the Office underwent a restructure, partly with the aim of addressing this problem.

5.46 As a means of illustrating the position identified by audit at the Moonee Ponds Office, an example of a high risk case which periodically remained unallocated for extended periods of time is presented below:

> *The case of a high-risk intellectually disabled child remained unallocated to a case worker for a total period of 8 months and 3 weeks between 26 April 1994 and 23 August 1995 which was slightly over 50 per cent of the time. Between 26 April 1994 and 23 February 1995, multiple caseworkers were assigned short-term responsibility for the child.*
>
> *During the period 7 to 24 February 1995, the case was transferred 3 times between teams without an allocation to a case worker. Similarly, between 3 April and 23 August 1995, the case was transferred a further 3 times between teams without allocation to a case worker, and it remained unallocated at the time of audit.*
>
> *In addition, between 26 April 1994 and 23 August 1995, the case was transferred between 3 offices in the region and between 8 supervisors. Discussions held by audit with the responsible supervisor at the date of the audit indicated that, because of the high risk level and the particular circumstances of the case, much work remained to be performed to ensure the welfare of the child and an urgent allocation of the case to a constant case worker would be attempted.*
>
> *This allocation occurred on 11 September 1995 and was subsequently contracted to a welfare agency on 30 October 1995. Notwithstanding the obvious benefits to case management as a result of the contracting of the case to the welfare agency, the case remained awaiting allocation to a case worker for the period of approximately 3½ months from 30 October 1995 to 19 February 1996.*

5.47 **Management information on unallocated cases is regularly produced for monitoring purposes within regions. Audit recognised that the ability to address high levels of unallocated cases was dependent upon the availability of case workers and that the problem is being progressively addressed by DHS as the large influx of staff following the 1995 recruiting campaign become more experienced. DHS, however, needs to ensure that cases classified as medium to high risk receive immediate priority and should not be allowed to remain unallocated for any period exceeding a set benchmark, ideally 2 weeks. In addition, the contracting of cases to non-government organisations does not relieve DHS of the responsibility for ensuring that such cases are promptly allocated to case managers who remain ultimately responsible for the child's welfare.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Although the Department aims to allocate all cases on a risk-priority basis, further work is required to ensure that at times of high workload demand standards are maintained.

  Department case contracting guidelines (Protecting Children: Volume One) define the contracting relationship with non-government organisations. Contracted cases are considered to require a level of departmental monitoring which is now the responsibility of the newly created SOC-3 position that audit refers to. The Department is committed to case contracting as one of the strategies designed to achieve improved service continuity and outcomes for children and families.

Emphasis on placement rather than services

5.48 Experienced case workers indicated to audit that the first 2-3 months subsequent to the Court issuing a Protection Order, was likely to be the most critical time for progress to be made by DHS in addressing protective concerns within a family. During this time, the impact of the Court appearance and the need to change are most clearly ingrained on the minds of the parents and the child.

5.49 Despite the importance of promptly providing assistance, audit established that in the early stages of many Protection Orders, emphasis was given by DHS to the placement of protected children. The subsequent provision of support services to the child and family, such as counselling and therapy, with a view to addressing protective concerns and the welfare of the child, was often delayed as evidenced by many of the case files examined by audit. Discussions held with case workers indicated that this situation was mainly due to:

- As soon as a protection application was proven, a Protection Order issued and placement arranged, workload factors required that priority be given to other urgent cases, including initial assessments of families and children for the purpose of preparing a Disposition Report and draft case plan to be submitted to the Court; and

- Once detailed case plans were finalised within 6 weeks and service links were identified, the welfare organisations and professionals designated to provide these services often had waiting lists and were unable to promptly provide the services identified. It was common for children and families to have to wait 3-6 months for the first therapy or counselling session to eventuate. Often, by this time, the life of the Protection Order had largely expired, leaving very little time for the case worker to assess the beneficial impact or otherwise of the services upon the risk factors within the family, and in order for the child to live safely at home.

5.50 Protective workers indicated to audit that giving priority to other cases once a child was placed, rather than arranging in conjunction with the placement the identified support services for the family, resulted in a loss of credibility and authority by case workers with a child's family. In such circumstances, little or no contact was likely to have occurred with the family for a significant period of time after the Court appearance. It appeared ludicrous to case workers for a family, not having seen a case worker for months, to be suddenly confronted, often by a new case worker, demanding action be taken in accordance with Court conditions and the case plan.

5.51 **Given the emphasis of the legislation on family re-unification wherever possible, it is unsatisfactory that parents are not given the opportunity, through the early provision of support services, to address specific risk factors, such as improving their parenting skills, until many months after the Protection Order is made. DHS needs to re-assess the emphasis given to investigations and intake at the expense of effective long-term case management inclusive of early assistance to families. It is also crucial that the relationship between DHS and the non-government welfare agencies which provide most of the support services is further developed with a view to enhancing the capacity of the private welfare sector to better service, in a more timely manner, areas of demand from families.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department has invested significant resources in the development and provision of services that are designed to work with families at an early stage of intervention and prevent where possible children and families penetrating into the more intrusive parts of the system (e.g. out of home placement).

  In Australia, Victoria has been the pioneer of family strengthening and preservation case management strategies and techniques. Ground breaking services include the Families First and Family Group Conferencing programs. The Families First program was piloted in Melbourne in 1991, and an evaluation of the program was completed by the University of Melbourne School of Social Work in 1993. Since this time the program has been expanded across the state. With a 13 per cent increase in funding in 1995-96, the program now operates in all DHS regions.

  The Family Group Conferencing program was piloted in 2 regions in 1994-95, and an evaluation was completed in December 1995. Funding became available in May 1996 to immediately begin establishing these programs in all regions. Programs will become operational from 1 July 1996.

Breaches of Protection Orders by parents

5.52 Protection Orders issued by the Court include certain conditions, some of which are imposed by the Court, although the majority are arranged through negotiations between DHS and the families involved. Examples include broad conditions for the parents, such as:

- accepting visits from, and co-operating with, DHS;
- refraining from excessive alcohol use while the child is in their care; or
- accepting support and services as directed by DHS.

5.53 Audit established, from examination of case files and discussions with case workers, that it was relatively common for certain families, subsequent to the Court appearance, to become reluctant to abide by the conditions imposed by the Court, including conditions such as attending counselling or therapy services.

5.54 Parents, who commonly denied any wrongdoing or existence of family problems, felt that the services to be provided were either not necessary, not convenient, or inappropriate and therefore lacked a commitment to participate. As such, the conditions of the Orders were subsequently breached and the approved case plan was often left in disarray in terms of addressing the identified protective issues.

5.55 Audit also considered that, in some cases, DHS had contributed to non-compliance by families with Court imposed conditions, in that although final case plans usually reflected details of how conditions were to be met by parents, case workers did not monitor the participation by parents from the outset in complying with the conditions. Workloads of case workers were such that it was relatively common for them to become involved with the family, as distinct from the child, late in the life of the Protection Order only to discover that parents had not complied and were not committed to adhering to conditions contained in case plans.

5.56 Case workers advised audit that the breaching of conditions by parents was an element of their work causing significant frustration and a degree of helplessness at times, in endeavouring to encourage re-unification of a family through addressing protective concerns. In this regard, audit acknowledges that Court conditions attached to Protection Orders cannot be legally enforced and that there are no penalty provisions available if parents choose to ignore such Orders. The only option available to DHS is to either continue to work with and encourage the family or to purposely breach the Protection Order and take the family back to the Children's Court.

5.57 Where Protection Orders are breached, conditions in the Order may be varied by the Court, but in all probability would continue to be ignored by the parents. Alternatively, a new Protection Order may be granted reflecting a more serious approach to the protection of the child. For instance, a Supervision Order under which the child may continue to live at home could be breached and a Guardianship to Secretary Order substituted, whereby the child lives out of home in the care of DHS.

5.58 **More effort needs to be applied by DHS in endeavouring to allocate cases to long-term workers as soon as possible and arranging support services for families at an earlier date. In addition, there is a need to ensure increased participation by case workers in working with families from the outset of a Protection Order as well as managing the children. Audit also considers case conferences could be held much earlier once it became apparent that families were not responding to Court conditions and available supports. Greater emphasis on earlier action should lead, in some instances, to an increased level of success in families responding to Court conditions and meeting objectives of case plans.**

Adequacy of security over information contained within the CASIS information system

5.59 An important aspect of case management, whether short or long-term, is the ability of case workers, protection workers and other authorised DHS officers to access large volumes of client information quickly and have confidence in its accuracy, completeness, reliability and quality.

5.60 An additional dimension exists with respect to client information held by DHS in terms of the confidentiality and sensitivity of data. The nature and sensitivity of information contained in the DHS's Client and Service Information System (CASIS) with respect to children, their families, and mandated notifiers requires the highest level of computer security in order to ensure that only authorised persons are capable of accessing this highly sensitive information.

5.61 Audit undertook an evaluation of certain controls and procedures in place over the security of CASIS and the general computer environment. A number of weaknesses in security, which placed at risk the confidentiality and integrity of the CASIS system, were communicated at an early stage by audit to DHS to enable it to initiate speedy corrective action. These weaknesses included:

- Poor security and controls over the use of passwords governing access to the system. For example, audit found that it was possible to gain access to the system, including confidential client information, through use of a common default password issued to all users first gaining access to the system;
- Users having knowledge and use of the passwords of other officers, partly brought about by failure of officers to change their passwords regularly; and
- The computer room, located in a basement area and secured by swipe card access, could also be readily accessed directly from the street through an unlocked glass door.

5.62 Possible consequences from the above weaknesses were identified as:

- a failure to provide a level of security sufficient to protect the rights of individuals as required by legislation;
- possible embarrassment to DHS through the unauthorised use of sensitive information recorded in respect of children and families;
- a potential for the fraudulent use of computer facilities resulting in lost data or destruction of data or programs; and
- the theft of computer equipment and, more importantly, the stored data.

5.63 **It was clear to audit that DHS needed to take action to ensure that the serious security weaknesses associated with its CASIS information system were effectively rectified.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*
  - *The Information Technology Branch had been requested to urgently investigate the feasibility of implementing audit recommendations regarding the logical security of CASIS.*
  - *A project had commenced to introduce an appropriate system to maintain, on an ongoing basis, a register of persons authorised to grant access privileges to designated personnel. All staff access levels were to be reviewed by the end of 1995, and subsequently continue to be monitored thereafter.*
  - *With respect to the physical location of the computer room, DHS supported audit's comments but stressed that it was limited in what it could do at a practical level to improve security, primarily because of the Department's commitment to the location until 1998. Other location options had been considered but, to date, a more suitable location had not been identified. The installation of a closed circuit TV surveillance of the entry point to the computer room had been completed. The basement area at 115 Victoria Parade was now secure with no access from the street. The computer room located in the basement could only be accessed via programmed swipe card.*

PREMATURE CLOSURES OF CASES

Parents not complying with Protective Plan

5.64 An investigation can take up to 3 months to complete depending upon the complexity of the case and the circumstances involved. Where abuse is not substantiated, files are closed and the parties formally informed by DHS of the case closure. In many cases where abuse is substantiated, DHS endeavours to ensure that protective concerns are effectively addressed through the provision of appropriate support and services focusing upon the child and the family's needs without the necessity to obtain a Protection Order from the Children's Court. Many cases are therefore substantiated each year, protective concerns addressed, in accordance with the Protective Plan, and files closed due to the voluntary participation of the family.

5.65 In 1994-95, 7 326 cases of child abuse or neglect were substantiated and, of these cases, 5 194 (71 per cent) involved circumstances where, due to the co-operation of the family, protection applications to the Court were unnecessary. In essence, in such cases, DHS considers that in arranging the appropriate linkages between family and welfare agencies and professionals to provide services to the family, the risk to the child is reduced or eliminated, and it can withdraw its involvement and close the cases.

5.66 Audit established from an examination of case files and discussions with protection workers that subsequent to advice from DHS that its involvement in the case had ceased, parents often did not keep their commitment to seek assistance through measures such as attending counselling and therapy. In addition, children were not always given the support agreed upon, and professionals and agencies did not, or were unable, to continue to provide their services to a stage where protective concerns identified within the family were being effectively remedied. Re-notifications of abuse or neglect often occurred in these circumstances reflecting potential further harm to the children and incurring further use of resources due to additional investigations.

5.67 Audit considered that, where abuse had been substantiated, the responsibilities of DHS extend beyond the initial establishment of linkages with professionals and agencies providing services and support to the children and their families. DHS should also ensure the effective delivery of those services and support so as to conclusively determine that the dysfunctional family factors that led to the abuse in the first place were being effectively addressed, and protective plan goals had been achieved in terms of ensuring the child's future safety.

5.68 Audit also considered that it would be of value if DHS, rather than closing case files upon the establishment of linkages of families to programs and services, kept files current until reports were received from welfare agencies and professionals indicating that the programs had been successfully undertaken or participation by the family was ongoing. Upon receipt of confirmation that the protective concerns were being effectively addressed, files could then be closed.

5.69 DHS staff acknowledged to audit the value of confirming the effective provision of services and subsequently reducing protective concerns. However, the following reservations were also expressed by protection workers:

- case files would have to be kept open for longer periods, thus impacting on the individual protection worker's ability to manage an additional case load, although it was acknowledged that worker involvement in most instances was likely to be minimal;
- families would remain under DHS scrutiny for a longer period of time due to ongoing protective services involvement, while the legislation places emphasis on minimum intervention in family lives; and
- professionals and welfare agencies preferred not to have continuing DHS involvement and oversight while they were providing treatment and services to the families.

5.70 While recognising, from a risk management viewpoint, the position of DHS, audit considered that, on balance, allowing a file to remain active would achieve the following benefits:

- ongoing DHS interest, albeit through a delegated role to a welfare agency, would most likely be minimal but would provide an extra incentive for families to persevere with the agreed programs, rather than reduce their commitment when informed that DHS involvement had ceased;
- the strategy would be likely to result in an enhanced level of effectiveness of protective services intervention and also be cost efficient in reducing the level of investigations arising from subsequent re-notifications; and
- a strengthened ability of case workers to evaluate the extent of actual achievement of goals agreed with the family in the Protective Plan, a process which audit established was not performed by case workers.

5.71 **DHS should assess whether its current strategy of early closure of cases is providing adequate protection to children who were assessed as being at risk. Through maintaining an interest in cases for often just a slightly longer period, DHS would gain additional assurance that protective concerns are being addressed, as an integral component of case management in further lowering the risk to children and achieving greater efficiency through reducing re-notifications.**

❑ ***RESPONSE*** *by Secretary, Department of Human Services*

The Department is concerned by audit's proposal in relation to the extended departmental monitoring of families where they are currently referred to more generic support services. This is proposed by audit as an additional procedure *but it would in effect constitute an extension of what is already acknowledged by audit as intrusive intervention by the State. Audit fails to acknowledge that such cases, while having had abuse and neglect substantiated, in fact fall into a low and/or no further risk category and that they are legitimately and most effectively serviced by non-statutory means.*

The Department is furthermore concerned at what audit claims to be minimal *resource requirements of this new* procedure*. This proposal would have significant throughput and costs implications for very doubtful benefits in terms of improved outcomes for families.*

Deallocation of cases

5.72 Deallocation of a case occurs when DHS considers the protective concerns are being addressed through the child's placement and the provision of services and support to the extent that, although the case remains assigned, i.e. **still allocated** to a case worker, active involvement by that case worker is no longer required. However, in these cases, the Protection Order still needs to remain in force for the duration of its term.

5.73 DHS considers the deallocation of cases to be a legitimate means of managing cases provided the practice is not misused. Generally, it considers a deallocation to be appropriate when:

- a child under a Protection Order moves interstate;
- circumstances clearly indicate that a child no longer requires protective supervision;
- the nature of the case no longer requires protective services involvement but revoking of the Order is undesirable as it would deprive the child of security or financial support or accommodation; or
- a Protection Order is about to expire and risks to the child are minimal or no longer exist.

5.74 DHS's practice standards further provide that a case is not considered suitable for deallocation if services have to be withdrawn from lower priority cases in order to respond effectively to high priority cases.

5.75 The extent to which cases were deallocated could not be established by audit as records are not kept within regions. The absence of management information on these cases also precludes DHS from monitoring the extent to which deallocations are occurring and whether practice directions are being adhered to. In addition, such information will enable DHS to identify areas where deallocations were not occurring, potentially suggesting that maximum productivity was not being achieved.

5.76 Audit discussions with various child protection workers established concerns that, in their view, a certain level of cases were deallocated by DHS as a consequence of management pressure to use deallocation as a work practice to provide additional throughput capacity and not necessarily because of the low risk nature of the cases. Audit was advised that non-compliance with this management pressure led to the transfer of a supervisor to other duties. The practice of prematurely deallocating cases to meet throughput needs is contrary to practice guidelines and a cause of aggravation between management and case workers in certain regions in terms of whether a case was clearly low risk and in accordance with the practice guidelines justified deallocation.

5.77 Audit was also advised by the workers that, as a consequence of the manner in which some cases were deallocated, their experience had shown such cases sometimes developed into crisis situations because services were withdrawn prematurely and progress made with the family actually regressed.

5.78 The deallocation of cases, unless strictly in accordance with DHS guidelines, has the potential to leave protected children at unnecessary risk. It follows, therefore, that deallocation must always be based on professional judgement.

5.79 **Management information systems of DHS need to be upgraded if it is to be assured that key decision-making on deallocated cases at both head office and regional levels is always soundly based and children are not at risk from premature deallocations. It would also be beneficial if DHS established effective dialogue with case workers and obtained input as to any concerns with existing practices.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Case deallocation involves the temporary withdrawal of a protective worker as case manager. It does not involve the withdrawal or reduction of other departmental and non-departmental support services that may be involved with the family. Deallocated cases remain nominally allocated within a team and families are advised to contact the Protective Team Leader (SOC-3) should they require assistance while deallocated.

Failure to renew Protection Orders where protective concerns still remain

5.80 Provision is made in the legislation for extensions of Protection Orders by the Court where the Secretary of DHS is of the opinion, after reviewing the operation of the Order, that a renewal is in the best interests of the child.

5.81 As the expiry date of the Protection Order approaches, a scheduled review of the case plan is made to evaluate whether circumstances are such that the Order may be allowed to lapse and the case closed, or, if particular risks persevere, whether the Order should be renewed. Case workers advised audit that, in their experience, a limited number of instances had occurred where cases were closed due to throughput pressures, although risks were still apparent. According to the workers, in such cases, it was common that although parents had not visibly responded to supports offered, the children were still permitted to return home.

5.82 Audit undertook a selective examination of case files to compare family circumstances as originally outlined in Court reports and accompanying case plans, with the level of progress made when the case was closed. This examination disclosed that, even with the provision of services, often very little change had occurred in the family circumstances and family functioning and case plan goals had clearly not been met at the time of case closure. Although superficial improvement may have been recorded in some cases, factors such as domestic violence, drug and alcohol abuse and continued denial by parents of any wrongdoing and their refusal to attend therapy and counselling were often still prevalent at case closure.

5.83 When undertaking this examination, audit considered that the critical question in terms of the appropriateness of a case closure was whether sufficient progress had been made to justify DHS withdrawing its involvement or whether there was a need to renew the Order and continue service provision and involvement for a further 12 months. As an illustration, in one case, a family had, over a 4 year period, received assistance from 17 agencies, with protective concerns remaining essentially unchanged even after these significant efforts. In another case, parents bitterly complained to the case workers that the number of counselling sessions scheduled for the parents and child was severely disrupting family life and routine. With this family, minimal change had occurred at case closure in parenting skills, alcohol abuse and family violence when compared with the situation identified at the initial involvement of DHS with the family. This case was closed despite the following comments in a report by the social worker from the welfare agency involved with the family:

> *"The Society ceased to actively case manage the above two clients* [the parents] *as at 31 August 1994 which coincides with the end of the Protection Order over the child. Up to that time, the parents were clearly not keen to see staff here any more than was necessary. They were continuing to deny that problems existed between them, and were resentful of any involvement by outside agencies (including us). It was difficult to broach the subject of specific problems they were experiencing due to their refusal to admit to these problems.*
>
> *"My personal opinion is that the child will not be at the receiving end of any deliberate harmful act by the parents. I am, however, concerned that due to continuing domestic violence and alcohol abuse within the family, the child may be indirectly neglected or harmed."*

5.84 Although the case was closed on 18 October 1994, a re-notification of protective concerns occurred on 15 December 1994 which proceeded to investigation and the process of protective intervention recommenced.

5.85 The full extent to which premature case closures were occurring on a Statewide basis could not be established by audit, as data concerning the incidence of lapsed Protection Orders and subsequent notifications received in respect of the same family is not recorded within the CASIS system.

5.86 **In audit opinion, the closure of cases coinciding with the expiry of Protection Orders should not occur until such time as DHS is satisfied that the child can live safely and case plan goals have been met. DHS needs to research this issue by compiling and evaluating data on the incidence of re-notifications involving the same family occurring subsequent to expired Orders. Such research would also assist it in assessing the appropriateness of, and the degree of compliance with, its risk management guidelines.**

REDEFINING THE ROLES OF CASE MANAGERS - THE NEED FOR CHANGE

5.87 Child protection activities, whether short-term or long-term focused, are essentially case driven, meaning that the proper management of each individual case plan is central to the provision of effective services to children and their families in order to remove protective concerns.

5.88 Audit comments made previously in this and earlier Parts of this Report clearly indicate that DHS is using case management primarily as an administrative strategy to assist in addressing an increasing level of substantiated notifications of child abuse. Comments made with respect to pressures for greater throughput, poor case plan preparation, premature closure of case where dysfunctional elements in families had not been rectified, and the high percentage of breaches of Supervision Orders and Interim Protection Orders due mainly to inappropriate assessments and placements, are all evidence of the consequences of this type of approach, which emphasises throughput at the expense of addressing welfare needs.

5.89 DHS, as a result of past resource constraints, coupled with major operational changes arising from factors such as the introduction of the single track system and mandatory reporting, had little option but to adopt an administrative approach to case management. However, this has been accomplished at the expense of providing less effective services to families and children, not adequately dealing with the often chronic problems and needs that confront families and ultimately adding to the financial and social costs to society in the longer-term.

5.90 The implications arising from the many issues identified in this Part of the Report led audit to conclude that case management, as currently applied by DHS, overemphasises the technical and procedural elements of the process to the detriment of the human or family oriented service aspects. In essence, there is a need to refocus direction **from** the current strong emphasis on investigations, placement of children and subsequent reliance on welfare agencies for family support services, **to** a more practice-centred case management strategy which provides for greater personal involvement by DHS case workers with children and families. Implementation of such a strategy would be facilitated through a range of measures such as:

- Establishing a culture and values, as recommended elsewhere in this Report, which emphasis professional care and services to families and children;
- Giving prominence to appropriate welfare and child development competencies in staff selection and training;
- Providing additional management training to senior child protection workers and managers;

- Encouraging more staff to specialise in long-term case management. While DHS at this stage expects its staff to be multi-skilled in all facets of child protection case management, specialisation in certain areas would be of benefit. Such specialisation could encompass the various stages of child development such as children of pre-school age, primary school age and adolescence. In addition, case workers could also specialise in dealing with sexually abused children, intellectually disabled children, severely traumatised children and children involved in substance abuse;
- Providing case workers with manageable workloads enabling more family contact, developing a more supportive environment which addresses issues such as low morale and poor community image, and better recognition of the valuable and essential work performed by case workers;
- Using some of the additional funds recently provided by the Government for child protection purposes to not only provide additional and expanded training, but to also increase the knowledge of protective services staff in areas such as prevention strategies, early intervention techniques and rehabilitation strategies and services; and
- Generally, raising the standard of its overall case management by:
    - placing stronger emphasis on the quality of case plans and their linkage to family needs and functionality;
    - systematically evaluating whether case goals are achieved before cases are closed;
    - playing a greater facilitatory role between the family and service providers to ensure family needs are being fully met where practical in an atmosphere of support and assistance rather than confrontation and conflict;
    - increasing the ability of care providers, including extended families and foster parents, to address the developmental needs of children;
    - better defining, negotiating and monitoring of the respective roles of the various service providers involved in individual cases;
    - better planning, managing and facilitating visitation and other arrangements between the birth parents and foster care-givers;
    - assisting family members develop social skills and overcome isolation factors such as cultural or language barriers while at the same time maintaining cultural, religious and ethnic integrity; and
    - developing a systematic research agenda and capability for the child welfare system which could assist in ongoing evaluation and improvement of professional practice, including long-term case management and formulation of policy.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department notes audit's earlier conclusion that the Child Protection Program had stabilised since the latter part of 1995 following the provision of significant additional funds. A number of strategies suggested by audit for improving long-term case management are accepted.

  However, while acknowledging the difficulty of work in this area, audit presents a number of negative conclusions based on limited examination of files. In addition, audit does not make any significant comments on the many positive aspects of the Department's work in this area, or the strategies that are being pursued to improve the program's performance and enhance outcomes for children and families.

  The Department is committed to the continuous improvement of case planning and management practices and competencies and endorses this as a high priority. However, recommendations for further improvement would benefit from identification of benchmarking standards which should apply. The Department maintains that current case planning and management standards are generally good and in advance of comparable services.

Part 6

Support services and short-term placements

OVERVIEW

6.1 The Placement and Support component of the child protection system has undergone a significant change over the past 3 years. Within a 5 month period, from June 1993 to the end of November 1993, DHS switched its service focus from Residential Care towards greater reliance on Home-Based Care. Funding reductions equivalent to 11 per cent of total budget were also imposed at that time, which coincided with the introduction of mandatory reporting resulting in an overall increase of more than 50 per cent in the number of children requiring placement and support services. The minimal lead time provided between the implementation of each of these initiatives subsequently caused an unprecedented level of pressure on the service system and severely impacted upon the ability of the system to provide quality of care to some children.

6.2 The widely accepted move towards home-based care to children was largely stifled by the Department's inability, at short notice, to estimate accurately the potential impact of mandatory reporting and its consequential effect on the placement and support system. This resulted in service focus and vital resourcing decisions being made in an environment which was significantly different to that in which they were applied.

6.3 The impact of the above on the quality of care provided to children was that the placement and support system was unable to cope with the large influx of children from early 1994, placing departmental and non-government placement and support workers and facilities under high levels of pressure necessitating, in some cases, the use of placements that were inappropriate. The consequences resulting from this scenario were as follows:

- regions operating substantially in excess of formal reception capacity;
- many instances of placements breaking down, and children being subjected to a multiplicity of different placements in a short period of time;
- instances where extreme measures were taken to provide a child with a "bed", such as placement in motels;
- sibling groups being separated or placed together in residential facilities that were inappropriate due to the age and needs of the siblings;
- establishment and/or reintroduction of high cost contingency facilities to cope with the excess demand;
- high percentages of children, especially in the short-term, were placed in regions other than that in which they were domiciled, or placed within the same region but remote distances from family and services; and
- instances of children re-entering the system repeatedly.

OVERVIEW - *continued*

6.4 Other problems were experienced by non-government sector service providers. For example, the non-government sector element of the network has been confronted by a higher number of children with challenging behaviours resulting in a high level of stress and worker burnout. In addition, fewer resources were able to be directed towards family support, community networking and other preventative activities that are traditional functions of many community agencies.

6.5 Conversely, a number of these non-government service providers were considered by DHS to be deficient in their performance with considerable scope for improvement in their overall efficiency and effectiveness. There was also considerable resistance from non government service providers concerning the method used by DHS to introduce a change in the funding arrangements, which will result in funding based upon outputs in contrast to the previous traditional method of subsidising expenditure.

6.6 In audit opinion, the central issue for these quality of care deficiencies has been the inability of the home based care system to cater for the numbers of children requiring this form of care. The Department's strategy directed towards a greater reliance on home based care was adopted notwithstanding the absence of a comprehensive plan on the likely successes and difficulties of home based care, and the failure to implement strategies to recruit the quantity of care givers necessary to cope with expected demand. Additionally, insufficient support to home based carers such as the inadequacy of the remuneration to care givers, have impacted negatively upon the ability of the system to retain existing care-givers and to attract potential care-givers.

6.7 Audit acknowledges that measures such as the placement of children in new type home based care, and the use of diversionary services aimed at improving the quality of care to children placed under the care of DHS have recently been implemented and that movement towards objectives outlined within the service redevelopment strategy, while slow, has occurred. It is now essential that the placement and support system continues to develop and implement efficiencies without generating a negative impact on service quality. To this end, DHS's intended restructure of the service agreement process, the improvements planned for the computerised management information system, and the proposed enhanced accountability measures will allow more effective measurement of service quality and a greater capacity to more readily identify service deficiencies.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department notes that audit accepts the direction of out-of-home care services moving from a reliance upon facility based care to home-based care.

  However, the Department remains concerned that audit examination in this Part misrepresents a number of key issues:

  - *The Department believes that audit overstates the impact of the introduction of mandatory reporting on the placement and support system. Audit's claim of a 50 per cent increase in the number of children/young people requiring placement and support services is only valid for reception care placements. Audit represents this as the impact across all components of care even though demand remained relatively constant across these other components. Increased demand was absorbed by the injection of an additional $4.5 million.*
  - *Audit states that it has primarily examined reception care services in this Part. However, the Report appears to use this component of care to make assumptions and extrapolations regarding the whole placement and support system. Reception and emergency care presently represent 22 per cent of all placement types.*
  - *The current service redevelopment was based on a formal plan articulated by Departmental policy in the "Placement and Support Program - The Vision for Redevelopment" document, which identified service redevelopment for 1993-1995. The Department therefore refutes audit's suggestion that the policy to place increased reliance on home-based care services was made in the absence of a comprehensive plan.*
  - *While the move towards strengthening home-based care has been a stronger focus since 1993 it is a strategy that has been implemented over many years. There has been increased reliance upon these services since the late 1980s when specialist programs were introduced, e.g. Adolescent Community Placement and the foster care program expanded.*

  The issue of multiple placements has been raised by audit on several instances throughout this Part. The Department acknowledges that placement changes can at times be disruptive to the ongoing care and stability for the children and young people in out-of-home care services. As a result of these concerns a major research project was commenced by the Department in late 1995 to examine the reasons for which placement changes are made, the decision-making processes undertaken and characteristics of the children, young people and their families concerned.

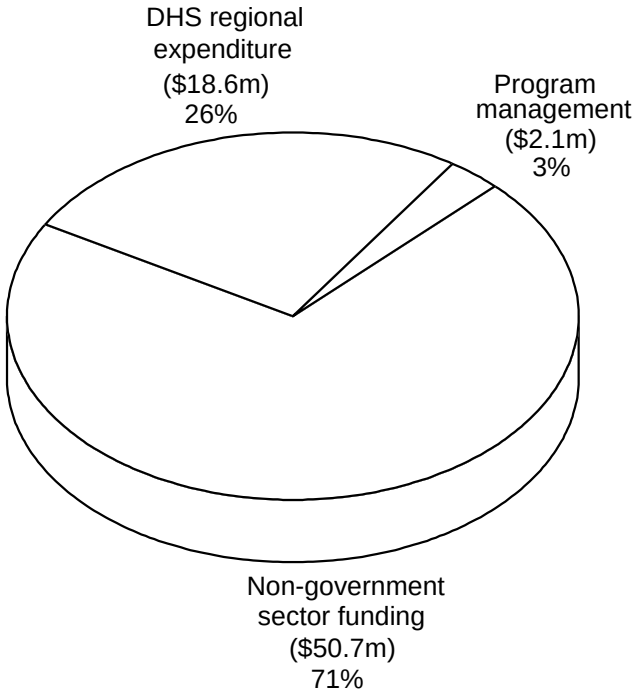
BACKGROUND

6.8 The *Children and Young Persons Act* 1989 provides for children requiring protection and who are removed from their family environment to be placed in suitable accommodation and provided with adequate services and supports to enable them to overcome the physical and emotional trauma suffered as a result of the abuse or neglect by their birth parents. Additionally, the family often requires welfare services and support in order to overcome the dysfunctional elements influencing the family so as to ensure, where possible, the eventual return of the child to the family environment. These services and support are known as *placement and support services*, the provision of which is the responsibility of DHS.

6.9 Placement and support services are delivered via facilities established by DHS and approximately 80 non-government sector service providers located across the State.

6.10 Chart 6A shows the components of the aggregate funding of $71.4 million allocated by DHS for placement and support services in 1994-95.

CHART 6A
ALLOCATION OF FUNDING FOR PLACEMENT AND SUPPORT SERVICES, 1994-95



6.11 The delivery of placement and support services can be categorised into 2 separate but interactive components known as placement services and support services.

Placement services for children who cannot remain in their own home

6.12 Where, for various reasons, a child's protective needs are best served by being placed outside its family home, if only for a short time, the type of placement will be dependent on the particular family circumstances in addition to the type of abuse incurred. Placements could involve one or more of the following:

- *Temporary/Emergency care* - provides for the placement of children for very short periods where there is only a temporary disruption in the family's capacity to provide care;
- *Respite care* - is similar in nature to Temporary/Emergency care as it allows for placements over very short periods but can represent an integral component of a planned intervention and may be of a recurring nature;

- *Reception care* - results from a child's removal from the family home subsequent to formal protective intervention, and will continue until a Court decision is made and the subsequent implementation of identified strategies within the child's case plan;
- *Short-term/Transitional placements* - occur when it is envisaged that it will take up to 24 months to achieve the case planning objectives;
- *Long-Term Placements* - are required for those children whose case planning objectives will take over 2 years to achieve; and
- *Permanent care* - is provided when a child is placed with a caregiver, who is not the child's biological parent, on a permanent basis and occurs when it is envisaged that there is minimal likelihood of the child returning to live with its birth parents. These children are normally under Custody or Guardianship Orders to the Secretary.

6.13 While the various types of placement listed above reflect timing considerations associated with the placement, the actual placement provided will be either home-based or residential.

6.14 *Home-based Care* placements are generally one of:

- Foster care (general care involving foster families);
- Adolescent Community Placement (special care for adolescents);
- Shared Family Care (placements directed at placing siblings together);
- Specialised Home-Based Care (targeting adolescents who are harder to place); and
- Kinship Care (placement with relatives or a community member known to the child).

6.15 During 1994-95 DHS incurred expenditure on home based care of $17.6 million, an increase of 12 per cent when compared with $15.7 million in 1993-94.

6.16 *Residential Care* placements are made within houses or units known as Family Group Homes or facilities operated by rostered staff on a 24 hours a day basis. Such care is generally provided for large sibling groups and placements with more difficult to manage behaviours that cannot readily be catered for within home-based care. This form of care is provided in:

- *Rostered residential facilities* which accommodate between 4 and 8 children with supervision and care provided by staff employed on a rostered or shift basis; and
- *Live-in residential facilities* characterised by the presence of at least one continuous "live-in" staff member to provide support while allowing the young person to live alone.

6.17 Residential placements absorbed $36.9 million in 1994-95, around 50 per cent of total placement and support funding for the year.

Support services to assist families, children and carers

6.18 Support services aim to enhance family functioning and/or meet special needs of children who are placed out of their own homes. These services can be categorised into 2 types, namely:

- *Placement Diversion* - aim to provide assistance to high risk families in crisis and strengthen their protective capacity in an effort to avoid the need to remove the child from home; and
- *Placement Support* - specialist services that assist the providers of the various placement services, such as foster care agencies, to plan for the needs of the particular children in their care, and/or provide additional support and expert advice in response to critical incidents that may be harmful to a particular child's placement.

6.19 This part of the Report comments upon the strategic planning and provision of placement and support services, focusing in regard to service provision on:

- placements in reception care and short-term/transitional arrangements (where the greatest impact of the influx of children arising from the very large increase in notifications following mandatory reporting and increased public awareness of child abuse and neglect was felt); and
- the provision of support services.

6.20 This component of the audit involved visits to, and discussions with, a range of non-government service providers situated throughout the State.

6.21 Part 8 of this Report includes comment on the operational provision of long-term placements and permanent care arrangements.

SOUNDNESS OF STRATEGIC RESPONSE TO MAJOR FACTORS IMPACTING UPON PLACEMENT AND SUPPORT SERVICES

6.22 The State's network of placement and support services was subject to 3 significant operational and environmental developments in the second half of 1993, which have had a far-reaching impact on the nature and numbers of children requiring services, the type of services offered to these children and the resources available to provide services. The 3 developments were:

- the implementation by DHS of a wide-ranging restructuring of placement and support services;
- the ramifications of the Government's budget reduction strategies; and
- the introduction of mandatory reporting.

Implementation of a wide-ranging restructuring of placement and support services

6.23 In April 1994, DHS announced a major restructure of its placement and support services. Details of the restructure were described in a document entitled *Placement and Support Program - The Vision for Redevelopment.*

6.24 The April 1994 document indicated that *"... the present placement and support system has developed without significant overview or design"* and that the system operated in an environment that had changed significantly from that of previous decades. The document also stated that it was more cost-effective to reduce the heavy reliance on residential services which were very expensive compared with placing a child in a home-based service.

6.25 The objectives of the restructure were:

- *"obtaining a better and more flexible mix of services to meet the special needs of disabled children and children who have been abused or neglected, or are at risk;*
- *achieving a fairer spread of services across the State;*
- *providing more cost-effective services;*
- *moving to unit pricing for client care, so that available funds are linked to clients, not services;*
- *improving the quality of services by increasing the support to service providers; and*
- *enabling client outcomes to be monitored and services to be evaluated".*

6.26 The redevelopment of the placement and support services was initially planned to be progressively implemented over the period 1993 to 1995. DHS advised audit that during 1995 it had decided to extend the redevelopment activities to June 1998.

Shortcomings in key aspects of planning and early implementation of the redevelopment

Lack of documentary evidence to justify the move to home-based care

6.27 For many decades, residential care has been a distinctive characteristic of Victoria's approach to the provision of placements for children. Historically, Victoria has had over two-thirds of its placement and support budget committed to funding residential services such as family group homes, hostels and other forms of group care.

6.28 There has been an increasing recognition in welfare circles that, in most instances, a child will receive more consistent and personalised care under the guidance of a continuous care giver, who can focus their attention on that child rather than on a number of children, from different families, with various levels of need. Consequently, DHS, as part of the redevelopment, recognised that a system geared towards the use of home-based care, as distinct from residential care, would provide children who could not live at home with a level of predicability and stability so important to the child's future development.

6.29 The redevelopment program acknowledged that no one model of care would suit all children and that elements of both home based and residential care would need to exist in the restructured system. The intention of the redevelopment was to introduce a change of focus from merely providing beds to catering for the needs of individual children including adolescents and seriously disturbed or disabled children of any age who require specialist services.

6.30 The impact of this change in emphasis under the redevelopment was that Victoria reduced its reliance on residential care as a percentage of total placements from around 50 per cent in 1991-92 to 31 per cent in the initial year of the service redevelopment in 1993-94.

6.31 The identification of the need to move the focus of the placement and support system towards the provision of a broader range and diversity of placements within home based care was generally acknowledged throughout the child welfare industry as a significant step towards a more client-focused system of care for children and young people.

6.32 Despite the generally accepted view that home-based care should be the preferred option for children, specialist advice to audit indicated that it is the view of some international experts that in fact such care can be less stable than residential care. Their research has indicated a placement breakdown of one in every 3 placements in home-based care, and that more children are likely to experience multiple placements in this care, thus offsetting the advantage of more individualised attention

6.33 **Audit was not in a position to form an opinion on the merits or otherwise of the benefits of moving to home-based care. However, DHS did not provide audit with any documented information to demonstrate that the move to home based care would lead to an improvement in the quality of outcomes for children. In addition, there was no evidence available to audit from DHS that it had taken into account any potential deficiencies in home-based care, such as the incidence of multiple placement breakdowns, in the redevelopment.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Since the 1960s there has been a move away from congregate care across all human service sectors including disability services, aged care, mental health, as well as child welfare. The benefits of individualised care include access for consumers to individualised care, attention and support; a reduced likelihood of abuse within the system by staff/carers; increased likelihood of meaningful participation in general community life through education, recreation and increased opportunities for decision-making. The move towards client-focused home-based care services rather than residential services is being implemented worldwide with improved outcomes for service users.

  In Victoria with agencies funded to recruit, train and support care-givers and undertake case management responsibilities, foster care placements are well supported which assists in maintaining individual placements. The Placement Changes Project examines in detail the issues of placement breakdown in Victoria.

Inadequate attention to service quality when assessing system capacity

6.34 The ability of the placement and support system to fully utilise its capacity, both in home based and residential care, was also one of the factors identified by DHS in its push to redevelop the system. Reference has often been publicly made by DHS that every night 400 beds within the placement system were vacant, signifying substantial under-utilisation of resources. As part of the redevelopment, this level of under-utilisation was used as the basis for decisions to reduce funding and close a number of residential facilities such as family group homes which were seen to be in excess of requirements.

6.35 While audit recognises some level of under-utilised capacity will always exist in such a system, audit found that the figure of 400 beds determined by DHS did not take into account the following factors for this aspect of its redevelopment:

- instances where beds have to be left vacant due to the existing children within a facility being unable to cope with any new admissions;
- circumstances which inhibited the filling of a bed because a newly-admitted child would be put at further risk of abuse due to the presence of existing clients with severe behavioural characteristics;
- the non-availability, for example due to recreational breaks, of suitable home-based care-givers on a continual basis; and
- the geographical matchings of supply of facilities to the needs of children.

6.36 **The over-optimistic assessment of the system's capacity by DHS under its redevelopment strategy created adverse relations between DHS and the non-government service providers, who saw themselves as being constantly pressured to accept referrals, often at short notice, to the detriment of service quality as a consequence of this assessment.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department does not accept that it is over-optimistic to expect 100% performance by the funded sector.

The Department queries statements made by audit and non-government agencies in relation to assessments of system capacity and the constant pressure suffered by the agencies. The Department involves the non-government agencies in determining target performance and capacity, and core service delivery tasks through the negotiation of funding and services agreements to ensure maximum service can be provided as required.

Inequitable distribution of resources

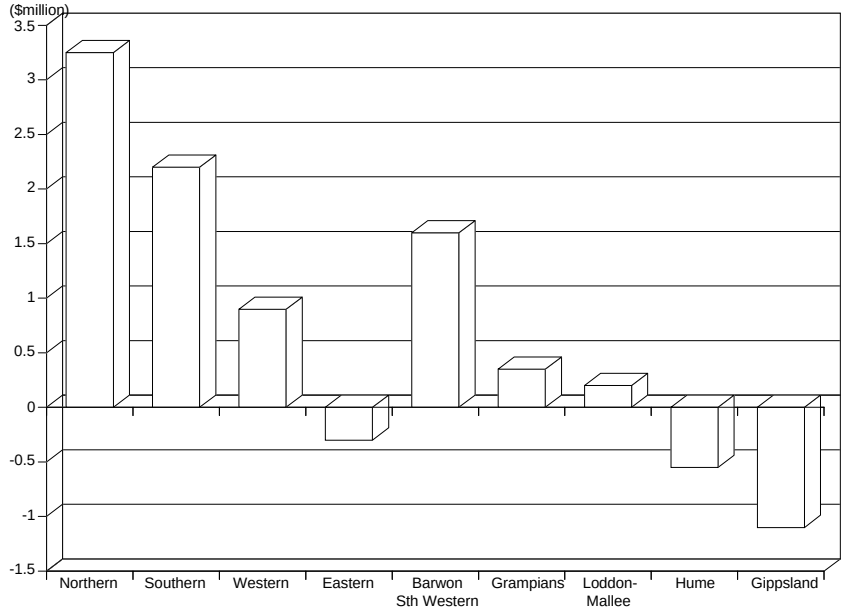
6.37 The redevelopment strategy identifies that a key pre-requisite for the placement and support in terms of effectively meeting the needs of children is the establishment and on-going enhancement of placement services which are spread equitably across the State and are available when needed. The strategy identified the substantial changes to Victoria's population patterns which had occurred over the last decade. It concluded that outer metropolitan suburbs and rural areas were now contributing a much higher proportion of DHS's client base compared with a predominance of children from the inner city suburbs in past years. This shift in demand had led to significant anomalies in the allocation of resources across the State with available placement and support services not located in the areas of greatest demand

6.38 In order to identify the extent of the anomalies in the matching of demand and supply, as part of the redevelopment, DHS commenced, in June 1993, an *"Equity Review"* to identify the factors influencing placement and support services for the purpose of developing a process for achieving equitable allocation of resources between regions. The conceptual model used by DHS to compute assessed resource requirements for each region was based equally on 2 elements, namely:

- the number of children within each region under Protection Orders at June 1993; and
- a range of social indicators such as population density and the percentage of children and young persons under 18 years of age.

6.39 The review by DHS centred on actual aggregate 1992-93 outlays of each region and found significant differences between assessed resource requirements and actual 1992-93 resources in a number of regions. Chart 6B shows the position for each region as identified by the review.

CHART 6B
COMPUTED DIFFERENCES BETWEEN ACTUAL AND ASSESSED RESOURCES IN REGIONS UNDER DHS EQUITY REVIEW (BASED ON 1992-93 OUTLAYS)



Source: Placement and Support Program - Vision for Redevelopment April 1994.

6.40 Chart 6B illustrates that, based on DHS's assessment of resource requirements, all metropolitan regions, with the exception of Eastern which reflected a minor shortfall, had a large surplus of resources, while Gippsland and Hume Regions were under-resourced.

6.41 The need for a redistribution of resources was seen by DHS as an important component of the redevelopment. The results of the equity review were initially discussed with regions with the view that regions with a significant surplus would be asked to reallocate resources to those found to be under-resourced. This intention was not pursued due to resistance from a number of regions. Audit was advised that it was subsequently decided that those regions in surplus would be burdened with the majority of the placement and support budget reduction, and regions assessed as under-resourced would be given highest priority in the allocation of any future funding increases. The actual level of budget reduction allocated to each region for 1993-94 and 1994-95, which was not in all cases consistent with that decision, is identified in the next section of this Part of the Report.

6.42 The Department's decision to attempt to redistribute resources across the State was seen by audit as an important step towards the achievement of the objectives established under the redevelopment strategy. However, the assessed resource position of each region and subsequent budgetary allocations relied heavily on the existing number of children under Protection Orders within each region at the date of the exercise in mid-1993. This exercise was undertaken only 4 months before the introduction of mandatory reporting in November 1993 (and announced in March 1993) that resulted in a significant increase in the number of additional children placed under the system.

6.43 Consequently, the redistribution of placement resources that was to occur was based on data that did not take into account the likely ramifications of the introduction of mandatory reporting. This has had the impact that some of the regions that were assessed as having excess resources in June 1993 and had subsequent budget reductions in fact received additional clients following the introduction of mandatory reporting. At the time of the audit, these regions were still experiencing considerable difficulties in making placements and were being forced into using contingency placements, such as the re-opening of previously closed residential facilities. These residential facilities are more costly than home-based care and are unsuitable for certain categories of children, particularly very young children.

6.44 **In audit opinion, in view of the impact of mandatory reporting and the ongoing difficulties in certain regions in making appropriate placements, it would be desirable within the redevelopment for DHS to reassess the distribution of placement and support resources.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The redistribution of resources across regions is the subject of major consideration and regular review. The service redevelopment process provided the opportunity to redistribute funds while introducing improved service response. The Department reviews, on a regular basis, the equity in resource distribution and takes into account the major indicators including the number of statutory clients.

Delays experienced in the implementation of output-based funding.

6.45 In complying with the Government's policy of movement towards Output Based Funding, of which the best recent example was Casemix funding in public hospitals, DHS is in the process of implementing this funding model within the State's placement and support service network.

6.46 Historically, DHS has funded its own facilities and those of non-government service providers on the basis of funding levels of prior years. The redevelopment recognised that an integral component of the shift towards enhanced service responsiveness and effectiveness was the need for funds to be allocated on the basis of outputs such as *placement-days* rather than historical costs. Consequently, the system was expected to become more responsive to client needs and more flexible in deploying scarce resources to areas of greatest demand.

6.47 The steps identified by DHS as part of the introduction of output-based funding involved 4 interrelated processes, namely:

- client assessment to identify the type and level of service required by individual children;
- establishment of funding levels to agencies based on agency type and number of children they would be required to receive;
- assessment of the appropriate level of payments to home based care-givers providing placement services for children; and
- development of quality assurance guidelines to allow service monitoring, evaluation and performance of service providers.

6.48 The effective and timely implementation of output-based funding was largely dependent on the negotiation of targets in service agreements with the non-government service providers.

6.49 The Department involved the non-government sector in the development of the system through a task group, under the auspices of the Children's Welfare Association of Victoria, which worked in conjunction with departmental officers and provided input by raising relevant issues and concerns from its member bodies. The principles of output-based funding were initially supported by industry bodies such as the Association which viewed the approach as leading to more flexible service delivery and better client outcomes.

6.50 Initially, DHS intended to implement output-based funding on 1 July 1994, around 12 months after it commenced work on the redevelopment strategy. This implementation timetable caused concern in the non-government sector due to the tight timelines for such a critical initiative. The process was to have been inclusive of the development of standards and benchmarks.

6.51 During early negotiations, significant concerns were expressed by non-government service providers in relation to the calculation of the cost of service delivery, the price offered by DHS for the services to be delivered, the benchmarks to be used in measuring performance, and the general redevelopment of the service agreement process.

6.52 The ensuing conflict between the parties could not be resolved and DHS was forced to defer the implementation of output-based funding by 12 months to 1 July 1995. During 1994-95, DHS continued to work closely with the non-government service providers but a number of conflicts, particularly with the task group established in conjunction with the Children's Welfare Association could still not be resolved, including:

- The appropriateness of performance benchmarks, in that service providers questioned whether performance criteria that concentrated on maintaining a high level of occupancy of placements could adequately measure the effectiveness or quality of care provided to children and young people, especially in that some children needed intensive treatment and prolonged care, factors that would obviously impact on the cost of care. Service providers were concerned that quality of care would need to be compromised in order to meet output-based performance targets, or that agencies placing highest priority on quality outcomes for children, in terms of provision of stable high quality care directed towards a child's development, would be disadvantaged if targets were not met; and
- The price to be paid by the Department for particular service types, in that the approach envisaged did not adequately recognise the costs of providing particular services.

6.53 The inability to reach agreement on these issues led to a continuing poor relationship between DHS and non-government service providers throughout 1994-95. In February 1995, the Children's Welfare Association advised its affiliated non-government agencies, *"... not to agree to any target or activity that they felt they could not achieve ... seek legal advice before signing any service agreement document"*. In such circumstances, DHS determined to further delay implementation of output-based funding by another 12 months with a new target of 1 July 1996, although a pilot of the new system was introduced in July 1995.

6.54 **In view of the 2 year delay which has occurred to date in the implementation of output-based funding, and the potential benefits to enhanced efficiency and effectiveness of the service delivery system, it is now important that DHS ensures that successful introduction of the new system within the latest revised time frame of 1 July 1996 is achieved.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The introduction of output based funding has been planned and will be implemented in consultation with regions and the funded sector. This development is in line with government strategy to fund services on outputs rather than inputs. The new framework was implemented in its initial phase as of 1 July 1995 as the shadowing trial to monitor service provision. Implementation of the fully developed system will occur during 1996-97. The lead time in development is not different to similar processes being developed in other programs.

The ramifications of the Government's budget reduction strategies

Basis for budgetary reduction of $7.7 million

6.55 A major strategic goal of the Government, following the October 1992 election, was to reduce the budget deficit as at 30 June 1993 through the implementation of spending cuts across the public sector. As part of its contribution to this goal, DHS determined to reduce the overall placement and support budget by $7.7 million over the 2 year period 1 July 1993 to 30 June 1995. This decision effectively meant a reduction of system capacity equating to around 185 placements.

6.56 Shortly after the introduction of mandatory reporting in November 1993, DHS calculated that, due to the resultant increase in notifications that translated into greater placement demands, the system needed to expand capacity by around 855 extra placements, including the previously identified reduction of 185 placements.

6.57 The basis identified by DHS for the budgetary reduction was as follows:

- a 2 per cent efficiency/productivity saving across-the-board for services provided by the non-government service providers;
- a 4 per cent efficiency/productivity saving across all services provided by DHS; and
- a redirection of resources away from high cost residential facilities towards less expensive home-based care options and placement diversion services.

6.58 The savings relating to the third point were directed specifically at those regions identified in DHS's equity review under the redevelopment as having a surplus of resources. Table 6C details the level of savings to be achieved over the 2 years by each region, DHS head office and services providing facilities across the State.

TABLE 6C
CONTRIBUTION TO BUDGETARY REDUCTIONS BY REGIONS, 1993-94 TO 1994-95
($)

Region	*Budgetary reduction over 2 years*
Metropolitan -	
Northern	1 723 676
Southern	1 578 941
Western	896 268
Eastern	852 722
Subtotal	5 051 607
Rural -	
Barwon South West	753 273
Grampians	342 460
Loddon-Mallee	325 321
Gippsland	62 873
Hume	61 464
Subtotal	1 545 391
Statewide facilities	771 050
DHS head office	365 858
Total	**7 733 906**

6.59 Table 6C illustrates that the metropolitan regions contributed the largest portion (around 65 per cent) of the budgetary reduction. However, 3 regions, Eastern Metropolitan, Gippsland and Hume, identified in the equity review as already having a shortfall in the minimum level of resources required to adequately meet service demands, were still required to meet further budgetary reductions, with a significant reduction applied to the Eastern region. When it become obvious to DHS that these regions could not support the placement demands imposed on them, some additional funding was made available at a later date.

6.60 The majority of the savings, $4.8 million (or around 62 per cent) was achieved in 1993-94, when the major impact of the increase in placement and support referrals from mandatory reporting was being experienced by the system. The decision to make significant resource reductions was also made at a time of great uncertainty as to demand patterns that would be placed on the placement and support network mainly as a result of mandatory reporting.

6.61 Audit was advised by DHS that the placement and support system has been required to meet further annual productivity savings of 1.5 per cent in 1995-96 and will face similar savings targets in 1996-97 and 1997-98. These savings have been directed at placement and support services while DHS activities relating to child protection services, which strongly correlate with the level of activity facing the placement and support network, are exempt from these resource reductions.

6.62 **Significant budgetary reductions were applied to the placement and support system in 1993-94 and 1994-95, at a time when system service demands escalated sharply as a consequence of increased public awareness of child abuse, as well as the introduction of mandatory reporting.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department rejects that the shift in focus for service redevelopment was strongly motivated by savings requirements. The move towards home-based care has been based primarily on the achievement of positive client outcomes. The Department has also clearly stated in the Placement and Support Program - The Vision for Redevelopment its plan to develop a continuum of out-of-home care services aimed to best meet the needs of individual clients.

Activities to compensate for the impact of budget reductions

6.63 In 1995, DHS sought, in a submission to the Government, additional funding for a range of initiatives to compensate for the impact of budget reductions on service quality within the placement and support system. Following consideration of this submission, the Government determined to build an additional amount of $4.5 million from 1995-96 into the budget base for placement and support.

6.64 In line with the initiatives identified by DHS, this additional annual funding is to be used to establish an extra 242 placements in the system as detailed in the following chart:

TABLE 6D
ALLOCATION OF
ADDITIONAL GOVERNMENT FUNDING FROM 1995-96
($'000)

Allocation of funding	*Amount*
Transitional funding for service redevelopment initiatives/contingency (66 placements)	1 590
HBC Placement Flexi Packs (50 placements)	1 200
Kinship care (70 placements)	1 000
Diversion and placement support (50 placements)	500
Western Region regional base enhancement (6 placements)	210
Total	**4 500**

6.65 **In the 1994-95 to 1997-98 phase of its redevelopment strategy, the Department envisaged that the extra funding will enable transitional contingency units to be funded within regions while new services build up to their target capacity, and result in strategies to realise funds for the increase in care-giver payments.**

Overall audit comment on strategic response by DHS to major factors impacting on placement and support services

6.66 Audit acknowledges the difficulties faced by a department such as DHS when government budget directives need to be implemented at short notice. Audit fully supports the efforts being made by DHS to make the placement and support system more efficient and cost-effective, and in particular the role of the non-government service providers.

6.67 **Nevertheless, audit considers that more effort needs to be applied to determining the impact of cost cutting measures on the quality of placement and support services, because if this component is not given first priority, ultimately the community will bear the social cost in later years in terms of the adverse effects on children in care.**

CAPACITY OF CURRENT PLACEMENT AND SUPPORT SYSTEM TO MEET OPERATIONAL DEMANDS

Effects at a regional level of the redevelopment strategy, increasing community awareness of child abuse and mandatory reporting

6.68 The preceding paragraphs outlining the strategic response by DHS to major factors impacting on the placement and support system indicate that, from late 1993, the system has operated under considerable pressure. Budgetary reductions and a large increase in children under Protection Orders requiring out-of-home care and relevant support services were accompanied by a high level of urgent demands to find accommodation for children requiring protection.

6.69 The DHS redevelopment strategy required a number of children within existing placement and support facilities to be moved from residential to home-based care and all new placements to be made, where possible, in home-based care. The sharp increase in demand, resulting from an increasing community awareness of child abuse and introduction of mandatory reporting, meant that the placement and support system did not have the capacity to cope with the significant increase in children needing protection. As a result, the philosophy that was forced to prevail at the time was best summarised by a quote to audit from a departmental officer that *"if beds are available, then fill them"* which obviously caused quality of care concerns for many children placed in inappropriate accommodation.

6.70 Against the above background, audit sought to analyse DHS's ability to cope adequately with the environment it was faced with in 1993-94 and subsequent years, particularly in relation to the timely placement of children in appropriate *reception care.*

6.71 Reception care, as indicated in the background section of this Part of the Report, results from a child's removal from the family home subsequent to formal protective intervention, and will continue until a Court decision is made and the subsequent implementation of identified strategies within the child's case plan. This type of placement is generally accepted as the most demanding component of the placement and support system because it involves accommodating all referrals, in most instances with very little lead time, during a period of severe disruption and stress for children and their families. Since 1992, the number of children accommodated in reception care has more than doubled.

6.72 Given the decentralised nature of DHS's operations, the audit analysis was performed on a regional rather than system-wide basis. Two metropolitan regions, Western and Southern, and a rural region, Gippsland, were selected for audit examination. Audit was advised by DHS that the operational environment of these regions would be representative of most, if not all, other regions.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department strongly refutes the notion that placements were indiscriminately made at any time. The Department has not held the philosophy that "if beds are available, fill them" and, therefore, strongly objects to this implication. All attempts are made within the case planning framework, where goals are established to meet the individual needs of the child/young person in care. Matching of children/young people to placements are made using available resources and the best available placement is made to suit individual needs. All placement services have eligibility criteria. The Department holds that quality of care is the major element in service provision.

  Agencies have also been provided with a range of opportunities to enhance their capacity to place children and young people in well-matched placements. This includes transitional funds to develop new programs such as specialised home-based care and flexi-pack arrangements.

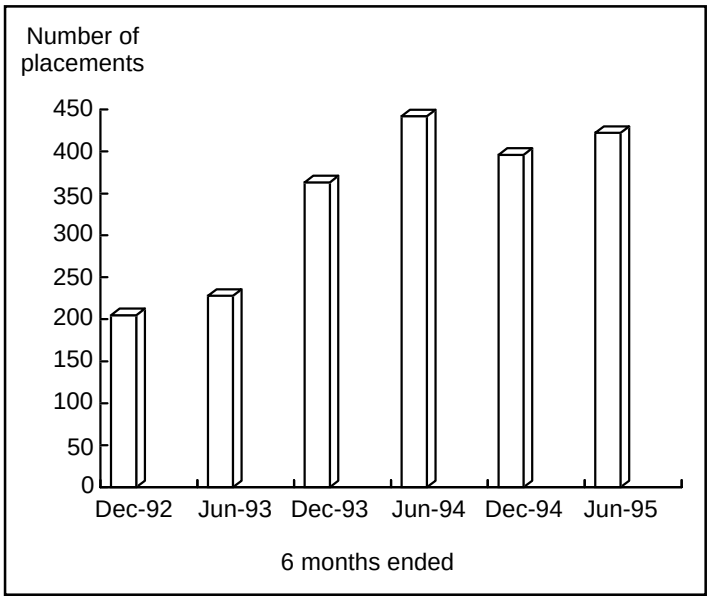
Impact on reception care

6.73 Reception care within the placement and support system can be categorised as either of a formal or informal nature, the former, which is the more significant, involving residential or home-based placements specifically established to provide reception care services. Reception placements can either be provided by the non-government sector on behalf of DHS through the service agreement process, or directly by DHS's placement facilities.

6.74 Consolidated Statewide information relating to the level of formal placements had not been prepared or regularly utilised by DHS for management decision-making. It was therefore necessary for audit to make specific arrangements for the development of the information in order to carry out its analysis. In addition, during visits to regions, audit was required to collate relevant information from manual records.

6.75 Chart 6E shows the significant increase in the number of children in formal reception placements over the period December 1992 to June 1995.

CHART 6E
NUMBER OF CHILDREN IN FORMAL RECEPTION PLACEMENTS
FOR THE PERIOD DECEMBER 1992 TO JUNE 1995



6.76 As indicated in Chart 6E, the total number of formal placements from December 1992 to June 1995 more than doubled. This increase was mainly experienced in the 12 month period June 1993 to June 1994 because of a 94 per cent rise in demand occasioned by growing public awareness of child abuse and the early impact of mandatory reporting.

6.77 The audit analysis identified that, in the Western Metropolitan Region, the existing formal reception capacity in November 1993 was 54 placements, a number which was just adequate for the region to cope with demand for placements, at a time when mandatory reporting was about to be introduced. The region increased its capacity from 54 to 79 in August 1994 by re-introducing a number of contingency accommodation units to the system. In the period up to August 1994, the region experienced significant excess of demand over capacity

TABLE 6F
COMPARISON OF ACTUAL PLACEMENTS AND SYSTEM CAPACITY
IN WESTERN METROPOLITAN REGION, JULY 1993 TO APRIL 1995

Period	*Average monthly intake of children*	*Average total placements*	*Average system capacity*	*Excess of capacity* (%)
July - December 93	56	70	54	30
January - June 94	72	91	54	69
July '94 - December '94	80	110	74	49
January '95 - April '95	75	126	79	59

6.78 At the time of the audit examination in April 1995, Western Region had 141 children classified as in reception care, 62 in excess of formal capacity. The magnitude of this excess demand was such that, while some of the over-capacity placements were able to be made in temporary foster care and emergency accommodation such as that provided under the Supported Accommodation Assistance Program, DHS had to resort to the use of inappropriate accommodation such as medium or long-term rostered units, wherever there was a "bed" available and even on occasions, motels. The adverse consequences of placing children, separated from their home for the first time, in inappropriate placements is detailed further in later paragraphs of this Part of the Report. An inappropriate placement is deemed to be where a child is placed in accommodation which is not suited to its needs by virtue of its age, individual characteristics, background, location of its family and availability of support services.

6.79 In relation to Southern Metropolitan Region, its formal reception capacity in June 1993, of 77 placements remained constant until September 1993. Up to this time, the number of children requiring placements varied between 68 and 76 in line with system capacity. Subsequent to the introduction of mandatory reporting, the system operated well in excess of its capacity throughout 1994 and the first 6 months of 1995. Table 6G illustrates this position.

TABLE 6G
COMPARISON OF ACTUAL PLACEMENTS AND SYSTEM CAPACITY
IN SOUTHERN METROPOLITAN REGION, JUNE 1993 TO JUNE 1995

Period	*Average monthly intake of children*	*Average total placements*	*Average formal capacity*	*Excess over formal capacity* (%)
June - December '93	72	94	77	22
January '94 - June '94	101	146	73	100
July '94 - December '94	93	140	78	79
January '95 - June '95	94	135	82	65

6.80 The significant stress on the system was particularly severe in the early months of 1994 immediately following the introduction of mandatory reporting, with a demand for 157 placements in March 1994 which exceeded the formal capacity of 73 by 84.

6.81 As was the case in the Western Metropolitan Region, the inability of the formal reception system to cater for all referrals of children in reception care, often at short notice, meant that inappropriate placements had to be made. At the time of the audit in June 1995, pressures had eased from the peak in early 1994, but the system still remained unable to cope with all referrals and children were continuing to be referred to placements that did not provide the optimum level of required care.

6.82 In the rural region of Gippsland, the formal reception placement capacity in June 1993 was 20 placements. From May 1994, the region operated consistently in excess of this number with the situation peaking in January 1995 when the region operated at 65 per cent above capacity. In June 1995, the system was operating at 25 per cent above capacity.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Reception care is crisis driven and placements are made at short notice. This is the nature of the child protection program: the safety of the child/young person is paramount and delays in action cannot be tolerated. Agencies funded to provide out-of-home care have a responsibility to provide placements at short notice and to train and support care-givers within this process.

  The increase in number of reception placements demonstrates a change in focus of the service system rather than inefficiencies in the system. Audit has not acknowledged that reception services were changed in response to nature of service required, that children or young people may have been maintained in the same placement rather than be moved and that children may remain in reception phase for extended periods due to external factors such as contest of the Protection Application.

  Regions have responded to increased demand for reception care within their service redevelopment strategies by developing a flexible, dynamic system aimed at meeting changing regional needs. The Department identifies this as a strength within the service system. Audit has not accounted for the total reception capacity such as kinship care placements.

Overall comments on results of audit analysis

6.83 The impact of the budget reductions imposed by the Government in 1993 on the placement and support system, in conjunction with a large influx of children into reception care as a direct consequence of mandatory reporting and increased public awareness of child abuse, forced DHS into a position of having to place many children in reception care into inappropriate placements which add further to the trauma already being suffered by these children from being placed out of home and creates added insecurity for the child.

6.84 The problem was further exacerbated by an inability of DHS to recruit sufficient numbers of home-based care-givers as referred to in later paragraphs of this Part of the Report, with what DHS considered to be an inadequate response from the non-government sector to provide adequate levels of placement and support services.

6.85 **Although the difficulties encountered by regions in providing suitable placements have eased as a result of the additional government funding for placement and support from 1995-96, DHS needs to undertake a range of significant strategic actions before it can be satisfied that the placement and support system is effectively meeting the needs of the children assigned to its care.**

6.86 **Audit considers that DHS needs to:**

- **undertake a comprehensive analysis of the capacity of all reception care facilities across the State, including temporary home-based care and match placement availability against current and future placement demands;**
- **prioritise funding allocations to those regions with the largest shortfalls in placement capacity;**

- **actively recruit care givers willing to take children in reception care at short notice; and**
- **in conjunction with the non-government service providers, develop a computerised on-line accommodation information system, which facilitates management decision-making, at both head office and regional levels, for planning and resourcing placement and support services.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department accepts audit recommendations and currently undertakes this work at the appropriate level, regional or central.

FACTORS ADVERSELY IMPACTING ON THE EFFECTIVENESS OF THE PLACEMENT AND SUPPORT SYSTEM

6.87 In the earlier paragraphs of this Part of the Report dealing with DHS's strategic response to significant emerging factors impacting on the placement and support system, audit concluded that more effort needed to be directed by DHS to determining the impact of cost cutting measures on the quality of placement and support services. If the question of quality of services is not given major priority, ultimately the community will bear the social cost in later years in terms of the adverse effects on children in care.

6.88 The importance of the overall quality of care provided to children was a prime topic raised in interviews conducted by audit with a range of DHS protection workers. The situation was best summed up in the following extract of comments provided to audit:

"The shortage of beds often leads to the use of motels to accommodate children. Throughout the State, children are often placed out of their region of origin, at significant distances from their families and workers. Long delays are often experienced in securing appropriate accommodation for children when they are taken into protective custody. This frequently means that the children are cared for at the DHS office for extended periods, sometimes well into the night, before accommodation is found. A lack of appropriate placements can lead to cycles of transience within the accommodation system as children are moved from place to place. In some cases, such institutional transience becomes, for some adolescents, simply too much and they end up on the street."

Consequences of inadequate system capacity on quality of care to children

6.89 The audit included an assessment of the impact on service quality of the inability of the placement and support system, particularly during 1994 and 1995, to find placements which were appropriate to the needs of children. **Audit found that the system's lack of capacity led to a number of significant consequences including:**

- **children entering reception care for the first time being placed in medium or long-term facility-based care with children of different age groups or children exhibiting severe emotional and behavioural problems;**
- **instability to children through constant placement movements in an effort to locate children placed in emergency or contingency accommodation in placements better suited to their needs;**
- **sibling groups being separated due to difficulties in arranging suitable placements, such as foster care or family group homes for older groups;**
- **dislocation of children from family, friends, schools and other services; and**
- **"*contamination*" of children (particularly adolescents), an industry term which refers to children, being adversely influenced by other children with whom they are placed who may have been in the system a long time with histories of challenging behaviour.**

6.90 **The overall effect of the above consequences is that preventable harm has been done to children as an indirect result of policies or programs designed to provide care and protection. In other words, what the welfare industry generally refers to as "*system abuse*" of children has in fact occurred in Victoria.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department acknowledges that on occasions "system abuse" can occur, a challenge faced by all human service systems. However, it should be noted that the Department has taken major initiatives such as service redevelopment, resulting in the establishment of new programs which are client-focused and able to better provide individualised support and services to children and young people.

6.91 While audit recognises the operational difficulties faced by DHS as a result of increased community awareness of child abuse and mandatory reporting, the impact upon children of the above consequences was significant, and has been a factor contributing to further instability in children's later years, as described further in Part 8 of this Report.

Unsuitable placements

6.92 The pressure applied to the placement and support network subsequent to the introduction of mandatory reporting was so intense that in a small number of instances, extreme measures were found to be necessary to temporarily place children who had been removed from immediate danger within their homes.

6.93 Some of the extreme short-term measures which DHS had to resort to included placement in motels and caravan parks due to a total lack of any other placement options in the entire system. Two of the examples of such circumstances brought to the attention of audit were:

> *A 16 year old adolescent with very difficult to manage behaviour and who was very outwardly abusive could not be placed in a short-term unit with an emergency one night accommodation facility because these facilities were being used as ongoing placements due to the intense demand on services. For 12 days, this adolescent had to be placed in a motel unit where his only supervision was through visits by intensive youth support services workers from a Salvation Army program each night. The only other supervision was conducted by the motel manageress who checked to inform placement and support workers if he was in his room. In addition, the fact that the boy was on his own with no restrictions on movement represented a significant risk factor for someone with violent tendencies who could cause damage to property or harm to himself or others.*

> *A 6 year old boy who had been badly beaten and abused was referred to a Temporary Emergency Care Unit (TECU) which would not initially take the boy due to the presence of another resident with major problems at the facility. The initial refusal was based on concern for the safety of the new referral, however, the facility relented, given the boy was in hospital and would have had to stay there if the TECU refused to take him. The initial agreement was for the boy to stay at the TECU for 3 days while more adequate facilities could be found. The boy finished up staying at the unit for 4 months.*

6.94 Instances such as the above are now less likely to occur as the system is better placed to deal with the influx of children through the additional funding and other initiatives of DHS in relation to placement and support identified in earlier paragraphs.

Instability to children through placement breakdowns and multiple placements

6.95 The state of the placement and support system, particularly in the first 18 months after the introduction of mandatory reporting, resulted in many instances of children located in placements that did not cater adequately for their needs, causing placement breakdowns and multiple placements. Such circumstances can be illustrated by the following case example:

> *A 2 year old girl, upon referral, was placed in foster care with a care giver who was unable to cater for her needs. This situation was clear from the outset but the foster care system was so stretched that it was the only foster care placement available. Subsequently, the girl was placed in a family group home, where she was located for 4 months despite numerous requests by the manager of the home for her to be transferred because the home could not meet her needs. This girl is one of 3 siblings presently in out-of-home care, where they have been reunited and separated repeatedly. While it was always the plan to keep the siblings together, it was never really attained.*

6.96 The frequency with which such unsatisfactory placements of children in reception care are occurring is also decreasing, as the system slowly responds to the restructuring and redevelopment.

6.97 DHS has yet to systematically analyse the reasons and extent of these occurrences due to inadequate information systems and a lack of resources. However, in the later stages of the audit, it commenced a review of multiple placements which was aimed at identifying measures necessary to negate the factors contributing to the instability of children in the placement and support system. The factors contributing to multiple placements included the following:

- excessive access requirements for birth parents of children on Court Orders contributing to behavioural problems of children leading to placement breakdowns;
- major delays in obtaining final Court decisions which means that long-term planning cannot occur for several months;
- the capacity of the system to support home-based care and kinship care placements with packages to suit individual children;
- the rate at which children and young people who have previously been in the placement and support system are being re-referred back into the reception system;
- limited after hours access to home-based care resulting in temporary cross-regional placements that necessitate placement changes at a later date; and
- the under-performance of permanent care teams in recruiting foster parents and permanent care givers.

6.98 **DHS has long been aware of the damage to children that can arise from multiple placements. Although placement breakdowns often occur as a result of factors such as a child's behaviour, the extent to which the placement and support system has in the past contributed to instability in the lives of children in care is a matter of serious concern.**

6.99 **In tandem with its current study on multiple placements, DHS should establish management information systems which are capable of monitoring multiple placements across the placement and support system and intensive efforts should be made to stabilise the lives of those children whose lives have already been disrupted by this form of systems abuse.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department acknowledges that placement changes can at times be disruptive to the ongoing care and stability for the children and young people in out of home care services. In late 1995, as a result of these concerns, a major initiative was undertaken by the Department to examine the reasons for placement changes, decision-making processes used and the characteristics of the children, young people and their families concerned. The results of this project are currently being collated and will inform future service redevelopment.

Separation of sibling groups

6.100 A census of children in the system undertaken by DHS identified that sibling groups represented approximately 46 per cent of all children in the system at 30 June 1994. Audit was advised by DHS that sibling groups still comprise a significant proportion of the population of children in the placement and support system.

6.101 One of the system's pressure points, and the major reason for the continued use of contingency placements, has been the inability of home-based care services to adequately provide for sibling groups of 2 or more children from the one family. As a result, some sibling groups have been placed in residential facilities, including contingency units which, because they lack a family environment, are not suitable for younger children. In addition, other groups have been separated, a position which can be devastating to those siblings who have formed a strong bond when in abusive situations. In making these points, audit recognises the view expressed by DHS in discussions that on occasions sibling groups may have already experienced separation due to family breakdowns and as such, the impact of separation within the placement and support system would not be so traumatic.

6.102 The problems experienced by sibling groups within the system is illustrated by the following case examples:

> *A family of 3 siblings, aged 2, 3, and 4, referred to the placement and support system in March 1995, was placed in 3 separate foster care placements for the first 3 weeks due to the inability of the foster care system to cater for them as a group. They were then placed in a Temporary Emergency Care Unit which was clearly not appropriate for children aged under 4, because of physical features and the use of rostered rather than continuous care givers. However, this Unit was the only available alternative in an effort to keep them together.*

> *Two siblings (aged 2 and 4) referred in October 1994 were put into foster care for 3 days before being released to return home. They were re-referred 2 weeks later but there were no fostercare places available to them. As such, they were placed in a family group home where the care giver had her own 20 month old child. It was clear from the outset that the children's needs were not being met and numerous foster care agencies throughout the region were unable to accommodate them. Placement and support workers believed that these 2 children should have been easy to place immediately, given they were normal children with no real behavioural problems.*

> *A brother aged 2 years and a sister aged 4 months had to be placed with separate foster care givers even though they had no behavioural problems. Placement and support workers tried desperately to place them together but there were no options available. They were both placed with the same foster care agency and pressure was applied to one of the foster care givers to take the other sibling. However, this outcome did not eventuate and they remained separated.*

6.103 The placement and support system needs to be able to cater for sibling groups who comprise a significant proportion of children under care. Audit recognises the difficulties faced by DHS in placing siblings, and avoiding their separation, in foster care arrangements. Nevertheless, the system must have sufficient flexibility in placing young sibling groups in home-based care as this form of care is most appropriate to their needs.

6.104 During the course of the audit, DHS, to its credit, introduced new measures to address this problem through the establishment of the Specialised Home-Based Care Program which caters for siblings who could not be placed in normal home-based care options but who should not remain in residential care. In addition, an extra $1.2 million was made available by the Government in 1995-96 to enable DHS to establish special arrangements (known as placement flexi-packs), which funds up to $23 000 a child to purchase placement services from non-government service providers.

6.105 **It is important that DHS assign high priority to providing suitable services to sibling groups and, in particular, to identifying the specific needs of home-based care givers that care for 2 or more children, including provision for extra bedrooms and bathrooms in the homes of care-givers.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department acknowledges that service responses to sibling groups require further attention to ensure that children are placed in the most appropriate placement available. This has been addressed to date by the introduction of new initiatives such as Specialised Home-Based Care and flexi-pack funding to provide additional resources for children with higher needs including siblings.

Excessive reliance on contingency placements

6.106 The focus of DHS's redevelopment of its placement and support system initially resulted in the closure of residential units operated by the Department and non-government service providers in favour of placements in home-based care. A failure by DHS to recognise the impact mandatory reporting would have on the placement and support system resulted in the system being unable to cater for all the children requiring out-of-home care. In order to provide the level of accommodation necessary, the Department was forced into a number of actions including the re-opening of previously closed residential units, expanding existing facilities and purchasing or leasing particular sites across the State. Thee placements are referred to as contingency units and have been heavily relied upon by DHS since 1994. In December 1994, a total of 100 contingency placements, involving all regions, were in use across the State. Table 6H shows relevant details of these contingency placements as provided to audit by DHS.

TABLE 6H
NUMBER OF CONTINGENCY PLACEMENTS,
AT 31 DECEMBER 1994

Region	*31/12/94*
Metropolitan -	
Western	32
Eastern	29.5
Northern	8
Southern	6
Rural -	
Barwon South West	4
Gippsland	12
Grampians	4.5
Hume	4
Loddon Mallee	0
Total	**100**

6.107 DHS advised audit that, by mid-1995, the demand for placements in contingency units had decreased to around 50 placements, but that, in the latter part of 1995, up to 20 per cent of the intake of children into the placement and support system had to be temporarily placed in contingency units.

6.108 While the use of contingency units varies in accordance with demand, the units are very expensive to operate, in that DHS estimates that each contingency placement costs around $32 600 a year.

6.109 Audit acknowledges that, in the aftermath of mandatory reporting, DHS had little choice other than to re-open contingency units in order to cater for the overflow of children who could not be placed in home-based care. The Department also acknowledges that contingency units, in addition to their high cost, are inappropriate for some children.

6.110 **The use of contingency units should be seen as an emergency measure only, with reliance on them kept to a minimum as other home-based placement services better suited to the needs of children are expanded.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department accepts that contingency units may be required during times of fluctuating demand to enhance service capacity, as well as to provide individually tailored services for children/young people, specific to their needs. The introduction of mandatory reporting along with service redevelopment may have necessitated the use of a higher number of contingency units to meet local demand.

  Use of contingency units is always carefully managed by regions and currently there is minimal use required of contingency units.

Dislocation of children from family, friends, schools and other services due to cross and intra-regional placements

6.111 A measure of service quality is the ability of the placement and support system to provide placements that are relatively close to the child's or young person's family, neighbourhood, friends, school and support services identified as necessary in the case plan. It is very important, particularly upon removal of a child from its family, that the placement minimises the disruption to the child's normal routine. Placement of the child a long distance from home and its family environment can result in emotional trauma for the child as well as causing difficulty for visiting by family members.

6.112 In a situation where placement and support workers within a region or within DHS's After Hours Child Protection Service are unable to place a particular child after all efforts have been made through the system, their only option is to contact another region in the hope that a placement may be available. Cross-regional placement is normally taken on a very short-term basis, e.g. overnight or over a weekend, and is only used as a last resort.

6.113 Audit analysis of the incidence of cross-regional placements made through the After Hours Child Protection Service established that, subsequent to the introduction of mandatory reporting, by November 1994, out of 75 placements made by the Service, 40 per cent, or 30 placements, were made across regional boundaries.

6.114 Further analysis by audit covering the period February to May 1995, showed a fall in the level of such placements, with 103 cross-regional placements made by the Service compared with total placements of 398, representing 26 per cent of all placements. Table 6I details cross-regional placements.

TABLE 6I
INCIDENCE OF CROSS REGIONAL PLACEMENTS BY THE AFTER HOURS SERVICE, FEBRUARY TO MAY 1995

Region	*Children placed in the region who have come from another region*	*Children who live in the region who have been placed out of the region*
Eastern	47	13
Northern	24	24
Southern	12	21
Western	20	27
Rural regions	-	18
Total	**103**	**103**

6.115 The table illustrates that the rural regions and Southern and Western Regions relied more extensively than other regions on having to make placements outside their Region. Conversely, Eastern Region accepted more than 3 times as many placements from other regions than it found necessary to refer, representing the better availability of alternative accommodation within that region.

6.116 The cross-regional placement of children was prevalent (at a level of around 20 per cent) even before the introduction of mandatory reporting, which suggests the system was not in a position to adequately accommodate existing placement requirements, let alone the additional requirements which eventuated from the introduction of mandatory reporting, particularly in the very short-term.

6.117 Discussion with DHS staff indicated that a further exacerbating element was represented by some foster care agencies not offering after hours reception placements, consequently caseworkers experienced significant difficulty in placing children after hours within the same region.

6.118 In terms of intra-regional placements, a second quality placement issue revolved around the placement of children and young people in the same region, but far removed from their familiar environment due to the geographic size of the DHS regional structure. This situation is illustrated in the following example:

> *Two children from Elwood had to be placed in out-of-home care. However, the Southern Region could only find them accommodation in Frankston which was clearly inappropriate as it represented an approximate 45 minute drive from family, school and other support.*

6.119 **The imbalance between demand and placement availability within regions as previously referred to in this Part of the Report needs to be progressively addressed by DHS, so as to ease the incidence of cross-regional and other inconvenient placements. In addition, research needs to be undertaken, in conjunction with the After Hours Child Protection Service, as to the incidence of the inability of DHS to place children in temporary foster care outside of normal hours.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Cross and intra-regional placements are kept to an absolute minimum, as the placement principle is to keep the child/young person engaged within their own community as much as possible. However, in some instances, such as where access to specialist Statewide services is required, cross or intra-regional placement may be sought as the best placement option.

  Where access to after hours placements has been a barrier, regions have undertaken strategies with agencies, particularly within home-based care services, and significant gains in access have been achieved.

Implications of increasing lengths of time spent by children in reception care

6.120 As mentioned in an earlier paragraph, reception care is seen as the most demanding component of the placement and support system. The removal of a child from its family is likely to be one of the most traumatic events in the life of the child as well as its family and, as such, the timeliness of relevant actions is absolutely critical. The amount of time a child spends in reception care depends largely on the time which elapses between the initial issue of a Protection Application by DHS and the subsequent decision reached by the Children's Court.

6.121 Under the standard time benchmark recognised by DHS and non-government service providers, children should not spend more than 3 months in reception care placements. However, because of the consequences of mandatory reporting, it became a relatively common occurrence for children to spend far longer periods in reception care.

6.122 Table 6J illustrates the significant increase in the length of time spent by children in formal reception care over the period December 1992 to June 1995.

TABLE 6J
LENGTH OF TIME SPENT BY CHILDREN IN FORMAL RECEPTION CARE, DECEMBER 1992 TO JUNE 1995

	< 1 week	*1-4 weeks*	*1-3 months*	*4-6 months*	*> 6 months*	*Total children*
At Dec. 1992	47	49	50	35	24	205
At June 1993	34	63	60	42	29	228
At Dec. 1993	70	104	116	42	31	363
At June 1994	88	128	107	61	58	442
At Dec. 1994	29	58	105	94	110	396
At June 1995	45	62	48	108	159	422

6.123 It is clear from Table 6J that children are entering the reception system in much larger numbers and staying in formal reception care for far longer periods of time than was the case 3 years ago. The table indicates that:

- the number of children staying in reception care for between 4 and 6 months has increased from 35 in December 1992 to 108 in June 1995, an overall increase of 209 per cent; and
- children remaining in reception care for in excess of 6 months have increased in numbers by a massive 563 per cent (from 24 to 159) over the 30 month period, representing around 37 per cent of children in formal reception care at 30 June 1995.

6.124 **The provision of reception care for children is only meant as a holding position for children pending a decision by the Children's Court on their future care. It is clear from the above information that, rather than serving as temporary arrangements, reception placements were assuming a longer-term nature, extending beyond 6 months for many children. These circumstances would be conducive to the development of emotional bonds between children and carers, particularly foster carers. Subsequent removal of a child after such bonds have been formed can add further to the trauma and instability already experienced from the earlier removal from its family.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department acknowledges that delays in reception care may add to the trauma experienced by the child. These delays, particularly following the introduction of mandatory reporting were partly a result of the delays in court decisions. The Department has undertaken significant work with the Department of Justice to minimise delays.

Specific implications of the DHS redevelopment strategy on non-government service providers

6.125 Earlier paragraphs of this Part of the Report referred to the major restructure of the placement and support system initiated by DHS in 1994 under its redevelopment strategy. As previously indicated, one of the objectives of the redevelopment involved "*improving the quality of services by increasing the support to service providers"*. The reference to support in this objective involved assistance to service providers to augment their managerial and organisational capabilities in responding to the ramifications of the redevelopment.

6.126 Non-government service providers deliver the major proportion of placement and support services, with approximately 80 non-government agencies of varying sizes providing services across the State. The level of annual DHS funding received by individual agencies ranges from almost $3 million to under $100 000.

6.127 For many non-government service providers, the DHS redevelopment required significant changes in the nature and level of their services. and in turn, their managerial and organisational needs. While the placement and support system has always been dynamic, the redevelopment, with its emphasis transferring from residential to home-based care, required a complete change in service culture for many providers with some having delivered a particular range of services for over 100 years. The redevelopment specifically recognised that to support such changes, service providers needed assistance in areas such as recruitment of carers, pre-service training, a process to maintain the skills base of the workforce and workforce planning.

6.128 The redevelopment also referred to the following factors as relevant to improving the quality of service providers:

- establishment of clear standards of practice and improved access to specialist training for service providers;
- recognition and reward for best practice;
- enhanced supervision and management of direct service staff; and
- possible introduction of an accreditation process for service providers.

6.129 In essence, the implementation of the redevelopment resulted in the placing of far greater reliance by DHS on the ability of the non-government service providers to deliver effective services to children in a climate of changing service focus coupled with significant increases in the numbers of children.

6.130 In order to measure the impact of this increased reliance, audit analysed the impact of the changes within placement and support on the capacity of service delivery in a sample of non-government service providers. The analysis included discussions with both management and workers, care-givers (both residential and home-based), children in care and their families.

Pressing need to increase financial support for foster families

6.131 The expansion of the home-based system automatically gave rise to a need for DHS to ensure that sufficient numbers of additional home-based carers were recruited. An important element of the audit analysis involved an assessment of the extent to which remuneration rates for foster families were conducive to attracting potential care-givers.

6.132 Home-based care-givers, generally referred to as foster families, do not enter into formal contractual arrangements with either DHS or non-government service providers. A number of home-based care givers, in discussions with audit, expressed the view that a major reason for DHS failing to recruit sufficient numbers was the inadequacy of remuneration. They indicated that, for most families, it was economically unviable to perform this role, particularly for low income families who constitute the major source of supply of care-givers.

6.133 Remuneration to foster families comprises 3 components:

- a weekly care-giver payment of between $55.50 and $107.00 depending on the age of the child;
- reimbursement for certain other expenditures such as school uniforms; and
- placement support grants from DHS for unusual expenditures.

6.134 Remuneration rates for foster families in Victoria have not been revisited since 1990. Figures published by the Australian Institute of Family Studies for the quarter ended 30 September 1994 on the direct costs of raising children indicate a significant disparity between such costs and the remuneration paid by DHS to foster families. Table 6K shows the relevant details.

TABLE 6K
COMPARISON OF THE DIRECT COSTS OF RAISING CHILDREN WITH THE REMUNERATION PAID TO FOSTER FAMILIES, QUARTER ENDED 30 SEPTEMBER 1994

Age of child	*Cost per week*	*Weekly foster care remuneration inclusive of schooling, medical etc.*	*Remuneration as a percentage of cost*
	($)	($)	(%)
0-1	187.89	71.55	38
2-4	153.70	69.33	45
5-7	166.25	66.41	40
8-10	200.55	92.90	46
11-12	222.98	112.96	51
13+	222.98	134.96	61

6.135 It can be seen from Table 6K that foster families carry a significant financial burden in their provision of home-based care to children and prospective families need to be willing to take on such a burden.

6.136 Audit recognises that inadequate remuneration and the significant emotional and physical effort required by foster families to support dysfunctional children, particularly those with challenging behaviours, can be compensated by the satisfying relationships developed between the family and child, and the knowledge that a child is being given a chance to re-establish its life. Notwithstanding this factor, the discussions by audit with families indicated that, for many families, they could not afford to provide foster care at current remuneration rates.

6.137 At the time of the audit, DHS advised that a review of remuneration rates for home-based carers was planned. In March 1996, the Premier announced, as part of the Government's Carers' Strategy, a funding increase of $4.2 million for foster families which provide care and support for young children from broken homes or children at risk of abuse or neglect. The Department has advised audit that the $4.2 million additional funds for care giver payments will result in significant improvements to these rates.

6.138 **In order to maintain the current level of home-based care-givers and enhance its capacity to recruit additional care-givers, there is a pressing need for DHS to increase remuneration rates and introduce other measures designed to financially support foster families.**

6.139 **As part of this process, DHS should:**

- **recognise the true cost of fostering a child and take the necessary steps to ensure that remuneration rates for care-givers reflect this cost;**
- **consider alternative forms of compensating foster parents, e.g. the provision of concessions similar to those available to other "disadvantaged" community members, including travel concessions and rate rebates; and**
- **examine the feasibility of the biological parents of children in care contributing to their maintenance as occurs with Family Court decisions.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department has acknowledged the existing care-giver payments do not adequately compensate the costs of care, and in the May 1996 Economic Statement the Government announced an additional $4.2 million to increase the base rate of care-giver payments and provide additional enhancements for children with additional needs.

However, the Department does not accept audit's opinion that care-giver payment is the essential barrier to recruitment. Local and international research demonstrates that support and training are the critical features to care-giver recruitment and training.

The Department has noted audit's recommendations regarding the structure of reimbursement to care-givers.

Implications for training of home-based carers and non-government service providers

6.140 It was strongly emphasised to audit, in discussions with managers, workers and carers, that children entering the system in recent years have more challenging behaviours than in the past, partly as a result of the transfer of children from residential facilities which were closed under the redevelopment. This factor, and the increasing number of referrals, created high levels of pressure on non-government workers who were required to be on-call after hours to deal with crisis situations, thereby creating further stress and worker burnout.

6.141 Placement breakdowns, often on account of behavioural problems with children, resulted in many instances in the referral of children back to DHS, thus creating further pressure on the system.

6.142 In order to effectively meet the additional demands arising from the redevelopment, non-government workers and home-based care-givers require intensive and high-quality training programs for dealing with children with more challenging behaviours. The importance of training in situations such as this environment, where governments purchase services from the non-government sector, was recognised by the Industry Commission in its June 1995 Report on *Charitable Organisations in Australia.*

6.143 According to information received from the non-government service providers, the level of access by non-government workers to DHS training programs was very limited.

6.144 **Audit considered that DHS should consult with the non-government service providers to identify training needs of all workers and home-based carers within the placement and support system, and provide suitable training programs to meet these needs. As part of this process, DHS should assess the desirability of:**

- **assigning high priority to the training requirements of the non-government sector with an emphasis on the "train the trainer" concept; and**
- **making available after hours crisis support to non-government workers.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department provides significant resources to agencies for training as well as funds to the Children's Welfare Association of Victoria to co-ordinate training needs for the sector. In addition, further funds were provided to a training provider to deliver 600 hours of training to agencies providing placement and support services.

While providing some access to non-government agencies to departmental training, the Department does not accept that this is the most appropriate forum for training. Review and consultation the CWAV has been undertaken to determine a more effective and efficient training strategy.

Benefits which could arise from the introduction of an accreditation process for service providers

6.145 The redevelopment strategy identified the importance of the establishment of clear standards of practice for service providers and signalled the possible introduction of an accreditation process.

6.146 Placement and support services provided by non-government agencies should be of the highest standard and meet the developmental needs of children under the care of DHS. In this regard, the *Children and Young Persons Act* 1989 empowers the Minister to issue directions pertaining to the standard of service to be provided by agencies and to take steps to ensure such directions are complied with. Under output-based funding, the service agreements to be negotiated by DHS in the future with service providers will provide for the development of quality assurance guidelines to allow monitoring and evaluation of services, and to enable the performance of service providers to be monitored against targets and benchmarks.

6.147 The accreditation process identified under the redevelopment would, if implemented, provide for an independent body to accredit the service delivery by the non-government sector to families and children against established standards of practice. Introduction of such an accreditation process should result in:

- raising the quality of service delivery;
- optimising efficiency in the delivery of services and providing an ongoing framework for further improvements;
- promoting best practice and consistency of quality service throughout all participating agencies;

- providing an improved level of accountability both to DHS for the funding provided and the general public who often provide donations to such agencies;
- improving outcomes for families and children receiving services; and
- having available accreditation standards equivalent to best practice elsewhere in Australia and overseas.

6.148 The concept of service accreditation for welfare agencies has been promoted for many years by industry bodies such as the Children's Welfare Association of Victoria. An accreditation system has operated for some time now within both the public and private hospital systems. More recently, the Australian Government introduced a system of accreditation for child care agencies. Accreditation of welfare agencies has been standard practice in America since 1977.

6.149 Audit is cognisant of the cost associated with establishing an accreditation process, which would presumably require subsidisation by the Government. In the longer-term, the benefits to be gained from such a process in terms of improved service standards and outcomes for families and children would be expected to outweigh the associated costs.

6.150 **There would be merit in establishing a joint working party involving DHS and representatives from the non-government sector to examine the feasibility of an accreditation system in Victoria covering service providers in the child welfare industry.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department notes audit's recommendation to move to an accreditation system for funded agencies. While service accreditation is one approach to ensure quality of service provision, the Department has a range of other mechanisms currently in place. These include formal contractual arrangements with the provider through the Funding and Service Agreement process; formal approval of all community services under the Children and Young Persons Act 1989; practice standards and procedures; and formal central and regional processes to review and monitor practice and service development strategies. Victoria has taken a key role in the development of National Baseline Standards in Out-of-home care which will be introduced in conjunction with the non-government sector.

Impact on other services delivered by the non-government sector

6.151 The impact of mandatory reporting on the level of referrals to the non-government sector, particularly to home-based care and family support services, resulted in considerable confusion as to the actual role family support services provided by the non-government sector was to have in the child and family welfare network. Traditionally, the philosophy behind family support was to provide a range of services to families who were socially disadvantaged in the context of the family's need for help and change. Another element considered just as important was the identification of systematic and structural issues within the general community. However, large increases in referrals of children requiring placement to non-government service providers from DHS led to the following:

- A high degree of frustration within many non-government service providers resulting from their reduced capacity to assist families referred from sources other than DHS. These referrals are often voluntary and are made in the likelihood of family breakdown rather than after entry into the child protection system; and
- Increases in referrals diminished the capacity of non-government service providers to develop and operate community development and network programs, home visiting exercises and community activities such as children's camps etc.

6.152 The Industry Commission Report previously mentioned, recognised the importance of programs and services provided by non-government service providers such as community development activities where outputs or outcomes could not be clearly defined, but were of obvious benefit in preventing family breakdowns and child abuse or neglect. It recommended that funding agreements for these programs be based on achieving joint and agreed objectives and that payments should fund overheads and staff salaries for these programs. Agreements on output-based funding between non-government service providers and DHS do not explicitly recognise such activities.

6.153 Audit established that the funding provided to the non-government service providers was primarily directed towards services to children and families already under protective intervention, at the expense of prevention and early intervention services which strengthen a family's ability to avoid breakdown and potential child abuse or neglect, which is discussed in Part 13 of this Report. The non-government service providers strongly communicated their concern to audit as to the extent that families were being denied access to preventative services.

6.154 **It is important that the extent to which family support services are to be provided by non government service providers is clarified and clearly identified, and that DHS consider negotiation, as part of the output based funding process, for community development activities with non-government service providers to occur as a form of prevention and early identification of potential child abuse.**

The ability of home-based care to perform the role identified within the service redevelopment

6.155 The service redevelopment, as previously mentioned in this Part of the Report, directed the focus of placing children towards home-based care and away from residential care, with the majority of home-based care delivered by the non government service providers. The placement of some children that were previously placed in residential care coupled with the substantial increase in referrals from mandatory reporting and increased community awareness of child abuse resulted in significant pressures on the home-based care system to the extent that it could not cater for the demand placed on it.

6.156 The lack of a centralised strategy that accounted for the difficulties experienced by home-based care Statewide, resulted in a number of deficiencies identified by DHS regions when developing their own strategies in 1994 and 1995. For example, in the Northern Region a study released in July 1995 titled *Placement and Support Northern Region Service Redevelopment Directions* revealed the following operational deficiencies:

- a continuing high reliance on residential services with over 50 per cent of children in residential rather than home-based settings, due primarily to the lack of home-based care options in that region;
- demand for home-based care was very high and far outweighed supply. The study revealed that in a 3 week data collection period only 9 children could be placed out of 34 referrals to foster care;
- better options were necessary for supporting families with children displaying difficult to manage behaviours; and
- the need was identified for residential services to be more focused on family reunification, transfer to home-based care, or independent living.

6.157 In addition, a study undertaken in the Western Region in mid-1995 to establish the reasons why the number of home-based care givers in that region was inadequate, established that:

- There existed a need for additional support within the Western Region for care-giver recruitment;
- Improvement to entry and placement practices, that were adversely impacting on maintaining care-givers and the relationship between the region and foster care agencies, was necessary;
- As a result of children spending longer periods in reception care while waiting upon Children's Court outcomes, bonding between some children, especially young children, with their foster parents began. As a result of the subsequent emotional trauma that was to occur when the child was either re-united with family or placed in permanent care, some families declined to continue as foster parents in the future;

- There was a need for greater care-giver and foster care agency input into the process of reunifying the child with its family; and
- Caregiver payments and support services provided to foster parents were inadequate.

6.158 To the credit of DHS, new programs were developed, mainly catering for adolescents who are difficult to place in foster care. Such programs included Adolescent Community Placements (ACP) and Specialised Home-Based Care, whereby care-givers are paid a premium above the normal foster care allowance to care for adolescents with "challenging" behaviours.

6.159 Apart from these programs, recruitment of foster families was left to the Children's Welfare Association of Victoria through its "Homesharers" program and various foster care agencies from the non-government sector. These strategies still failed to provide the necessary levels of home-based care-givers and it was then left to the individual DHS regions to devise their own strategies for recruitment, which was inconsistent in the absence of documented guidance and direction from DHS at a central level.

6.160 At the completion of the audit, DHS was still experiencing difficulties in providing home-based care for all children to which this setting would have been appropriate. In audit opinion, the problems identified by the 2 regions that displayed initiative in conducting reviews were likely to be common across the State.

6.161 **There exists a need for DHS to qualify the extent of the problem in all regions in establishing adequate levels of home-based care to meet an increasing demand. Subsequent to such an exercise, high level strategies would need to be developed and communicated to all regions on issues such as foster care recruitment and retention, and protocols with foster care agencies.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department believes that audit has overstated the issue of the incapacity to recruit adequate numbers of care-givers, given the ongoing growth within home-based care programs. It does, however, accept that work is required to monitor the implementation of strengthened home-based care services.

  In addition to the role played by funded agencies in recruiting, training and supporting care-givers, a number of initiatives to address quality of care in home-based care are being undertaken. Examples include the implementation of the Baseline Standards in Out-of-home Care, piloting of the "Looking After Children" program and recurrent funding has been made available to foster care-giver support groups to provide support, information and training for care-givers.

Monitoring the quality of care provided to children by home-based carers

6.162 While audit acknowledges the significant contribution that most foster families are providing, and at the same time saving the State money through not having to place children in care in the highly more expensive residential facilities, of some concern was the absence of any form of measurement of the quality of care provided by foster families. Issues such as whether the child's developmental needs were being met in terms of education, quality of care, cultural and social upbringing, relationship with both parents, physical well being, recognition of their wishes, opinions and concerns were not evaluated and documented. Conversely, audit was not advised of any research being conducted on behalf of DHS as to the experiences of foster parents and any concerns or suggestions they may have had.

6.163 Audit was advised by DHS that there was a continuing high level of placement breakdown within foster care, reasons for which had not been systematically evaluated and addressed where possible. Placement breakdowns in foster care in turn place further pressure on residential facility-based care to accommodate these children, and contribute to the unsatisfactory incidence of multiple placements. Audit considers DHS should:

- **develop a mechanism whereby the quality of care provided by foster parents could be systematically evaluated against pre-determined standards;**
- **identify and develop appropriate support measures necessary to relieve the pressures experienced by many care givers; and**
- **consider offering training to selected foster parents in meeting the development needs of children in care.**

PROVISION OF SUPPORT SERVICES TO ASSIST FAMILIES, CHILDREN AND CARERS

6.164 Family and specialist support services are provided to children through a variety of different programs throughout DHS, including protective services, psychiatric services, disability services, primary care services, alcohol and drug services, and juvenile justice.

Overall monitoring of support services

6.165 The Specialist Support Unit within the Protection and Care Branch has program development responsibility for improving the range and quality of services that focus on family strengthening and placement diversion. These services are delivered by either government or non-government auspiced services, and the service delivery approach aims to promote a renewed emphasis on family centred permanency planning practice. The unit is also responsible for the establishment of links with other services provided within the Child and Family Support Network.

6.166 **The establishment of this specialist unit to concentrate on the present support services delivered, and the effectiveness and economy of that delivery, is a positive initiative taken by DHS. It is imperative, however, that links with other support services provided within the child and family support network, and the identification of deficiencies and overlaps in the present support system, be identified and eradicated in a timely manner. It is also important that linkage projects and service effectiveness reviews already commenced remain a priority of the Unit together with the identification of further initiatives of this type to be undertaken in the future.**

6.167 The Department has indicated to audit that the restructure of the Branch has resulted in the establishment of protocols between programs such as Child, Adolescent and Family Services, and Primary Care including the commencement of joint initiatives as discussed in Part 13 of this Report.

6.168 Table 6L below details the level of funding provided to direct support programs in 1994-95 and the proposed funding for 1995-96.

TABLE 6L
LEVEL OF FUNDING PROVIDED TO SUPPORT PROGRAMS
IN 1994-95 AND PROPOSED 1995-96 FUNDING
($'000)

Program	*Funding 30/6/95*	*Proposed funding 1995-96*
Families First	1 595	2 210
Placement Support Work Program	1 210	1 210
Behavioural Intervention Support Teams	381	419
Mobile Support Team	193	193
Family Group Conferencing	100	200
Other/New initiatives *(a)*	481	542
Total	**3 960**	**4 774**

(a) This category includes services that have a strong support/ prevention focus that either exist in one area only, or are being piloted.

Mechanisms by which support services are delivered

6.169 There are 6 main programs that deliver support services to children in the child protection system, details of which are outlined below.

Placement and Support Worker Program

6.170 This Program, which commenced in June 1988, was operating in all DHS regions. The principles of the Program were based on the premise that:

- protective interventions into families should be to the minimum extent necessary to secure the protection of the child;
- effort should be made to strengthen the relationship between the child and the family; and
- all efforts should be made to find solutions that enable the child to remain at home in safety.

6.171 Some children will require out-of-home placements despite efforts to resolve protective issues in the family, and therefore placement support workers can be called upon to help avert or resolve a crisis that is threatening the viability of an out-of-home placement.

6.172 The operation of the Program differs slightly between regions. However, it is broadly based on short-term intensive work with children and their families, in order to prevent further involvement in the protective system. Referrals are accepted from any point in the protective investigation and the normal length of involvement is 3 months, although examples of shorter and longer involvements have been noted.

6.173 An internal review of the Program was conducted in late 1993 resulting in a number of recommendations that were subsequently implemented. However, the review failed to result in the development of a central policy and operational guidelines and consequently the Program currently operates on draft guidelines dated December 1988 which obviously do not reflect the correct operating environment. While regions have developed their own policy documentation and procedures to ensure the parameters and objectives of the Program are relatively consistent across the State, the environment in which the Program is operating has undergone enormous change even since the 1993 review. These changes included:

- reduction in DHS regions from 13 to 9;
- introduction of mandatory reporting resulting in increases in demand for protective intervention and accommodation services;
- implementation of the Families First Program and Case Support Worker Program;
- position and person specifications were amended to include a clear case management role for placement and support workers; and
- significant staff turnover rates within Child Protection Services.

6.174 **The significance of these changes and the changing role of placement support workers demonstrates the need to develop a central policy and procedure document aimed at ensuring consistent application of departmental objectives across all regions.**

6.175 Audit was advised subsequent to the audit review that revised policy and operational guidelines were being developed in collaboration with regional management and service providers, for anticipated release in 1996.

Behavioural Intervention Support Teams

6.176 This program which was developed in 1989, arose from the process of de-institutionalisation within DHS through the Disability Services Division. The primary focus of Behavioural Intervention Support Teams (BIST) is the provision of intensive intervention with clients of all ages, but predominantly 10 - 16 years of age, who are displaying challenging behaviours, are extremely difficult to manage, and represent a significant risk to themselves and/or others. BIST team members are closely aligned with placement and support and have a significant input into the development of case plans for severely disturbed children which are subsequently implemented by the placement and support workers.

6.177 The form of intervention comprises 3 phases which include:

- behaviour treatment, which focuses on the teaching of behaviour replacement skills;
- behaviour management, including the introduction of necessary environmental changes; and
- behaviour control, where the protection of the child or others is paramount.

6.178 The demand for these services has increased due to the intake of more children with "challenging behaviours" resulting from the de-institutionalisation policy, and the shift in focus by DHS towards higher risk children. For example, in the Southern region the BIST program was providing services to 16 children while the target case load was 12 at 30 June 1995.

6.179 **The Department proposes that funding for 1995-96 will include an additional $38 000 which will be added to the $380 593 funded in 1994-95. The additional support being provided to the program will strengthen the capacity of placement support teams to maintain home-based care where severely disturbed children are involved.**

Families First Program

6.180 The Families First Program is an intensive, home based, time limited service which now operates in all DHS regions. It aims to prevent the need for placement of children considered to be at risk by assisting families in crisis. This service is provided on DHS's behalf by non-government service providers. Referral to this service is only accepted where there is a vacancy and there is no waiting list. The caseworker works with the family for an average of 4 weeks at approximately 20 hours a week.

6.181 The Program allocates one worker (who has a 2 case workload limit at any one time) per family. The preventative element of the Program concentrates on increasing life skills, coping ability, parenting skills, problem solving, linking the family with the relevant community supports and ensuring adequate protection for the children.

6.182 The implementation of this Program was a positive initiative that has been widely acknowledged by both government and non-government service providers. However, concerns were raised with audit about the lack of flexibility and intensity of the Program. These concerns centred around the ability of the standard service format (i.e. 80 hours over 4 weeks of 20 hours a week) to most effectively service families with differing needs and situations. For example, a family may be more effectively serviced with 8 hours a week over 10 weeks. In audit opinion the service format should be flexible and designed around the specific needs of a family, rather than a standard format within a maximum time frame.

6.183 The demand for the Program was unable to be determined by audit as waiting lists were not maintained, nor were there any formal mechanisms for recording families concerned to be at high risk and for which the Program may have been of assistance. Families in this category would most likely include dysfunctional families where there has been a history of notification, welfare support has been largely unsuccessful and while abuse or neglect was highly likely, it may not have been capable of substantiation in the Children's Court.

6.184 In addition, demand was reflected in statistics provided from the Children's Court which established that around 75 per cent of Interim Protection Orders fail and intervention becomes necessary. Interim Protection Orders are intended to allow families in crisis a period of 90 days to rehabilitate themselves to the stage where it becomes safe to allow a child to return home. Although supports are provided to such families usually as a condition of the Orders, the high incidence of failure would suggest that some of these families should receive priority for an intensive program such as Families First.

6.185 In essence audit considers that the demand for the Program needs to be identified and taken into account when DHS determines annual funding for the Program. Audit acknowledges that funding for the Program was boosted in 1995-96 by $625 000, thereby providing an annual recurrent base of $2.2 million. A cost-benefit analysis would be useful in terms of ascertaining the demand for the Program, the success of the Program in avoiding protective intervention in families and the projected costs both tangible and intangible, that the State would have borne had these families and children not been assisted.

6.186 There is no doubt that the Program is effective, with information supplied to audit from Southern Region that 85 per cent of children whose families had been involved in the Program had remained at home following case closure. Nevertheless, scope could exist for further analysis of the Program as applied in Victoria, given that the Program was adopted from New Zealand which has a different welfare system and child protection legislation to that of Victoria.

6.187 As stated previously, Families First in effect provides a high cost-intensive service to families on the verge of breakdown. While it was apparent that the Program is effective, audit was advised by welfare workers that they considered there was a gap between this service and the type of welfare services families were normally referred to following investigation but not requiring intervention, as concerns mainly related to welfare issues rather than child protection matters. The type of family service that was seen as being needed was a model based on the "Homebase" Program being operated by a non-government service provider in Bendigo. The Program seeks to determine the competencies of families in areas such as parenting and problem solving skills and then develops an individualised package of services that addresses areas of deficiency. Participating families are requested to provide evidence of change that meets the pre-determined goals developed for their needs. Essentially what was seen as being needed was a range of family programs of varying levels of intensity that sought to be built on family strengths, caring for their children and preventing family breakdowns.

6.188 **Audit considers that DHS needs to:**

- **determine the level of demand for prolonged family support beyond the usual forms of welfare support offered by non-government service providers;**
- **capture data of this nature on the Department's Child and Services Information System when recording investigation outcomes involving families at risk; and**
- **develop a Statewide integrated family support program that attempts to match the intensity of support to be provided with the competencies and needs of the families.**

Mobile Support Team

6.189 The Mobile Support Team provides an after hours support service to community-based residential units and family group homes, is funded by the Placement and Support Program and is located in the Melbourne metropolitan area. The composition of the team comprised selected youth workers who can respond quickly to a crisis occurring at a placement facility and present a number of options to staff for defusing and mediating incidents of challenging child behaviour.

6.190 The scope of the audit review did not provide for an evaluation of the operations of this unit. Discussions held by audit with departmental and non-government service providers identified 2 issues of concern which warrant further investigation by DHS, namely:

- The unit is staffed by a team of 6 youth workers on a rostered basis, with 2 workers on call at any one time. Consequently, doubts have been expressed to audit with respect to the ability of this team to provide a satisfactory level of service on a Statewide basis; and
- The non-government service providers emphasised to audit that the services provided by the mobile support team were available only to DHS-run facilities, and that there existed a need for the availability of the service to be provided to all children in care of the State.

6.191 **The Mobile Support Team provides a very useful service that bridges the gap between the ability of protection workers and accommodation and support staff to address serious behavioural and emotional problems displayed by children, and those incidents requiring a Victoria Police presence. Research needs to be undertaken on any need to extend this service.**

Family Group Conferences

6.192 Family Group Conferencing Program (FGC) was an initiative first introduced in New Zealand following an inquiry into the over-representation of Maori children in the child welfare system. The program, in Victoria, seeks to harness and utilise the resources of the immediate and extended family to avoid the need for removal of the child. In some circumstances the model was seen as being more effective than the traditional use of case conferences.

6.193 This program began in 1994-95 with funding of $100 000 for the conduct of 2 pilot projects in the Northern Metropolitan and Gippsland Regions. A recently completed evaluation of the pilot projects by DHS confirmed this new approach was being effective in Victoria. It is anticipated that funding for 1995-96 will be increased to $200 000, and subsequent to the review DHS has advised audit that this program has now been implemented across all 9 departmental regions.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  In Victoria, the Family Group Conferencing Program seeks to harness and utilise resources of the immediate and extended family to avoid the placement of children out of their family system. However, given the underlying approach is predicated upon principles of family empowerment and partnership with professional workers, its applicability extends beyond preventing placements to include engaging families in decision making on permanent care.

Kinship Care

6.194 Another important family-centred practice in the effective provision of care to children has been the implementation of the Kinship Care Program. In the event that children have to be removed from home, DHS endeavours to place them with an extended family member (e.g. aunt or uncle etc.) or other person known to the child, wherever possible. This situation minimises the disruption to children by placing them with persons they know and trust, and eases the strain on an already overextended placement and support system. The use of kinship placements has been utilised in the service re-development framework and is to be further expanded in the 1995-98 re-development strategy. As previously stated in this Part of the Report, of the $4.5 million recurrent funding allocation for 1995-96, approximately $1 million of funding will be allocated to fund 70 kinship placements.

6.195 **Audit supports DHS in the search for new initiatives in the provision of placement and support services, particularly the use of extended family resources that have an intimate knowledge of the family circumstances.**

Other initiatives by DHS to enhance support services available to children and their families

Review of Voluntary Placements - Short/Long-term Child Care Agreements

6.196 A major diversionary strategy utilised by the placement and support system is the use of voluntary placements.

6.197 This form of placement is seen as a process that incorporates the capacity to divert children from intrusive legal intervention and ensure ongoing contact by the parents when a child is in out-of-home care. This process provides a mechanism by which a child can be placed voluntarily by its parents or guardians with an approved community service through a voluntary child care agreement between the 2 abovementioned parties.

6.198 Departmental analysis shows that approximately one-third of children in approved community services are on voluntary child care agreements, and that since the introduction of the Voluntary Placements Program in 1993, there has been a considerable amount of service re-development. The Department acknowledges that a review is necessary in the context of the significant changes that have occurred during the period in which the program has been in operation, including issues relating to the practice approach and standards for voluntary placements.

6.199 **Given the number of children in voluntary care and the need to establish a basis for refining and strengthening the use of these placements as an appropriate intervention for children at risk, this review is a welcome and necessary initiative.**

Community Support Fund

6.200 The Community Support Fund was established by the Victorian Government under the *Gaming Machine Control Act* 1991. The Department made various submissions to the Minister for Gaming over the past 2 years for resources to fund the development and/or expansion of support programs to children and families experiencing difficulties.

6.201 For the 3 year period 1994-95-1996-97, DHS applied for $16.85 million spread over 4 separate projects. The outcome of the application was that DHS received approval of $4.87 million for 1994-95 and that subject to satisfactory review of these pilot projects DHS would be given the opportunity to apply for a continuation of funding for these projects.

6.202 Table 6M provides details on projects approved by the Community Support Fund:

TABLE 6M
PROJECTS FUNDED BY THE COMMUNITY SUPPORT FUND
($m)

Project	*Total*	*1994-95*
Support to families to deal with family and parenting crises	5.90	1.30
Expansion of family support and services for victims of child abuse and neglect	3.70	1.20
Support to families in crisis - Respite care for families of young children with severe disabilities	5.50	1.80
Financial counselling - expansion of services across the State	1.75	0.57
Total	**16.85**	**4.87**

6.203 The Cabinet Committee expressed its concern to the Minister for Community Services about a likely public expectation, especially from non-government service providers, that the programs would receive ongoing funding.

6.204 **Audit agrees that the funding received, while of considerable benefit to DHS in supplementing funding of programs already in existence, does not guarantee the same levels of funding will continue in the future for a Child Protection Program that continually receives an increasing number of notifications of child abuse each year.**

6.205 **The challenge for DHS is to develop a comprehensive research program dedicated to addressing deficiencies within the Child Protection and Accommodation and Support Programs in the context of the Victorian environment, in conjunction with prevention strategies as part of the National Prevention Strategy.**

6.206 **Audit considers that it is only through such efforts that the incidence of child abuse will be reduced at the same time as a reliance on ever increasing funding subsides.**

Recognition of the need for support service enhancement to adolescent children

6.207 Past practices have seen a tendency within protective decision-making to give priority to younger children as it was generally acknowledged that very young children were more vulnerable and required a more immediate response in the investigation phase. However, it was subsequently recognised by DHS that as over 40 per cent of children in the placement and support system were adolescents, a higher priority was necessary to address the needs of adolescents at risk. In addition, DHS had endured some sustained public criticism as to its perceived neglect of adolescents. As a result, the Child, Adolescent and Family Welfare Division established the Adolescent Services Development Project with a mandate to examine existing policy, practice and service response to adolescent children. The development process produced 3 outcomes, namely:

- A higher priority was to be given to focusing on the Department's protective response, including the provision of appropriate services aimed at improving the adolescent's circumstances and reducing the risk. This scenario was in addition to the creation of Adolescent Protective Teams to improve the skills required of both youth workers and child protection workers to communicate with young people;
- The successful negotiation with Protective Services and the Psychiatric Services Division for additional positions to be made available to Intensive Youth Support Services (IYSS). These services are operated by non-government agencies to provide 24 hour intensive case management to some of DHS's most difficult to manage adolescent clients; and
- A comprehensive report on the service systems available to adolescents and the construction of a framework for the delivery of services to adolescents.

6.208 The development process led to the establishment of a specific Adolescent Services Redevelopment Unit which has responsibility for adolescent protective teams in addition to adolescent support services and intensive support services.

6.209 The Western Metropolitan Region of DHS prepared the report on service systems available to adolescents. The Western Region report identified the deficiency of adolescent services within its own boundaries and the overall service network when it stated *"There needs to be far greater co-ordination of services at a policy and practice level to enable assessments of young people and their families needs to be quickly translated into service access away from the statutory net, wherever possible".*

6.210 The service system at that time in the Western Region, as it was Statewide, in 1995 was seen as having the following deficiencies:

- Adolescent services suffered from a lack of comprehensive planning;
- Adolescents were being "locked out" of services;
- Some services demonstrated difficulty in responding quickly to immediate demands of adolescents;

- Evidence indicated that adolescents had fallen through the gaps of a fragmented service approach; and
- Support services appropriate to an adolescent's needs were provided within specific time frames. Where a continuation of these services was required or supplementary services needed, the provision of these services had to be continually re-negotiated and could not be guaranteed, thereby losing effectiveness.

6.211 The Western Region, released the *Western Adolescent Service System* (WASS) report in June 1995. This report was a comprehensive plan of action analysing the existing service system to adolescents, and detailing a number of recommendations for the Placement and Support and Protective Services elements of the process. In addition, the plan also focused on the role played by other program areas within DHS and other government departments by making a number of broad recommendations specific to their function.

6.212 While the Western Region report identified specific problems within that particular region those problems along with conclusions were applicable across the State. Subsequent to the WASS report, a Children and Adolescents Regional Steering Committee was formed to implement the recommendations arising from the report within the Western Region. The development of this comprehensive plan of action focusing on meeting the needs of adolescents in the most effective manner was a commendable achievement by the Western Region. However, audit would have expected that given that the treatment of adolescents is a major policy consideration for DHS, the plan developed by Western Region would have formed the basis for a Statewide strategy on adolescents to be co-ordinated by the Adolescents Services Redevelopment Unit.

6.213 **Audit recommends that DHS:**

- **develops a Statewide strategy on the treatment of adolescents, particularly those in State care or subject to other protective orders;**
- **devises a methodology that can monitor the effectiveness of such a strategy, particularly in relation to the ability of departmental or non-government service providers to respond promptly and effectively to the needs of adolescents; and**
- **arranges for the Protection and Care Branch to develop protocols with other branches of DHS such as Primary Care, Public Health and Psychiatric Services as to the services and methods of delivery of such services in relation to adolescents.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department is developing protocols with other relevant programs as identified in the audit report, with the aim of improving cross service provision to adolescents with a range of needs including psychiatric, intellectual disability and substance abuse.

MECHANISMS EMPLOYED TO MONITOR AND CONTROL THE PROVISION OF PLACEMENT AND SUPPORT SERVICES

Funding agreements and accountability processes

6.214 The responsibilities of non-government organisations in the provision of placement and support services, are formalised in the establishment of service agreements with the DHS. Historically, these agreements have been for a 3 year term, however, with DHS's move to greater accountability, agreements are now for a 12 month period. The major accountability requirements on funded organisations include:

- the maintenance of records of all financial transactions and accounts;
- the provision of annual audited financial statements of cash receipts and payments, balance sheet and statement of income and expenditure; and
- provision of monthly performance reports, annual reviews and service evaluations.

6.215 The funding for services is paid bi-monthly and can be altered through the annual adjustment of service funding; adjustments according to the performance of the organisation in achieving agreed targets; and adjustments necessary through changes to parliamentary appropriation and on agreement by both parties.

6.216 Accountability is an important element in service provision as it ensures that services are delivered to a certain standard and should allow DHS to monitor the overall effectiveness of services to children. It is important that parties to these agreements have a clear understanding of and are amenable to their roles, responsibilities and other criteria within the agreements.

6.217 After extensive communication with various non-government service providers, audit was informed that the service agreement process is one of their major issues of concern. The non-government sector strongly supports accountability requirements but has significant concerns regarding the present service agreement structure. The non-government service providers see the service agreement process, as it presently stands, as a mechanism that decreases its ability to provide services which are flexible and responsive to client needs by limiting service response into a number of components that are not always directly compatible with the reality of children's needs. The submission to audit from a non-government body stated that many of its constituents perceived the service agreement process as follows:

- *becoming a tool to achieve cost reductions;*
- *focusing exclusively on outputs, with no reference to quality assurance;*
- *lacking clarity on the definition of services;*
- *misunderstanding the complexity of services being provided to children, for example family support; and*
- *being used to coerce fully funded agencies to agree with departmental goals and targets which are inconsistent with those of the agencies".*

6.218 Some of the more specific areas in need of resolution, which were raised by the sector, included:

- The changing relationship between the parties from one of partnership to the purchasing of services from the non-government sector as a service provider. The nature and terms of this restructured relationship needed to be clarified and clearly articulated in service agreements;
- Unilateral price setting across departmental or program areas within agencies often did not reflect the full cost of service delivery. This cost was different depending on location of the services (i.e. metropolitan or rural), the size of the service agency, and the nature of the children being serviced;
- Timing of negotiation and review of service agreements must allow agencies to properly plan for the services they deliver. The move to 12 month agreements was not considered adequate for long-term planning. Subsequently, DHS has advised audit that it planned to revert back to 3 year agreements in accordance with the broader corporate approach;
- The non-government sector does not feel that it has adequate authority to influence decision-making in relation to the resolution of any disputes with DHS;
- The lack of access to an independent arbitrator where a breach of the service agreement was alleged; and
- Lack of benchmarks to which quality of service could be measured, thereby not allowing an accurate indication of whether a client was receiving the level of care entitled to.

6.219 Audit fully supports the concept of service agreements whereby non-government service providers are funded on the basis of agreed outputs. Audit also acknowledges that inefficiencies existed within the non-government sector with poor targeting of services to meet children's demands, excessive overheads and inefficient practices. Notwithstanding these problems, it was also apparent to audit that there was widespread discontent among non-government service providers as to the existing service agreement arrangement, especially in that service providers felt that their concerns were not being properly acknowledged by DHS.

6.220 As referred to earlier in this Part of the Report, extended delays have already occurred in relation to the implementation of output-based funding, on top of the existing problems with service agreements.

6.221 **For these problems to be addressed, both the non-government service providers and DHS need to reach agreement on the principles underlying service agreements, particularly in relation to the service and quality management standards expected, along with the degree of assistance DHS will provide in helping non government service providers reach the standards specified. Recognition must also be made of the general lack of suitable management information systems within the non-government sector by which performance could be monitored and informed decisions made. Audit also considers agreements need to allow for independent mediation of any disputes which cannot be resolved at a local level.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Comment made by audit regarding the funded sector view of funding and service agreement (FASA) processes is noted. However, the Department believes that funding and service agreements are an excellent mechanism to detail the contractual arrangements, specify targets of core service and define clear accountability processes. The Department denies that FASA are a tool to achieve cost reductions and lack clarity in the definition of services.

  The impact of the FASA process on the non-government agencies' operations has been, and will continue to be, the subject of detailed discussion with the sector to ensure core service delivery occurs. With the introduction of output-based funding, improved performance management systems will be implemented at the cost to the Department.

The ability of management information systems to provide effective and timely information to placement and support workers

6.222 Effective management of the Placement and Support service system requires DHS to have an information system that provides timely and reliable information, and allows an accurate assessment of qualitative and quantitative performance criteria. Information systems also have an integral role to play in the planning of future activities through the provision of high level program performance information to senior management, and lower level operational data to line managers and staff involved in the service system.

Key Information Data System

6.223 The Department currently monitors the performance of government and non-government agencies delivering placement and support services through the Key Information Data System (KIDS). This system was designed within DHS and implemented in July 1992 as an interim system until its functions could be incorporated into the Client and Services Information System (CASIS). KIDS is currently operational at 105 sites throughout Victoria and collects information on the following:

- child name, gender and date of birth;
- a history of all placements for each child;
- a history of the child's legal status;
- child income; and
- details on home-based care-givers.

6.224 Information gathered throughout the 105 sites has resulted in KIDS containing records on 9 000 children and 45 000 placements. The current growth rate of information is 2 400 children and 12 000 placements a year.

6.225 The method of data collection involves non-government service providers and departmental facilities down loading information onto diskettes and forwarding them to the Supported Accommodation, Concessions and Resource Management Section, located centrally, on a monthly basis. This method of off-line data collection was found to be inefficient, labour intensive and fails to deliver timely information to DHS regions.

6.226 The availability of an effective information system that provides quality information to all users in a timely manner is crucial to placement decisions particularly those of an emergency nature. The placement and support network, namely all government and non-government service providers, requires the information system to have the following characteristics to ensure its effectiveness:

- a central computerised accommodation and placement service within DHS that will allow efficient access by users to the range of placement and support services, and enable matching of individual children with appropriate carers in a timely manner;
- a central record of all possible placements, their availability, and an on-line ability to identify the location of all children within the placement and support network;
- be accessible to all organisations supporting children on behalf of DHS; and
- be able to monitor the adequacy of placements for children and adolescents, the timeframes of those placements, and indicate/report where concerns exist, especially in respect of multiple placements.

6.227 Presently, KIDS is running on software that is inadequate, obsolete and does not provide the quality of information necessary to identify the extent of system inadequacies that planning processes need to be directed to. Reports are generated on an ad-hoc or as needed basis. Central management receive reports that measure agency performance against agreed quantitative performance criteria, such as average occupancy per agency, length of stay of completed and incompleted placements, average occupancy per component of care, and number of clients per type of care (e.g. respite, emergency, reception etc.). While these measures give an overall indication of where clients are placed within the system on a given date, they fail to measure the quality of care that each child has received. These quality of care issues centre around the appropriateness of the care provided to the child, more specifically:

- the type of placement and the clients already in that placement;
- the geographical location of the placement in comparison to the child's family and services; and
- the number of placements to which a child has been subjected.

6.228 Given the system is not on-line, each region receives information produced by KIDS on a quarterly basis. The information is therefore untimely and largely useless for management purposes. Most regions establishing their own information systems to provide information that should be supplied by KIDS. For example, up to July 1995 the Western Metropolitan Region used a manual system to collate information on reception clients which made analysis very resource intensive and the production of consistent detailed reports impossible. The region has since developed a computerised information system to provide the data considered necessary for appropriate analysis.

6.229 The need to develop an alternative management information system to record data that KIDS was meant to provide, reflects an inefficient and uneconomic use of resources, which also restricts informed decision-making. The information which the non-government sector provides on KIDS is meant to satisfy accountability requirements with DHS under service agreements. However, the information should also be used for research and targeting areas of greatest need. In its present format, KIDS does not meet this need. Similarly, the range of alternative systems that have had to be developed by the non-government sector means that comparable consistent data cannot be produced on a Statewide basis.

6.230 In recognising the obvious deficiencies in the current KIDS management system and to cater for the introduction of output-based funding, DHS at the date of the audit was in the process of redeveloping KIDS at an estimated cost of $485 000. The redeveloped system was initially planned to commence operations on 1 July 1995 but due to uncertainty surrounding the exact requirements of output-based funding the project was delayed until July 1996. The redeveloped system will introduce a number of efficiencies and improve the access capabilities of regional staff and non-government agencies through the networking with the Head Office of DHS. The new system will also incorporate the following characteristics:

- Provide additional information on placement of children;
- Output information on service functions not presently covered, such as referral and post-placement support;
- Provide information from service types not yet contributing to the KIDS database, such as specialised home-based care, prevention and support, and Kith and Kin. The inclusion of these services will extend the system to 267 services capturing data at 122 sites; and
- Integrate with the proposed Family Support system and have the potential to integrate with other systems within the Child, Adolescent and Family Welfare banner such as disability services etc. The system will also have capacity to integrate with information systems in existence in the non-government sector so as to ensure non-government service providers do not have to continue entering data on multiple systems that cannot share information.

6.231 **The inadequacies of the KIDS database reduced DHS's ability to monitor the quality and efficiency of the placement and support system in a timely and effective manner. It is essential that the redeveloped KIDS system be continually updated so as to reflect the characteristics necessary to maximise the effectiveness of information supplied to users within the Placement and Support system, and ultimately, the quality of placement and support services to Victoria's children in need.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department will replace the Key Information Data System with a new computer-based system (FACTS) in July 1996. This system will collect both performance information for output-based funding and more detailed data to an individual client service use.

Part 7

Relationship between Victoria Police and the Department of Human Services

OVERVIEW

7.1 Since the introduction of the single track system and mandatory reporting of alleged child abuse, it has been of paramount importance for the Department of Human Services (DHS) as the lead agency responsible for child protection to foster a close working relationship with Victoria Police in all protection matters where suspected criminal offences involving sexual abuse or serious physical assaults on children have been notified. Audit established that this relationship has at times been unsatisfactory, with numerous breaches of protocol being brought to attention and impacting on investigations undertaken of child abuse by both agencies.

7.2 The future role of Community Policing Squads, including their relationship with DHS needs to be firmly defined within the community as audit considers that since DHS assumed the lead responsibility for child protection, Community Policing Squads have been searching for a new focus and image, rather than as a police facility that can be called upon to supplement resources in other areas of police activity.

7.3 Notification levels of suspected child sexual abuse within the community have risen substantially in recent years, stemming mainly from the "Stand-up Victoria" campaign initiated by Community Services Victoria in 1992 and from the introduction of mandatory reporting in 1993. Despite the increase in notifications of sexual abuse of children, DHS has experienced difficulty in proving protection applications on these grounds in the Children's Court. Concurrently, the rates of successful prosecution of alleged perpetrators of child sexual assault by Victoria Police has also been very low.

7.4 Audit considers that there is considerable scope for further addressing the incidence of sexual assaults on children within the community through such measures as specialist multi-disciplinary teams comprising staff from both Victoria Police and DHS, better evidence gathering, including the use of video and audio taping of child interviews, development of a computerised intelligence network to supplement existing systems and use of specialist solicitors to brief barristers within the Family Division of the Children's Court and in Criminal Courts.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  While accepting a number of findings, the Department is generally disappointed by the lack of objectivity and poor research effort by audit. Audit bases many of its findings on anecdotal evidence apparently provided largely by individual members of Community Policing Squads and aggrieved parents. Audit gives little credit to the Department and its staff for what has been a very substantial improvement in performance in this area in recent years, despite what is acknowledged as very difficult circumstances.

  The Department recognises the very important role that Victoria Police members have to play in combating child abuse and related criminal offences and has always stood ready to co-operate with Victoria Police at an operational and policy level.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  Since DHS became responsible for the protective intervention role, following on from the Children's Protection Society, in 1985, a procedure has been instituted with a view to reconciling any differences between Victoria Police and DHS.

  A 3-tiered approach has been developed for dealing with these inter-agency difficulties. An attempt is firstly made at the local police district level with a view to reconciliation. When there is no resolution at this level, the issue is referred to the Community Policing Squad Co-ordinator to resolve with the Manager, Child Protection, DHS. Over the past 2 years, most of these complaints have been answered although not always to complete satisfaction. An Inter-departmental Liaison Committee has since been established to bring together the Assistant Commissioner (Operations) and senior staff of DHS as a further point to resolve any inter-agency difficulties. This particular committee has had a great deal of success.

  The protocol initiated between the Victoria Police and the Department of Human Services in 1992 contains an agreement for police to hand over all investigations of child abuse, where protective concerns exist, to DHS. Likewise, the Department of Human Services agreed to hand over cases where a criminal offence is indicated. Under this "single track" system police do not take protective action, as DHS are the only "protection interveners".

  Notwithstanding this new approach, the "dual track" approach to child protection still exists. Both DHS and police are still jointly involved in many investigations of child abuse. While DHS has responsibility for the protective aspects, and police the criminal, the roles of our 2 agencies overlap regularly. It is difficult to separate protection and criminality in many instances. Even in cases where no criminality is evident, DHS frequently call upon their local Community Policing Squads (CPS) to provide protection where a violent response is anticipated in a home visit.

  Many of the problems noted in the Auditor-General's Report relate to the tensions that arise when 2 separate agencies, with different philosophies, management structures and accountability, are both involved in an investigation. The suggestion of combining resources in a multi-disciplinary team does have merit but needs more exploration.

INTRODUCTION

7.5 Since the introduction of the single track system in March 1992, whereby child protection became a welfare issue under the control of DHS, the role of Victoria Police, via its Community Policing Squads (CPS), has been to jointly investigate with DHS cases of suspected child abuse involving the criminal offences of sexual abuse and serious physical assault. Where initial investigations indicate criminal offences may have occurred, such cases are normally referred to the Criminal Investigation Branch except in circumstances where CPS officers have had previous experience in conducting criminal investigations.

7.6 CPS currently play an important role in Victoria's child protection system through providing an initial response to allegations of sexual and physical abuse of children and through assisting victims of those crimes. The CPS can also fulfil a role in preventing child abuse through their school and community education activities, including helping and advising children, parents and families, and through addressing domestic violence, which is considered a major factor in child abuse.

7.7 Previously, a significant proportion of the work of the CPS was dedicated to investigating all forms of child abuse including neglect, presenting Protection Applications in the Children's Court, and providing support to victims and families. It was anticipated that with the advent of the single track system the workload of CPS would decrease with welfare functions associated with child protection largely undertaken by DHS. However, audit was advised by Victoria Police that the expected reduction in workload has not occurred, mainly due to additional duties assigned to CPS and the advent of Mandatory Reporting in 1993 which has seen a continuing increase in all notifications including sexual and physical abuse. Since 1992, notifications involving alleged sexual abuse have increased by 72 per cent and severe physical abuse by 105 per cent.

7.8 Under the *Children and Young Persons Act* 1989, Victoria Police is still regarded as a protective intervener along with DHS, to which notifications of suspected protective concerns for children can be made by any person. However, under the single track system, notifications to Victoria Police are passed on to DHS. Victoria Police will only act as a protective intervener in circumstances where a child is in immediate danger and the situation requires immediate action to be taken to remove the threat of serious injury or loss of life and DHS is, for any reason, unable to respond. Victoria Police can continue to apprehend young persons and take out Protection Applications where circumstances warrant this action. In practice, this rarely occurs.

7.9 In areas where CPS are either unmanned or unavailable, DHS will either rely upon local police to assist with investigations or will undertake initial responses without police support in urgent situations.

PROTOCOL BETWEEN VICTORIA POLICE AND DHS

7.10 Protocols are guidelines prepared by agencies to define and highlight the roles and responsibilities of the respective agencies in relation to areas of common interest.

7.11 The single track system brought about a new protocol agreement in 1992 between Victoria Police and DHS. The agreement established guidelines to be adopted where joint investigations were required as a result of potential criminal offences involving children. The protocol also incorporated various other matters including training processes and complaints procedures.

7.12 Of particular relevance was the agreement that where DHS considered that reasonable grounds existed for believing that a child had been sexually assaulted or had suffered significant harm as a result of physical injury, Victoria Police was to be notified immediately for possible criminal investigation. This notification was to occur prior to DHS interviewing any family members, in order to assist both agencies in determining priorities, gathering information and planning the investigation after taking into account the interests of the child.

7.13 In May 1994 it was agreed between the 2 agencies that the protocol was to be revised to reflect the introduction of mandatory reporting in November 1993, as well as to clearly reflect the legislative responsibilities and obligations of DHS and Victoria Police to each other. Since that time, protracted negotiations occurred concerning the substance of protocol arrangements. While DHS believed that negotiations had reached finality in July 1995, the draft protocol document remained under consideration by Victoria Police, in terms of its legal implications, for some months.

7.14 The need for a revised protocol agreement was very evident during the course of the audit given the changing circumstances arising from mandatory reporting and the need to address common areas of conflict. As an example, the 1992 protocol requires DHS to report to Victoria Police circumstances where *"reasonable grounds exist"* for believing that a child has been sexually assaulted or where *"significant harm"* as a result of physical injury has occurred. The interpretation of what is considered to be *"reasonable grounds existing"* or *"significant harm"* can vary widely between protective workers and can partly explain why Victoria Police complained to audit of not being notified promptly by DHS of suspected criminal offences against children.

7.15 Conversely, audit was also advised by DHS of instances where Victoria Police were notified and declined to accompany DHS on an investigation pending further examination by protective workers of the circumstances involved.

7.16 **It became very clear to audit that the revised protocol arrangements needed to be formalised without further delay with a view to improving relations and enhancing co-operation and professionalism in both agencies in the paramount interests of the children involved.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The protocol was finalised in January 1996 and will be publicly launched in June 1996.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The protocol between DHS and the Victoria Police on child protection response has been closely scrutinised by both agencies over the last 12 months. A point in issue has been exchange of information between the 2 agencies, with DHS reluctant to pass over some information to police, especially where it emanates from workers' notes.

  The Protocol document was completed in March 1996, and has now been signed by DHS and Police. Recent inter-departmental meetings have been productive and in a spirit of co-operation, and the Protocols provide clear and straightforward guidance to operatives.

NEED FOR CLEAR DEFINITION OF THE ROLE OF CPS IN CHILD PROTECTION

7.17 Given the revised duties of the CPS following the introduction of the single track system, the audit sought to determine the precise functions and roles of the 29 CPS located throughout Victoria.

7.18 Information on the functions of the CPS is found in a variety of documents, including the CPS Standard Operating Procedures, Victoria Police Operating Procedures Manual, Victoria Police Gazette and other documentation involving position descriptions. Examination of the various documents disclosed conflicting descriptions of what the primary objectives of the CPS were and the mechanisms by which these objectives were to be achieved.

7.19 Audit ascertained from discussions with experienced officers in certain CPS that, since the advent of the single track system, the priority accorded in Victoria Police to the role played by CPS in protecting children has diminished, as the functions of CPS have been more closely aligned with general police duties, including assisting with adult rape investigations. The CPS are now largely regarded as an additional resource from which other police units can draw upon, rather than as a separate police function with a clear vision as to their objectives and purpose within the community.

7.20 As indicated in earlier paragraphs, CPS play an important role in Victoria's child protection system through providing an initial response to allegations of sexual and physical abuse of children, and helping prevent child abuse through community education activities and working with families and children who are in difficulty. Audit therefore considers it essential that the functions and roles of CPS be clearly defined by Victoria Police.

7.21 At the date of audit, a review by Victoria Police was in progress to determine future directions in community policing in the context of world trends and the Victorian environment. **It will be important that the results of this review provide the CPS with strong future direction, guidance as to their role with agencies such as DHS and an impetus directed towards community benefits for existing and new generations of families and children, as part of a broader government strategy aimed at preventing child abuse.**

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The Report identifies conflicting descriptions of what the primary functions of the Community Policing Squads are and the mechanisms by which the functions are to be achieved.

  The Community Policing Squads Standard Operating Procedures Document has been completed, authorised and distributed to CPS Units. The SOPs explain the role of the Squads, and the manner in which they are required to perform their tasks. The undertaking to review this document 3 months after circulation is currently being complied with, and will result in some further refinements.

  The current Community Policing review will result in some further changes being implemented, however, the Standard Operating Procedures, as circulated, is capable of overcoming the problems identified by VAGO.

  The role and functions of the Community Policing Squads are currently being reviewed by a Working Party headed by the Officer-in-Charge of Community Services and Planning Division. The completion date of July 1996, will be difficult to achieve, however, the project has high departmental priority. Performance and workloads, and information systems will be included in the recommendations required of that review.

QUALITY OF THE RELATIONSHIP BETWEEN VICTORIA POLICE AND DHS

7.22 Under protocol arrangements between the 2 agencies, Victoria Police must be advised by DHS, and vice versa, when reasonable grounds exist, based on a notification, for believing that a child has been sexually assaulted or has incurred significant physical harm. The protocol requires that joint interviews are to be arranged, with DHS assessing grounds for protection and the CPS initially determining the likelihood of criminal offences having been committed.

7.23 When Victoria Police become aware of protective concerns other than of a criminal nature, such as neglect or emotional abuse, DHS are advised but no further involvement by Victoria Police becomes necessary unless there are criminal grounds for charging parents with maltreatment or neglect. Victoria Police also has a responsibility to provide assistance to protective workers where they are under threat of physical violence.

7.24 Given the importance of the roles of both DHS and Victoria Police as protective interveners, audit sought the views of both parties on the effectiveness of their working relationships.

7.25 **Many problems which are impeding a cohesive working relationship between the 2 parties and, in turn, limiting their capacity to adequately protect children, were raised with audit. The problems are predominantly addressed in protocols between the 2 agencies although obviously such protocols are not always adhered to or necessarily understood, particularly in relation to defining protective concerns. It is only through improved communication and co-operation between the 2 agencies and mutual respect by each agency for their professionalism and different responsibilities that these problems can be progressively overcome.**

Views of Community Policing Squads regarding Department of Human Services

7.26 Audit surveyed all CPS to obtain their views on the effectiveness of the working relationship between CPS and DHS. Of the 24 CPS that were staffed at the time of the audit, 17 advised of varying levels of concern as to their relationship with DHS at a local level. The remaining 7 CPS reported good relationships, with common themes revolving around knowledge and acceptance of respective roles and mandates, joint training and sound communications. Given the extent to which problems existed in the majority of the CPS which were surveyed, audit formed the view that, overall, relationships between the 2 organisations were not satisfactory.

7.27 Apart from isolated breaches of protocol, the most common criticisms levelled at DHS by CPS were:

- delays in DHS informing Victoria Police of notifications;
- failure to inform Victoria Police of notifications;
- inadequate response or inaction by DHS where joint investigations were necessary; and
- inconsistent assessment by DHS of circumstances involving protective concerns.

Delays in DHS informing Victoria Police of notifications

7.28 Numerous instances were cited by CPS to audit where CPS asserted that DHS had accepted notifications of suspected sexual and/or physical abuse but had failed to immediately notify CPS in order to plan joint interviews with the family. Delays commonly ranged from one to several days, but on other occasions extended to weeks and even months.

7.29 On most occasions joint interviews do occur. Statistics prepared by DHS for the period 1 July 1994 to 30 April 1995 in relation to 1 689 investigations of sexual abuse, recorded that 1 482, or 87 per cent, were jointly investigated with Victoria Police. In the 13 per cent of cases where DHS solely responded to notifications, most were with the knowledge of Victoria Police who were subsequently informed of outcomes. The main problem from the CPS viewpoint revolves around delays in being informed and the expectation by DHS that the CPS will be able to respond immediately upon being contacted. Where CPS are unable to promptly attend a joint interview and DHS conduct the investigation, it is possible that potential criminal concerns are not adequately handled. By the time the CPS are able to become involved, alibis may be established by the family and/or the child intimidated. For example, with suspected physical abuse, it is common for bruising to be attributed to hyper-active children, falling off bikes etc. Both agencies acknowledge it is critical that, wherever possible, notifications of a suspected criminal nature be acted upon within 24 hours, given that forensic evidence can quickly disappear.

Failure to inform Victoria Police of notifications

7.30 The protocol provides that in the event of either agency not being able to attend a joint interview, or the extent of abuse is unclear, a single agency may attend provided the other agency is informed and liaison occurs after the investigation.

7.31 Various examples were given by CPS where DHS conducted investigations and did not liaise with the Police at all. This occurrence normally only came to the attention of Victoria Police after re-notifications were made. This issue was viewed seriously by CPS which considered that a large number of protective workers do not have well-developed investigative skills. Consequently, criminal offences could remain undetected.

7.32 Instances were also mentioned by CPS where, in the absence of Victoria Police, protective workers interviewed suspected criminal offenders. Apart from Victoria Police having this responsibility under the Crimes Act, protocol also clearly provides that a protective worker does not have the responsibility of determining whether or not a criminal offence has occurred, but is required to immediately alert Victoria Police where a suspicion of crime exists. Friction occurs when DHS decides on when a criminal offence is likely to have been committed and whether CPS should be advised, particularly in instances of physical assault. While DHS will decide whether it is a serious assault warranting police intervention, or merely an accident or chastisement by a parent, CPS view is that they should make these decisions and not DHS, as serious physical assault is a criminal offence.

7.33 Conversely, DHS is in a difficult position where its staff have not initially involved CPS, or CPS are unable to attend. In determining whether there are grounds for protective concerns, it is incumbent upon the protection worker to undertake an investigation and to advise the parent of the grounds being investigated, including those of a potential criminal nature such as sexual abuse or severe physical assault. While obviously Victoria Police should undertake such a role, audit acknowledges that occasions can arise where the protection worker has no option but to interview a suspected perpetrator given the immediate seriousness of the protective concerns for the child. Circumstances of this nature further emphasise the need for specialist joint teams as referred to in later paragraphs of this Part of this Report.

Inadequate response or inaction by DHS where joint investigations were necessary

7.34 Many instances were brought to audit's attention where notifications from CPS to DHS of both a criminal and non-criminal nature were not acted upon by DHS, extensive delays occurred in arranging joint interviews or Victoria Police phone calls inquiring on the status of the notification were not responded to by DHS. Although Victoria Police, as protective interveners, could take out a Protection Application in their own right if DHS did not act, in practice they regarded this action as pointless given that any welfare concerns associated with a notification can only be addressed by DHS.

7.35 Another common complaint of CPS and other police was that they were sometimes left *"baby-sitting"* children for extended periods pending arrival of protective workers. These situations often involved the After Hours Service established by DHS, where workload considerations can influence the Service's ability to quickly respond to every situation. "Baby-sitting" was seen as an inefficient use of police resources for situations that were the responsibility of DHS, although at times audit considers they may have had little alternative.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The Report describes problems in planning joint investigations. The creation of an integrated model, where the CPS, DHS and the CIB are able to respond to any report as a team is currently being examined by the Victoria Police. Joint training, allowing for Victoria Police and DHS staff to intermingle and exchange views in a formal and informal environment, is a start to facilitate greater co-operation.

Inconsistent assessment by DHS of circumstances involving protective concerns

7.36 The legislation broadly defines a child as being in need of protection when a person who has a duty of care fails or is unlikely to protect the child from significant harm resulting from sexual abuse, physical assault, emotional abuse, neglect or the child has been abandoned. Tension can arise between the 2 agencies in terms of determining when statutory intervention and a Protection Application becomes necessary. Frequent comment was made by CPS as to what was seen as inconsistencies in decision-making by DHS or a reluctance of protection workers to make prompt decisions.

7.37 One of the more common areas of concern revolves around deciding when intervention is necessary as a result of neglect. Neglect can be defined in terms of failure to provide adequate shelter, supervision, nourishment, clothing or medical care resulting in the child's development and health being put at risk.

7.38 A number of CPS referred to what they saw as continuing neglect in certain families, but for which DHS considered Protection Applications were not warranted although welfare concerns may have been evident. This conflict commonly arises in respect of a small percentage of families which exhibit characteristics below what may be considered acceptable from a broad community perspective, in terms of substance and alcohol abuse, poor housekeeping and low standards of hygiene. Drawing the distinction between welfare issues such as poor parenting skills and low living standards, and the stage at which those skills and standards drop to unacceptable levels and the child becomes at risk can be very difficult and open to varying standards of interpretation. Neither the legislation nor case law has sought to determine what are minimum parenting standards, the level below which can constitute neglect.

7.39 In the normal course of duties, CPS and other Victoria Police encounter family situations, including children left to fend for themselves, which they can consider to be neglect. Audit was advised that Victoria Police can feel frustrated when, after notifying DHS of such situations, sometimes repeatedly, no apparent action occurs nor does DHS advise Victoria Police of their reasons. Notwithstanding difficulties in deciding whether intervention in a family is necessary, the audit did establish, in certain DHS regions, evidence that investigations and subsequent action should have occurred in respect of a number of such notifications.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  "Significant harm" is now adequately defined in Protocols (10.2). While there is no specific definition of "minimum parenting standards", C.P.S.S.O.P's (9.36), the Protocols and the training programs explain the range of circumstances considered by courts to be unacceptable. Training also cautions against imposition of subjective personal values and standards.

DHS perspective of its relationship with Victoria Police

7.40 The level of dissatisfaction expressed to audit by DHS on the relationship between protection workers and Victoria Police was not as pronounced as the reverse situation. Complaints about Victoria Police brought to the attention of audit mainly related to:

- changing of police officers as a result of shift hours, despite joint interviews not being completed (it was stated that leaving an interview prior to completion can seriously undermine the importance of the meeting and, where another police officer becomes involved, the meeting virtually needs to start again);
- ongoing difficulties by protection workers in arranging for Victoria Police to be involved in joint interviews in a timely manner;
- failure of Victoria Police to involve protection workers in preliminary investigations of sexual abuse of children within families;
- long delays by the Criminal Investigation Branch in interviewing alleged perpetrators;
- an unwillingness of Victoria Police to be jointly involved pending a preliminary investigation by DHS;
- withdrawal of Victoria Police from joint interviews once they considered criminal concerns were not present;
- failure of Victoria Police to take an active interest in joint planning of investigations;
- multiple police officers attending some interviews which can bring about a feeling of intimidation in some children and families; and
- lack of Victoria Police concerns as to the safety of protection workers.

7.41 The above complaints tended to be concentrated around certain DHS offices and could have involved personality conflicts and entrenched attitudes as to roles of respective staff.

Cumbersome nature of dispute resolution process

7.42 The 1992 protocol arrangements between DHS and Victoria Police provide for a 4-tiered dispute resolution process whereby concerns are to be initially dealt with at a regional level. In the event of failing to resolve an issue at that level, the concerns proceed to the next hierarchical level, and so on ultimately to the CPS Co-ordinator and the Manager of the Child Protection Unit in the Protection and Care Branch, DHS.

7.43 Given the cumbersome nature of a 4-tier dispute resolution process, it was not surprising to audit that breakdowns of this process were identified at all levels. Substantial delays were occurring, mainly within Victoria Police, in forwarding CPS complaints to DHS and informing the relevant CPS of eventual outcomes in those cases which were not resolved at a local level. Joint regional meetings between Victoria Police and DHS to discuss complaints varied considerably across the State as to frequency of meetings, attendance, documentation of discussions, outcomes and communication processes. The combination of these factors led audit to conclude that in many regions these meetings did little to enhance working relationships between the 2 agencies.

7.44 **Overall, it was apparent to audit that irrespective of the merits of the dispute process, the professional relationship between certain CPS and DHS regions was below the standard expected of the 2 organisations who have responsibility for seeking to achieve the best outcomes for children in need of protection.**

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The Report notes ongoing concerns by Community Policing Squads regarding the work practices of DHS Child Protection Units. It is again recommended that acknowledgment needs to be made, at audit level, that a "dual track" system still exists. We are currently undertaking joint training with DHS in order to obtain a more integrated response to child protection.

  The introduction in 1995 of the Inter-departmental Liaison Committee between DHS and Victoria Police at senior officer level, i.e. Assistant Commissioner (Operations) and Director, Psychiatric Services DHS, has been successful in improving communication between our agencies at senior management level. This committee has been successful in resolving matters surrounding the introduction of the Crisis Assessment and Treatment Teams (CATT) and has expanded its charter to address a wider range of communication and policy issues. The benefits of these negotiations should lessen any breakdown in communication between Victoria Police and DHS at other levels.

  Although apparently cumbersome, the four-tier process has been proven effective, and most problems are resolved at the lowest level. The hierarchy is considered necessary to involve the various supervisory levels, as much as a quality control mechanism as a complaint resolution process. The provision of conjoint training and better protocols/S.O.P's has also been instrumental in reducing friction and creating a professional appreciation of roles.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department is concerned at the nature of audit's survey *and the reporting in this part of its* findings. *While audit surveyed the views of staff in the 24 CPS Offices, no comparable survey was conducted in relation to the views of DHS staff. To the Department's knowledge, the DHS perspective represented in the Report is based on informal discussions with DHS staff in only 2 of the 9 DHS regions.*

The Department is committed to working closely with Victoria Police and has been the instigator of many strategies statewide and regionally to improve working relationships and effectiveness. These include;

- *development and review of protocols;*
- *central and regional liaison;*
- *joint training;*
- *support for Operation "Paradox";*
- *involvement in Video Audio Taping of Evidence Project (VATE).*

NEED FOR AN INTEGRATED APPROACH TO DEALING WITH ADOLESCENTS AND YOUNG PERSONS IN CARE

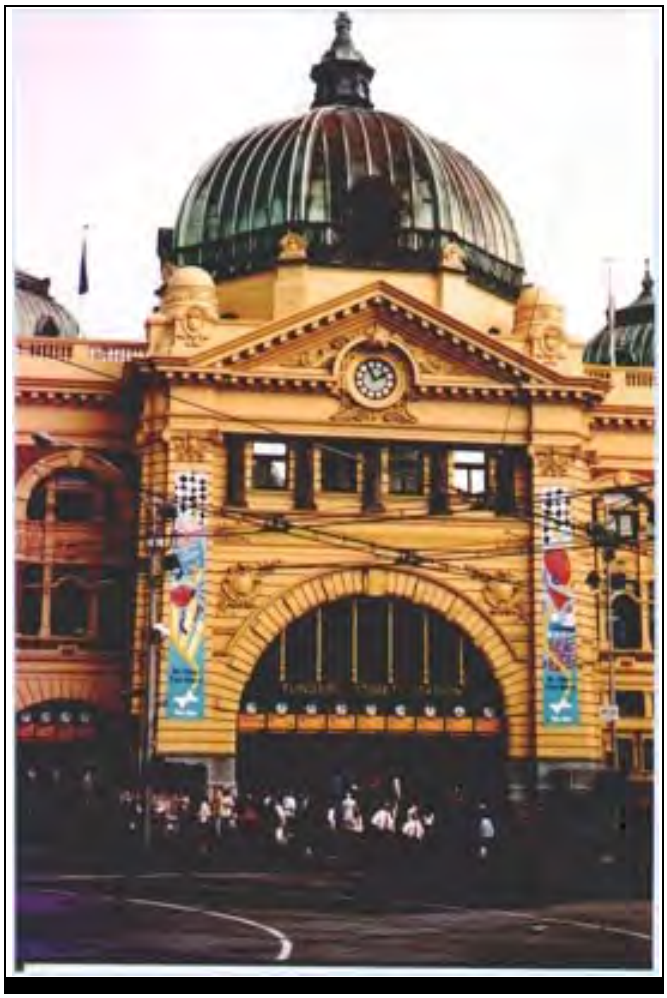
7.45 Another area of concern expressed by CPS relates to adolescents and young persons in the care of DHS under Guardianship or Custody Orders, who frequent the streets of Melbourne and inner suburbs during the night. The Salvation Army's CrossRoads Program stated in 1995, that around 70 per cent of the children they dealt with on the streets of Melbourne were either currently on Protection Orders or had previous involvement with DHS. The report indicated that these children had often absconded from medium or short-term departmental placements and accommodation units.

7.46 The 1992 protocol between DHS and Victoria Police provides "inter alia" that:

- If a child/adolescent is likely to contact its placement within 48 hours and is not at an unacceptable level of risk, then a "*Missing Persons"* report is not necessary;
- Where a Missing Persons report is made to Victoria Police and the child is located, Victoria Police have no legal powers to apprehend, detain or return the child/adolescent to their placement in the absence of a search warrant. Police are only empowered to inform the protective worker as to the whereabouts of the child and to encourage the child to return to its placement. If the child/adolescent refuses to return to its placement or to stay with the police officer, Victoria Police have no further authority to retain the child; and
- A warrant authorising Victoria Police to apprehend and return a missing person will only be initiated by DHS when the child is deemed by Victoria Police to be at immediate risk of substantial harm, and apprehension is the only option.

7.47 The crucial point is what constitutes a risk of significant harm. Bad behaviour, such as being intoxicated from alcohol or other substance abuse, on the part of the child who has absconded does not in itself necessarily constitute grounds for apprehension on the basis of immediate and substantial risk of harm.

7.48 Under the legislation, the Secretary of DHS has, in respect of a child under the guardianship of the Secretary, the same rights, powers, duties, obligations and responsibilities as a natural parent of the child would have. During the course of the audit, several natural parents of children under Protection Orders drew the attention of audit to the above legislative responsibility, in that they were concerned that their children's behaviour had become noticeably worse as a consequence of what they saw as a freedom to frequent the streets of Melbourne. The argument was along the lines of whether a responsible parent would allow such actions to occur, and if so, what would be the police reaction?



Melbourne's busy Flinders Street Station - a place often frequented by young people, including children in care.

7.49 Audit acknowledges that it is never the intention of the Secretary to allow actions to happen that could lead to significant harm occurring to a child in the care of DHS. The issue is whether reasonable steps have been taken to prevent the likelihood of harm occurring and it is on this issue that Victoria Police concerns can arise.

7.50 The reality of the situation, as observed by audit during a night at St Kilda, is that a significant proportion of the "street kids" are not homeless in that they are under the protection of the State and have accommodation they could go to. The police, particularly CPS, who may feel strongly about the potential exposure of these children, who can be as young as 10, and adolescents to criminal activities, substance abuse, prostitution and paedophiles, are largely ineffective in attempting to address these potential problems. In addition, DHS is also restricted in that:

- Although the Secretary has power under the legislation to detain without a warrant a child under a Guardianship or Custody Order, in practice this provision is ineffective if the child refuses to return to their placement as:
  - DHS cannot use physical force to apprehend a child; and
  - DHS does not have the power to forcefully enter any premises where it believes a child to be residing.

- Warrants of apprehension of missing children can only be executed by Victoria Police, a process which in effect is using essentially a criminal mechanism to apprehend children who can be in the care of the State, and who have not committed criminal offences. This aspect can also contribute to police officers being reluctant to be involved in this process, which they see as a welfare responsibility, as compared with undertaking a policing role; and
- The issue of a warrant of apprehension is a very serious matter and when applying to the Court, DHS must be able to convince a Magistrate or bail justice that the situation warrants police action. Consequently, warrants are not issued unless a young person is unlikely to return to their accommodation within a few days and strong evidence of risk of substantial harm exists.

7.51 Under the legislation Victoria Police can apply for a search warrant where the child is absent without lawful authority from its placement while under an Interim Accommodation Order. However, the mechanics of this process can mean that it will take in excess of 2 hours to arrange the warrant. As Victoria Police have no authority to detain the child in the interim period, and this fact is widely known on the streets, the child can go into hiding. Police rarely initiate warrants in their own right.

7.52 Young persons under Protection Orders who frequent the streets at night appear to audit to be fully aware of the legal limitations of Victoria Police actions and their "rights" as children, and can exploit this situation. Further discussion on this issue is contained in Part 8 of this Report.

7.53 It is acknowledged by audit that DHS has several initiatives in place in an attempt to address this problem, such as introducing a specialist team of youth workers known as *"The Streetwork Outreach Service"* to liaise with these children on the streets, and arrange to transport them back to their accommodation where possible. Unfortunately, many of these children reappear on further nights as there is limited capability of restraining them from leaving their accommodation at will. The Department has also introduced *"Intensive Youth Support Service"* which targets problem adolescents and actively works with them in an attempt to address their needs.

7.54 **Both agencies obviously must work within the constraints of legislation and any attempt to force young people, even though they may be in the care of the State, to adhere to rigid rules and restrictions on freedom can be very difficult, unless Victoria sought to impose curfews on adolescents congregating late at night as occurs in some overseas countries and was under consideration in Western Australia. Irrespective of any limitations on action arising from the legislation, audit considers that a solution to this problem will require an integrated approach between Victoria Police and DHS in developing strategies to deal with children in care frequenting streets.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Victoria Police are protective interveners under the Children and Young Persons Act 1989 and have the power to investigate suspected protective concerns and to take appropriate action to reduce unacceptable risk factors. These powers are in addition to criminal investigation powers, and enable Police to act in situations where a young person may be at risk.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The issues raised in the audit reflect the philosophical differences which continue to exist between the 2 agencies on protective issues concerning adolescents, and whether it is appropriate and useful for police to take protective action. Joint training will help each agency to understand the decision making process and policies of the other, and police are instructed to initiate protective action when circumstances dictate. Police remain concerned about DHS policies and standards of care regarding adolescents (especially "street kids" under their care).

VALUE OF JOINT TRAINING

7.55 In order to enhance training for what in many respects can be overlapping responsibilities, a number of CPS have actively pursued joint training with DHS protective workers, although the extent to which this occurs depends on operational requirements of Victoria Police as well as the availability of staff from both agencies. Other training initiatives have included interchanges of staff between DHS and CPS and joint attendances at seminars on child protection issues and related subjects. Audit also found that certain regions of DHS had initiated joint training. One DHS region developed a joint seminar in mid-1995 specifically directed towards improving the working relations between Victoria Police and protective services within the region.

7.56 The above initiatives can be of substantial benefit, not only to the participants in breaking down professional barriers, but to enhancing child protection generally. Unfortunately, such initiatives are not common in all regions and Victoria Police districts and largely depend upon management attitudes both centrally and locally in both agencies, as well as operational requirements and training resources. Procrastination is common in that while the benefits can be agreed upon, actually setting a mutually acceptable date can be a major obstacle.

7.57 **Audit considers that joint training involving protection workers and Victoria Police should be encouraged by senior management and co-ordinated at a central level within both agencies. Agreement should be reached on a Statewide professional development program which would address specialist topics and provide refresher courses on evolving areas such as legislation and Court processes. A strategic approach to joint training would be preferable to the current ad-hoc arrangements which largely lack co-ordination and are not meeting the needs of all workers from both agencies who are involved in child protection activities.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department rejects audit's view that there is an ad hoc and unco-ordinated response to joint training. Joint training is encouraged and supported by senior management in both agencies. The Inter-departmental DHS/Police Liaison Committee has formally endorsed joint training and other such initiatives. These initiatives have been planned and implemented under the direction of the DHS Child Protection/Community Policing Squads Central Liaison Committee. This is complimented by regional initiatives including Joint Training in the Investigation of Sexual and Physical Abuse and Work Exchanges (Job Swaps).

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  Since 1987, the CPS Co-ordinator's Office has invited DHS to take up places on the CPS training courses. When joint training did take place it proved extremely successful.

  In February 1992, and during 1993, a number of joint training sessions, each of 2 days duration, were conducted. The first of these centred around the introduction of the "single track" system, and the second when 80 new social workers were brought over from the UK to augment dwindling staffing levels in Victoria. Both of these courses met with favourable responses from the staff of both agencies. It is envisaged that the planned joint training will be conducted in a similar manner to that conducted in November 1995 on child sexual abuse.

  Most of the subjects on this course are already covered in CPS training courses and the Video and Audio Taping of Evidence (VATE) training. It is hoped the notion of "joint" investigations and co-operation between the 2 services will be the major benefit for both agencies.

  An evaluation of CPS training has already been conducted, and recommendations which include placing responsibility for the course with Training Department, and meeting National Competencies are being considered in conjunction with the Community Policing Squad Review being conducted. The VATE project is now well advanced, and also includes the opportunity for joint training.

SEXUAL ABUSE

Seriousness of sexual abuse and resultant investigative skill needs

7.58 The sexual abuse of children was the subject of an intensive review by the Crime Prevention Committee within the Victorian Parliament. The Committee's first report titled *Combating Child Sexual Assault - An Integrated Model* was published in May 1995 and contained 130 recommendations aimed at addressing this serious crime within the community. Certain of the areas addressed by the Committee were also relevant to this Report and accordingly will not be replicated in detail where appropriate. In its response to the Committee's Report, the Government supported the need for high quality, accountable and effective services to child victims of sexual assault and their families. However, a number of recommendations were not supported due to the Government's view that many were already in operation and because of resource implications, inadequate evidence as to their effectiveness and the need for alterations to Ministerial responsibilities. In addition, the recommendation for Sexual Assault Response Teams was seen as potentially leading to a fragmentation of response to child victims.

7.59 Children, including adolescents, have a right to be protected from sexual abuse, a criminal act which can ultimately have a long-term impact on the child's future life. The impact of sexual abuse on the victim can manifest itself in many forms, including low self-esteem, substance abuse, difficulty in forming relationships, sexually inappropriate behaviour, aggression and depression. Allegations of sexual abuse must be taken seriously and investigated in an organised and professional manner.

7.60 Investigation and substantiation of sexual abuse of children can be extremely difficult due to a variety of factors including:

- Forensic evidence to support allegations of sexual abuse is only available in around 15 per cent of cases and timeliness is critical. In any event, such evidence can be inconclusive as to the identity of the offender and additional evidence is necessary. Some forms of sexual abuse such as fondling, cannot be substantiated from a forensic examination;
- Offences are inevitably committed in private and as such there are no witnesses to independently support evidence. It then becomes a matter of determining whether to believe the child or the alleged offender;
- Children under the age of 7 are not generally deemed to be capable of instructing a lawyer or providing evidence. Children in this category are particularly vulnerable to exploitation;
- The non-offending partner in a family relationship may choose not to believe any disclosures made by a child; and
- A child may subsequently deny a disclosure of sexual abuse in order to protect the family or retract disclosures as a result of threats from the alleged offender, or they may have a close relationship with the offender, particularly when it is their father and accept the abuse even though they do not like it.

7.61 Sexual abuse of children exists in all levels of society, but Victoria Police advised audit that it is even harder to prove within middle to upper class families who can be better placed to defend such allegations, or to conceal a problem through better access to a range of professional services.

7.62 From the perspective of DHS protective workers, specific courses on investigating reported sexual abuse are conducted from time-to-time. In addition, the DHS policy advice and practice manual provides comprehensive guidance and references on the subject.

7.63 By virtue of their background, protection workers cannot be expected to have the investigative skills and practice levels demanded of Victoria Police, particularly detectives, when investigating potential criminal offences against children. Similarly, very few police would have the background knowledge possessed by some experienced protection workers of the behaviour patterns initially displayed by children which may be indicative of child abuse. A skilled protection worker, working with a child and consenting parents, can develop the child's trust in the worker, which may lead to an eventual disclosure, probably without any forensic evidence. It is the combination of the strong investigative skills of police and the competence of protective workers in analysing behaviour of children that can make joint investigative teams dealing with sexual abuse very effective.

7.64 In some Victoria Police districts, sexual investigation units have been formed comprising both detectives and CPS officers. Such units obviously possess, from their experience over time, skills in conducting investigations of sexual assault including those involving children. DHS does not have equivalent specialist teams, notwithstanding the inherent complexity of such investigations and the importance of DHS's role in arguing cases before the Children's Court on the grounds of a child needing protection as a result of the probability of sexual abuse having occurred.

7.65 **Because of the above factors, persons investigating reported sexual assault need to be highly trained and conversant with interviewing children using the best available techniques. Even where highly trained personnel are involved, investigations can take a long time and successful prosecutions are relatively few. Audit considers that the combination of the respective skills of both DHS and Victoria Police in specialist teams would be more effective in substantiating sexual abuse.**

❑ ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

All the examples cited on the level of investigation and quality of evidence are valid, however, the issue here is the collection of admissible evidence. Further, much of the Report implies that formal training in interviewing techniques is a panacea for the perceived low rate of prosecutions in child sexual assault matters.

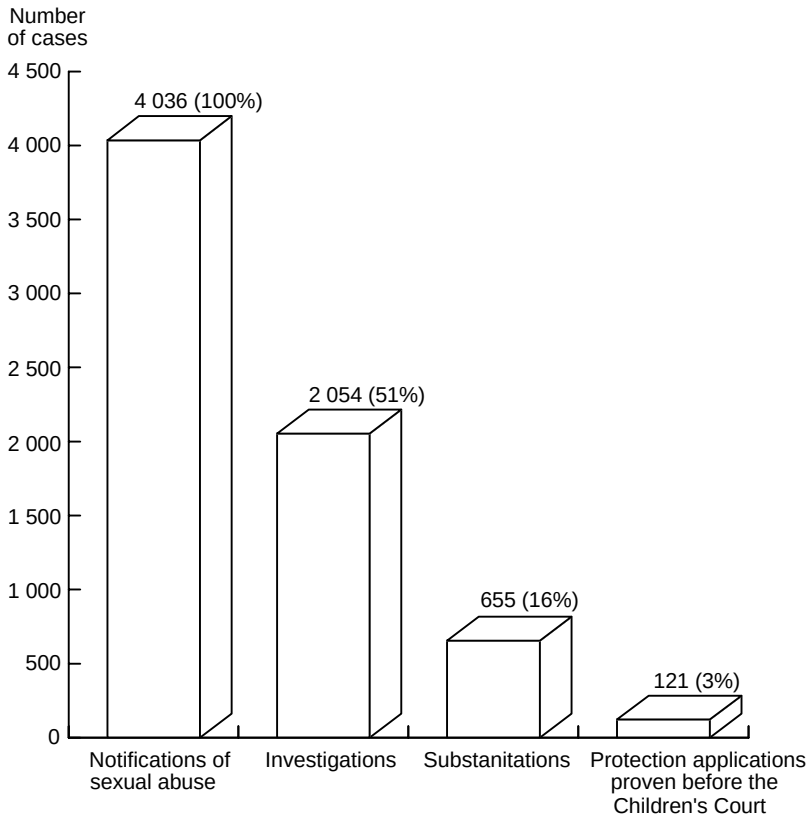
The behavioural sciences are heavily relied on when children are interviewed and, as such, the professional experience of an interviewer will go further in gaining admissible evidence from a child than an interviewer without that experience. The ideal mix for any successful child interviewer is formal training and practical experience.

No matter how highly trained or skilled an interviewer is, unless there is sufficient admissible evidence the case should not proceed.

Low levels of substantiation and prosecution of sexual abuse

7.66 During 1994-95 31 619 notifications of suspected child abuse were made to DHS, of which 4 036 notifications (12.8 per cent) related to suspected sexual abuse. Chart 7A shows the percentage of notifications of sexual abuse that were subject to investigation during 1994-95 (51 per cent) together with those cases that were substantiated (16 per cent) and those cases in which protection applications were proven before the Children's Court (3 per cent).

CHART 7A
SEXUAL ABUSE NOTIFICATIONS, INVESTIGATIONS, SUBSTANTIATIONS AND PROVEN PROTECTION APPLICATIONS DURING 1994-95



Source: Advocacy Unit of DHS.

7.67 During 1994-95, DHS received 4 036 notifications of suspected sexual abuse of children. Of these notifications, 2 054 (51 per cent) were investigated, mostly in conjunction with Victoria Police. Sexual abuse, on the grounds of the probability of it having occurred, was substantiated in 655 cases (32 per cent) of those reports investigated. Of the 655 substantiated cases, only 121 (18 per cent) resulted in Protection Applications proven before the Children's Court. DHS maintained that this low level of substantiation could be attributed to the difficulty in proving sexual abuse applications before the Children's Court and was advised in many instances by their lawyers not to proceed with such applications. Magistrates at the Children's Court also advised audit that it is not unusual for DHS to fail to prove cases through reasons such as the poor quality of investigations and omission of key evidence.

7.68 With respect to cases that were not brought before the Court, most involved cases where the perpetrator was no longer in the family and the child was regarded as being protected by remaining family members. These arrangements in the longer-term, unless reinforced by an intervention order, can prove to be ineffective if the perpetrator decides to return to the family home.

7.69 Audit attempted to establish the extent to which those cases substantiated by DHS were referred to the Criminal Investigation Branch of Victoria Police and whether successful prosecutions occurred. This task proved to be impossible to achieve in the short-term, as it would have required manually tracing notifications of sexual abuse through DHS and Victoria Police records. Reasons for this critical lack of statistical data included:

- The CPS Co-ordinator's Office does not keep routine data on cases referred by CPS to the Criminal Investigation Branch. Such data can be prepared manually but does not record outcomes of Branch investigations or Court outcomes;
- Virtually all reports of sexual assault are recorded manually as casebook entries by CPS. These casebook entries in relation to suspected sexual assaults on children predominantly arise from notifications made to DHS, but also come from reports from mandated groups, members of the public and the victims themselves. Police exercise discretion as to whether casebook entries are recorded as Crime Reports. The discretion exercised relates to the likely substance of the allegation, whether the allegation is based on hearsay and a range of other factors. It is probable that less than 50 per cent of casebook entries involving sexual assault are recorded as Crime Reports; and
- Failure to include a casebook entry as a Crime Report means that it is not recorded on the Victoria Police *"Law Enforcement Assistance Program"* system (LEAP) which is the source of crime statistics on reported crime and prosecution outcomes. The situation can occur that even though sexual assault may be proven as grounds for protection, it is not necessarily recorded on LEAP because discretion has been exercised by the Victoria Police that a Crime Report is not warranted as a result of the CPS investigation.

7.70 DHS has access to the LEAP system when investigating notifications of sexual abuse. However, for the reasons stated above, the system cannot be relied upon to provide a full record of reports of sexual assaults against children, a fact which can influence the level of any future investigations conducted by both agencies.

7.71 The lack of statistical data is also further compounded by the fact that, as part of pre-Court negotiations, a suspected offender will concede to a Protection Application on grounds other than sexual abuse, on the condition that no record is maintained at the Court of the suspected sexual abuse. The reasons for this situation relate to the fact that any acknowledgment of sexual abuse in a Protection Application could prejudice any criminal prosecutions on these grounds at a future date.

7.72 In the absence of reliable management information within Victoria Police involving joint DHS/CPS investigations of sexual abuse, basic information provided to audit established that around 20 per cent of these investigations eventually result in criminal prosecutions. Of these prosecutions, around 75 per cent are successful, with a community-based order being the most likely outcome. Imprisonment is rare. Often the perpetrator will plead guilty to a lesser charge in order to avoid a more serious offence such as rape.

7.73 On the above basis, of the 2 054 cases warranting investigation by DHS in 1994-95, successful criminal prosecutions would only be in the vicinity of 100 cases (5 per cent). Based on research studies which indicate that around 40 per cent of convicted sexual offenders are likely to re-offend, the likelihood is that of the 121 cases proven by DHS before the Children's Court, on the balance of probability, around 50 of these persons will re-offend.

7.74 **Given the serious nature of all forms of sexual abuse, audit considers that the extent to which this suspected crime is reported by the community and successfully prosecuted by Victoria Police should be fully reflected in the statistical information maintained by Victoria Police. Such information, if complete, should be of benefit to both Victoria Police and DHS in their investigations of suspected offenders.**

Factors inhibiting the proving of sexual abuse

7.75 The Crime Prevention Committee in its May 1995 report dedicated itself to emphasising the serious nature of sexual assaults on children and what it saw was a wide range of deficiencies in the existing system of combating the sexual assault of children. The low rate of success in prosecuting offenders within Victoria was attributed in part to a lack of corroborating evidence, low standards of investigation, restrictions in existing legislation and absence of case law.

7.76 Although this Report is primarily focused on the protection of children, there is a clear linkage between the difficulties encountered by DHS in proving Protection Applications in the Children's Court on the grounds of sexual abuse and the capability of Victoria Police to successfully prosecute offenders, particularly in that many investigations are conducted jointly and the standards of evidence required in both jurisdictions have become increasingly similar. Detailed below are the factors which audit saw as limiting the ability of both agencies to prove sexual abuse:

- restrictions within legislation;
- low standards of investigation and need for a co-ordinated joint approach;
- lack of facilities for videotaping interviews; and
- incomplete intelligence information.

Restrictions within legislation

7.77 The law itself is seen by Victoria Police as presenting certain barriers to the successful prosecution in cases involving the sexual abuse of children.

7.78 A High Court Decision, *S v. R* (1989) CLR at 77, established that charges in relation to sexual abuse should not proceed unless material events could be related to a specific date, or a date that could be reasonably recalled. The requirement, in line with this decision, to specify a particular date when an offence supposedly occurred gave the accused an opportunity to try to establish an alibi for that date. Under these circumstances, it is extremely difficult for a child, particularly for a very young child, to establish a specific date of an offence. Defence tactics will commonly involve concentrating on disproving actual dates of offences, rather than the offences themselves.

7.79 Section 47A of the *Crimes Act* 1958 was amended in 1991 in an attempt to overcome the above problem of children having to try to particularise events. The amendment provides, in effect, for specific dates to be no longer necessary. As a result of the amendment, it is now necessary for the prosecution to prove beyond reasonable doubt 3 separate sexual incidents between the accused and the victim. Section 47A only applies where the accused has had care, supervision or an authority relationship with the victim, otherwise the dates have to be particularised. This amendment has proven to be largely ineffective in improving prosecution rates, particularly as the consent of the Director of Public Prosecutions is required before cases can proceed under this section. This condition does not apply to virtually any other criminal offence except for treason.

7.80 The Crimes Act also provides that, where an offender is charged with multiple offences involving a number of victims, separate trials are usually held for each victim, as compared with all victims presenting evidence concurrently. Accordingly, a jury cannot be aware of the complete picture of an offender when considering a verdict. In addition, if the first prosecution launched is unsuccessful, there is a tendency for the prosecution not to proceed any further.

7.81 The impact of barriers to prosecution may also be reflected in the child protection system in that Magistrates in the Family Division of the Children's Court, on isolated occasions, have waited upon the outcomes of criminal prosecutions before deciding on protection applications involving sexual assault. Presumably, the reason for this approach is that it could be seen that the proving of grounds for protection in the Children's Court on account of sexual abuse may influence criminal proceedings in higher Courts. However, the implication from a child protection viewpoint is that the standard of proof applicable in Courts of criminal jurisdiction may be used in determining Protection Applications in the Family Division of the Children's Court, where a lesser standard of proof on the *"balance of probabilities"* is required.

7.82 **The overriding factor, in audit opinion, is that the interests of the child are paramount. In this regard, audit strongly supports the Crime Prevention Committee's recommendation for legislative change, action which has also been supported by the Government in its whole-of-government response to the Committee's Report. A review of the legislation is highly desirable in order to address the current restrictions which are seen by Victoria Police as giving rise to an imbalance of justice in favour of the alleged offender to the detriment of the child.**

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The Victoria Police supports the audit's recommendation for legislative change "to redress what is seen as an imbalance of justice".

Low standards of investigation and need for a co-ordinated joint approach

7.83 Sexual assaults on children, particularly within the family, are one of the hardest crimes to identify and substantiate in terms of protective concerns as well as on criminal grounds. DHS acknowledges that many protective workers feel they lack sufficient expertise, ongoing training and access to support facilities in investigating and substantiating sexual abuse, despite the availability of a large volume of reference material and dedicated training courses on sexual abuse.

7.84 Due to constant turnover of staff and changes in duties, many staff at the lower classification levels do not get the opportunity to build expertise in sexual abuse cases over an extended timeframe. As a result, it is unlikely that these workers will constantly perform well in the Children's Court in attempting to prove Protection Applications on sexual abuse grounds, particularly in the face of intense scrutiny from defence counsel. In addition, any shortcomings in evidence are not compensated for by evidence from CPS or the Criminal Investigation Branch involved in a joint investigation as this evidence is not normally presented or available in the Children's Court to support evidence presented by DHS.

7.85 CPS officers and detectives are obviously skilled in investigations but not necessarily those involving sexual assaults on children. An exception would be the Child Exploitation Unit which is part of Victoria Police, but which concentrates mainly on paedophiles and multiple offenders. The need for development of special skills and support services in this difficult area is acknowledged by both agencies and was further confirmed by the Crime Prevention Committee.

7.86 The existing arrangements under the protocol established in 1992, which required DHS and Victoria Police to jointly investigate notifications of sexual abuse, has had limited success due to a range of factors such as:

- high turnover of staff, particularly protection workers, which has meant a lack of consistency in competence, team composition and teamwork in undertaking joint investigations;
- extended delays in conducting investigations which ideally should be properly planned and undertaken without delay;
- differences in professional approaches, especially in that Victoria Police do not consider that DHS should be involved in investigating matters that involve criminal concerns;
- poor communications between the 2 agencies, particularly in relation to adhering to protocol and timely resolution of issues;
- failure of investigating staff to gather all available evidence;
- the difficulties in maintaining consistency of evidence where multiple interviews of the victim have occurred due to the involvement of DHS, CPS and CIB staff; and
- protracted delays in finalising Protection Applications in the Children's Court.

7.87 All the above factors have obviously been, in many cases, to the detriment of the child's best interests, including being returned home to live with the likely perpetrator, lack of victim counselling, increased trauma, and long-term psychological impact. Cases also came to the attention of audit where the child was forced to leave the family home due to the perpetrator remaining.

7.88 The Crime Prevention Committee report advocated the establishment of Sexual Assault Response Teams (SARTs). These teams would provide a multi-disciplined approach to the problem and comprise specially trained police officers skilled in investigation of sexual assault, in conjunction with protective workers known as protective advocates who would address the welfare concerns of the victim and family. The need to further involve the Criminal Investigation Branch as currently occurs would not be necessary. This concept was supported by the Government but it stated in its response to the Committee's Report that the matter warranted further consideration, including a cost-benefit analysis and evaluation of alternative models.

7.89 **Multi-disciplinary teams already operate successfully in England and the United States of America. In Australia, Queensland has established multi-disciplinary teams although such teams are not co-located. Irrespective of whether the Committee's recommendations on multi-disciplinary teams are ultimately accepted in some form by the Government, audit firmly agrees with the Committee that change is needed as to the manner in which child sexual assault is investigated and dealt with in the community.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department strongly supports the need for improved performance on child sexual abuse matters currently within its jurisdiction and for investigations where responsibility is shared with Victoria Police.

  Work is under way with Victoria Police to develop an improved joint investigative response and the Department is taking steps to improve its performance in Children's Court cases where protection applications are based on alleged sexual abuse of children.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  The criticism of child interview skills within Victoria Police and DHS is harsh. It is the experience of police that most prosecutions fail for one or more of the following reasons:

  - *Emotional instability of victim as a witness. Some victims are unable to reconcile the need for them to attend court. In the interest of victim welfare such matters are usually withdrawn;*
  - *Inferior quality of investigation. The investigating officer has not canvassed all avenues of inquiry and, therefore, has allowed the defence to create doubt as to the quality of evidence; and*
  - *Legal precedence and procedures. Once legal precedence and procedures are applied, both the strength and quality of evidence is often lessened, e.g. separation applications.*

  Child victims are often emotionally fragile and usually do not fully understand court procedures and the legal process. For these reasons the prosecution case is often unfairly disadvantaged before the case begins. In the past, Child Exploitation Squad prosecutions have been lost, not because the veracity of the evidence is questioned but because child victims have been unable to cope with the giving of their evidence on multiple occasions. Similarly, a long period of time can pass between the giving of evidence at a committal hearing and trial.

  Child victims are unique witnesses. There is potential for emotionally detrimental effects on these witnesses in a protracted court process. Consequently this requires re-assessment of the procedural reception of their evidence.

  Consideration must be given to these witnesses giving evidence in chief and being cross-examined only once during the process. Ideally, that should be at the earliest opportunity.

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police - continued*

  The issue of the Sexual Abuse Response Teams (SART), raised in the Victorian Parliament Review on Child Abuse Response (Chaired by Mr Ken Smith, MLA) has been under discussion between the 2 agencies, and while it is acknowledged there are potential benefits by providing an integrated/co-ordinated response, the industrial issues, co-locating facilities and resourcing problems have been raised, and are significant obstacles to overcome. It is acknowledged that the proposal does have merit, but needs further consideration.

  At present, under the Protocol, the 2 agencies continue to respond according to the "single track" system. Discussions to date indicate DHS do not favour the implementation of the SART model, but favour a Local Assessment Response Panel, which will ensure all cases are properly managed. This model is clearly a worthwhile case review system and good progress towards trial implementation in 2 Police Districts has been made.

Further advantages of a co-ordinated team approach

7.90 In addition to supporting the concept of a multi-disciplinary team, audit considers there are further advantages to be gained from such an approach in the areas of:

- specialist focus on notifications of suspected sexual abuse;
- maximising resources of teams; and
- improvements to the legal representation of DHS and Victoria Police.

Specialist focus, through multi-disciplinary teams, on notifications of suspected sexual abuse

7.91 At present, notifications of suspected child sexual abuse can be received by either Victoria Police or DHS. Under the single track system, all notifications received by Victoria Police are to be referred to DHS where a child may be in need of protection within the family. Protocol requires that Victoria Police is informed by DHS of notifications where there is a reasonable belief that an offence may have occurred.

7.92 Audit established that decisions made as to whether notifications should be accepted or investigated can vary widely between regions within DHS depending on the level of experience of officers involved in the notification/intake phase. Notifications which at face value lack substance, could in fact involve suspected perpetrators of sexual abuse elsewhere in the community.

7.93 The difficulty in determining which notifications warrant further investigation is acknowledged by audit and a certain percentage of allegations are malicious, particularly in Family Court matters. Nevertheless, audit concurs with the recommendation of the Crime Prevention Committee that all notifications of sexual abuse should be referred to, or made directly by the public to, a multi-disciplinary team.

7.94 **The advantages of specialist multi-disciplinary teams analysing notifications would include:**

- **use of specialist expertise in determining which notifications warranted investigation and the priority thereof;**
- **the recording of notifications on a Statewide intelligence database which would assist in determining the likelihood of children being exposed to risk through contact with suspected offenders already recorded on the database, as well as other information relevant to investigations; and**
- **enhanced workforce planning and prompt response times.**

Maximising resources of teams

7.95 An important consideration to be addressed when contemplating multi-disciplinary sexual assault teams is the likely volume of workload and the tasks to be undertaken by the respective team members. It is recognised that, if multi-disciplinary teams were to be established, only around 30 per cent of notifications to a team would involve protective concerns under the *Children and Young Persons Act* 1989, and the remaining 70 per cent would constitute Crime Reports beyond the responsibility of DHS.

7.96 In 1994-95, 2 054 investigations of child sexual abuse were conducted by DHS and Victoria Police of which only 655 were substantiated as having protective concerns. Based on the above data, notifications warranting investigation could average around 40 per week across the State, hardly a large workload particularly as only around one-third of this number are likely to be substantiated. Experiences with similar teams established interstate suggest that workloads fluctuate widely. Audit acknowledges that with improved investigative techniques and skills, workloads would be expected to increase due to higher substantiation rates and prosecutions.

7.97 To overcome the above potential problem of how to maximise the use of specialist resources, consideration could be given to assigning to teams the additional responsibility of investigating the severe physical abuse of children which is also a joint DHS/Victoria Police concern. Considerable judgement is required on many occasions to distinguish between what can be regarded as lawful chastisement of a child by a parent or a genuine accident, in contrast to serious physical assaults requiring protection of the child in conjunction with the potential prosecution of the offender. Serious physical assault is the cause of the vast majority of child deaths involving protective concerns.

7.98 **Victoria Police has for many years recognised the advantage of specialist focus teams. Audit considers that extending this concept to include DHS and other professionals would have considerable merit in maximising the use of resources in the areas of sexual and serious physical abuse of children occurring within the community.**

Improvements to the legal representation of DHS and Victoria Police

7.99 The successful prosecution of sex offenders and the issuing of Protection Applications in the Children's Court on the ground of sexual abuse rely heavily on the legal briefs and evidence provided to barristers representing both the Victoria Police and DHS.

7.100 DHS engages a number of barristers from the private sector to represent its in protection matters before the Children's Court. These barristers are instructed by a solicitor from the Children's Court Advocacy Unit within DHS. The solicitor, in preparing instructions, relies on the evidence provided by the protection workers involved in bringing Protection Applications before the Court on the ground of sexual abuse. Many Protection Applications are withdrawn on the advice of the solicitor due to insufficient evidence, while some other Applications are proceeded with on grounds which are easier to sustain.

7.101 A problem associated with Court appearances by DHS is that the protection worker who undertook the investigation and lodged the protection application is usually not the same worker as the one who prepares the Protection Application report and gives evidence in the Children's Court. Reasons for this situation relate to the practice by DHS of transferring responsibility of cases from notification/intake teams to long-term protection workers who will manage the case plan with the family. Accordingly, prior to the Court appearance, the long-term protection worker allocated to the case will interview the family and prepare the Disposition Report and Protection Application Report outlining the grounds for the Application to the Court. The problem with this approach is that the long-term worker can be closely scrutinised in Court as to the evidence, including the initial interview with the family and child, despite not having conducted the interview.

7.102 As a consequence, Magistrates advised audit of the often poor standard of evidence presented, the need for inexperienced witnesses to constantly refer to their superiors for advice, poor justification for the grounds sought in the application and minimal use of expert witnesses to back up evidence. As a result, Protection Applications on sexual abuse grounds could be lost because of Court poor presentations rather than their underlying validity. Abused children may then return home even though the perpetrator remains.

7.103 Although notification/intake workers can provide evidence in cases before the Children's Court, in practice, except in the more serious sexual abuse cases, this does not occur.

7.104 If joint multi-disciplinary teams were established, comprising specialist investigators from DHS and Victoria Police, the quality of evidence and presentation in Court would most likely improve. In addition, such teams would tend to develop evidence to a standard of "beyond reasonable doubt" which would enhance the ability to prove cases both within the Children's Court and criminal jurisdictions.

7.105 Under the concept of a multi-disciplinary team a solicitor would be attached to the team to provide legal advice and to brief barristers acting on behalf of the Director of Public Prosecutions (DPP) where criminal prosecutions are launched.

7.106 Audit considers that there is further scope for enhancing appearances by DHS before the Children's Court if the solicitors attached to multi-disciplinary teams were outposted from the DPP. In addition to briefing barristers for the DPP in committal hearings, the solicitor would also be able to brief, under the supervision of the solicitor from the Advocacy Unit, the barristers representing DHS in protection applications before the Children's Court. The advantage of this action would relate to the specialist skills of the solicitor in sexual abuse cases being further utilised in protection matters, given that the evidence to be used in both the Children's Court and a criminal jurisdiction will be largely the same. Other benefits would be consistency of evidence in both criminal and family matters and the elimination of opportunities for plea bargaining on protection matters involving suspected sexual assaults.

7.107 **Through utilisation of specialist investigators in conjunction with expert legal advice, audit considers the success rate of protection applications on sexual abuse grounds before the Children's Court is likely to be improved, to the advantage of the children involved.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department accepts a number of the difficulties identified by audit in relation to the investigation and prosecution of sexual offences against children and is committed to the development of a more responsive and effective service approach.

  To this end, the Department is already involved in a range of initiatives to fund and develop an enhanced child sexual assault response. These include:

  - *funding of sexual assault forensic assessment and counselling services;*
  - *research into factors affecting child protection court performance in sexual abuse matters;*
  - *the development of a system of assessment review for all jointly investigated cases;*
  - *joint investigation training of Child Protection and Police; and*
  - *community and professional education to raise awareness of sexual abuse of children in the community.*

Lack of facilities for video taping interviews

7.108 In May 1992, a Video and Audio Taped Evidence Project (VATE) was initiated by Victoria Police following an expression of interest in this development by the Attorney-General. The purpose of the project was to evaluate the potential for introducing video taped evidence in criminal proceedings from witnesses who were likely to be traumatised within a courtroom, such as children and young persons and mentally impaired persons. The witnesses would still need to be subject to cross-examination, however, with the advent of closed circuit television facilities in criminal jurisdictions, a witness would not need to be present in the courtroom where they could be subject to intimidation from the accused and the courtroom environment.

7.109 The *Crimes (Sexual Offences) Act* 1991 requires that *"video statements"* must be conducted by *"prescribed"* persons who have undergone training in the techniques involved in interviewing children about alleged sexual and/or physical assaults. This role would be likely to be undertaken by selected CPS officers in that the legislation is directed towards criminal proceedings rather than Protection Applications.

7.110 The video taping of evidence is common in the United States of America, the United Kingdom, Norway, Sweden and Queensland. Given the low rates of substantiation of sexual abuse of children in Victoria, both from a child protection viewpoint and as a criminal offence, any mechanism available to improve this situation would be beneficial. Apart from lessening the impact of court proceedings on vulnerable witnesses, other benefits would include:

- producing witness statements of a high evidentiary standard, leading to increased prosecution rates;
- providing a stronger basis for protective intervention;
- ability to record complaints of assault and sexual abuse contemporaneously with the event and thus to achieve consistency of evidence irrespective of time factors, a child's memory and the various Courts involved; and
- anecdotal evidence from overseas suggests that offenders are more likely to make admissions after viewing video statements of evidence, especially where abuse has occurred within the family.

7.111 A pilot program within Victoria Police on the use of video taping facilities commenced in January 1995 with a view to considering Statewide application during 1996.

7.112 In audit's opinion, video taping of interviews by highly skilled operators will be of benefit, providing it is supported by an appropriate infrastructure. Audit strongly supports its introduction as soon as possible, given that these facilities were initially proposed in 1991, but not authorised in regulations until December 1994. However, in doing so, the following potential factors will need to be considered:

- video taping in itself will not produce any improvement in Court outcomes unless a number of other matters are also addressed concurrently, such as the need for high level investigative skills, adequacy of resources, the removal of current legislative restrictions and the raising of community awareness and recognition that sexual abuse of children is a serious offence;
- a need to overcome obstacles which currently make it difficult for video-tapes developed for use in criminal proceedings to be presented by DHS as evidence in the Children's Court;
- the potential for a defence counsel to more vigorously attempt to discredit the child victim during cross-examination in the Children's Court on the premise that to do so successfully could weaken the subsequent prosecution case on criminal charges;

- questions of natural justice in that the accused family member is not legally permitted to view video taped evidence in advance of a protection hearing in the Children's Court in cases other than where criminal charges have already been laid, which in many cases may not occur in advance of a Protection Application hearing; and
- the converse of the above point in those cases where the accused family member is given a transcript of the tape after a criminal charge is laid, which means a defence counsel is better placed to oppose a Protection Application to the detriment of the child.

7.113 **On balance, audit considers the benefits of video taping of evidence outweigh the potential impediments. However, in order to maximise these benefits, further research should be undertaken with a view to restricting the levels of trauma that a child could be exposed to within the legal system as a direct result of introducing video taping, without compromising the basic rights of the accused.**

❑ ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

The Report strongly supports the video or audio taping of interview with victims as one strategy in improving evidence at Court. The Victoria Police has already made significant advances in this regard but is not in the financial position at present to introduce this initiative Statewide. The Report points out a number of possible disadvantages and legal difficulties in using such taped evidence at either the Children's Court or during a criminal trial. These issues are being addressed by our Prosecutions Division and our Corporate Policy Planning and Review Department with a view of improving the legislation.

Incomplete intelligence information

7.114 The main computer software package utilised by Victoria Police is the Law Enforcement Assistance Program (LEAP), which was progressively developed from 1989 at a cost of around $37 million and implemented across the Force in 1993. The system provides factual information about crime, convicted offenders, wanted persons, field contacts and other comprehensive information essential to operations, resource deployment and decision-making.

7.115 A CPS module of the LEAP system was developed and trailed in 1991 in a police district and was considered, subject to needing some modifications, to meet the needs of the CPS. The module was considered by Victoria Police as superior to the Personal Computer (PC) based system referred to below, in relation to its capacity as an integrated Statewide information network storing vast amounts of information for management purposes. Benefits would include a capability to better co-ordinate CPS activities, especially in terms of resourcing areas of greatest demand based on case loads, improved recording of Court outcomes arising from joint investigations with DHS and CIB, and providing the current status of investigations in progress.

7.116 At the date of preparation of this Report, the CPS module was not operational. From audit discussions, part of the problem in implementing the module is that it was designed to operate in terms of recording factual substantiated data, as compared with the intelligence and unsubstantiated data which CPS rely on.

7.117 As part of the VATE project outlined in an earlier paragraph, it was necessary for Victoria Police to measure the impact of video recording on the workload of the CPS. Given that at the time a computer-based case management system was not in existence, a decision was made in April 1993 to install a prototype computerised case management system on an experimental basis in 4 CPS in an attempt to measure workloads and work practices of CPS officers. The system, which was PC-based, was developed from existing information collected manually by the Squads. The system also provided numerous other fields, including Court outcomes, which were to be of assistance in case management and staff administration. As data entered on the system is derived from casebook entries of reported crimes, suspected offenders and other relevant background information, the information is very useful for intelligence purposes should other offences be reported involving the same suspects.

7.118 While generally the PC-based system was regarded as very useful for measuring workloads, its principal benefit was ready access to intelligence information which is not part of the LEAP CPS module. The CPS recognised the major disadvantages of the PC-based system as its limited capacity to store vast amounts of information due to its reliance on personal computers and an inability to share information across police districts and to simultaneously update information on a Statewide basis. As a consequence, the system has not been extended beyond the 4 pilot CPS sites.

7.119 In audit opinion, the linking of information held within LEAP's CPS module with that of the type recorded on the PC-based system would provide Victoria Police with information on a Statewide basis to target suspected child sexual offenders. In effect, the LEAP system could be used as an index system, indicating that further information on suspected offenders was held elsewhere and which could only be accessed under strict security conditions. Potential could also exist for further linkage with the DHS CASIS system which also records information on suspected offenders in respect of notifications which have been received regarding sexual abuse. This could provide further valuable information to DHS in identifying children potentially at significant risk within families.

7.120 The computer linkages suggested above would need to be subject to privacy laws and strict security over access. In this context, future consideration could be given to allowing Victoria Police on-line access, under strict conditions, to the CASIS system maintained by DHS in respect of any notifications of suspected sexual assaults and physical assaults that were not investigated. At present, Victoria Police can only access this system by arrangement with local DHS regional management.

7.121 Such a linkage would also be of immense benefit in facilitating reference checks by DHS for persons engaged in caring for children, including foster parents, youth workers, protection workers and families providing permanent care.

7.122 **The implementation of a Statewide information system based on linkages between the CPS module of the LEAP system, the PC-based system currently in operation in some CPS units and CASIS is strongly recommended by audit as a means of strengthening the intelligence capability of agencies. More effective and efficient use of resources devoted to child protection and prosecution of suspected sexual offenders would be the resultant outcome of such action.**

- ***RESPONSE*** *provided by Chief Commissioner, Victoria Police*

  Inquires have been made with LEAP regarding the possibility of obtaining their assistance in casebook management systems. The "intelligence gathering" as opposed to "fact management" requirements create an obstacle which is currently being addressed. LEAP have estimated that access to their system could take some 2 years to achieve. Possible alternative systems such as PCs linked by modem or other network system is also being considered, but security of this sensitive information will need to be an important consideration. Additionally, the resourcing problems, such as variety of levels of access to computers by the Squads has proven to be one of the difficulties to be faced.

Government initiatives to address past problems associated with forensic evidence

7.123 Forensic evidence dealing with suspected sexual abuse and serious physical assault is important for the purposes of assisting DHS in proving Protection Applications on those grounds in the Children's Court and to provide Victoria Police with evidence when undertaking prosecutions of alleged perpetrators. Forensic examinations must be conducted by medically qualified experts and should include, as a minimum, the examination, documentation and interpretation of bodily evidence in conjunction with documenting the child's medical, social and developmental history. Following a forensic examination, it is essential that the broader health needs of these children are addressed.

7.124 Because evidence of physical and sexual abuse can dissipate quickly, it is imperative that medical forensic examinations be conducted as soon as possible once the child comes to the attention of DHS and Victoria Police. Any delays in the conduct of an examination, particularly with sexual assault, can result in the loss of critical evidence.

7.125 Approximately half of the forensic medical examinations of children suspected of being sexually or physically abused were, until late 1993, undertaken by the Office of Forensic Medicine within Victoria Police through a network of full-time and part-time Forensic Medical Officers. Forensic examinations of children were also carried out at special units at Monash Medical Centre and the Royal Children's Hospital.

7.126 By mid-1994, a crisis in the provision of forensic services to DHS and Victoria Police had developed with the virtual collapse of the service ability of the Office of Forensic Medicine due to a range of factors, including loss of experienced staff, reduced quality of service and an inability to cope with the level of additional referrals mainly resulting from mandatory reporting. The consequential sudden and unanticipated escalation in workload of the 2 major public hospitals providing these services caused severe resourcing problems in those hospitals, with the result that, on occasions, forensic examinations could not be carried out in the necessary timeframe and the children were often shunted to other hospitals, adding to their trauma.

7.127 In a positive response to the crisis, the Government initiated a review of the provision of forensic medical services and associated support services throughout Victoria. This review culminated in the establishment, from 1 October 1995, of the Victorian Institute of Forensic Medicine which absorbed the functions of the Office of Forensic Medicine. The new Institute, through a core group of forensic medical specialists assisted by a network of part-time physicians, is expected to considerably enhance the quality and timeliness of the provision of forensic medical services to public sector agencies, and become a world class research centre in this field. The Monash Medical Centre and the Royal Children's Hospital have also been designated for the delivery of specialist clinical forensic medical services and, in 1995-96, DHS provided additional funding totalling $310 000 to these hospitals.

7.128 **The Government's action in addressing what was seen as a crisis in the provision of forensic medical services during 1994 and 1995, is viewed by audit as a positive initiative.**

Part 8

Children under the care of the State

OVERVIEW

8.1 In recent years, the Department of Human Services (DHS) has been progressively reducing its traditional reliance on placing children in care in facility-based care such as family group homes and rostered units in favour of a range of other settings, better suited to a child's needs, with a strong emphasis on home-based care. This strategy is strongly supported by audit, after allowing for the fact that in some instances, facility-based care meets a child's needs. However DHS has not been successful in providing the level of home-based care needed to replace the facility-based accommodation being phased down, in conjunction with more children coming into care. As a result many children, mostly adolescents, were being located in family group homes and rostered units for long periods, whereas their time in these units in many instances was intended to be short- term.

8.2 The impact of the above arrangements, although unavoidable to a certain degree with highly disturbed adolescents who are difficult to place, has contributed to a situation where due to a range of factors including the effect of abuse suffered and the influences of other children, a substantial number of these children exhibit severe behavioural problems. Audit established that of the children over 10 years of age in care, a high percentage regularly absconded from placements, leading to a potential for serious harm and criminal behaviour. DHS staff in residential units have a limited capacity to exercise firm control over children in their care.

8.3 Within the confines of legislation and available resources and support, audit found that the majority of case-managers were strongly committed to endeavouring to provide a high degree of care for children allocated to their charge. Case files also indicated that DHS was committed to exploring and providing a range of options and support for most of the children experiencing difficulties.

8.4 It is acknowledged that the disturbed nature of many of the children can be attributed to the abuse they suffered, often from dysfunctional family lives involving substance abuse and serious social and personal problems. Nevertheless audit considered that there were also a range of factors during their time in care which further contributed to the already serious problems being faced by these children.

OVERVIEW - *continued*

8.5 Factors included:

- multiple placements;
- constant changing of case managers and care-givers;
- regular attempts to re-unite children with birth parents who had consistently demonstrated an inability to provide their children with a minimum standard of care;
- unsuitable placements;
- inadequate psychiatric services;
- the lack of facilities catering for children who pose a serious risk to themselves and others, but are not able to access psychiatric facilities. Secure welfare does not meet this need;
- long delays, particularly at the Children's Court, in determining a child's future;
- difficulties by children in care possessing special needs accessing education;
- insufficient attention given to permanent care arrangements at the earliest possible stage once it was highly unlikely that a child would be able to return home; and
- poor use of the capacity of DHS to arrange Permanent Care Orders;

8.6 Given the onerous responsibilities placed on the State in protecting children who cannot return to their parents, audit considered there was inadequate accountability by DHS through its Annual Report to Parliament and the public in disclosing the outcomes of children placed in its care.

8.7 In addition, audit considered there was also an obligation on DHS to provide a form of after care service to children discharged from care in order to help them adjust to community life and help prevent, in some circumstances, serious social consequences in the future.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Audit identifies some of the critical challenges faced by the Department in regard to adolescents who have suffered profound harm and trauma within their family of origin and who have subsequently been placed in the care and custody of the DHS by the Children's Court. These issues are not new to the Department and are the subject of current and ongoing scrutiny both internally and within the community.

  While the principal focus of the audit is upon adolescent clients who have suffered abuse and neglect within their family, discussion of critical developmental and intervention issues relating to these adolescents is not included. No theoretical base is offered, nor is there any attempt to locate the critical issues within a broader context. Thematically, audit appears to adopt a "common sense" approach to many of the most complex and subtle issues for "damaged adolescents" and on this level audit appears overly simplistic in its approach.

  There is a lack of benchmarking to measure practice in Victoria, compared with other States or international practice.

  Issues relating to younger children in care have not been addressed in this Part.

  In some instances audit has brought statistical data from disparate sources together and attempted to establish a causal relationship upon which to draw conclusions and advice regarding departmental practice and policy. This "quasi-research" approach lacks rigour and is of limited reliability or value. For example, audit links data on absconding behaviour by adolescents and associated offending behaviour. The implication offered by audit is that offending behaviour is caused by absconding behaviour. A more likely connection is that both behaviours are symptomatic of difficulties for an adolescent in responding to interventions by DHS aimed at addressing their needs for care, protection and development of behavioural controls and alternative coping strategies.

  While audit recognises the strong commitment of DHS to improving practice and service delivery to vulnerable young people in its care it criticises DHS as lacking in vision and reactive only to major reviews imposed by outside agents. This is a significant criticism and is rejected by the Department.

INTRODUCTION

8.8 This Part of the Report deals with children who are placed in the care of the State with the custody or guardianship responsibility being assigned to the Secretary of DHS.

8.9 Under a Custody to Secretary Order the child will live out of home with DHS working towards returning the child to the family when it is safe to do so. Under a Guardianship to Secretary Order the Secretary of DHS assumes the guardianship of the child and the responsibility of caring for the child. The child will live away from home but may be able to return at some future date, although this event is seen as more remote than would occur under a Custody Order. A Guardianship to Secretary Order, also referred to as wardship, is the most extreme Protection Order granted and is normally reserved for those circumstances where parents have clearly not protected their children and are unlikely to do so. Exceptions occur where the natural parents have died or are disabled to the extent that they cannot exercise proper parenting responsibilities, or where due to a child's behaviour or disability the parents are unable to exercise control.

8.10 Table 8A provides an overall perspective of the number of children in the care of the State over the period 1991-92 to 1994-95.

TABLE 8A
NUMBERS OF CHILDREN UNDER CUSTODY OR GUARDIANSHIP ORDERS

Year	*1991-92*	*1992-93*	*1993-94*	*1994-95*
Number	2 039	1 927	2 147	2 324
Change from previous year	-11.3%	-5.5%	+11.4%	+8.2%

Source: Department of Department of Human Services.

8.11 Data from DHS indicated that until 1993-94 there had been a decreasing trend in the number of children admitted into the care of the State as a consequence of the Children and Young Persons Act introduced in 1989. However, over the past 2 financial years there has been an increase, with the number of new admissions exceeding the number of discharges. DHS advised audit that new admissions to guardianship or custody during the years 1993-94 and 1994-95 were 908 and 950 children respectively. Discharges of such Orders during the same period were 1 607 and 822 children respectively.

8.12 Children under care can represent some of the most emotionally damaged, abused or neglected children in the community. They can pose a large challenge to the community and DHS with respect to the provision of appropriate accommodation, rehabilitation, therapeutic treatment and general care, such as education and health.

PLACEMENT OF CHILDREN IN THE STATE'S CARE

8.13 Part 6 of this Report dealt with the adequacy of the State's capacity to provide for the accommodation of children in reception care, ie those children requiring accommodation on a short-term basis pending the outcome of Court processes and determination of longer term needs. Placement options for children placed under the care of the State following Court decisions are usually of a longer-term nature and are dealt with in this section, in that the placement of children in care particularly in the initial stages, can influence their future development.

8.14 Accommodation options available to the State to place children under care fall into 3 broad categories as outlined below in Table 8B.

TABLE 8B
TYPES OF PLACEMENTS AVAILABLE FOR CHILDREN IN CARE

Facility-based care	*Home-based care*	*Supported Accommodation*
Family Group Homes	Kinship care	Lead tenant
Rostered Units	Foster care	Independent living
	Adolescent Community Placement	
	Specialised Home-based care	

8.15 When a child has been removed from parental care, the prime objective is to, whenever possible, return the child back to the birth family when it is safe to do so. In cases where an assessment is made that resumption of care by the family is not a viable option, the case plan is normally amended allowing for a permanent care family arrangement or independent living arrangement, depending on the age and circumstances of the child.

8.16 The interests of the child are generally best served when the placement is within a family environment, preferably with members of the child's extended family such as grandparents, aunts, uncles and cousins ie. kinship care. This type of placement is favoured because it maintains the child's sense of identity and attachment with their family. However, kinship care is not always available or appropriate to the needs of individuals and other placement options are sought, such as adolescent community placements or residential care.

8.17 Depending on the age and disposition of the child it is not always possible to readily find an appropriate home-based care placement. Sibling groups can be difficult to place in home-based care because of the number of children involved. Therefore, children coming into care are likely to be at some stage, particularly when first removed from home, placed in rostered units or family group homes until such time as a permanent placement or a more appropriate alternative care placement can be facilitated. In essence, facility-based care placements are meant to mainly cater for holding situations until a Court outcome is available, or to provide transitional accommodation until a child may be able to return safely to home. Sometimes DHS will consider that facility-based care will meet an individual's needs.

FACILITY-BASED CARE

8.18 History has proven that large institutions did not provide the appropriate environment that was essential for a child's emotional and physical development and in reality, life-long damage was being inflicted on large numbers of children. The Department's current policy is to make maximum use of family type placements whenever possible. Consequently, in Victoria there has been a phasing down and eventual closure of large orphanages and institutions, which even into the late 1980s were still housing up to 100 children in each facility. Facility-based residential care now consists of community-based houses or flats operated by DHS and various non-government organisations and are referred to as family group homes or rostered units.

8.19 Although home-based care usually represents the preferred option for the placement of children, data produced by the Australian Government in the *Report on Government Service Provision* in 1995 indicated that Victoria, in relation to other States, still places a higher level of reliance on facility-based care with 24 per cent of placements in 1994-95 in this category. However, the present level of reliance on facility-based care by Victoria represents a significant reduction from levels of previous years.

TABLE 8C
COMPARISON OF PLACEMENT TYPES
ACROSS SELECTED AUSTRALIAN STATES 1994-95

Type of care	*Vic.*		*NSW*		*QLD*		*SA*	
Facility-based	749	24%	468	12%	216	7%	82	6%
Home-based	2 331	74%	3 253	83%	2 520	87%	1 195	93%
Other	53	2%	183	5%	167	6%	6	1%
TOTAL	**3 133**	**100%**	**3 904**	**100%**	**2 903**	**100%**	**1 283**	**100%**

Source: Report on Government Service Provision 1995.

8.20 The Department's policy as indicated in its policy document, *Placement and Support Program: The Vision for Redevelopment*, is to move from a system which is highly dependent upon residential care to one where home-based and community care options have been strengthened. DHS plans to maintain a number of residential facilities for children and young people whose needs are best met within there settings with trained staff.

Family group homes

8.21 Family group homes (also known as cottage homes) are suburban houses in which care-givers reside on the premises and care for a small number of children (usually 4-5) on a 24 hour a day basis. These homes are run by a live-in house parent (employed by the Department or contracted agency) and his/her partner. These "cottage parents" may have children of their own and are able to provide a family like setting for the children placed in their care. This form of accommodation is most appropriate for sibling groups as the children can remain together and retain a semblance of a family unit because of the live-in carers. At date of audit there were 120 family group homes operating.

8.22 As with rostered units, family group homes are not meant to provide a permanent placement as most children will eventually return to their own family or relatives, be placed in foster care or move onto an independent living arrangement. In the interim, family group homes provide a reasonably stable environment and a viable option for accommodating children under the State's care. The Department has progressively been closing down family group homes in accordance with its strategy to move towards more home-based care.

8.23 Audit supports the development of home-based care in preference to facility-based care such as family group homes, but only on the basis that adequate facility-based accommodation is maintained to provide placements for those children unable to be placed in home-based care.

8.24 The audit found, that closures of residential facilities, including family group homes were undertaken without adequate planning having been undertaken to ensure that a sufficient pool of home-based care-givers were available to accommodate the increasing numbers of children entering the system. DHS also considered that the non-government agencies funded by DHS to recruit care-givers and arrange alternative care were initially slow in responding to DHS requests for placements. The result was that the Department was forced to open contingency units to provide temporary accommodation for these children until such time as the non-government sector was able to respond to the accommodation demands of DHS.

8.25 **The further closure of family group homes needs to be deferred until it can be demonstrated that other viable options are available to cater for the needs of children initially entering the system, and in particular, sibling groups.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  Placement and Support services are undergoing service redevelopment to develop a continuum of care services as outlined in the policy - Placement and Support Program The Vision for Redevelopment which outlined the strategy for 1993-95.

  There are currently 120 family group homes operating and the Department does not accept audit's view that further closure should be deferred, given that all regions have service redevelopment plans which are being progressively implemented in a strategic manner to ensure that regional needs continue to be met.

Rostered units

Operation of rostered units

8.26 DHS operates short and medium-term units which accommodate between 4 and 8 children. These units are usually suburban houses. Supervision and care is provided by staff employed on a rostered shift basis.

8.27 The purpose of short-term units is to function as admission units and be accessible for placements on a 24 hour basis. Placements can be of up to 3 months duration, although this is influenced by the availability of alternative accommodation and Court outcomes not decided upon due to extensive delays at the Court. These units mainly take children in the 12-17 age range but may also provide accommodation for younger children. The units are intended to provide emergency placement or short-term placement pending Court outcomes, assessment of needs and determination of long-term placement.

8.28 Medium-term units provide longer-term placements for children in the 12-17 age range, of between 3 and 12 months, but are not intended to provide indefinite placement. These units were established to provide placements for children who generally have special needs and usually display challenging behaviour requiring intensive supervision and support. These children have been unable to be placed in a preferred placement with kinship or foster care.

8.29 Because of the multiplicity of reasons why a child is under care these units are meant to provide a range of placement services which reflect the length of time the child is expected to be accommodated pending assessment and determination of future placements. However, because of the need to provide beds to children who cannot be accommodated with a substitute family, DHS maintains a flexible approach to placing children and these units accommodate a variety of placement types within the same unit. As a result children in need of respite or emergency care are accommodated alongside children who have been under the Department's care for a long time.

8.30 The above situation can expose children entering the child protection system for the first time, to the risk of negative influences of other children who may have been in the system for a lengthy period. This can mean that well adjusted children can come under the negative influence of other children and proceed to display similar behaviour patterns, such as aggressiveness, absconding, substance abuse and disrespect for authority.

8.31 From an examination of case files, supplemented by field inspections, audit was able to gain an insight into life in rostered units and concluded that troublesome or rebellious children caused significant problems for DHS. There were numerous instances of children generally urging each other to act out disruptive and challenging behaviour. Having to live in such a disruptive environment can have a detrimental effect on the child.

8.32 On occasions there was a failure to remove children from short or medium-term units when there was an obvious need for a more specialised placement. As an illustration:

> *An adolescent male with severe sexual behavioural problems which placed staff and other children at risk, was kept in a short-term unit for over 7 months. Staff at the unit complained about not having the staff resources to provide the level of supervision the situation demanded. Because of the risk the adolescent posed to others, he had been provided with an extensive range of psychiatric support and therapeutic services but reports clearly showed there was no improvement. Notwithstanding the concerns of the residential staff he was not moved. He subsequently sexually assaulted a very young girl while on unsupervised leave from the unit and thereby entered the juvenile justice system.*

8.33 DHS faces problems in dealing with children who exhibit sexual behaviour such as that described above, in that unless the child voluntarily agrees to undergo treatment or has been convicted in the juvenile justice system and mandatory treatment is ordered, there are very few options available to treat the problem. Options can include specialist support agreed to by the child which was provided in the above case, or arranging a specialist placement facility.

8.34 The Serious Offender Unit of the Juvenile Justice Branch of DHS has established a program for sexually offending adolescents which is known as the Male Adolescent Program for Positive Sexuality (MAPPS). Initial indications are that the program has been successful. However, admission to the program is limited to young offenders who have been convicted of sexual offences, and the program is not available to adolescents displaying sexual behaviours who are within the DHS child protection program. Audit acknowledges the legal issues involved with any form of mandatory treatment for adolescents who have not been found guilty in a Court of committing an offence. Nevertheless, it is a matter of serious community concern that potential offenders cannot be treated at a very early stage with a view to prevention of more serious behaviour at a later stage of development. DHS has a duty of care to offending adolescents as well as the actual/potential victims to arrange suitable placements as well as treatment.

8.35 While the rostered units may be accommodating only 4-8 children, the lack of a substitute family life and the throughput of children means that these units still impose upon some children similar conditions and negative influences to those found in the former large institutions. This is particularly evident when children are left in this type of accommodation for extended periods. While these rostered units ideally should be considered as a short or medium term temporary placement for children pending transition to permanent care arrangements, for many children the units become the only type of placement until the children go onto independent living arrangements or leave the care of the State.

8.36 The effects of children adversely influencing other children have a significant bearing on the future well-being and character development of children coming into care. In audit opinion, if DHS is to minimise this risk, **there should be a detailed assessment of the interpersonal behaviour characteristics of each child so as to ensure that their placement is appropriate in limiting their potential for adversely influencing the behaviour of other children in care. More effort needs to be applied by DHS to addressing the needs of children who need specialist care, and in accommodating such children in appropriate placements. In addition, while audit recognises that in limited situations placement of children in rostered units can be appropriate, management information systems need to be developed to monitor the period of time spent in such units by children unsuited for long term placement in these facilities. In most circumstances a maximum period of time is appropriate, beyond which every effort should be made to arrange alternative placements better suited to a child's needs, where return to the family is not appropriate.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The Department accepts that young people placed in rostered residential unit usually present in crisis and are often characterised by significant behavioural difficulties. DHS always seeks to make the most appropriate placement available though accepts that in some circumstances, owing to the crisis driven nature of referrals, this may not always be immediately possible. The Department has invested heavily in developing a more flexible range of responses to meet these young people's needs, for example, Specialised Home-Based Care placements, Intensive Youth Support Services, Mobile Support Teams and Behaviour Intervention Support Teams.

  Audit has not considered the work of Adolescent Services Redevelopment Unit which is developing the interface with a range of specialist support services to meet the needs of young people in care who have extremely complex needs. The Department acknowledges that further work is required to respond to these needs, such as sexual offending, and that this is an issue being pursued by national and international programs.

  Audit's recommendation to "set a fixed period for accommodating individual children" fails to acknowledge the individual needs and circumstances of clients. Existing case planning policy and practice emphasise the need for timely decision-making and are based upon permanency planning principles.

Aspects of life in rostered units

8.37 The review of case files indicated the existence of major problems in the rostered units relating to the inability of staff to provide adequate supervision during periods of disturbance. In providing such comment audit emphasises that in many rostered units serious problems generally do not occur due to the efforts of trained staff in supporting children in these placements. Nevertheless, for many children their needs would be better served other than in spending long periods of time in rostered units.

8.38 There are usually only 2 staff on duty at any time in a rostered unit and their only departmental assistance in the event of serious disturbances comes from the Mobile Support Team (consisting of 2 staff available at any one time) which often may not provide a prompt response because its limited resources are engaged elsewhere. Support from the relevant regional office is based on the availability of staff and the tendency of the office is to provide advice over the phone wherever possible. Police are also called frequently to intervene where assaults occur on staff or other residents. Staff are extremely reluctant to personally intervene where assaults are occurring because of risk of injury and the lack of legal authority, factors which are exploited by the children.

8.39 The case files and discussions with protective workers and children enumerated a range of issues which reflected life in some rostered units:

- The congregation of troublesome children with children who could be easily influenced meant explosive situations developed with the children feeding off each other's anger and frustration. The following quotation from a case file provides an illustration:

> *"Workers were greeted by police at the front door. Workers walked into the hall, and then to the lounge room. Every light had been smashed bar the one in the office. It was not possible to walk on the carpet without crushing glass under foot. In the lounge room, the lounge suite had been slashed and the stuffing had fallen on the floor. The 3 boys were seated on the floor. The boys had been controlled and briefed by the police before workers arrived. The workers were informed by police that 2 of the children would be charged tomorrow ... A bed had been terminally damaged, workers walked into the kitchen, there was food matter strewn over the floor. It was not possible to set foot inside the kitchen without their shoes sticking to egg. The floor resembled an omelette, uncooked." This event took place because at the time there was only one worker on duty who was forced, out of fear, to barricade herself in the office.*

- Children displaying criminal tendencies and/or a history of absconding were placed with children who were not so inclined, but often developed these traits over time;
- Staff offered a meek response to children who came and went at will and who stayed overnight with their girlfriends/boyfriends. The only course of action was a Missing Persons Report if the child was absent for 48 hours and was deemed to be at risk. However, this action usually had no lasting influence on the children;
- Instances of staff failing to take action when children were known to be in the company of sexual deviants or drug and other illicit substance abusers;
- Children with disturbed sexual or mental behaviours were placed with other children who were then exposed to physical or emotional harm. There was a lack of decisiveness by case workers in attempting to find an alternative placement for such children. Other than placement in secure welfare which has very strict admission criteria, DHS has few facilities available to accommodate such children, adding to the problems faced by staff in rostered units;

- Children were placed in unsuitable accommodation and when problems arose with other children, were unable to be moved because of bed shortages elsewhere within a region. They were then left exposed to continued abuse with staff apparently powerless to stop it; and
- Staff lacked the capacity to impose discipline, such as containment in a room, as this was seen to infringe the "rights" of children or discourage rehabilitation. Accordingly, some children knew how to play the system and did whatever they pleased, knowing they could not be stopped.

❑ ***RESPONSE*** *by Secretary, Department of Human Services*

Audit provides a range of selective case examples to identify major difficulties within rostered residential units. These young people are invariably in crisis with an accompanying range of highly disturbed behaviours. The expansion of home-based care was in part a recognition that facility-based care is only appropriate for a small minority of children and young people. Rostered residential facilities are now targeted at children and young people with high levels of behavioural disturbance and needs who cannot be placed elsewhere in the service system. Simultaneously, home-based care has significantly expanded its capacity to meet a more diverse range of behaviours and needs, for example through the expansion of Specialised Home-Based Care and flexipack placements.

Case examples fail to include any positive aspects of the service system. Audit should acknowledge examples where individual needs can be addressed by trained staff and other specialist services provided to support placements.

Placement breakdowns

8.40 The unstable situations outlined above results in a high incidence of placement breakdowns leading to a substantial number of children circulating around the welfare system, especially within the DHS placement and support system.

8.41 Placement breakdowns are a major cause of instability in a child's life. Multiple placements arising mainly from placement breakdowns were detrimental in that moving from one placement setting to another meant that:

- education was often disrupted and learning impaired;
- attachment with care-givers could not adequately develop, adding to a child's insecurity;
- potential to affect a permanent placement was diminished;
- social network of friends and other supports was weakened; and
- the risk of system abuse was increased.

8.42 Movement between residential units frustrated the care-giver's ability to identify and assess any special needs of the child. The lack of knowledge of the child also hindered the determination of the most workable response to the particular type of challenging behaviour acted out by the child.

8.43 Often, the care-giver's response to a situation where the child's challenging behaviour became unmanageable was to recommend a change of placement. This approach only served to perpetuate the cycle of continual movement within the system. The end result for some children was an extreme resentment of the system and pre-determined rejection of further placements arranged by DHS. All that these children then wanted was freedom; which meant at best independent living, or at worst a life on the streets.

8.44 Audit recognises that rostered units and family group homes are not detention centres and as such the staff are legally constrained from exercising firm discipline and control. The DHS training program includes courses available to workers in residential units on changing challenging behaviours. Although such courses are of benefit, further strategies need to be explored if the problems encountered in some rostered units can be contained.

8.45 Having observed the situations in some of these units where children can be out of control and pose a threat to themselves as well as others, audit considers there needs to be a compromise reached between the voluntary provision of support and accommodation to these children and the responsibility of the State to protect and secure assistance for these children, even though they may display a reluctance to co-operate.

8.46 Placement breakdowns also frequently occur with home-based care, through the high pressure placed upon foster families and permanent care families. This is particularly prevalent where adolescents are involved or where a child has extremely disturbed behaviour but cannot be treated by adolescent psychiatric services unless certified as psychotic. As discussed later in this Report, DHS places emphasis on providing help for *"at risk"* families through programs such as Families First. Such programs attempt to maintain the family unit so as to avoid a child having to be placed in alternative care. Ironically, while these programs are of benefit in assisting parents, similar programs do not exist in Victoria to help foster families and permanent care families facing similar strains with placements.

8.47 Audit was advised that in the United States of America there are specialist programs which operate out of foster care and adoption services to prevent placement breakdown. Failure to provide such programs in Victoria identifies a gap in the service system, which in audit opinion, needs to be addressed if every effort is to be made in stabilising the lives of some children and preventing some of the serious side-effects which can result from a transient lifestyle.

8.48 The Department has long been aware of the above problems, particularly the deficiencies in rostered units which tend to perpetuate the worst excesses of life in the former institutions, along with the inadequacies in supervision of a large number of children in the care of the State. In mid-1993 DHS commenced a 2 year, major redevelopment of placement and support facilities with the intention of reducing reliance on facility-based care, expansion of home-based care and providing a range of more flexible accommodation options designed to address the individual needs of children. Audit strongly endorses the concept behind the redevelopment and particularly the development of a range of other accommodation options for adolescents, such as independent living arrangements and lead tenant roles. Nevertheless such options will not remove the need for a minimum level of facility-based care to be provided for short-term placements and for children who cannot, for various reasons, be placed in home-based care, particularly adolescents.

8.49 **The impact of children remaining in facility-based care for extended periods can be extremely damaging to a child in the longer term, leading to criminal behaviour, substance abuse, poor education, long term psychological damage and diminished employment prospects. However, in recognition that placement in home-based care is not always possible nor practical, more attention needs to be given by DHS to:**

- **Monitoring from a regional and central perspective the amount of time individual children are spending in facility-based care with the intention of minimising their stay wherever practical, where this type of care is not appropriate to the child's needs;**
- **Identifying children who may be particularly hard to place and assigning specialist social workers to explore the range of options and incentives needed to place these children in more appropriate accommodation;**
- **While audit recognises the efforts of the Behaviour Intervention Support Team in attempting to address severe behavioural problems displayed by certain children, a certain element of these children will not respond to infrequent treatment. In audit opinion there exists a need for specialist facilities that can provide intensive support for such children over an extended period in a secure residential environment; and**
- **Developing and strengthening the capacity of staff in facilities, particularly rostered units, to exercise adequate supervision over children in their care within existing legal constraints.**

❑ ***RESPONSE*** *by Secretary, Department of Human Services*

Audit fails to acknowledge the Adolescent Services Framework document and establishment of the Adolescent Services Redevelopment Unit within the Protection and Care Branch to give priority to the implementation of strategies to better address the specific needs of young people.

HOME-BASED CARE

Kinship care

8.50 The Department's top priority when determining a placement is to ensure that whenever possible the child should be placed in an environment where he/she can receive the support of relatives and friends who are known and trusted by the child whilst remaining within the local community to which they are accustomed. For a child under a kinship care placement, care is provided by relatives or friends in their own homes. These types of placements range from emergency (short-term) to long-term (including a possible conversion to permanent care) and the care-givers are eligible for the same support services and statutory payments as other care-givers.

8.51 Audit agrees that this type of placement is highly preferable, provided the relative or friend can provide the secure environment the child needs.

Foster care

8.52 Foster care refers to a range of accommodation and support services for children and families, whereby children are accommodated away from their natural parents in the care-givers' own homes for varying periods ranging from overnight stays right up to the time they can appropriately be returned to their parents or another permanent placement can be found. If return to the natural parents is no longer considered a viable option the foster care arrangement may also be converted to permanent care.

8.53 The DHS placement and support redevelopment program envisages that eventually Victoria will have an improved home-based care program where care-givers are recognised, trained and adequately supported for the significant job that they do. The redevelopment program is heavily reliant upon the creation of a pool of foster parents of sufficient numbers to accommodate children relocating from facility-based residential units. Without adequate numbers of foster parents DHS will have to continue its heavy reliance on facility-based care.

8.54 Submissions were received by audit from various foster care agencies and individual foster parents which detailed the problems faced by foster parents in caring for children that were clients of DHS. The more common concerns expressed were:

- A lack of acknowledgment by DHS of the difficulties foster parents experience especially in respect of the emotional and financial burdens they carry;
- A distinct lack of interest from some case workers as to how foster parents were coping (the foster parents felt that the only time they were called was when the case worker wanted something);
- Children were often referred to foster parents at short notice, with the case worker failing to provide the foster parents any personal background history of the child. Foster parents felt they were only given minimal information on what may have been serious problems or special needs of the child which needed to be quickly understood;
- Case workers were either too busy or unavailable to spend time with foster parents discussing progress of the placement;

- The high turnover of case workers meant there was a lack of consistency in case management creating uncertainty over the future direction of the placement. Foster parents indicated that they were often not advised in advance of a change in case worker;
- Foster parents were often inadequately informed of their entitlements, such as financial allowances and grants, unless the foster parents specifically asked;
- DHS was sometimes seen as appeasing the child's natural parents at the expense of the foster parents, usually in respect of access rights. Parents did not always turn up for access visits and children were left waiting and in distress, and yet minimal attention was seen as being given by case managers to preventing future abuse of access rights. It was common for children to be difficult to control and emotionally disturbed for a period of time after access visits, and was a contributing factor to placement breakdowns;
- Foster parents were required to make a commitment but when they made a funding request the answer was usually - "yes, but we will have to get back to you". Nothing further is then heard for several months; and
- Support services were available but there were often lengthy delays in getting approval from DHS. As an illustration, DHS took 5 months to approve of an occupational therapy test for a child in care who had severe problems in reading and writing. It was a further month after approval was given for the actual arranging of the test to take place.

8.55 The foster parents indicated to audit a general feeling that DHS was indifferent towards them in that any requests made by foster parents were not responded to promptly. Also, foster parents expressed the view that they often feel that they are treated as a convenience, to be used and then discarded once the child is returned to his/her parents or another placement is found. They indicated there is a lack of acknowledgment of the emotional input of the foster parents in that they are urged not to form a close attachment to the child because of the uncertainty over the child's future.

8.56 There was frustration with the high turnover of case workers which resulted in protracted periods of inactivity and a lack of continuity of effort towards securing the goals established in the child's case plan. The consequence was often an attitude of disrespect towards the system by foster parents and children and generated a feeling that "no-one cares anyway".

8.57 The foster parents perceived as unreasonable the concessions granted to abusive and neglectful parents. High frequency of access was granted without an appreciation of the effect that this might have on the children or foster parents. They felt there was little understanding by the Courts when granting frequent access to parents as to the costs that access entailed nor of the confusion felt by children and their subsequent inability to be placated when access was over. A further concern expressed by these foster parents was that, when parents abused their access privileges DHS was loath to go back to the Children's Court to seek a variation on access conditions. This in turn reflected badly on the Department's image which was then seen as a "paper tiger".

8.58 Audit established that DHS regards access by birth parents to their children in alternative care as an automatic right. Recent moves in the Family Court have replaced the principle of a parent's responsibility and a child's rights to continuing contact only where this is in their interests. There are some children in permanent foster care for whom access is a source of intense distress and insecurity, and not necessarily in their best interests.

8.59 Significant concerns related to care-giver payments which had not increased since 1990 and consequently foster parents were becoming increasingly burdened with costs which they had to meet from their own finances.

8.60 **Audit acknowledges that DHS has taken some initiatives during 1995 to address certain concerns, including flexible funding provisions for children requiring high levels of support and the establishment of foster parent support groups. However, it was apparent to audit that the performance of foster care agencies needs support as well as monitoring by DHS and that there is considerable scope for better liaison between the parties, with a view to ensuring that contractual obligations between the 2 parties are fully understood and are capable of being successfully met.**

8.61 **If the Department's redevelopment strategy is to be successfully implemented, the continuing concerns expressed by foster parents and agencies need to be better acknowledged, further researched and addressed by DHS. Failure to resolve these concerns is likely to result in existing foster parents withdrawing from the system due to the increasing burdens they face and potentially new foster parents being discouraged from entering a system which provides a substantial cost effective benefit to the State, as compared to the provision of facility care.**

8.62 **In recognition of the concept that home-based care will always be preferable to facility-based care, audit recommends that programs be developed to provide intensive support to care-giver families as well as natural families, so as to reduce the high incidence of placement breakdowns occurring with home-based care.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  Audit describes a range of concerns raised by agencies and care-givers. Audit has not demonstrated an understanding of the role of the non-government agencies and their responsibility as service providers of home-based care services.

  Foster care agencies are fully funded by the Department to recruit, train and support care-givers and to undertake case management responsibilities for children and young people in placement. Criticism of the Department in this section in relation to support, liaison and information for care-givers is misdirected as agencies are contracted to undertake these roles.

The Department rejects the statement that "DHS was sometimes seen as appeasing the child's natural parents at the expense of foster parents, usually in respect of access rights". The best interests of the child/young person in care is always considered paramount. Audit fails to demonstrate an understanding that in the majority of cases, access is a right and is paramount in ensuring the child/young person is able to maintain strong links with their family. Access is also one of the strategies to ensure that wherever possible family reunification is strongly pursued. The Department has noted these comments which may reflect the need for increased training and support for care-givers by agency staff to understand their critical role to work with the children's families.

The Department, along with agency staff, identify foster care-giver as key players within the service system and do not regard them as a "convenience" Foster care-givers represent the major care providers in the Placement and Support system. Providing them with support is a key responsibility of foster care agencies. It is an expectation that in long-term cases, agencies will assume case management to ensure continuity for the child or young person and care-givers.

The Department acknowledges audit's opinion that increased liaison and support should be provided between Protection and Care, agencies and care-givers. Some current initiatives include by-monthly liaison with foster care agencies at a central level, bi-monthly liaison with the Foster Care Association of Victoria at a central level, recurrent funding of local foster care-giver support groups and regional liaison and support to foster care agencies. The Department does not accept the statements made in this section as representative of care-givers and agency staff across the State.

Need for registering the location of children in care

8.63 Audit inquiries disclosed that DHS does not maintain a register of foster parents, leaving such matters to the attention of foster care agencies. In addition, the Department's client information system (CASIS) does not record the foster parent's and child's address, but instead lists the address of the foster care agency. The reason for this direction can be related to the desire of the foster family to remain anonymous to avoid potential problems from the child's natural parents, accompanied by doubts as to the ability of DHS to keep such details confidential.

8.64 Discussions with departmental staff indicated that delegating the recording of foster parent details to foster care agencies is done as a matter of administrative efficiency. Audit was advised that from a central perspective DHS is aware of the location of foster parents through its regular listing of reimbursements made to foster parents, even though this information is not recorded on CASIS.

8.65 **Audit considers that the absence of a central register of foster parents and the lack of supporting information in CASIS does not provide the Department with complete and up-to-date global information on the location of children in its care. In addition, the child may have multiple placements under foster care which from a central perspective the Department is unaware of. Consequently, the Department's ability to formulate effective short and long term strategic plans is restricted by the inability to readily extract and sort data on foster care placements on a Statewide basis despite the heavy reliance by DHS on this form of care.**

8.66 **As the Secretary of DHS is the legal custodian or guardian of many of these children audit considers the Secretary, as the de-facto parent, should be expected to know the placement of all children in care at any point in time. The recording of the specific placement location of all children in the care of the State is seen by audit as essential both for monitoring and control purposes.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The Department does not agree with audit that it requires a central register of foster care-givers and the address of each child in foster care. This information can be accessed at the regional level and its central location would be of no benefit either to the child/young person or the care-giver. CASIS provides the individual case details and location of the child required for case management purposes.

Adolescent community placement

8.67 Adolescence is the transition period between childhood and adulthood and is usually a difficult time for children in the 12-17 age group. Even children from supporting and well functioning families can find this period in their lives turbulent and distressing. The trauma of adolescence is often heightened for children in care who can have histories of sexual, physical or emotional abuse, alcohol and substance abuse, psychiatric illness, antagonistic and/or aggressive behaviour, neglect and low self esteem.

8.68 Whereas children under 12 years of age can more readily be placed in foster care pending return to their birth parents or arrangement of permanent care with a substitute family, adolescents are very difficult to place in home-based care. As an alternative to facility-based care, the Adolescent Community Placement Program is an initiative to place adolescents with volunteer care-givers who are specifically counselled and trained to care for older children. The care-givers are eligible for an increased level of care-givers allowance as compared to foster parents, the payment varying according to the age and special needs of the child.

8.69 The key feature of this program is that it is designed to primarily accommodate adolescents who are difficult to place in foster care or other placements. The program is intended to provide a stable environment until the adolescent is ready to move on to independent living.

8.70 Audit is supportive of this form of placement which was originally developed in England and since adopted by DHS. It is a preferred alternative to facility-based care but its success will largely depend on the early placement of adolescents once it is clear that their return to their birth parents is undesirable. It is less likely to be successful with adolescents who have experienced multiple placements and who display severe behavioural and emotional problems. These adolescents, particularly those who spent long periods of time in the former institutions, are likely to experience difficulties in coping with this type of setting.

8.71 **Adolescent Community Placement Programs can be an effective form of providing placement and support for certain adolescents who would otherwise be difficult to place. The ongoing success of the Program relies not only on recruiting volunteer care-givers, but in providing an appropriate level of ongoing involvement with the family from case workers in conjunction with availability of intensive support services.**

SUPPORTED ACCOMMODATION

8.72 Certain young persons in care may be unsuited to both facility-based care and the usual forms of home based care such as foster care. Supported residences enable young people to live alone but with substantial support provided by a youth worker either as a live-in "lead tenant" or through regular visits.

8.73 Adolescents and young persons are generally more difficult to place in home-based care because of their age and perceived challenging behaviour associated with adolescence. In addition, children who have been in care for a number of years may also display symptoms of "system abuse" or "welfare drift" particularly if they have spent a significant time in facility-based care. In these instances supported accommodation offers a preferable alternative to remaining in facility-based care, whereby the young person is able to live in much the same manner as a young person leaving home from a functional family. Details are provided below on the major forms of supported accommodation.

Lead tenant

8.74 Certain children flourish better with individual support where they can build a trusting relationship with one continuous care-giver, or who require closer supervision because of their self-destructive tendencies or challenging behaviour which can be disruptive to other residents. Under this type of placement the young person is provided accommodation in a home or flat with support from a "lead tenant" who is a live-in volunteer and who resides rent-free in the unit, in exchange for support given to a sole tenant or small group of tenants.

8.75 Lead tenant accommodation can provide significant benefits to children in care, including:

- a more home-like and less disruptive environment;
- a one-on-one relationship providing an opportunity to develop a closer relationship with the care-giver;
- an enhanced opportunity for the child to observe and respond to the positive benefits of the care-giver acting as a role model; and
- better preparation for independent living.

8.76 Notwithstanding the significant benefits of this type of accommodation, in audit opinion there was a general lack of consideration by DHS for this type of placement in that children with challenging behaviour were usually given another placement, rather than attempting this model. Audit was advised by DHS that placements of this nature were generally reserved for young people who were being prepared for independent living. Apart from supervisory responsibilities, the lead tenant was there to show the young people how to manage their lives and finances in order to live a stable independent life.

8.77 Audit believes that this model is a preferable alternative to the rostered units and should be given greater priority; particularly for those young persons whose behaviour was detrimental to other children. As an illustration audit reviewed a case where an adolescent female who was placed in a rostered unit continually acted out disturbed and aggressive behaviour and failed to respond to all the support services provided. She also had self destruction tendencies, used drugs and other illicit substances and was not only a danger to other persons but also to herself. When moved into accommodation managed by a lead tenant case workers indicated a marked improvement in her behaviour and attitude.

8.78 The success of lead tenant programs relies heavily on the level of intensive support the lead tenant receives from the professional staff who recruit for such arrangements. Without the intensive efforts of supporting staff such arrangements can quickly breakdown due to the extremely challenging behaviour of some of the adolescents in care. Audit was not made aware of any evaluation being undertaken of this program as to what factors were needed for the arrangements to be successful or whether they were adequately supported.

8.79 **In audit opinion, more emphasis needs to be placed by DHS on promoting this form of placement as providing a more secure and stable environment, through involvement of an adult acting, in effect, as a role model for often severely disturbed adolescents. However, before expanding such arrangements, DHS needs to undertake an evaluation of such programs and identify the resources and organisational structure required for maximum effectiveness.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  The full range of placement options are made in accordance with case planning to meet the individual needs of the young person.

Independent living

8.80 Audit observed that in certain cases where adolescents in care were in the 15-17 age group, unsuitable for permanent care and displayed poor behaviour in a facility-based placement, the case workers encouraged an independent living arrangement. The impression audit gained from reviewing individual cases was that in some instances the move to independent living was often more to do with the young person's age rather than their capabilities and maturity. These children were expected to develop skills for independent living years in advance of children who reside normally with parents.

8.81 Audit found that the response to some adolescents who were displaying a rebellious attitude or were generally unco-operative, was to case plan for independent living rather than continue strategies for changing their behaviour. Case workers advised audit that in order for counselling and other therapeutic treatments to work effectively, the child or young person must want to be helped. Certain children reject professional help for a variety of reasons and also resent being in the care of the State. Such children crave freedom from the "system" and want an independent lifestyle where they can develop their own identities and sense of self-worth.

8.82 Audit agrees that independent living is a preferable alternative to facility-based care so long as the young person has displayed a capacity of self reliance and willingness to accept responsibility for their own welfare. However, because of their often disturbed life experiences and lack of positive role models, children in care inevitably require assistance in developing living skills in areas such as, personal health and hygiene, budgeting for personal and household expenses, knowledge of legal rights, self education and finding gainful employment.

8.83 The Department endeavours to provide the above forms of assistance to these children through visiting youth workers. On occasions this assistance and support was not responded to by certain adolescents who regarded independent living as "party time" and a means of escaping direct supervision while under State care.

8.84 **Audit established that some adolescents were obviously not ready for independent living, as exhibited by the extreme behaviour patterns that emerged. The Department is then faced with the option of either returning the adolescent to a rostered unit in the knowledge that the behavioural problems will remain, or monitoring the situation until the Protection Order lapses and the adolescent moves onto the welfare system. The second option invariably occurs with no further involvement by DHS once the Order lapses.**

8.85 **In reality, it can be argued that DHS has done all it can to assist certain adolescents up to the stage where they must become responsible for their own future. Audit largely sympathises with this view, but suggests that DHS undertakes research on the outcomes of independent living arrangements over a period of time to establish whether there is a high incidence of premature movement to such arrangements, particularly with younger adolescents. Should this be the case, other options such as lead tenant arrangements can become a preferable alternative.**

SPECIFIC PLACEMENT ISSUES REQUIRING REMEDIAL ACTION

8.86 The audit of placement strategies for children under Custody or Guardianship Orders highlighted a need for specific remedial action to be taken by DHS with respect to:

- multiple placements of children in care;
- secure welfare facilities; and
- psychiatric facilities for children in care.

Multiple placements

8.87 Multiple placements refers to the situation whereby children are moved continually from one type of placement setting to another type during their time in care. While recognising that it is inevitable that most children will need to be moved from short term reception centres or temporary foster care to longer term accommodation or permanent care once the Children's Court outcome is decided, the problem arises when, due to a range of factors, decisions are made to move children more frequently.

8.88 Factors causing movement between placements include:

- disturbed behaviour from children causing placement breakdown, including while in foster care;
- shortage of home-based care and suitable medium to long term residential facilities;
- inappropriate placements in the first instance mainly due to *"bed shortages"*; and
- failed re-unification attempts between a child and its birth parents, causing further instability and emotional upset in the child's life.

8.89 Removal from birth parents due to protective concerns is likely to be one of the most traumatic events in a child's life. It is essential that as soon as re-unification with the family is seen as not possible in the short term, a secure, stable long-term environment should be sought, ideally in home-based care.

8.90 Where home-based care cannot be arranged, and audit acknowledges the difficulty in placing adolescents in this type of placement, facility-based care becomes the next alternative. Extended time in facility-based care means that the child can quickly develop feelings of instability as a result of multiple care-givers, particularly in rostered units. Research has shown that the instability from multiple placements leads to other consequences including low self esteem, depression, poor social skills, repressed anger and hostility and an inability to place trust in people. Such feelings can culminate in aggressive behaviour, absconding, lack of interest in education, substance abuse, homelessness and potentially, criminal behaviour.

8.91 Where placement breakdown occurs, the most common outcome is movement to another placement, rather than attempting to stabilise behaviour patterns over time. Paradoxically, the more placements a child has the less likelihood there is of the child being placed in a permanent care placement. A non-government agency providing short term reception services advised audit that up to 45 per cent of children referred to its care pending placement were re-referrals, following placement breakdowns. Of these re-referrals only around 15 per cent were able to be placed in long-term supported care, with the remainder returning to short-term accommodation. For some adolescents the continual transience within the placement and support system becomes too much and they end up homeless not knowing what a *"normal"* family environment should be. The problems faced by these children can be further added to with the numerous changes of DHS and agency case-managers that occur, with no continuity of case direction.

8.92 Audit requested data from DHS as to the extent of the problem in relation to children in the guardianship or custody of the Secretary. The Department's management information system (CASIS) was unable to provide the data due to:

- the actual location of all children in State care not being recorded;
- placements which were not regularly updated in all Regions; and
- the accuracy of the data being doubtful as well as incomplete as to category of placement.

8.93 The Department subsequently undertook a manual exercise involving the case files of 572 children who were recorded as not living in permanent care arrangements, details of which are recorded below.

TABLE 8D
MULTIPLE PLACEMENTS

Total number of placements	*Children*	*Per cent*
1 to 3	423	74%
4 to 6	98	17%
7 or more	51	9%

Note: The above figures are likely to be understated in that multiple placements at the same address were only counted as one placement irrespective of the number of times the child resided there.

8.94 As previously acknowledged by audit, it can be routine for a child to have up to 3 placements while in care and as Table 8D indicates, around 74 per cent of children come within this category. However, beyond this level serious concerns as to the child's welfare and development begin to emerge, which can ultimately impact on a child's future. Of the 9 per cent of children who had 7 or more placements, some had in excess of 30 placements, and who were obviously among the most seriously disturbed children in the State.

8.95 **The inability of DHS to provide a secure environment for many children was further illustrated in that of the 1 287 children recorded as being in State care for more than 3 years at April 1995, 332 or around 26 per cent were not recorded as living in a permanent care arrangement. In audit opinion, time had run out for many of these children as to their ability to successfully blend into society as adults, a factor brought to audit's attention by some of the birth parents of these children.**

8.96 As the guardian or custodian of the children experiencing multiple placements DHS has a clear responsibility to minimise wherever possible or practical, the incidence of multiple placements occurring. Audit acknowledges the complexity of the issues involved and that in certain circumstances, particularly with adolescents, successful long term placements are highly unlikely. In these situations the best DHS can hope for is to contain the risks prior to an independent living arrangement being entered into. Audit acknowledges that the current program of redevelopment of accommodation and support services is providing DHS with more flexibility in addressing the individual needs of children in care.

8.97 During the course of the audit a research project was commenced by DHS in relation to multiple placements. It was anticipated that the outcomes from the research would provide direction as to any service changes required along with the development of some risk indicators.

8.98 **The *Children and Young Persons Act* 1989 recognised that too many children in State care were in a perpetual state of limbo and introduced the concept of permanency planning, designed to assist children in achieving stable and secure living arrangements. Judging by the incidence of multiple placements and the large number of children still in short term placements after 3 years, this legislative intention is largely not being achieved.**

8.99 **In addressing the harmful impact of multiple placements of children the following factors need to be considered:**

- **Every effort should be made to assess and plan for a child's future at the earliest possible date once it becomes apparent that long term care is likely;**
- **In conjunction with the Department of Justice it is imperative that the delays that are occurring at the Children's Court be reduced in order that decisions on a child's future are made promptly in line with the intention of the legislation;**
- **Establish performance criteria on minimising multiple placements and develop CASIS in order that appropriate and accurate management information on placement movements can be provided for monitoring purposes; and**
- **Establishment of a specialist accommodation unit that concentrates on finding placements for children and adolescents identified from CASIS as requiring special attention. Audit was informed that given time, support and marketing strategies, virtually any child available for permanent care could be placed.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  Multiple placements have been the subject of considerable research within the Protection and Care Branch to identify systemic factors contributing to placement change. The outcomes of the Placement Changes Project will be used to modify practice, including enhancements to information and monitoring systems..

  Further detailed analysis is being undertaken in the placement changes project. This reflects that some children and young people have extremely complex needs and while placement change may not always be desirable, it may reflect the nature of the client group. Unfortunately there are no absolute solutions to these issues, however, the Department is strongly committed to improving the placement outcomes for children and young people in care.

Secure welfare

8.100 DHS has 2 gender-based facilities providing secure welfare facilities for children in State care, young people taken into Safe Custody (without warrant) by protective interveners, and certain children placed under Interim Accommodation Orders. These children are seen by DHS as exhibiting extreme behaviour to the extent that they are judged to be at substantial and immediate risk of death, permanent injury or severe harm to themselves or others. Such behaviour could be related to drug or alcohol abuse, self mutilation, attempted suicide, acts of vandalism or uncontrollable aggression. These children, when admitted, are placed in secure surroundings under 24 hour supervision of youth workers.

8.101 The Windsor Secure Welfare Service catering for young females has an 8 bed capacity and the Ascot Vale Service for young males has a similar capacity. During the first 48 hours of the child's stay an intensive case conference is held whereby the child's needs are assessed in terms of factors causing placement, treatment to date, medical and psychiatric condition, educational standard and personal hygiene.

8.102 A child can only be placed in secure welfare for the shortest period consistent with their safety. The legislation stipulates that this period is to be for a maximum of 21 days, or in exceptional circumstances an extension for a further period of 21 days. During 1994-95 the average length of stay was 11 days.

Effectiveness of Secure Welfare

8.103 The function of secure welfare is to provide an immediate response and a limited strategy for dealing with a crisis period in a child's life. During this time it would be expected that either the crisis would pass or the risks could be managed with the child's needs being met elsewhere in the welfare system. In practice this does not readily occur.

8.104 Table 8E below was prepared from admission statistics held at the secure welfare service at Windsor which caters for young women.

TABLE 8E
FREQUENCY OF ADMITTANCE TO A SECURE WELFARE FACILITY

Admission frequency	*1993-94 Number of children*	*1994-95 Number of children*
1	33 (53%)	37 (57%)
2	11 (18%)	15 (23%)
3	7 (12%)	4 (6%)
4 or more	11 (17%)	9 (14%)
Total	**62**	**65**

8.105 The above table establishes that of the total admissions during 1993-94 and 1994-95 around 47 per cent and 43 per cent, respectively, were re-admissions. There were individual instances of young women being re-admitted between 10 and 15 times in a single year. In 1993-94, one young woman spent 104 days at the service, while another 8 spent in excess of 70 days. Re-admissions can readily occur in that although the legislation provides for a maximum period of containment of 42 days, in practice provided there is a one day break, a new cycle can commence immediately.

8.106 Audit was advised by secure welfare that for around half of the admissions there may have been a temporary crisis in a child's life which after counselling or other forms of therapy, the child would not return. For the remaining children the problems were deeply entrenched, with assessment being directed more towards containment of the problems rather than treatment, which in all probability for many was too late, due to the sustained abuse incurred in the past at home, the subsequent environment while in care or from living on the streets. Some of these children were described as *"feral"* and were virtually illiterate, despite their age. For these children secure welfare provided nothing than a brief *"bus stop"* in their troubled lives before moving on to more multiple placements, probably in rostered units, and further absconding.

8.107 The fact that around half of the admissions kept returning to secure welfare is a clear indication that the needs of these young women were not being met elsewhere in the welfare system. In addition, the Secure Welfare Service was never designed or intended to be used for long term detention for young women as is occurring because they cannot be suitably placed elsewhere. DHS staff assigned to the Service do not have the clinical expertise to assist those young people in desperate circumstances.

8.108 During the course of this review DHS undertook an audit of admissions to the Windsor service, which established that around 70 per cent of the young women had drug/alcohol problems and around 51 per cent had mental health concerns, including suicidal issues. DHS has since considered developing specialist support services for these vulnerable young persons. As further referred to in this Report the ability of the State to treat adolescent mental health problems, including personality disorders, is dependant upon the voluntary co-operation of the adolescent unless they are certifiable as psychotic. Similarly drug rehabilitation centres do not specifically cater for drug addicted adolescents. Audit was also advised that children admitted to secure welfare experience difficulty in accessing drug and alcohol addiction programs conducted by the Public Health Division of DHS, as children under Protection Order do not receive priority access.

8.109 Prior to the establishment of the secure welfare service the practice was to place children in institutional settings such as Winlaton, which also functioned as a juvenile remand centre and Youth Training Centre for young women who had committed criminal offences. In line with the government's policy of de-institutionalisation and separation of young offenders from non-offending young people in need of care and protection, Winlaton was closed, with the result that secure welfare has since become the only form of involuntary treatment available to seriously disturbed children.

8.110 Audit was informed from several sources that despite the confines of the former Winlaton, the young women residing there for protective reasons largely benefited from the support services provided over extended periods. Secure welfare cannot provide this same level of intensive treatment and judging on the level of re-admissions, it is apparent that the welfare system also is not meeting the long-term needs of many of these young persons.

8.111 Secure welfare, after the intensive assessment of the child's needs, can arrange to provide from external sources where deemed necessary or available, various support services such as therapy, counselling, development of self-esteem, encouragement of education and advice on personal health practices. Audit was impressed with the commitment of youth workers in attempting to assist these children at the extreme spectrum of the child protection service. The more important concern however is the ongoing availability of programs and support upon the exit of these extremely disadvantaged young persons.

8.112 DHS does not regard secure welfare as a *therapeutic facility*, but primarily as a containment and accommodation facility. In view of the highly disturbed nature of children and young persons contained in the Service, audit considers that the Service should be clearly therapeutic in orientation, with mental health and other professionals readily available for residents.

8.113 **Secure welfare does provide an important service for a selected range of severely disturbed children facing a short-term crisis in their lives. It does not address, nor was it intended to, the long-term needs of a significant number of children who are among the most severely disturbed in the care of the State. The needs of these children must be given priority and met where possible or practical through intensive support services available from the Public Health Division and the Psychiatric Services Division of DHS. Alternative forms of support and structured programs, including the potential for extended mandatory treatment in a suitable setting subject to strict control and providing a 24 hour clinical service, also need to be researched. It is inappropriate that the Secure Welfare Service is providing longer-term detention for young persons contrary to the intention of the governing legislation.**

8.114 **Audit also considers that young persons identified within Secure Welfare Services as having specialist needs, need to be strictly monitored upon leaving this Service, to ensure these needs continue to be met.**

Environment

8.115 Audit inspected the secure welfare facilities of DHS at Windsor. The building was an old 2 storey dwelling that had been modified for departmental purposes. Modifications included provisions such as removal of any fittings by which young persons admitted could attempt suicide or inflict injury to themselves or others and securing the building with an electronic locking system. The fire safety system has recently been redeveloped.

8.116 **DHS has long acknowledged that the Windsor building is unsuitable for the purpose for which it is used. Audit strongly endorses any move intended to replace the facility with a purpose built building providing a secure but safe, functional and aesthetically pleasing environment.**

- ***RESPONSE*** *by Secretary, Department of Human Services*

  Audit fails to note that the Department has initiated a review into secure welfare services which is due to be completed by June 1996. This is a major initiative driven from the Adolescent Services Redevelopment Framework.

Windsor Secure Welfare Unit. One of 2 facilities used by DHS to accommodate and provide support to disturbed children during times of crisis.

Facilities for severely disturbed children

8.117 As a result of being abused, in conjunction with the various traumas associated with being placed under protection, a small but highly vulnerable number of children in the care of the State are severely disturbed, with significant psychological and/or psychiatric disorders.

8.118 The photograph below provides an illustration of ongoing difficulties faced by abused children notwithstanding intense counselling and therapy.

Sketch by 9 year old girl sexually, physically and emotionally abused by mother's boyfriend. Drawn after 6 month's counselling, the sketch displays pleasure by the girl that the perpetrator is behind thick iron bars. The cross upon the perpetrator's mouth displays a wish by the girl to say things to him without his ability to answer back. The girl stated she was angry, would like to put the perpetrator in jail for 1 000 years and to shoot and kill him. Now at 14 years of age, the girl still receives therapy and continues to display severe trauma and fear.

8.119 Within the community there are a range of community based out-patient mental health services available to the public. With respect to children and adolescents there are only a limited number of in-patient facilities for emotionally and disturbed children including:

- Austin Hospital (16 beds);
- Monash Medical Centre (20 beds); and
- Royal Children's Hospital (16 beds).

8.120 A survey in January 1995 by DHS disclosed a shortfall of 26 beds or around 50 per cent of the minimum required in the State for the treatment of child and adolescent psychiatric patients.

8.121 Austin Hospital advised audit that around 10 per cent of its admissions to these facilities were clients of DHS. Although figures were not available, similar percentages would probably apply at the other hospitals. All hospitals advised of heavy workloads in these areas and inability to accept many referrals. Audit was advised by one of the hospitals that the effectiveness of the treatment which is provided by multi-disciplinary teams, was dependent on the case plan developed by DHS for the child. The provision of adequate care, and a safe and predictable environment were of paramount importance to such children, without which therapy was unlikely to be effective.

8.122 As the children who are referred to these Centres are not certified as psychotic under the Mental Health Act, they are regarded as voluntary patients and are free to leave at will and refuse treatment. This situation, in audit opinion, exposes a void in Psychiatric Services in that although these children, who are displaying characteristics such as violent or suicidal behaviour are clearly in need of professional assistance, they cannot be made to attend treatment unless certified and admitted to psychiatric hospitals. Even where children and adolescents are certified as psychotic, the State, at date of audit did not have separate secure psychiatric units within Psychiatric Services dedicated to the treatment of children and adolescents, although a number of developments were occurring including a locked unit at Monash Medical Centre.

8.123 The result has been that children and adolescents were placed in psychiatric hospitals such as Royal Park or Larundel where they mixed with adult patients and had the potential to become even more disturbed. The particular needs of difficult adolescents may not be satisfied with psychiatric services designed for adults. A further problem also arises in that on occasions, these hospitals have not had beds available to admit emergency patients and in isolated instances DHS has been forced to use Secure Welfare Services as an emergency measure, as illustrated in the following case example:

"An adolescent in the care of the State (referred to as 'Kay') had been walking around her hostel for some days with a date written on her arm. She constantly referred to the date as her "expiry date after which she would not be here". Shortly afterwards Kay returned to the hostel during the night drowsy and barely able to walk after consuming some unidentified tablets. Her behaviour became extremely erratic and a decision was made to take her to the Austin Hospital. Because of Kay's chronic self destructive behaviour a psychiatric ward was seen as essential. However, due to a lack of psychiatric beds at the Austin Hospital she could not be admitted and was certified by a doctor at the Hospital and transported by a Mobile Support Team to Royal Park Psychiatric Hospital.

The Royal Park Psychiatric Hospital refused admission on the basis that she was considered unsuitable for the facilities available due to the unknown nature of the overdose. The Hospital contacted Larundel Hospital which initially agreed to admit Kay. Upon arriving at Larundel Hospital the Mobile Support Team was informed that the certification provided by the doctor at the Austin Hospital was incorrect, admission was refused and that she should go back to the Austin Hospital. By this stage Kay's physical condition had deteriorated substantially and she was transported back to the Austin Hospital where she was admitted to a general ward.

While in the general ward Kay inflicted further substantial physical injury upon herself. Despite being certified she was still unable to gain admission to a psychiatric bed and the Mobile Support Team had virtually no option but to transport Kay to the Secure Welfare Service at Windsor."

8.124 **There is a need for the State to provide sufficient psychiatric beds within the hospital system specifically for children and adolescents, with priority access being given to children in care who are some of the most disturbed children in the State. Additionally, in circumstances where children are deemed to be at extreme risk but are not psychotic, audit considers there is a need for a form of mandatory treatment in secure, but appropriate facilities designed specifically for children and adolescents. Audit would envisage such facilities as being staffed by mental health staff as well as protective workers and offering a wide range of specialist services over an extended time frame.**

8.125 **The legal basis of mandatory treatment programs requires further investigation. However, there is increasing community concern about the State's duty of care to very vulnerably adolescents and it may be time to consider whether the legal *"rights"* of highly disturbed adolescents should always over-ride the *"needs"* of many of them.**

❑ ***RESPONSE*** *by Secretary, Department of Human Services*

Audit fails to acknowledge work being undertaken by the Psychiatric Services program to enhance the capacity of Child and Adolescent Mental Health Services to more appropriately respond to the needs of Protection and Care clients. Co-operative links have been developed between Protection and Care and Psychiatric Services which has lead to the funding of specialist mental health positions in Protection and Care's Intensive Youth Support services. Additional work continues to maximise the effectiveness of both community and in-patient services to meet the needs of Protection and Care clients.

The Department rejects, on both legal and therapeutic grounds, audit's recommendation for the establishment of a mandatory treatment program in a secure setting over an extended time frame for young people not eligible for psychiatric interventions. As foreshadowed in the document Adolescent Services - a Framework for Service Delivery Within Child Adolescent and Family Services, the department will examine the resourcing and staffing mix of both secure welfare services and some rostered residential facilities with a view to enhancing the capacity of those services to work with some of the department's most challenging adolescents.

CONVERSION TO PERMANENT CARE

8.126 Permanent care describes a situation where a child is cared for on a permanent basis by care-givers other than their birth parents, such as extended family members or foster parents accredited through a foster care agency or permanent care service. The notion of permanent care is based on the concept, as acknowledged in the United Nations Charter on the rights of the child, that a child's development is promoted by stability, security and continuity of relationships with nurturing parents or care-givers.

8.127 The *Children and Young Persons Act 1989* emphasises the importance of re-unifying the child with the birth parents, as the best interests of the child are deemed to be served when the child is placed safely within the family unit. The Act specifically requires that attempts to return the child to the birth parents must be pursued whenever possible. Only where this is not possible, or has been attempted and failed, should consideration be given to permanent placement in an alternative family or other permanent arrangement, where stability and long-term nurturing and support can be provided.

8.128 The DHS *Protective Services Practice Manual* requires that a permanent care arrangement **must** be considered when it is not in the best interests of the child to be reunited with his/her birth family, or where there is no other family member able or willing to care for the child.

8.129 In general, children over 8 years of age are more difficult to place than younger children, particularly if they have an intellectual disability or have experienced extended periods of facility-based care. The difficulty in placing adolescents lies both in the recruitment of families interested in permanent care arrangements, and in maintaining adolescent permanent care placements, which have a higher rate of breakdown than placements of younger children. With adolescents, permanent care options available can also include adolescent community placements or lead tenant models.

8.130 Given the difficulties in securing stability and security in the lives of many children, a high level of expertise is therefore required to develop permanency planning programs and strategies to establish permanent placements for children where a re-unification with birth parents is not possible.

8.131 Permanent care services are provided across the State by 9 regionally based permanent care teams, of which 5 are resourced through non-government organisations. In addition, the Catholic Family Welfare Association is responsible for facilitating adoptions Statewide.

8.132 The primary role of the permanent care teams is to assess the suitability of children for permanent care placement and to determine the optimal matching of these children to available families. Initially, the permanent care team attempts to find placements within its designated region. If no suitable matches are found advice is sought from the DHS Central Resource Exchange Unit where information is maintained on a Statewide basis about children available for placement and approved families. This process is intended to maximise placement opportunities, particularly for those children who are difficult to place. It is also intended to address imbalances between regions with respect to availability of applicant families.

Placement of children in permanent care

8.133 An audit analysis of the accommodation arrangements of 2 279 children under either the Custody or Guardianship of the Secretary at April 1995 disclosed that:

- 572 or 25 per cent of the children were not in a permanent care placement; and
- Of the 1 287 children who had been in the care of the State for more than 3 years at that date, 331 children or 26 per cent of that number were not in a permanent living arrangement. Most of these children were either in Family Group Homes, rostered units or Reception Care awaiting placement.

8.134 The consequences of so many children in State care, which in isolated instances has extended over 10 years, not having secure living arrangements after 3 years, is a matter of serious community concern. As discussed elsewhere in this Report this uncertainty and insecurity reflects on the future lives of these children in terms of long term psychological problems, distrust of people, homelessness, inability to obtain an education and employment opportunities.

8.135 Audit accepts that for children under Custody Orders to Secretary there may be a delay, particularly if adolescents are involved, in finding foster care or other home-based care due to the recognition that these children could still be returned to their parents within the first 12 months of the Order. However where children are under Guardianship to Secretary Orders and the chances of family re-unification are more remote, audit finds it unacceptable that 1 in 4 children do not have secure living arrangements after more than 3 years. In addition DHS was unable to produce aggregate information indicating the length of time children had remained in its care.

8.136 The legislation intended that if an extension of a Custody or Guardianship Order beyond 2 years was sought by the Secretary, the extension was to be conditional on the Secretary taking steps to ensure that custody or guardianship could be transferred to a person other than the child's parents if it was to be seen in the best interests of the child. Irrespective of the Children's Court rarely questioning DHS on its efforts to secure permanent living arrangements, DHS policy also acknowledges its responsibility to determine secure, alternative permanent care arrangements for a child when it is in the child's best interests.

8.137 Although departmental statistics indicated that potentially, in excess of 500 children in State care should have had permanent care included as a goal in their case plans, at August 1995 DHS had only assessed 69 children as suitable for permanent care placement of whom 17 had been available for more than 12 months.

8.138 Audit acknowledges the difficulty of matching children, particularly adolescents, with a suitable family, and the difficulties experienced by DHS in recruiting permanent care-givers. DHS moved to redevelop permanent care teams and planning strategies during the course of the audit.

8.139 **The Department has a clear obligation to make a concerted effort to provide security in the lives of a large number of children in its care through the active promotion of permanent care arrangements within the community.**

Overemphasis on family re-unification

8.140 Due to the emphasis on the legislation on re-uniting a child with their parents case plans are directed at providing support to parents and encouraging a commitment from them as to removal of protective concerns. Case studies examined by audit disclosed that even where the chances of re-unification were remote, persistent efforts were made to facilitate the return of children. As a consequence, minimal consideration was given in early years to finding an alternative permanent placement for children.

8.141 Audit acknowledges that the intrusion of the State into family life must be kept to an absolute minimum and is only a last resort when a family fails to protect a child. It is also accepted that where Protection Orders are made that every effort must be made to re-unite a child with their parents when it becomes safe to do so. Research undertaken overseas suggests that even where birth parents continue to demonstrate poor parenting skills, provided protective concerns are addressed a child is likely to be better off in the longer-term than it would have been had the child been placed with alternative care-givers.

8.142 Notwithstanding the above concepts, the legislation also places high priority on the Children's Court having regard to *"the need to protect children from harm and to protect their rights and promote their welfare"*. Clearly in some circumstances the welfare and rights of children would be better served with the child being permanently placed in a secure environment outside of the family home, rather than persisting with attempts to bond children with their birth parents who can be clearly unfit or unwilling to care for them. While the decision as to when this should occur remains the prerogative of Magistrates, a constant source of friction that occurs between the legal system, DHS, parents and professionals is whether the rights of parents are at times given priority over the best interests of the children.

8.143 Magistrates acknowledged that they felt bound to agree to re-unification attempts in the absence of compelling evidence to the contrary. It is also natural for a child to wish to be re-united with their family and Section 20(8) of the *Children and Young Persons Act* 1989 specifically directs a legal practitioner representing a child to act in accordance with *"any instructions given or wishes expressed by the child so far as it is practical to do so"*. The reality is that wishes expressed by a child to return home may conflict with what is in the child's best interests.

8.144 Various cases were brought to the attention of audit whereby unsuccessful attempts were made, by DHS sometimes repeatedly, to re-unite children with dysfunctional families that had consistently exhibited no intention to meet their parental responsibilities. This action was taken at times despite the fact that a child may have been securely placed in foster care.

8.145 Of particular concern are the high risk dysfunctional families with a history of substance abuse and consequent impact on both mental and physical health and lifestyle. Children who remain with these families inevitably display emotional and behavioural difficulties that will influence their childhood functioning and adult lives. These families can be very aggressive to deal with and will bitterly contest in Court any intervention by DHS. Support services provided to such families are usually ineffective with minimal or no improvement resulting.

8.146 Comment was provided to audit from protective workers and welfare agencies in constant contact with dysfunctional families, often due to multiple notifications. A recurring theme was the need to *"break the cycle"* of children from these families becoming dysfunctional themselves in the future. This can be brought about by these children being exposed to constant disruption and abuse, thereby never knowing what *"normal family life"* is, including being given the chance to develop their own parenting skills.

8.147 An experienced worker from a prominent welfare organisation advised audit that she was now dealing with third generation children displaying the same dysfunctional characteristics and poor parenting skills of their parents and grandparents.

8.148 From a review of case files a common characteristic of children who had been in State care for long periods, lacked permanent placement and displayed severe behavioural problems, was a series of failed re-unification attempts with birth parents over several years. The subsequent placement breakdown meant that the children felt rejected and acted this out in their subsequent behaviour.

8.149 Audit acknowledges that successful re-unification with parents often occurs following changed circumstances and modification of risks and is an ideal outcome from intervention. However, there is concern that, at other times, re-unification is clearly inappropriate, particularly when a child has experienced multiple care-givers over an extended period in the hope that the birth parents will eventually cope with their parenting responsibilities. It is not uncommon for some families to be persevered with for up to 4 years in relation to children on Protection Orders other than Guardianship Orders. During this waiting period immense damage can occur to the child.

8.150 Attempting to re-unite a child with its natural parents must be a primary aim in a case plan, but should only be persevered with to the extent that rehabilitation of the parents has occurred or a genuine commitment has been given, such as a clearly demonstrated willingness to utilise drug rehabilitation services. A submission to audit from an organisation involved in providing assessment and treatment for emotionally disturbed children and their families stated that:

> *"The system works to timelines that are not appropriate to the developmental needs of children. Two years out of the life of a 4 or 5 year old child is critically important and, if a child is already at risk because of disturbing life experiences, the child cannot be expected to "hang around" for a couple of years on the chance that its biological parent(s) may or may not get their life in order. This is particularly the case with quite young children whose major psychological need is to establish a secure, trusting and predictable relationship with a care-giver or small group of care-givers - a process referred to as "attachment" in Child Psychiatry. Failure to develop secure attachments by early childhood is very strongly associated with later childhood and adolescent difficulties."*

8.151 The submission supported its views with a number of case studies illustrating examples where despite a distinct lack of rehabilitation by the parent(s) the primary long-term case plan goal was to achieve family re-unification. The following comments by this organisation in relation to specific case studies demonstrates the potential adverse impacts on children when the goal of family re-unification is rigidly applied, at times despite the failure of previous re-unifications:

"This represents a complete disregard of the significance of the previous extensive support offered to the family without any enduring improvement in the care of the children and a decision to return them to their mother meant that the children's developmental needs were not going to be met yet again, repeating the well documented cycle of ineffective Child Protection interventions in both Victoria and interstate."

"The system struggles with the concept of children needing a long term secure placement to develop secure relationships and internalise controls (i.e. begin to develop a code of acceptable behaviour and learn to delay impulses). The practice of annual Wardship Review and continuing Rights of appeal of the biological parent works against the provision of a secure environment, which is of crucial importance if traumatised children are to recover from their previous experiences of neglect and abuse."

"The system appears to have done everything possible to deny this child the opportunity to attach to care-givers and to gain a sense of stability in his life. The rights of this abusive parent appear to have taken precedence over those of the child."

8.152 In audit opinion, in some instances the rights of children to be placed in a secure, nurturing and caring environment are being jeopardised by repeated attempts by DHS to return children to families that have not demonstrated a willingness to rehabilitate their lives and are highly unlikely to accept parenting responsibilities. The concept of *"ownership"* of children by both parents is seen as prevailing over what is intended to be a paramount focus on actions necessary in the best interests of the child.

8.153 The concepts of ownership and custody of children as distinct from parental responsibilities have been recognised in English legislation and more recently in the *Family Law Act 1975*. This legislation emphasises the concept of parental responsibility for the care, welfare and development of children rather an automatic right of access or custody of children indicative of ownership. In essence the legislative intent is that unless parents accepted and exercised their parental responsibilities they did not have an automatic right to daily care or control of a child. This does not, and is never intended, except in exceptional circumstances, to prevent a child from maintaining contact with its birth parents even though the child may be permanently located out of home.

8.154 **Audit recommends that:**

- **More emphasis be placed by the legal profession as well as DHS upon whether birth parents have made genuine attempts to rehabilitate their lives and remove or minimise protective concerns, before consideration is given to returning children;**
- **The outdated concept of parental ownership of children influencing repeated attempts at re-unification be replaced with an emphasis on whether parents are capable and willing to exercise parental responsibilities in respect of their children under Protection Orders;**
- **Where initial applications for extensions of guardianship or custody to the Secretary are brought before the Children's Court, the disposition report accompanying such applications should clearly state whether protective concerns are likely to remain in the foreseeable future. If this is the case, then Magistrates would need to ensure that case plan goals are amended with a view to permanent placement;**

- **Consideration be given to the appointment of *Guardian Ad Litems* to independently assess and advise Magistrates on what are considered to be the best interests of the child in terms of future placements;**
- **Alternatively, the services of the Children's Court Clinic or independent experts be sought by Magistrates prior to consideration of applications to extend Guardianship to Secretary Orders, to assess the capability and commitment of dysfunctional families to exercising parental responsibilities in the future; and**
- **The case planning system needs to provide for whole of life planning in some circumstances whereby early recognition is made of the unlikelihood of a child being able to return home and long term projections are made as to their future care and the extent of contact to occur with their birth parents.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department reminds audit of legislative principles in regard to maximising families capacity to protect and care for children. While, in some instances, a parent may exhibit limited capacity to care for a child, the department adopts a broad definition of "family" and strives to explore all reasonable care options within a child's family within the context of permanency planning principles and the requirement for timely decision making.

The Department rejects audit's assertion of an "overemphasis on family re-unification". Audit correctly identifies the framework of legislative principles within which both the Department and the Children's Court operates. These principles are framed to closely reflect prevailing societal expectations and values.

Consistent with the Children and Young Persons Act and international research DHS takes the view that, generally speaking, the best care and protection is offered to children within their family and that State intervention to family life is only acceptable in cases where adequate standards of sustained care and protection is not available to a child.

Contemporary practice driven by research increasingly recognises that best outcomes for children are achieved through approaches which value and reinforce the mutual significance of child and family to each other and which strengthen families capacity to safely care for their children, prevent family breakdown and maintain family relationships. Such approaches do not necessarily demand return of children to the full time care of birth parents, but emphasise the importance of maintaining and strengthening family connection through the provision of information and the facilitation of regular and meaningful family contact.

The Department is cognisant of the issue of inter-generational transmission of abuse and neglect. This is an issue which raises a number of highly complex and politically and ethically sensitive matters. Audit stresses the importance of "breaking the cycle" of family dysfunction. This is an area of critical concern to the department and forms an important part of the understanding of the concept of "harm" in terms of the long-term impact of child abuse and neglect.

Audit may be viewed as advocating pre-emptive decision-making to place a child permanently away from parents in the interests of preventing the possibility of further harm to the child and future parenting dysfunction.

Audit asserts, on several occasions, the "immense damage" to children of failing to make such early decisions on termination of parental rights. Audit fails to acknowledge the potential for "immense damage" to children resultant from disruption of family relationships.

The Department acknowledges the critical importance for some children of prompt termination of parental rights where parental capacity and commitment to necessary change is in significant doubt. However, caution is required in policy direction setting if the rights of children are to be adequately protected from the potential for premature and heavy handed State intervention.

The Department refutes that policy or practice reflect a concept of parental "ownership" of children. The department takes the view that an emphasis upon the importance to children of attachment to and position within family of origin is grounded in research-based knowledge of the critical significance of these to the health and welfare of the child.

Audit fails to describe criteria which should be used to measure a parent's "genuine attempts to rehabilitate their lives". Dispositional reports presented to the Children's Court contain Case Planning directions which should reflect the current and long-term options available or possible markers for use in the early detection of "unlikelihood of a child being able to return home."

Audit suggests that children's interests could be better represented by the appointment of Guardians ad Litem and comparisons are made with the representation offered in the Family Court. The Family Court and the Children's Court are not comparable jurisdictions in regard to the representation of children. The Family Court can order the child to have separate representation but this is their only representation. In the Children's Court children's wishes are represented by their lawyer and, the Department is mandated to represent their interests to the Court. A proposal to establish Guardians ad Litem would have major resource implications.

The Department accepts that further work is required with the Department of Justice and the Legal Aid Commission to examine a number of issues including avenues for improving the representation of children in the Children's Court.

Use of Freeing Orders to secure permanent placements

8.155 Further to the situation outlined in the previous section whereby audit is advocating early decision making on permanency planning, this concept has been further addressed in England and some European countries through what is know as a *"Freeing Order"*.

8.156 Use of such an Order involves an application before the Children's Court by the responsible authority equivalent to DHS, to *"free"* a child for permanent placement, with a view to eventually transferring the guardianship of a child to the care-givers. The birth parents have the capacity to contest such an application at that stage. If granted, the Freeing Order effectively removes the parents' future rights to a child and allows the care-giver to proceed with some authority and conviction in securing the child's future.

8.157 Audit considers such an approach in Victoria has some merit, particularly in cases where it is clear at a very early stage that parents will most likely never be in a position to properly care for and protect their children, such as where a single parent was mentally incapacitated.

8.158 Advantages would include:

- If the permanent care plan was working satisfactorily and a Permanent Care Order after a set period such as 2 years was intended, the birth parents would have no authority to contest such an application. At present there is considerable reluctance from permanent care-givers to agree to guardianship unless consent from birth parents was available;
- Care-givers of children under Custody or Guardianship to Secretary Orders face a review of these Orders in the Children's Court every 12 months. There always remains the uncertainty that a parent may successfully contest such an Order and a child is suddenly returned to its parents, despite a degree of bonding having developed between care-giver and child. The granting of a Freeing Order would remove the trauma associated with annual reviews;
- A small number of birth parents routinely oppose guardianship or custody extensions out of principle, in the full knowledge that they have done little to modify protective concerns. The subsequent trauma caused to the child undermines the security that permanency planning was meant to achieve. A Freeing Order would prevent this annual occurrence; and
- A Freeing Order does not prevent access between a child and birth parents, but in order to minimise disruption to placements, access would be restricted and on terms agreed upon by all parties.

8.159 **Freeing Orders would only be suitable in a limited number of cases and where parents were not prepared to co-operate with permanency planning. Nevertheless, audit considers that the introduction of Freeing Orders would assist in providing secure permanent placements at an early stage for more children than is currently the situation.**

Permanent Care Orders

8.160 Permanent care placements can be formalised through the granting by the Children's Court of a Permanent Care Order, which has the effect of transferring the custody and guardianship of a child to suitable persons. The Order continues in force until the child turns 18 or marries, whichever happens first.

8.161 Similar Orders transferring guardianship and custody can also be made under the *Family Law Act* 1975, a venue which is preferred by DHS in that these Orders have application Australia wide. In circumstances where a child cannot return to their family, the transfer of guardianship and custody under either the *Family Law Act* 1975 or the *Children and Young Persons Act* 1989 is the optimum outcome for a child with the possible exception of adoption which is less likely to occur with older children.

8.162 Permanent Care Orders are not made unless the Court is satisfied the birth parents have not had care of the child for at least 2 years and it was not in the best interests of the child to return home. Despite the benefits of a Permanent Care Order to a child in providing future security in a nurturing environment, relatively few Orders are sought by the Department and usually only in those cases where the consent of the birth parents is obtained.

8.163 The use of Permanent Care Orders followed proclamation of the relevant section of the *Children and Young Persons Act* 1989 in April 1992. Since 1992 the number of Permanent Care Orders granted has been as follows:

- 11 in 1992-93
- 44 in 1993-94
- 135 in 1994-95

8.164 These figures need to be viewed in the context of there being 2 324 children in the care of the State in 1994-95 of which many were in permanent, long-term foster care placements. Reasons for the low number of Permanent Care Orders sought by DHS are varied, but include the following:

- A reluctance by some foster families to assume permanent responsibility for a child in their care, particularly if birth parents are unco-operative or the child has "challenging behaviour";
- The legislation requires a Magistrate when considering a Permanent Care Order application, to have regard to any wishes expressed by the birth parents. Even where a Permanent Care Order is granted, the legislation further allows the birth parents to appeal against the Order at any stage. Audit was advised that these provisions could be seen as placing the concept of parents rights beyond the best interests of children to be cared for in a permanent secure environment;
- Partly as a consequence of the above provisions DHS displayed considerable reluctance in applying for Permanent Care Orders except where the consent for such Orders had been obtained from the birth parents. Even where DHS was prepared to enter into a contested application outcomes were unpredictable. As an example, in a 1995 case where the Children's Court granted a Permanent Care Order after a contested hearing, the case was appealed to the County Court. The mother, who was not legally represented, was successful in having the decision overturned despite the fact that the child could not return home and had been under the Guardianship of the Secretary since 1983; and

- Audit established that once a child is placed under a Permanent Care Order and the Secretary of DHS ceases to be the guardian, the future involvement of DHS ceases quickly, with the foster care agency terminating its involvement with the family within 2 months of the Order. The Order can also mean that supervision of access rights of birth parents by DHS will also cease. Audit discussions indicated that although in theory support for the placement can continue under a voluntary agreement with the foster care agency or from other community services, in practice the same level of support is not provided as the agencies maintain they are not specifically funded for these services. Permanent care teams, including those staffed from non-government agencies may continue to provide ongoing support to families involved in Permanent Care Orders, but this is discouraged after a period of time as this is not the primary function of the teams.

8.165 Apart from the above barriers, children need to be settled in a permanent care arrangement for an extended period before consideration can be given to a Permanent Care Order. As referred to previously, DHS has difficulty in recruiting families willing to offer permanent care. By default this will mean that opportunities for Permanent Care Orders in the future may continue to be restrained due to the lack of permanent care placements.

8.166 Audit also formed the view at the time of the audit, that permanent care placement teams were under-resourced, lacked authority to promote their aims, and generally lacked support from the Department. DHS were seen as giving priority to continually trialling children back with their parents and displaying a preference for short-term placements of children, as opposed to a concerted attempt to find permanent placements for children which could hopefully be converted to Permanent Care Orders. Effective strategies to find permanent placements were lacking. For example, in certain overseas countries children available for placement are actively publicised, including on television.

8.167 Although DHS does not prevent publicity for children who are difficult to place, the permission of both birth parents is insisted upon before publicity is given. Not surprisingly, permission is usually refused by the parents despite the potential advantage for the child.

8.168 **In audit opinion, more effort needs to be applied by DHS in seeking Permanent Care Orders for children in long-term foster care. In doing so new strategies will need to be developed and legislative change initiated, if necessary, to address the barriers contributing to the low levels of Permanent Care Orders being sought. In particular:**

- **Permanent Care Placement needs to be treated as a high priority program within DHS, adequately resourced and with ongoing research in permanent placement strategies;**

- **families agreeing to Permanent Care Orders must be assured of ongoing support, where required, for these placements, such as the availability of highly skilled clinical services to assist permanent care families in dealing with the disruptive and demanding behaviour of disturbed children; and**
- **decision-making on permanent care must take place at an earlier date, ideally at the first application for an extension of Guardianship to the Secretary of DHS.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

Audit states that more effort needs to be applied by DHS in obtaining Permanent Care Orders in long-term foster care. DHS has a policy of proactively seeking the conversion of long-term foster placements into permanent care placements, where this is consistent with the child/young person's case plan and the caregiver is willing to become a permanent caregiver.

The Permanent Care Program is strongly supported by DHS and the availability of suitable permanent care placements is viewed as being of critical importance to the well-being of children and young people case planned as requiring this form of care. In order to strengthen the visibility, viability, program planning and co-ordination of the permanent care program, the Department consolidated all of the permanent care and adoption functions under the one head office Specialist Services Unit in 1995.

In 1995, DHS commenced a Permanent Care Redevelopment Project, with a view to enhancing the capacity of the Permanent Care program to provide placements, and strengthen the overall provision of permanent care services. Other key aspects of the redevelopment exercise, include: the identification, and overcoming of barriers to permanent placement; consideration of improvements to service design; and, the development of performance indicators that measure a broader range of program variables, including those relating to the level of support offered to caregivers following placement. This project has involved consultation with both DHS and Non-Government permanent care service providers over the planning of the project and oversighting its progress.

DHS has also sought to strengthen the Permanent Care Program and increase the availability of placements throughout the state. As a consequence, an additional $605,000 was allocated to the program in 1995-96, which has resulted in the creation of three new regional programs and expansion of some existing services. Permanent caregivers will also benefit from increases in the overall level of payment to home based caregivers and improved funding flexibility in relation to special needs.

Audit has recommended the introduction of Freeing Orders *to assist in providing secure placements at an earlier stage in the planning for children than is currently the case. DHS is examining the feasibility of applying this approach to the Victorian situation.*

IMPACT OF BEING IN CARE

8.169 As previously referred to, the *Children and Young Persons Act* 1989 imposes an obligation on the Secretary of DHS to ensure that in any dealings relating to children in care he must;

- have regard to the welfare of the child as the first and paramount consideration; and
- make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would.

8.170 In seeking to achieve the above obligations there must be a network of accommodation and support services appropriate to the needs of the children in conjunction with protecting the child's mental and physical health and well being, providing an education and generally doing all that is necessary to promote future opportunities for a stable lifestyle and employment.

8.171 Audit fully acknowledges the immense difficulties DHS can face in caring for severely disturbed and abused children. With some of these children, particularly those who were previously accommodated in large institutions, even the best endeavours and support will have little impact on the child's future. Audit also acknowledges the efforts of DHS in reuniting children with families that have undergone a temporary crisis and with support have been able to modify their lifestyles. In other cases, long-term foster parents and other suitable care-givers have been able to provide a stable environment for many of the children who have come into State care. Unfortunately, DHS does not attempt to measure the extent to which it has been successful or otherwise in enhancing the future of those children for which they have had custody or guardianship.

8.172 Conversely, for a significant number of children, their time in the care of the State has resulted in further disruption to their lives and has added to the traumas associated with the abuse from parents from which they were removed. The damage suffered by children while in care is common to either a lesser or greater extent in all child protection systems in Australia. The issue for Victoria's child protection system, while acknowledging that any system will never be entirely successful, is to minimise those factors which can lead to children leaving care for a life of substance abuse, unemployment, homelessness, criminal behaviour and an inability to cope with adulthood.

8.173 Some factors can never by fully addressed such as the long-term emotional, psychological and sometimes physical damage inflicted by abusing parents, especially where sexual abuse has occurred. However, factors adding to these problems as referred to in the Auditor-General's Special Report *No. 41 - Protecting Victoria's Children: The Role of the Children's Court*, such as the extended delays and other problems occurring at the Children's Court, multiple placements, inappropriate placements, inadequate psychiatric care, being returned prematurely to abusing parents, numerous changes in assigned case workers and care-givers, and inadequate attention to permanent placements are all factors which can be addressed, and which would materially assist in reducing the turmoil in lives of children in care.

8.174 To the credit of DHS, the examination of case files by audit did indicate a high level of support services such as counselling, therapy, medical treatment, financial assistance, specialist programs etc. being provided to children in care. The dedication and commitment of many case workers was also apparent. However, this support can become largely ineffective unless the children, especially adolescents, can be brought up in a secure, permanent and nurturing environment. Failure to provide this environment at a very early stage gives rise to 3 further areas of major concern, namely, inadequate education, absconding from care and criminal activity.

EDUCATION OF CHILDREN IN CARE

Background

8.175 Due to the disruption and trauma occurring in a child's life following removal from parents, it is crucial that a child's education continue with minimal interruption where possible. For many seriously disturbed children in long-term care, education can be the catalyst to generation of self-respect and confidence. With support and the assistance of teachers, absorbing an education can make the difference between future employment and opportunities for tertiary education, compared with homelessness, reliance on social security and crime.

8.176 Unfortunately, for a proportion of children in State care, their school attendance is characterised by truancy, refusal to attend school, challenging behaviour disruptive to other children and being denied enrolment in schools of choice. The extent to which these problems occur was difficult to broadly establish due to an absence of comprehensive information. However, reference to the problems encountered by children in care in attaining a satisfactory standard of education was referred to in various submissions to audit. Further evidence was available from case studies and discussions with adolescents.

8.177 The above problems were also highlighted in a March 1995 report from Kildonan Child and Family Services entitled *Getting an Education in Care.* From a study of a sample population of 487 students in residential care, the research identified that:

- More than 50 per cent of the students were found to be below average age levels in literacy and numeracy, personal development, social skills and emotional and behavioural development;
- Nearly 50 per cent had frequent episodes of truancy, school expulsion or suspension. Around 7 per cent were not attending school at all; and
- Less than 10 per cent received additional education support, despite over 50 per cent of the sample population being identified as having special educational needs.

8.178 Audit did not seek to establish the accuracy of the report, but based on the limited audit review of this area, in conjunction with views expressed by protection workers, it was apparent that serious problems existed in relation to educational opportunities for some children in care. It was acknowledged that the disturbed, emotional state of some of these children placed substantial limitations on their ability to be educated despite the best efforts of authorities. Nevertheless, audit considered that action could be taken to address other factors influencing their educational opportunities.

8.179 The review of case files established that many case workers had a firm commitment to ensuring that education opportunities were provided to children in their care. Case conferences attended by teachers and case workers were a relatively common feature at the local level, albeit usually when disciplinary issues emerged.

Factors influencing education of children in state care

8.180 The difficulties which DHS experiences in endeavouring to ensure that children in their care receive an adequate education are acknowledged by audit. By virtue of their background, in many cases, in dysfunctional families coupled with the abuse they have suffered, the children tend to mirror the characteristics of their former home life, such as aggressive behaviours, lack of respect for authority, substance abuse and emotional insecurity. As a consequence, their behaviour in classes can be unpredictable in conjunction with short attention spans. As a result, many of these children could be categorised as disadvantaged and in need of professional support with their education. Audit was advised from various professionals dealing with some of these children that they can be very intelligent, but lack the capacity to adjust to learning with traditional teaching methods.

8.181 Apart from the obvious impact of their background on their learning capacity, certain barriers to learning could be addressed including;

- the impact of multiple placements on children's education;
- relationships between schools and case managers; and
- the lack of liaison between authorities in addressing the suspension, expulsion and exclusion of children from schools.

Impact of multiple placements on children's education

8.182 As referred to previously in this Report, the constant re-location of a proportion of children while in care adds further to their insecurity and emotional instability. The ability of these children to frequently need to adapt to new schools, teachers and students when they already lack in socialisation skills creates many problems in gaining an education.

Relationships between schools and case managers

8.183 Audit was advised by the Directorate of School Education (DSE) and other sources that schools were not necessarily advised of students attending that were in State care and may have special needs requiring support. This situation was common to cases contracted to non-government agencies, which also coincided with the situation whereby the actual location of children in care contracted to non-government agencies is not recorded on the DHS central management information system (CASIS), for supposed reasons of confidentiality and avoidance of a stigma for the children.

8.184 The above attitude ignores the fact that most teachers are responsible persons and care about what is in the best interests of their students. Obviously, failure to advise a school of the background history of a child, including any special considerations, could place a child at a disadvantage. In addition, the school could also be disadvantaged through not seeking funding for students with special needs.

8.185 Apart from not always being informed that a child in care was being enrolled, audit was also advised that schools were not necessarily informed about a child's level of intellectual or physical ability or what particular aptitudes they possessed. These qualities can be determined from a psycho-educational report conducted by an educational psychologist. The conduct of such a test is seen by audit as a distinct advantage both to the enrolling school and the case-manager as to what special considerations and supports a child needs. Audit established that these tests are only conducted on an exceptional basis and are largely dependent upon the views of the individual case manager.

8.186 Audit acknowledges that the above tests are not required in many instances, but rather than leaving it up to teachers to try and determine a child's needs purely from observation over time, any tests which would assist both the school and the child in meeting a child's needs should be encouraged by DHS. In addition, audit would have expected that the conduct of such tests would be a factor in assisting DHS determining what schools best suited the needs of individual children.

8.187 Audit established that case managers in general strongly encouraged children in their care to attend schools. It was noted, however, that while case conferences between case managers and teachers occurred, the conferences inevitably involved disciplinary issues and actions required, rather than academic progress. Of importance is the need to clearly determine what information a school needs to know when enrolling a child under care and what are the expectations of the school as to the role of the case manager as the de facto parent.

Truancy

8.188 Truancy is a common outcome for children who are at the onset emotionally disturbed, and as a consequence have difficulty in building up self-worth and learning to control emotions. These children experience difficulty in learning and forming relationships with other children, particularly if they have been in facility-based care. This situation is made worse if their needs are not identified at an early stage and suitable support provided at schools.

8.189 In a submission to audit from a group of adolescents in care frequent truancy and refusal to attend school was regarded as common. Reasons for this situation were seen as schools being unable to satisfy the needs of disturbed children requiring special educational help. As a result, these children felt inferior and frustrated, became disruptive and subsequently chose to stay away from school.

8.190 The extent of truancy among children in care, although considered a frequent problem, was difficult to measure. Anecdotal evidence provided to audit from various sources, including parents, suggested that for many adolescents, especially those in facility-based care, attendance at school becomes a daily option. Staff at residential units have no power to force any child to attend school. Audit would have expected case managers, as de facto guardians, to record on case files any advice received or requested from schools as to non-attendance of children. Advice to this effect may be received, but documentary evidence was not available and consequently actions by case workers could not be assessed by audit.

8.191 On isolated occasions notations on files indicated that children may not have attended school for several days, weeks or even months, with only an occasional record of any actions taken. This could indicate that case managers felt powerless to address the problem, despite case managers having the delegated power under the legislation to act as defacto parents in ensuring that the children in their charge receive an education. In addition, the DHS Policy Advice and Practice Manual provides no guidance on this issue.

8.192 Policy guidelines on truancy issued by DSE state that although school attendance is primarily the responsibility of the individual school with support from DSE, success depends on making the school environment attractive for students in conjunction with parental support. Schools and parents are encouraged to develop a joint relationship that highlights the responsibilities of each party in addressing the problem. Case files examined by audit indicating that truancy was occurring, revealed no evidence of such agreements between case managers and schools.

8.193 **DSE has developed a computer system known as CASES which records the enrolment and attendance of all students and tracks their movement between schools. Once fully operational, an opportunity exists for DHS to utilise this system to monitor the attendance of all children in its care. Perpetual offenders could be identified and given specific attention in conjunction with the schools.**

Lack of liaison between authorities in addressing the suspension, expulsion and exclusion of children from schools

8.194 It is relatively common for children suffering severe emotional problems to become disruptive in class and challenge authorities. As a consequence, discipline can be exercised by schools through either suspending or expelling students. Where expulsion occurs, the Student Code of Conduct implemented by DSE in February 1995 places an obligation on the Director of School Education, with assistance from the principal from the school from which the student was expelled, to enrol the student in another school, except where the student is over the age of 15.

8.195 Audit acknowledges that efforts are made by most principals, with the encouragement of DHS case workers, to re-enrol expelled children. From case studies examined, these efforts are not always successful in that some schools refused to enrol children who were likely to be disruptive. A common reason for refusal to accept a child was that the school was unable to devote the resources needed to assist the children with their specific needs. Other case studies indicated that even where children were re-enrolled in schools, they refused to attend regularly. If the child was over the age of 15 DSE's responsibility to ensure enrolment ceased, with assistance being limited to DSE providing advice to DHS on future educational options.

8.196 Where children are unable to be enrolled in a school of their choice it is incumbent on the Regional Disabilities and Welfare Manager of DSE to place a child in a suitable school. Case files examined by audit did not provide documentary evidence of contact between case managers and welfare managers in relation to children who were difficult to enrol. Again, the DHS Policy Advice and Practice Manual provided no guidance on this issue of serious concern.

8.197 **Suspension or expulsion from schools adds to the problem faced by children in care, especially the feelings of rejection and low self esteem. Addressing the problem is difficult and to an extent largely depends upon a supportive school environment and a close working relationship between schools and DHS. DSE informed audit that although acknowledging that these problems were occurring at a local level, they had not been brought to their attention by DHS management with a view to developing appropriate, joint strategies between both Departments.**

Support services for disadvantaged children

8.198 In acknowledgment of the special needs of children experiencing social and educational difficulties, DSE has made available a range of settings to assist students in this category. These include:

- community schools, which provide ongoing schooling for secondary students who have difficulty adjusting to mainstream schools;
- special education units, providing limited term specialised teaching for students with behavioural problems;
- medical centres, which provide limited term schooling with specialist teachers for students with psychiatric problems;
- teaching units, usually attached to mainstream schools, offering students from nearby schools specialised teaching for a limited term of up to 3 months to overcome educational and behavioural problems; and
- the Distance Education Centre, which provides schooling by correspondence and is able to include students who, because of extreme behavioural problems, usually involving physical threats to the safety of other people, need to be excluded from other schools.

8.199 These specialist settings provide evidence that a framework is in place to address the various problems of children with special needs. However, it is recognised that there are some children in care who, in experiencing educational problems, become *"school refusers"*. Such children, regardless of whatever support can be made available, decide they have no intention of continuing their education. DSE has developed programs, such as *Extra Edge* and *Students at Risk* which focus on issues that cause students to leave school. DSE also advised of its intention to establish further programs to meet the needs of students where family or other personal circumstances affected their ability to learn or experience success.

8.200 The scope of the audit review did not encompass an evaluation of the special programs currently being offered by DSE, and in particular their application to children in care. Nevertheless, it was apparent to audit that considerable effort is being made by DSE to provide educational opportunities to disadvantaged children, including those children in care who commonly need to overcome many barriers resulting from their past and existing environments.

8.201 Despite case managers having the responsibility of ensuring that children in care receive the same educational opportunities and support as children from functional families, audit's review of case files of children placed in facility-based accommodation disclosed that case plans were generally only focused on encouraging the child to continue attendance at school. Case files contained minimal documentation relating to evaluative comment on the child's academic needs, nor did files contain any term reports issued by schools as to academic progress or other involvement at the school. This is important not only to the case manager in terms of taking an interest in the child's educational progression but also in maintaining, for the child, a record of any achievements at the school which a normal child would reflect upon later on in life. Examples would include photographs relating to sporting achievements, group photos and any commendations received. From discussions with some former children in care their life at school was a void.

8.202 Documentation in case files was generally limited to observation of behavioural problems at school, including truancy, rather than possible learning difficulties and how best to overcome these difficulties through school support. Audit would envisage that a case manager undertaking a defacto parenting role would seek to advocate the school to provide any special supports needed, evaluate the effectiveness of such supports and monitor the child's progress in conjunction with close liaison with teachers. In most instances, case managers did not see their responsibility for a child's education extending beyond encouraging the child to attend school, despite their role under legislation.

8.203 As a consequence of the above practices a request by audit as to the educational standards reached of adolescents discharged from care by DHS was unable to be satisfied, as data was not maintained on CASIS. Apart from a reference in the DHS Policy Advice and Practice Manual as to the need for case workers to ensure that children in care receive an education, no further guidance is provided.

8.204 **Given the crucial importance of education to children in care, many of whom have enormous educational disadvantages, and who inevitably have special needs, DHS has an obligation to provide detailed guidance to case workers on how the educational needs of these children can be met from a departmental perspective.**

Improving the education of children in care

8.205 Where children taken into care are able to be placed in home-based care including permanent care at an early stage, the stable environment will greatly influence their educational opportunities. Unfortunately for many other children, particularly adolescents, these opportunities do not readily occur for the range of reasons outlined elsewhere in this Report. Whereas many of these children can possess the capability to become well educated, the environment from which they have come from as well as the disruption to their lives from being placed in facility-based care will deny them the opportunity to maximise their abilities compared with other children. The onus is on DHS to minimise the trauma associated with their environment in order that they can more readily adapt to education.

8.206 The impression gained by audit was that despite the legislative responsibility of the Secretary of DHS to ensure that each child in care is provided with educational opportunities in the same way as a good parent would, the role delegated to case managers rarely extended beyond encouraging a child to attend school or calling case conferences where disciplinary issues emerged, such as non attendance. The education of children in care must be a joint responsibility between DSE and DHS, with DSE providing the schooling opportunities and DHS providing every support and encouragement necessary to assist the child with their schooling. The lack of attention given by DHS to this crucial aspect of a child's life was evidenced by:

- Absence of a protocol between DSE and DHS as to the respective responsibilities and duties of each agency in relation to the education of children in care;
- Lack of co-ordinated research between both agencies on measures designed to address problems common to educating children in care, and children with similar problems, such as truancy, refusal to attend school, challenging behaviour, short attention spans, inadequate supports, availability of alternative school settings and barriers to homework. Audit acknowledges that some of these matters may be considered at a local level between case managers and teachers, but this was seen as an exception rather than an established process;
- The Policy Advice and Practice Manual provided to all protection workers provides no guidance as to a case worker's responsibility as a defacto parent for the education of children assigned to their care;
- No consolidated data is maintained on educational outcomes of children under the guardianship of the Secretary of DHS, nor for that matter, are the regular progress reports issued by schools for each child retained on case files; and
- There was no documentary evidence to suggest that case managers evaluate the success or otherwise of any special supports provided by schools as to children with learning difficulties.

8.207 **Audit considers that considerable scope exists for developing between DHS and DSE a co-ordinated, Statewide approach to addressing the specific problems associated with children in care in obtaining an education. In conjunction with such an approach, DHS also has a major role in identifying at the earliest possible stage emerging problems with children, including truancy, refusals, challenging behaviour and poor academic performance and actively seeking to work with schools to develop constructive solutions where possible.**

Education opportunities for severely disadvantaged children

8.208 DHS provides annual funding of around $1.2 million to St Vincent's Boys' Home, a large former orphanage in South Melbourne which is managed by a religious order. The Home provides residential facilities for up to 16 children and is funded by DHS to provide intensive schooling for up to 12 students. Other child residents attend local schools. Of the $1.2 million, approximately $230 000 is dedicated to the education facilities.

8.209 In essence, the education facilities provide a last chance for severely abused and disadvantaged children, mainly in State care, who cannot be accommodated within the mainstream State education system. Tutoring can be on an individual basis depending on the educational level of the child. Most children attending the school for the first time are virtually illiterate or well below the educational standard expected of children of similar age. Challenges faced by the teachers include children with severe behaviour problems, emotional instability and the need to teach these children basic literacy and how to acquire knowledge before any semblance of education could begin.

8.210 The Home endeavours, through providing regular tuition and stability in accommodation to raise the education standard of the children to a minimum level whereby they could be absorbed back into the mainstream education system. On average this can take up to 18 months, with other children remaining at the Home for longer periods or until they reached school leaving age of 15. There were varying degrees of success in providing the desired educational opportunities, but a common factor was that once a child gained confidence, they often became voracious in obtaining an education and learnt quickly. Unfortunately this impetus was lost if difficulties emerged in enrolling the child in a suitable mainstream school.

8.211 Of the children who attended the school over the past 3 years, 75 per cent of the students were able to return to mainstream schools or gain access to further education through TAFE colleges. Another 10 per cent were given workplace experience and taught survival skills while the remainder could not be helped.

St Vincent's Boys' Home is able to enhance educational opportunities for disadvantaged children by providing a more personalised approach through a lower teacher-pupil ratio.

8.212 Specific concerns expressed to audit by the Home in relation to residents included:

- The lack of background information and expert assessments on children being sent to the Home by DHS. As a result difficulties were experienced in determining the level of intellect and type of support the children needed at the onset;
- Difficulties experienced by the Home in enrolling children in mainstream schools, including non-government schools. As a result, the children stayed at the Home longer than was necessary, with the inherent danger of becoming institutionalised; and
- The extent to which many of these children in care were damaged, being highly disturbed, virtually illiterate, displaying highly aggressive and dangerous behaviour and lacking in self-esteem, usually as a result of abuse at home before coming under care, but made worse from experiences while in care of multiple placements and care givers, periods of homelessness and further abuse both within the system and from the streets.

8.213 For some of the children sent to the Home the help provided was too late due to irreparable damage to their lives. The challenge for future child protection programs is to acknowledge the causes of these problems and seek to address or prevent them at a very early stage wherever possible. Audit acknowledges that the damage caused to some of the adolescents was a direct result of institutionalisation, a policy which has since been discarded in recent years by governments.

8.214 St Vincent's Boys' Home is virtually the last of the former large institutions providing a fully integrated setting of residential support and educational facilities for children mainly under the protection of the State. The existing infrastructure consists of a very large building developed in the 1850s as an orphanage, catering for in excess of 200 children. The building is now largely under-utilised and in need of major maintenance. The religious order that managed the building at the date of audit was planning, in conjunction with other religious orders, a major redevelopment, relocation and reassessment of the future services to be provided.

8.215 The future of the educational facilities which are currently funded by DHS and are staffed by private school teachers and members of the religious order, is a matter for urgent consideration between DHS and DSE. The State, through DSE, does not offer an equivalent facility providing long-term intensive education in a residential setting for severely disadvantaged children as institutional style settings are contrary to government policy. Equally, the religious order could argue that it is not their role to provide this service to the State.

8.216 From observation there will always remain a need for such a facility in the future, in terms of what is virtually the last hope for a small group of severely disadvantaged children to assimilate into society. The alternative for many such children, unless given some semblance of education and basic life skills is to become virtually unemployable as adults, committed to a life of crime, unemployment and despair.

8.217 In audit opinion, the educational needs of the type of children referred to St Vincent's Boys' Home should properly be met by DSE, instead of the current arrangement whereby funding and responsibility is shared between DHS and the religious order. This is seen as particularly appropriate in the light of the Schools of the Future Program, whereby special problems, strategies and research are being dedicated to children coming from dysfunctional families and possessing highly disturbed backgrounds and learning difficulties. Programs envisaged in the future included *The Prevention of Adolescent Depression, Deliberate Self-Harm and Substance Abuse Project* and *Early Literacy Intervention Programs.* By assuming responsibility for the education of the type of children attending St Vincent's Boys' Home, DSE could apply such programs towards the benefit of these children.

8.218 **Children in care, particularly adolescents, have special needs compared with other children and it needs to be accepted that some of these children may only respond to an alternative style of education to that provided in mainstream schools. DSE has the responsibility to work in conjunction with DHS to ensure their educational needs are met if other alternatives are not appropriate or available within the State school system.**

- ***RESPONSE*** *provided by Secretary to the Department of Human Services*

  The Department acknowledges the broad issues raised by Audit in relation to educational opportunities for children/young people in out-of-home care.

  The Department has concern that children and young people in care can become vulnerable within the school system, due to a range of reasons. A range of strategies have been undertaken with the Department of School Education (DSE) to seek an increase in access and continuity of education for children/young people in care.

  Meetings were held during 1995 between the department, DSE, and the non government sector at senior levels to raise issues of concern that many departmental clients appeared to be disadvantaged within the school system. DSE has undertaken to ensure regional strategies are undertaken to address these needs and have called all regions to identify local action. The non government sector has also been funded to undertake a study of the educational levels of all children in out-of-home placement. Following the analysis of the information further joint work can be undertaken at the state and regional level, with baseline data upon which to access effectiveness.

  On an individual basis, case managers and care-givers are expected to be involved in the day-to-day educational issues of children/young people in care. School teachers are also routinely involved in case conferences and case planning meetings as appropriate to the child/young persons circumstances.

Absconding and homelessness

Incidence of absconding

8.219 Children who have been removed from their family and placed with unfamiliar care-givers, may lack a sense of attachment to their new home, particularly if they are housed in facility-based accommodation with other disturbed children. As previously stated in this Report, a major contributing factor to a child's instability and lack of attachment is the occurrence of multiple placements and care-givers.

8.220 Each new placement requires a child to continually adjust to new attitudes and expectations. Care-givers also need time to understand the needs of the child and build up a rapport. These children, who often have inherent dysfunctional characteristics as a result of being abused, find themselves exposed to new group dynamics and stresses with which they may not cope. Consequently, out of frustration they begin rejecting their placement and absconding occurs. Audit emphasises that this situation is common to most protection systems in Australia and elsewhere in the world. At issue is the extent to which absconding occurs and measures available to reduce the frequency and incidence of this occurrence.

8.221 The extent to which children in the care of DHS absconded is illustrated in Table 8F. The table shows that between March 1993 and May 1995, 256 children or approximately 20 per cent of children under Guardianship or Custody Orders to the Secretary of DHS and aged between 10 and 17 years were reported to Victoria Police as missing persons. Of even greater concern is that around 55 per cent were reported on more than one occasion with around 10 per cent being recorded as multiple offenders missing in excess of 13 times.

TABLE 8F
FREQUENCY OF CHILDREN IN CARE RECORDED AS MISSING PERSONS BY VICTORIA POLICE FOR PERIOD MARCH 1993 TO MAY 1995

Number of children	*Frequency of listing as missing*	*Per cent*
116	1	45.3
19	2	7.4
22	3	8.6
14	4	5.5
12	5	4.7
14	6	5.5
9	7	3.5
7	8	2.7
6	9	2.3
2	10	0.8
4	11	1.6
5	12	2.0
26	13+	10.2

8.222 The above data, although indicating a serious problem in respect of around 20 per cent of children in care, significantly understates the dimension of the problem of absconding children due to the following factors:

- The data only represents those cases where missing person warrants have actually been sought by DHS. Practice guidelines provide "inter-alia" that Victoria Police are not to be involved unless:
    - the child has been missing for more than 48 hours and has not made contact;
    - there is a risk of significant harm to the child, a factor that is difficult to determine when the whereabouts of the child is unknown;
    - the protection worker has made reasonable efforts to locate the child; and
    - intervention by the Victoria Police is seen as the only viable option.
- Overnight absences are not notified to Victoria Police and are a common occurrence. DHS regards overnight absconding as a normal part of adolescent behaviour. Where children leave their placement without permission, case managers are meant to be notified and an incident report is placed on the child's case file. It was not possible for audit to ascertain to the extent to which short-term absconding occurs as aggregate data on incident reports is not maintained; and
- Even where a child has been missing for an extended period, Victoria Police will not necessarily be involved as protective workers will take into account the threats posed to the community and the child, the survival skills of the child, the likelihood of the child eventually returning and the capacity of the child to develop support networks.

8.223 Audit discussions with departmental staff indicated a sense of frustration and powerlessness to stop children from absconding because existing legislation does not give care-givers the power to physically restrain children from leaving at will because of the potential for assault allegations. Care-givers are also unable to apply strong disciplinary measures beyond providing counselling to regular absconders.

8.224 Children in care, who are often *"streetwise"*, are aware of the limitations in the powers of care-givers (and police) to detain and constrain them. Consequently, they treat the system with contempt. A common concern expressed to audit by professionals in the child protection system is that in exercising their rights, and taking advantage of the system's limitations, these children often fall prey to the criminal elements in the community, as referred to further in this Part of the Report.

8.225 Audit considered there was a prevailing attitude in DHS that absconding from placements was indicative of normal adolescent behaviour in testing authority or striving for autonomy, as opposed to behaviour which audit considers for a large number of children to be symptomatic of more serious problems which need to be dealt with by DHS. While DHS may argue that adolescents in their care have the same rights and responsibilities as other adolescents in the community, insufficient recognition, in audit opinion, is given to the reality that the needs of young people in the care of DHS are very different from those of most young people in the community and different approaches are needed.

8.226 Expert opinion was provided to audit that the *"acting out behaviour"* of many adolescents in care was far removed from normal adolescent behaviour and represented very regressed behaviour at a developmental level. Such behaviour, including regular absconding and criminal activities, was very attention seeking and was aimed at trying to get care-givers to care for them and contain their sense of being out of control. Where the response from DHS was seen as permissive and tolerant of such behaviour, their behaviour often became worse in a desperate attempt for their unmet dependency needs to be responded to.

8.227 Part 7 of this Report details the concerns Victoria Police have with young persons under the care of DHS and the limited ability of the Victoria Police to detain these children without a warrant, despite exposure to a range of hazards on the streets. Victoria Police were of the opinion that many of the children in care that they encountered were clearly not supervised adequately by DHS.

Reasons why children abscond

8.228 Audit discussions with DHS staff, welfare agencies dealing with homeless children and a number of adolescents in care including *"streetkids"*, indicated that common reasons for children absconding were:

- Frustration with constant movement between foster care and facility-based care as a result of placement breakdowns;
- Attention seeking;
- Multiple placements in residential units;
- Displeasure with the rules imposed by residential units;

- Boredom coupled with a lack of freedom and control over their living environment;
- Views that their needs, including availability of leisure pursuits and activities, were neglected by care-givers;
- The seeking of friendships, which may include children living in other units, causing them to abscond so as to be together. This factor was sometimes compounded by the failure of certain children to establish friendships with other children in the same placements;
- Allegations of physical and/or emotional abuse from other children or staff at their placement; and
- Lack of a significant adult to trust and turn to for help and advice, a factor made worse by multiple care-givers and case managers.

8.229 Audit also established through visiting residential units that while boredom was a factor in causing some children to abscond, funding constraints severely restricted staff at residential units in providing activities such as participation in regular sport, excursions, visits to cinemas and a range of other activities designed to enhance a child's life.

8.230 **Audit acknowledges that many of the above factors would be common to most protection systems and despite the best endeavours of DHS, may well be incapable of being fully addressed. Notwithstanding this view, efforts should continue to research these problems and address what can be improved, such as the incidence of multiple placements, rather than allowing a feeling of despair and inevitability to exist as audit observed with staff constantly dealing with these problems. There also needs to be a stronger emphasis by DHS on its duty of care in relation to the young people in its custody.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

Many young people in care have a range of complex issues to address, which may create enormous personal difficulties.

As part of the duty of care Unit staff and Protective Workers will issue a missing persons notice, without warrant, within 24 hours of a young person being missing and not making contact. It is a police standard, applied to the whole community, that they will not accept a formal Missing Person Notice under 24 hours.

The Police may not be notified that someone is missing after an extended period. Circumstances where this might pertain is when a young person is actually being sighted by departmental workers (ie Streetwork) and where the case management strategy is to have the young person return of their own volition. This is a strategy that has worked well with a number of young people seriously estranged from the protection and care service system.

Conversely where a young person is viewed as being particularly vulnerable to exploitative environments protection and care staff will institute a strategy of issuing a missing persons notification, with warrant, each time a young person runs away. The aim of such a strategy is to confirm to the young person that the place from which they have run-away is their placement and will not change notwithstanding the number of times they run away from it. This strategy, whilst often successful, requires considerable perseverance on the part of protection workers.

Young people provided community based accommodation by Protection and Care have the same rights and responsibilities as any other adolescent living in the community. The provision of such a service does not diminish those rights and staff looking after such young people know this when they are appointed. Such staff do have a duty of care and as a consequence it is anticipated that they will employ all lawful means to persuade a young person not to leave if this is seen as not being in the best interests of the young person. The Department rejects Audit's view that 'strong disciplinary measures or physical restraint' is appropriate to young people who may abscond.

The Department does not detain young people, and therefore, one of the challenges in providing quality care is to develop positive strategies to ensure young peoples safety and encourages them to return to placements if they run away.

Homelessness

8.231 In 1989, the Human Rights and Equal Opportunity Commission released a report entitled *Our Homeless Children: Report of the National Inquiry into Homeless Children* (commonly referred to as the Burdekin Report). This Report described homelessness as:

- *"... a lifestyle which includes insecurity and transience of shelter. It is not confined to a total lack of shelter. For many children and young people it signifies a state of detachment from family and vulnerability to dangers, including exploitation and abuse broadly defined, from which a normal family protects a child".*

8.232 The abovementioned Burdekin report identified *"multiple and unsuitable placements of children in care, frequent and poorly judged returns to the family environment, and placement in children's homes and detention facilities"* as major contributing factors to youth homelessness. The report concluded that *"... a period of time spent in a child welfare or juvenile justice institution, or otherwise detached by the welfare system from the natural family, seems to increase significantly a child's chances of becoming homeless".*

8.233 A recent major report conducted by the Salvation Army (published in May 1995) titled *Being Young and Homeless*, sought to identify the means by which Australia could better address homelessness among young people. In its key findings, the Salvation Army concluded that many of the young homeless had been removed from their homes by State child protection authorities and that for some children this proved to be a first step towards homelessness rather than towards safety.

8.234 Most children surveyed in the above report had moved from placement to placement and had attended more than 5 schools. They had left school and became homeless simultaneously. Children in care left school earlier than others, and the earlier they left school, the longer they were likely to remain homeless. The street life adopted by children, some as young as 10, obviously entailed the risk of significant physical and emotional harm through exploitation by criminal elements who recruit and encourage the children to adopt a life of crime. In order to survive, children and young people found they had to fit in with the way of life and culture of the streets. As a consequence their identities were shaped, not by parents or other stable influences, but rather by dysfunctional people, criminal elements in the community, and other young persons who frequented the streets.

8.235 In its submission to the audit team a major welfare organisation estimated that approximately 70 per cent of the homeless youth seeking their support were either current or past children in care. Audit's own survey of children given shelter by a welfare organisation providing emergency accommodation for homeless children and young persons, disclosed that out of 130 children who were given shelter by the organisation during April 1995, 30 children or 23 per cent were identified as children in care.

8.236 The above perceptions of homelessness were corroborated by interviews held by audit with a number of streetkids who were clients of DHS. The interviews indicated that although these children had been allocated accommodation they regarded themselves as homeless because they were not able to live with their families and because of dissatisfaction with their placement as arranged by DHS. Consequently, these children preferred to live a transient lifestyle notwithstanding the associated dangers that accompany such a lifestyle.

8.237 DHS strongly disagreed that children in care who regularly absconded for a transient life on the streets should be defined as homeless. The Department maintained that it had met its obligation to provide accommodation for such children, and the fact that certain of these children preferred not to live there for varying periods should not mean that they should be classed as homeless in line with the Burdekin definition.

8.238 Audit does not dispute that DHS does provide accommodation for every child in its care. In addition, the audit review did not seek to undertake a study of youth homelessness as this issue has been the subject of various major reviews in recent years. Nevertheless, the issue of the regular absconding of children in care, as established by audit, and the link with "homelessness" as defined by Burdekin and others is a matter of serious concern for DHS and the general community, in terms of the ultimate cost to the community in the longer term. For the majority of children placed in care and who were successfully reunited with their families, placed in permanent care or who were able to become independent "homelessness" is rarely an issue. At issue is the remaining numbers who were placed in State care for their own protection, became frequent absconders, and eventually ended up as homeless.

8.239 The extent to which homelessness occurs following protective intervention is impossible to determine due to lack of aggregate data, particularly after children leave care. However, the May 1995 report by the Salvation Army identified that in the survey sample of 104 homeless children, 22 per cent were either existing or former wards of the State. The first stage to becoming homeless for children under Protection Orders is frequent absconding.

Views of streetkids in the care of the State

8.240 The views of *"streetkids"* in care were sought by audit by accompanying a youth worker well known to children around Melbourne, on a tour of an inner suburban area late at night. From discussions with many of these young persons, the common conclusions reached were:

- They chose to live on the streets because of the ability to choose their own friends and were free from any disciplinary constraints found in DHS placements;
- For some children the streets were a preferred alternative to the life in rostered units where they experienced boredom, as well as physical and emotional abuse from other residents;
- The predominant elements of streetlife included substance abuse, sexual activity and minor crime;
- The protection "system" had failed to treat them as individuals and human beings;
- Experiences with Victoria Police were mostly negative, with the exception of Community Policing Squad members;
- DHS case workers were treated with contempt, particularly in relation to relating to the children's problems and making them feel important. Surprisingly, most of the children found youth workers from DHS and non-government agencies to be generally good;
- The problems faced by streetkids were often compounded by their own difficult behaviour and sometimes frustrated attempts to help them;
- Some of the children were vulnerable to exploitation and prostitution in order to fund substance abuse; and
- It was relatively common for the children to refuse emergency accommodation in youth refuges, compared with sleeping in *"squats"* or elsewhere.

8.241 Audit accepts that some of these views reflected biased opinions, particularly in that other children spoken to by audit indicated good relationships with their case workers. However, the interviews further reinforced the poor image that DHS was seen as having, the problems faced by children in residential care, and the dangers faced on the streets. It was also obvious that many of the children lacked the intellectual development and maturity to understand that streetlife diminished their future prospects.

Initiatives to assist youth homelessness

8.242 Since 1992-93 the Victorian Government has, on the basis of various reports on the issue of homelessness, redefined policy directions and implemented the following initiatives in relation to the problem of youth homelessness:

- $35 million provided for youth services, including the establishment of 9 family reconciliation services, 6 sexual assault services and 3 intensive youth support services;
- $16.7 million from the Community Support Fund to provide counselling services for sexually abused children, early parenting programs, and financial counselling;
- $16 million contribution to the Commonwealth/State Supported Accommodation Assistance Program, representing an increase of $7 million for homeless young people; and
- $8.8 million from the Community Support Fund to assist youth through the provision of; $5.1 million for training and employment support, $1.9 million for preventative education and $1.8 million for housing access.

8.243 The scope of the audit did not include a detailed assessment of the above initiatives and therefore, audit cannot attest to the effectiveness of the above initiatives, nor to the efficiency or economy of the funding allocation. However, **audit commends the development of these initiatives and the increase in resources aimed at alleviating the serious problem of youth homelessness. Of concern is that the above extremely worthwhile initiatives are directed at addressing homelessness once it has occurred, rather than researching the factors that lead to children in State care becoming homeless.**

Involvement of children in care in criminal activity

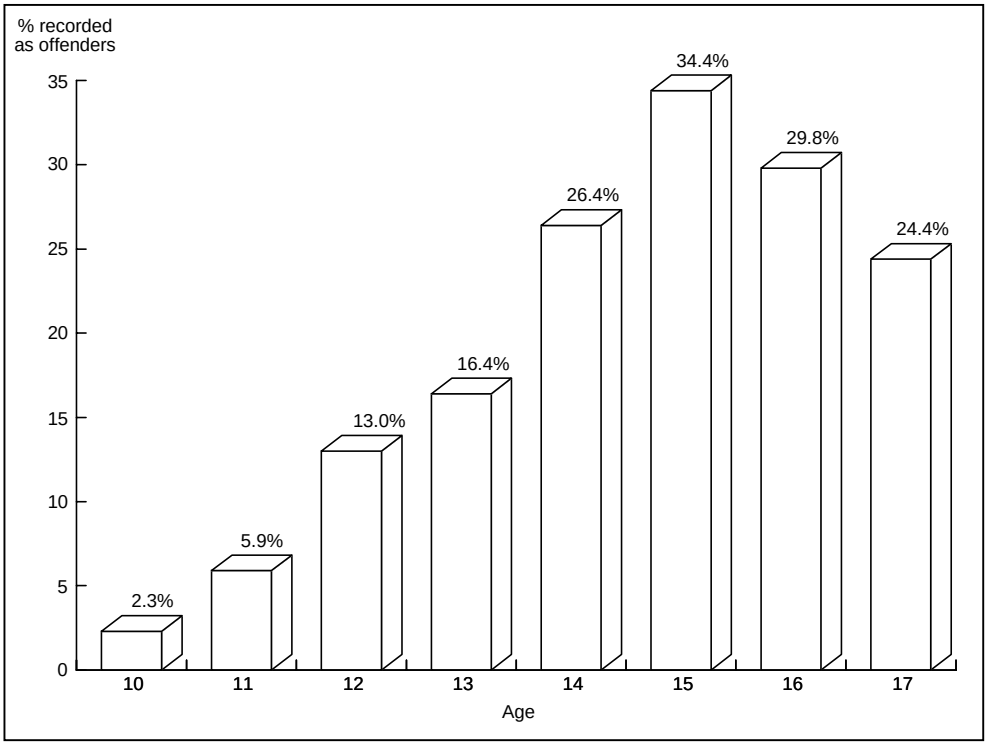
8.244 The purpose of this section is to attempt to illustrate the linkage of criminal activity of children in care with the extent to which their experiences in protective Custody or Guardianship of the State contributed to these outcomes, as compared with other factors. Other factors predominantly stem from the dysfunctional families from which many of the children came from, the long term impact of the abuse they suffered, being subject to emotional and social deprivation while in care, learning difficulties at school and the absence of an upbringing by parents exercising proper responsibilities.

8.245 Audit stresses that for the vast majority of children brought into care the outcomes are likely to be favourable, even though definitive data on outcomes is not maintained by DHS. Audit also stresses that overall, DHS endeavours to provide children in its care with adequate supports and attention, subject to financial and resource constraints. The high incidence of criminal activity among children in care, particularly older adolescents, as referred to herein should not under any circumstances be regarded as a reflection on the vast majority of children for whom DHS has responsibility for. Such children through no fault of their own are disadvantaged and require special consideration as compared with other children being brought up in a normal family environment.

Incidence of criminal activity

8.246 For purposes of the audit study, of the 1297 children under Guardianship or Custody Orders at April 1995 and who were over the age of 10 years, data was obtained on the incidence of reported criminal activity to Victoria Police during the period March 1993 to May 1995. The outcome revealed that 274 children or around 21 per cent of the total had been formally processed as offenders by Victoria Police during this period, a rate many times in excess of the average incidence of criminal activity among adolescents in the community. Around 34 per cent of the 274 children were multiple offenders, with more than 4 separate reports to Victoria Police. Of particular concern was that the older the children and the longer they remained under protective care, the more likely the incidence of criminal behaviour as outlined in Chart 8G:

CHART 8G
CHILDREN IN CARE INVOLVED IN CRIMINAL ACTIVITY
AS RECORDED BY VICTORIA POLICE FOR THE PERIOD MARCH 1993 TO MAY 1995



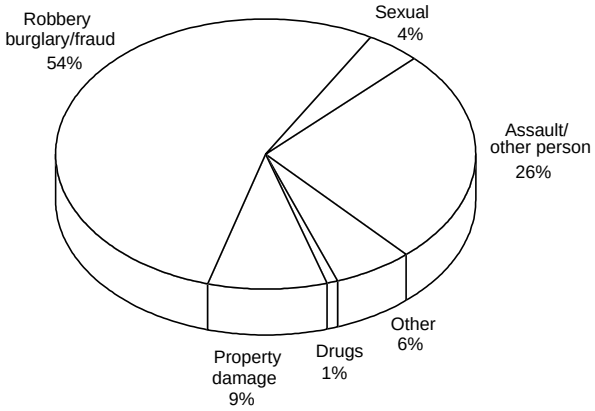
Source: Department of Human Services and Victoria Police.

8.247 The chart illustrates graphically that of the total number of children in care at April 1995, of the 14 year olds 25.4 per cent had been reported to Victoria Police, 34.4 per cent of 15 year olds and 29.8 per cent of 15 year olds. The future life of such children obviously is of serious concern.

8.248 During the review of the Children's Court audit was advised by an experienced Children's Court Magistrate that most children who committed offences as juveniles did not go on to become adult criminals. With children in care the reverse situation was likely to occur, with most offenders under State care going on to become adult criminals. Their environment, background and difficulties in obtaining an education were all considered factors in these outcomes. From experience, the Magistrates also found that children in care were more likely to be involved with violent crimes, such as assault and the more serious crimes such as homicide and sexual offences. The Department of Justice further confirmed this observation. Chart 8H below illustrates these outcomes when a comparison was made between the type of criminal activity involving children in care as compared to all juveniles appearing before the Children's Court in 1994. It was also established that of the 18 homicides committed by children in Victoria between 1991 and 1995, 9 or 50 per cent were committed by children under Protection Orders.

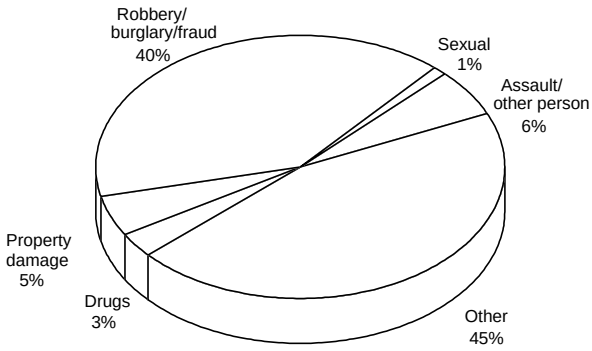
CHART 8H
JUVENILE CRIMINAL ACTIVITY - 1994

CHILDREN IN CARE



Source: Victoria Police.

ALL JUVINILE OFFENDERS



Source: Department of Justice.

8.249 Audit did not undertake detailed research on the linkage between criminal behaviour and children in care, but suggests there is a strong link between the impact of abuse to the children within their families which may predispose them towards criminal behaviour, life in alternative care, multiple placements and the relative ease by which children frequently absconded. With regard to absconding, audit established that of 85 children who had missing persons warrants issued for them on more than 5 occasions, 87 per cent or 74 children had also been reported to Victoria Police for criminal offences. DHS disputes that there is a linkage between absconding behaviour and criminal activity.

8.250 Audit also did not attempt to research the linkage between criminal offences committed by children in care with future criminal activity as adults. American and United Kingdom studies clearly establish such a linkage and this was also the view of Magistrates who had spent considerable time both in the Children's Court and the Criminal Division of Magistrates Courts. Audit strongly emphasises that such a phenomenon would be likely to be common in many protection systems and would not be unique to Victoria. A longitudinal study involving Australia-wide protection systems could be of benefit in assessing the effectiveness of the various types of protection systems in reducing ongoing criminal behaviour.

8.251 **Time in the care of the State is likely to lead to involvement in criminal activities for 1 in 5 children based on the number of children in Custody or Guardianship Orders at April 1995. It is strongly emphasised by audit that this high incidence of behaviour should not imply a stigma for the vast majority of children in care who seek to adopt normal lifestyles despite the disadvantages in their lives. Notwithstanding the positive outcomes, the high incidence of criminal behaviour and the likelihood of it continuing beyond discharge from wardship is of serious community concern and warrants research as to causes and prevention strategies.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Audit links absconding "... leading to a potential for criminal behaviour" and the fact that staff "have a limited capacity to exercise firm control over children in care due to a range of restrictions, including the main factor being that residential units cannot be used to confine children". Audit is unable to link absconding and criminal behaviour without supporting evidence and contextualising the client group. This is a complex issue and should not be reported in this simplistic manner.

Addressing the problem of criminal behaviour and absconding by children in care

8.252 Audit fully acknowledges the considerable difficulties faced by DHS in modifying the behaviour of children within legislative constraints and the availability of resources. Total solutions to these problems will never be available due to the extremely disturbed emotional state of many of these children coupled with the normal rebellious nature of adolescents. The most DHS can expect is to endeavour to reduce the incidence of such behaviour by addressing the underlying causes of these problems. Actions which have occurred to date have included reducing the reliance on facility-based care in favour of home-based care and the extension of the Behaviour Intervention Support Teams.

8.253 Factors which audit considers would assist in reducing inappropriate behaviour, and which in many instances DHS agree with or have considered include:

- Early and decisive decision making at the Children's Court;
- Continuation of the existing program of reducing reliance on facility-based care, in favour of home-based care;'

- More effort be applied to matching the needs of children to the type of care arrangements they require. In this regard audit observed that absconders are inevitably returned to the same type of care arrangements, usually facility-based, which may have been unsuitable for various reasons;
- Ensuring that a full range of support services are made available to residential settings, including general health, psychiatric counselling, behaviour management and drug and alcohol dependence treatment;
- Ongoing research dedicated to assisting staff in dealing with difficult residents in conjunction with disciplinary measures that could be applied;
- More attention to the educational needs of children in care;
- Collection of aggregate data on missing persons with an emphasis on continual offenders and targeting them for intensive support, including consideration of a secure environment having access to a full range of support services;
- Establishment of a form of children's advocate, whereby children can express their grievances to an expert who is seen to be independent of DHS;
- Ongoing research and programs dedicated specifically to prevention strategies relating to the high incidence of absconding and criminal behaviour;
- Re-examination of the existing DHS philosophy of accepting that absconding will occur and provided the child is not considered to be at serious risk, such behaviour is normal with adolescents;
- More attention being given to structured activities for children in residential units in order to relieve boredom;
- Working with Community Policing Squads in developing programs for children under care, on issues such as community values, roles of Police, expectations of adolescents, dealing with homeless children, understanding children's needs and the negative impact of criminal behaviour; and
- Continuing research into making more effective the range of services DHS provides in relation to adolescent care, protection activities and alternative care settings. Audit suggests there is a need for a systematic research agenda to be developed as part of the Protection and Care Program to assist in ongoing evaluation, policy formation and improvement of practice.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

Audit does not provide evidence supporting the contention that placement in out of home care services has contributed to involvement with the juvenile justice system. It is simplistic to regard involvement in one service system as causatively linked to involvement with another. There is overlap in the young offender population and children in State care and this sub-group on dual orders have multiple problems.

Characteristically the sub-group involved in both systems are more likely to have:

- *Been victims of physical, sexual or emotional abuse and neglect or socioeconomic disadvantage;*
- *Come from fractured families and disruptive homes;*
- *Been exposed to parental drug and alcohol abuse, antisocial behaviour and mental illness;*

- *Experienced learning difficulties and school failure; and*
- *Suffered chronic health problems.*

Amongst these young people it is extremely likely that as a consequence of their experience of these significant psychosocial stressors they will behave during adolescence in ways which bring them into conflict with authority figures including their care givers, school authorities and the legal system.

The Department firmly refutes the suggestion that time spent in the care of the State is causatively linked to involvement in criminal activities.

Audit has identified factors to assist in reducing 'inappropriate behaviour', most of which is in line with current Departmental policy. In addition, the Department has procedures including:

- *Incident Reports which are completed by the department and non government agencies to record critical incidents such as instances of running away so these can be addressed through the case management processes.*

The department is currently strengthening its complaints handling capacity and has funded VAYPIC (Victorian Association of Young People in Care) to represent the views of young people. The Department does not accept Audit's recommendation for the need for a children's advocate.

LEAVING CARE

Post-care support

8.254 Under the *Children and Young Persons Act* 1989 the Secretary of DHS, when assuming guardianship of a child, exercises the same responsibilities as a natural parent would in relation to the present and future well being of a child. These responsibilities consist not only of the obligation to provide financial and material support including accommodation, but also involves advice and concern for the needs and long term well being of a child. In audit opinion such concerns should extend, to a limited extent, as to how a child adapts to living independently once discharged from State care, given that their capacity to adapt will be significantly influenced by their experience in the care of DHS.

8.255 The Department's view is that children in care who are unable to return to their parents should progress to independent living or adolescent community placement whereby living skills can be taught and assistance provided up until the stage they are discharged from care. In addition certain non-government organisations specifically provide programs dedicated to teaching adolescents independent living skills and adjusting to life within the mainstream community.

8.256 Once Guardianship to the Secretary has been terminated future involvement of DHS ceases, with the view that adolescents can avail themselves of services available within the broader community. DHS does not provide any specific Post-care programs.

8.257 The Practice Manual provided to protection workers provides no specific guidance or policy advice on children leaving care. In practice however, audit observed that DHS endeavours as part of case plans to provide a range of supports to adolescents who are to be discharged from care, mainly on account of age. There is also tacit recognition that even where a case no longer necessitates protective worker involvement, revocation of a Custody or Guardianship Order becomes undesirable where it would deprive the child of security in terms of financial support or accommodation.

8.258 Audit discussions with several agencies dealing with former children in care, along with discussions with a group of adolescents who were either still in care or had been discharged from care, indicated that there are children who are totally unprepared for their new responsibilities. Subsequently, the children felt that they were neglected by both DHS and society in general. It was not possible for audit to establish the extent to which this problem exists nor the likely impact on the lives of these children, but homelessness is a visible outcome.

8.259 Most of these children who can be as young as 15 are virtually expected to assume adult responsibilities at an age when the majority of children do not leave home until several years later in life. This situation can become particularly traumatic for adolescents who have spent a long time in facility-based care such as family group homes or hostel placements and suddenly need to fend for themselves with virtually no financial or material assistance being provided, except in terms of welfare from charitable organisations or in some circumstances, a placement support grant of up to $2 000 to buy basic furniture and household goods.

8.260 Adolescents contacted as part of the review felt there was a need for a form of advice service or advocacy service to be provided by DHS workers familiar with their backgrounds, and to provide support where needed until they could become established. Whereas support services may have been readily available from agencies when these young persons were in State care, once they became *"voluntary clients"* many of the same agencies were unable to cater for their needs, nor were the young people able to readily gain admittance to the services. Audit was not aware of any specific programs being funded by DHS to provide "after care" services.

8.261 The type of support seen as being needed by young people after being in care included the following:

- assistance with obtaining accommodation and basic household items and furniture;
- assistance with accessing education and training options, health services, legal services and counselling;
- provision of an advocacy service when attempting to lease accommodation or resolve disputes with landlords;
- providing job references;
- accessing emergency relief services;
- drug and alcohol rehabilitation programs; and
- finding someone to talk to about their problems.

8.262 The need for a form of after care service has been recognised in other protection systems. Queensland and South Australia have instituted special programs to support young people after leaving care, particularly in the area of obtaining housing and initial assistance with areas such as household skills, budgeting and financial matters. In England the need for after care services have long been recognised with an ongoing commitment to young people continuing into their early 20s, including an establishment grant of £2 600 (1993) to enable them to establish themselves in their own accommodation.

8.263 There is also a system of Children's Rights Officers in England who operate independently from statutory authorities. These Officers provide support to children while in care and after leaving care and take up any grievances they have. Similar programs operate in the United States and Canada.

8.264 **In audit opinion research needs to be undertaken by DHS as to the demand for and type of after care arrangements and support, including financial support, that should be provided by the State in relation to adolescents leaving care. This is seen as a high priority given that successive published reports in recent years have linked a high percentage of homeless youth with having spent time in State care.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department accepts that further research and improvements in practice are required in relation to the type of after care arrangements and supports required to ensure appropriate post placement support is available for young people leaving care.

  In the absence of specific case details it is misleading for Audit to suggest that young people aged 15 years and under are routinely placed in highly vulnerable circumstances by DHS. In those cases involving young people who are in such vulnerable circumstances DHS endeavours to provide and ensure necessary support and assistance is made available.

  All of the components of support suggested as necessary by Audit are routine aspects of current departmental practice and policy of service provision to young people in care.

Accountability

8.265 DHS makes no reference in its Annual Report to Parliament as to the numbers of children that were discharged from Guardianship or Custody Orders during the year. In audit opinion DHS has a responsibility to publicly account for these children, not only in terms of numbers but to also provide aggregate data on outcomes such as educational standards attained, reasons for leaving care such as age, independent living arrangements or alternative Orders, their ability to enter employment or advance to further studies, the receipt of AUSTUDY and any other factors reflecting on care, including entering the juvenile justice system. Information of this nature can be readily captured on CASIS at the point of a Protection Order being revoked, and could be compared on an aggregate basis with similar data, if available, in relation to the general population of children and interstate data on children leaving care.

8.266 Audit was unable to conduct what was initially thought to be relatively simple reconciliation between the number of children recorded as being under Protection Orders at 30 June each year with all new admissions and discharges being accounted for, including deaths and interstate transfers. Reasons for this situation were attributed to DHS staff failing to regularly update CASIS along with reasons for revocations not being recorded.

8.267 Audit would expect that, as a minimum, movements of all children in the care of the State should be able to be readily accounted for at any point of time in terms of aggregate data. As previously referred to earlier in this Section, DHS was also unable to determine at any point of time without reference to an agency the specific location of many children in its care, including movements between locations and the type of placement.

8.268 **The inability of DHS from a central management perspective to accurately profile the movement of children in its care restricts its capacity to publicly account for its legislative responsibilities, as well as limiting its ability to analyse such data in determining future policies and strategies.**

Part 9

Quality of strategic management

OVERVIEW

9.1 The quality of the Department of Human Services (DHS) strategic management of child protection services is crucial, given the significant change and growth in departmental responsibilities in this area in recent years.

9.2 The audit revealed that improvements are needed in the DHS's strategic planning and performance measurement and reporting frameworks for protection services.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is committed to ongoing improvement of its strategic management and performance measurement capability. Currently, monthly data reports covering a number of key performance areas are produced and used by management at central and regional levels. The Department is actively supporting the Council of Australian Governments (COAG) auspiced process to develop nationally comparable performance indicators and will consider audit's suggested framework in that context.

ADEQUACY OF STRATEGIC PLANNING FRAMEWORK FOR CHILD PROTECTION SERVICES

9.3 A key element of the Government's management improvement initiative has been the Integrated Management Cycle which is a stable calendar of events co-ordinating annual departmental planning and budgeting activities on the basis of periodic corporate plans and annual business plans.

9.4 At the time of the audit, DHS did not have a formal corporate plan, and hence there was an absence of departmental-wide guidance on program planning at the strategic level to management and staff in relation to corporate objectives, priorities, principles and values.

9.5 As a consequence, audit found that DHS's management of child protection services lacked a specific corporate focus and was not guided by:

- a corporate statement on vision and values relating to such services;
- a formalised approach to annual and long-term strategic planning; and
- mechanisms, including targets and performance indicators, for progressively monitoring and evaluating the discharge of its responsibilities for the protection and care of children.

9.6 While DHS has not adopted a high level corporate approach to strategic planning for child protection, its 1992-93 Annual Report to the Parliament identified a range of objectives for this area. These objectives included:

- the provision of protective services *to protect children and young people from significant harm resulting from abuse and neglect within the family*; and
- seeking *to ensure the ongoing safety of the child by linking families with support and services and strengthening the family's capacity to provide care.*

9.7 In addition, priorities to 1995 for its Child, Adolescent and Family Welfare Program (which covers child protection services) were outlined in November 1993 in a departmental document entitled *Meeting the Challenge in Child, Adolescent and Family Welfare*.

9.8 Audit also found that several strategies had been pursued on an individual basis, e.g. a focus on dealing with the specific problems of adolescents, training for staff involved in sexual assault investigations and development of an intensive induction program for the high number of new recruits over the past 2 years.

9.9 While DHS considers the above actions and strategies to have been beneficial, it was not possible for audit to determine their value in the absence of a strategic plan for child protection services or whether resources had been effectively directed to areas of highest priority.

9.10 **Given the importance of its responsibilities for the protection of children, DHS should upgrade, as a matter of urgency, its strategic planning framework for child protection services. As part of this process, a periodic strategic plan, which complements a corporate plan, should be developed. Such a strategic plan should:**

- **be consistent with international developments and those occurring across Australia in the context of a national approach to child protection;**
- **establish an overall child protection strategy for Victoria, which outlines the roles of both government and non-government service providers;**
- **draw on available expertise in, and encourage input from, all areas of child protection and welfare;**
- **encourage a high degree of staff involvement in and ownership of the plan;**
- **ensure that the direction of the plan is known to all staff, agencies and other parties who are involved in the provision of any services articulated under the plan; and**
- **constitute the principal means of central co-ordination of performance and accountability for this plan within DHS.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department's corporate planning takes place on a corporate basis in keeping with government business planning requirements. Audit's suggestion in relation to a strategic plan for protection and care is agreed and it is taking place in the context of a strategic directions document currently being finalised.

SHORTCOMINGS IN THE PERFORMANCE MEASUREMENT AND REPORTING FRAMEWORK

9.11 In order to be effective, the strategic planning process should include systematic monitoring and measuring of performance against targeted outputs and outcomes.

9.12 In terms of ongoing performance measurement, DHS has established a range of quantitative indicators under the following categories which are used to develop monthly reports on a regional and department-wide basis:

- numbers of notifications and investigations;
- timeliness of investigations;
- substantiation rates; and
- numbers of Court applications and Orders.

9.13 Other Parts of this Report include comment on the performance of DHS in these areas and identify departmental activities to address related issues, e.g. strategies aimed at reducing the number of notifications which do not lead to investigation.

9.14 The audit established a number of shortcomings in the approach followed by DHS for measuring and reporting on performance in that:

- its performance indicators were principally quantitative measures dealing with activity and throughput and did not include measures which addressed the effectiveness and quality of child protection activities, such as the success of DHS to place children, where appropriate, in permanent care, or the extent to which State intervention improved children's present and future lives;
- variances across regions of information compiled under the monthly indicators were not systematically analysed; and
- while goals established for the protection and care of children under case plans should provide a sound basis for assessing effectiveness, other Parts of this Report indicate that they were of varied quality and were not used by regional management as performance indicators to measure the effectiveness of case plans, or to support assessments of departmental-wide performance on addressing the protective concerns of children.

9.15 In effect, audit found that substantial scope existed for DHS to improve its overall performance management, in particular, through the identification and use of sources of information to enable periodic evaluations of its effectiveness in protecting children. For example, the following avenues, which would be likely to generate useful performance information of a qualitative nature, have not been extensively explored by DHS:

- independent peer reviews of case management;
- practice deficiencies identified in departmental reviews such as the findings of child death inquiries;
- analyses of outcomes from the Children's Court; and

- regular debriefing sessions within regions on investigations and case management, both short and long-term; and
- Victorian-based longitudinal research, on issues such as the long-term impact of the placement of children outside the home and the soundness of protection and care of children in the Custody and Guardianship of the State.

9.16 In December 1994, DHS commissioned a consultancy study, at a cost of $65 000 by a firm of chartered accountants to provide it with comparative benchmarks of child protection activities in 2 other States. The final report by the consultants on the results of the study, presented to the Department in August 1995, provided only a comparison of Victoria with 2 other States in regard to the costs of screening notifications and undertaking investigations. The study was *"... unable to draw any conclusions about whether the pattern of expenditure in one State contributes to different outcomes as there is little data collection by any of the States on outcome measures"*.

9.17 **In summary, more work needs to be done by DHS in order to have in place a structured performance monitoring and measurement framework for child protection services. Such a framework would enable periodic appraisal by DHS of overall performance against targeted outputs and outcomes and be the principal means of reporting to the Parliament and community on the extent to which its management strategies have resulted in maximising protection and care for children in Victoria.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is significantly advanced in its data collection and analysis capacity, and is committed to implementing measures for continuous performance improvement, including research.

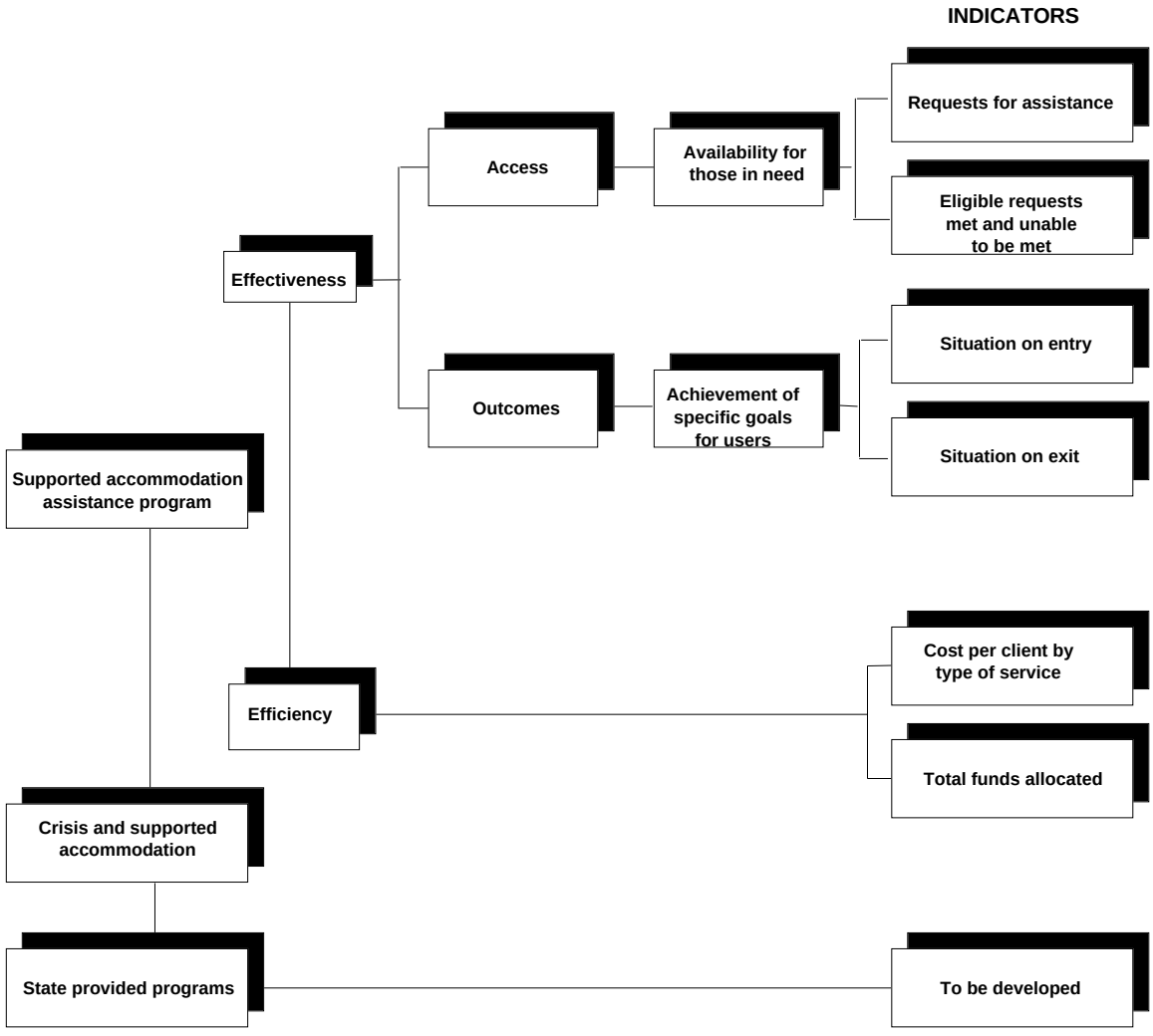
  The Department is concerned to establish consistent interpretations and counting rules on key performance measures across regions and is undertaking considerable work in this regard in conjunction with its efforts in the development of such measures for the COAG, auspisced report on Government Service Provision 1995 (Support Services for Individuals and families).

  The Department actively implements the findings of child death inquiries, case audits, court outcome analysis and other practice based research. Examples of initiatives include production of practice guidelines for high risk cases, development of working agreements with key agencies, piloting of court specialist positions, and establishment of specialist Adolescent Protective Teams.

PROGRESS IN DEVELOPING A FRAMEWORK OF PERFORMANCE INDICATORS

9.18 The development of performance indicators, suitable for comparison on a national basis, for a range of services provided by governments, including child protection services, was given impetus by the Industry Commission in October 1995 in its *Report on Government Service Provision*. That report incorporated a *preliminary framework of indicators* for each of the addressed services. Chart 9A shows the framework developed by the Commission for child protection services.

CHART 9A
PRELIMINARY FRAMEWORK OF INDICATORS FOR CHILD PROTECTION



Source: Industry Commission, *Report on Government Service Provision,* October 1995.

9.19 Some contributions were made by DHS to the Commission's report based on available data at the time, and DHS intends establishing mechanisms through which it can more fully contribute to future reports which the Commission has indicated will occur on an annual basis. The main areas requiring action by DHS cover quality of service and effectiveness of outcomes. The importance of work by DHS in comprehensively meeting the information requirements of the Commission in future years is reinforced by the fact that the annual publication of performance data is expected to become the principal means of comparing performance in common features of child protection services across States.

9.20 The national performance measurement framework established by the Commission is at the preliminary stage and will provide the opportunity for DHS to work with the other States and the Commission in further developing meaningful performance indicators particularly in terms of quality of service and measuring the effectiveness of outcomes for children requiring protection and care.

9.21 As part of the audit, which was completed prior to the publication of the Industry Commission report, a range of potential performance indicators was provided to DHS to assist its work in this area. The indicators suggested by audit, which are set out in Tables 9B and 9C, cover the objectives established by DHS for its child protection services as well as the key elements of the various service categories.

9.22 **With the increasing emphasis by the Victorian Government on measurement of outputs and outcomes and, at the national level, on comparisons of performance between States, DHS should adopt, as a strategic priority, achievement of leadership status in performance measuring and reporting of the delivery of child protection services.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is playing a leading role in the development of national performance indicators through the current COAG process on Government Service Provision.

TABLE 9B
PROGRAM OBJECTIVES AND CORPORATE LEVEL PERFORMANCE INDICATORS

Objective	*Measure/Indicator*
Protecting children *"To protect children and young people from significant harm resulting from abuse and neglect in the family"*	*level of undetected abuse/neglect:* • incidence of notifications disclosing a past history of abuse hitherto unknown • random surveys • juvenile criminal offenders with abuse/neglect in the past not previously known
	effective protection activities: • percentages of re-notifications where cases have been closed • speed of allocation of cases to workers • incidence of missing persons notifications per number of children accommodated other than in home-based care • reduction of notifications of abuse over a specified time period

TABLE 9B
PROGRAM OBJECTIVES AND CORPORATE LEVEL PERFORMANCE INDICATORS *- continued*

Objective	*Measure/Indicator*
Protecting children *- continued*	*effective care of children under protection:* • incidence of children previously in care committing criminal offences as adolescents or adults relative to population norms • health and education levels achieved by protected children compared with general community standards • children's care meets their assessed needs • number of deaths and serious injuries to children in care compared with general community statistics.

Notification & investigation
"Investigate reports of abuse and neglect"
	• reduction of notifications from mandated professionals and the general community which do not warrant investigation
	• timeliness of responses and investigations
	• percentages of re-notifications where:
	  • notifications have not been investigated
	  • notifications were investigated but not substantiated
	• per cent of re-notifications which are not investigated
	• per cent of re-notifications which are substantiated
	• quality of investigative work in terms of clear investigation strategy and completeness of evidence assembled before home visit

Family support *"Ensure the ongoing safety of the child by linking family with supports and services"* *"Strengthen the family's capacity to provide care"*	• percentage of notifications resulting in effective linkages to family support services • effectiveness of diversionary services, in terms of number of interim accommodation orders which become final orders • impact of support services in changing family behaviour and attitudes • attendance by clients at agreed counselling/therapy sessions
Effective Court interfaces *"Where safety cannot be ensured, take matter to Court and advise Court on Protection Order and Case Plan"*	• settlement rates of pre-hearing conferences • per cent of DHS recommendations accepted by the Court • per cent of DHS recommendations not challenged by family members. • reduction in number of interim protection orders that result in final order
Family preservation *"Where safe to do so, return child to family as primary objective"*	• per cent of successful, sustained re-unifications with families • per cent of renotifications after case file has been closed • per cent of families where problematic circumstances have improved (e.g. stable housing, improved income, use of child care, employment).
Effectiveness of permanent placements *"Where not safe to do so, work towards either alternative permanent family care placement or independent living arrangements"*	• per cent of permanent placements which are made within 12 to 24 months • analysis of numbers of multiple placements over different time periods • waiting times for children awaiting permanent placement • school enrolment and attendance levels and achievements • reduction in average length of time in care
Staffing Maintenance of an adequate, professional workforce and a culture of continual learning and improvement	• staff profile matches target • staff retention levels improve • supervision standards met • incidence of staff studying for further qualifications

TABLE 9B
PROGRAM OBJECTIVES AND CORPORATE LEVEL PERFORMANCE INDICATORS *- continued*

Objective	*Measure/Indicator*
Case management and case planning	• timeliness of case allocation • quality and achievement of case planning objectives • adequacy of supervision • reduction in de-allocation rate attributed to work demands • post-closure evaluations
Community Support Community appreciate and support DHS	• public surveys • surveys of welfare and other service agencies
Good client relations	• incidence of complaints • per cent of complaints resolved early • surveys of children and adult clients - satisfaction levels • reduction in number of investigations by Ombudsman

TABLE 9C
SAMPLE DETAILED PERFORMANCE MEASURES AND INDICATORS

Objective	*Measure/Indicator*
Notifications	
Minimise unnecessary notifications through effective education and communication with mandated notifiers and general community, and effective screening of notifications	• reductions achieved in notifications from mandated notifiers and general community requiring no further action other than referral to welfare services.
Timely response and handling of notifications	• per cent of connections to intake team within 2 minutes • per cent of incoming messages responded to within 2 hours • per cent of notifications from mandated notifiers where notifier is informed of outcome or progress within 7 calendar days.
Quality of assessment	• information to intake is high quality, identifies protective concerns and salient points • clear justifications why no further action taken on relevant files • minimum and average experience levels of staff on intake team
Staff helpfulness	• per cent of complaints about staff unhelpfulness

Successful referrals of families to services	• per cent of notifications with no further action where referrals have been made to services where such referrals were considered warranted.
	• per cent of re-notifications:
	  • where referrals had been made
	  • where referrals had not been made

Stakeholder satisfaction	• level of notifications which have an outcome which is agreeable to the notifier, particularly mandated notifiers

TABLE 9C
SAMPLE DETAILED PERFORMANCE MEASURES AND INDICATORS *- continued*

Objective	*Measure/Indicator*
Investigations	
Efficiency and timeliness of investigation	• per cent of investigations commenced within 7 calendar days of notification. • per cent of investigations completed within 28 days of notification.
Quality of investigation	• per cent of renotifications where investigation previously undertaken • clear strategies and key information regarding allegation and circumstances established before visit • high quality documented evidence supporting non-substantiations of notifications • per cent of substantiated cases not supported by Court when presented • adequate planning of joint investigations with Victoria Police
Customer satisfaction	• per cent of parents who understand reason for intervention • per cent of families endorsing fairness of investigation
Adequacy of risk assessment	• per cent of children removed where allegations subsequently unsubstantiated • per cent where child not removed and subsequently suffers further abuse or neglect • file contains clear identification of risks and risk level
Effectiveness of investigation	• per cent of re-notifications of unsubstantiated cases which are then substantiated • all proposed investigations involving potential sexual and severe physical abuse notified immediately to police
Minimisation of disturbance to those investigated	• number of unreconciled complaints regarding unsubstantiated cases • evidence of assessment and reparation activity • surveys of clients
Short-term case management	• per cent of substantiations successfully negotiated without going to Court
Improved incidence of cases satisfactorily handled without proceeding to Court	• per cent of disagreements with families successfully resolved without going to Court • per cent of cases renotified after initial agreement with family on conditions
Improvement for families by short term intervention	• per cent of improved family circumstances • quality of improvements for family and child • at end of intervention • at later date
Long-term case management	• detail, relevance, consistency of plan put to Court
Case plan	• quality and practicability of goals • adequacy of action plans, and monitoring provisions • plans illustrate thorough consideration of needs and alternatives, flexibility etc.
Management	• time taken to allocate case to workers • per cent of cases allocated to most appropriate case worker • regular reviews and reassessments of plan child/parents/siblings • adequacy of services, appropriateness and timeliness

TABLE 9C
SAMPLE DETAILED PERFORMANCE MEASURES AND INDICATORS *- continued*

Objective	*Measure/Indicator*
Supervision	• internal supervision 2 hours per week, high quality, 85 per cent of cases • team consultation with outside professionals and experts • all clients - in accordance with supervision standard 85 per cent
Achievement of goals	• per cent achievement of goals, assessed in conjunction with client • continued relevance of goals, maintained as and when necessary
Case allocation	Allocation 90 per cent within 2 weeks to most appropriate worker
Quality of services	• attendance by clients to 80 per cent of scheduled sessions • evaluation by client and case worker on effectiveness of services
Timeliness of services	• connection of family to support programs within 6 weeks of Court Order • all agreed services delivered and family assessed, at case conference one month prior to expiry of Court Order
Continuity of case managers	• per cent of case managers still allocated to same case after 12 months
Achievement of case plan/objectives	• evaluation of client every 3 months
Case closure	• extent to which case objectives have been achieved
Outcomes	
Protection of child	• renotification levels after case closure
Improvements for child and family	• impact on child behaviour and future through objective assessment at case closure • connection of family to appropriate services at case closure • improved child attainments and social skills through objective assessment at case closure
Restoration of functional family	• per cent children returned successfully to family after removal • removal of pre-existing dysfunctionalities • number of renotifications of children returned to families
Education	• children attain 80 per cent of standard level for age at school • children attend 90 per cent of classes • all children enrolled in school within 2 weeks of foster care placement
Family support services	
Type of families referred and length of time requiring services - short, medium, long-term	• per cent of families receiving supports identified against actual supports received
Number of families re-referred to the system subsequent to receiving family support	• per cent of times re-referred for the same reason
	• per cent of instances where case planning objectives achieved within designated time frames
Quality of service	• assessment against appropriate criteria for service • client surveys

TABLE 9C
SAMPLE DETAILED PERFORMANCE MEASURES AND INDICATORS *- continued*

Objective	*Measure/Indicator*
Placement of children in care	
Reduce reliance on facility based care	• annual increase in the proportion of children placed in home-based care compared with facility-based after defining minimum levels of facility-based care required • annual increase in the number of foster parents, lead tenants and volunteers for the Adolescent Community Placement Program • increase in resources supporting adolescents living independently
Reduced level of multiple placements	• reduction in average number of placements for children • maximum number of placements for an individual child
Secure welfare placements	• reduction in number of multiple admissions through provision of alternative services
Conversion to permanent care	
Decision to return child to natural parents when protective concerns have been reduced	• number of renotifications of children returned to parents • number of new orders for children previously on supervision, custody or guardianship orders
Prompt action in obtaining a permanent care arrangement for children when situation with natural parents has not improved and reunification is unlikely	• increase in number of permanent care orders issued • reduction in average length of time in care for children under custody or guardianship orders • reduction in number of children not living in a permanent care arrangement
Permanent placements	• reduction in waiting times of children identified as requiring permanent placement • increase in available families • per cent reduction in children not in permanent care, independent living or adolescent community placement after 3 years
Placement and support services	• number of cross regional placements made from After Hours Child Protection Service (ASCPS) • per cent of children between 0-6, 7-10 years of age placed in residential facilities • number of contingency placements used • number of sibling groups separated and put into different placements • number of children in informal placements • length of time children remain in reception care • occupancy levels of placement categories e.g. Adolescent Community Placement, Specialised Home-based care etc • Level of foster care applications for additional funds • number of inquiries made by AHCPS before placement obtained • number of children required to travel across regions for particular service types • reduction in number of Interim Accommodation Orders which finish up as final orders - effectiveness of diversionary services

TABLE 9C
SAMPLE DETAILED PERFORMANCE MEASURES AND INDICATORS *- continued*

Objective	*Measure/Indicator*
Impact of being a child in care	
Provide adequate educational opportunities for children in care	• decrease in average number of multiple schools attended • decrease in truancy rates for children in care
Provide effective education support services for disadvantaged children in care	• increase in average age levels in literacy, numeracy, personal development, social skills and emotional and behavioural development • increase in number of children receiving educational support
Reduce level of absconding behaviour	• reduction in number of children absconding from placement • reduction in number of missing persons reports • reduction in level of frequency of absconding behaviour by individual children • increase in number of alternative care services specialising in children difficult to place and challenging behaviour
Prevent involvement of children in care in criminal activity	• reduction in number of children being cautioned by police • reduction in number of children appearing before the criminal division of the Children's Court • reduction in the frequency of criminal activity by individual children
Client management good client communication recognition and reconciliation	• number of complaints of poor service - categorised • number of complaints which go to executive or Ombudsman without earlier recognition and resolution • client assessment of intervention • impact on family • suitability of services • length of involvement • skills of workers • performance of Department • personal communications
Practice standards	• development of new practice and techniques • use of research to develop practice • transfer of good practices into general practice standards • regularity of review of all practice • endorsement of practice standards by recognised external professionals and experts • peer reviews of actual case practices against practice standards using checklists • communication of practice standards, objectives and strategies to customers and professionals

9.23 It is emphasised that the performance indicators listed here are suggestions only, and that selecting effective performance indicators will involve considerable care by DHS. Some key factors in establishing performance indicators are listed below.

- For many of the more complex outcomes, DHS will need to firstly identify the factors which indicate successful outcomes, e.g. in respect of the quality and safety of family life, and adequacy of personal development of children in protective care;
- Potential measures will need to be evaluated carefully to ensure they measure the outcome they purport to measure and that confidence can be placed in the measurement;
- Determination of appropriate and effective indicators will need to take into account the feasibility of gathering the data, costs associated with data collection and dissemination, the relevance of the indicators to the program and the number of indicators to be utilised;
- While there may be some obvious simple measures, e.g. the incidence of re-notifications in respect of closed cases, these need to be subject to the same careful assessment of suitability and validity; and
- In all cases a number of factors influence the determination of the measurement, many outside the control capability of the Department. Hence, individual indicators are likely to be less reliable than combinations thereof. Values of, or changes in, individual indicators will generally in the first instance point to a need for further information, rather than a problem.

Part 10

Human resource management in protection services

OVERVIEW

10.1 Child protection is an inherently difficult and unglamorous work area which involves intrusion into private lives, generally without family acceptance and sometimes without subsequent justification. The difficulties are exacerbated by challenges for staff in the work environment including sensitive and sometimes violent client environments, and significant interference with personal life calling for spouse and family understanding.

10.2 The massive increase in workload in the past 2 to 3 years, due to an increasing community awareness of child abuse and neglect, and the emergence of mandatory reporting, certainly tested the protective services workforce almost to crisis point. Nevertheless, audit found that many of the present problems faced by the Department of Human Services (DHS) were contributed to by poor planning and an under-resourced position at the time of introduction of mandatory reporting, forcing DHS to rapidly expand staffing numbers, almost entirely through base-grade recruitment. The consequential involvement of a large number of relatively inexperienced staff in demanding work situations has impacted adversely on the quality of services given to children in need of protection and care.

10.3 Notwithstanding that the provision of child protection services by DHS has often been the subject of external criticism, audit found that there was a significant core of mature, experienced and dedicated protection workers, a situation which has assisted DHS in tackling the serious challenges arising from an escalating workload.

10.4 The audit revealed that a substantial attempt had been made by DHS during 1994 and 1995 to establish an adequate, stable and skilled workforce through measures such as the introduction of significant central recruitment and training programs. While some improvements in workforce stability became evident during the latter part of 1995, after a sustained period of high staff turnover, factors such as high workload, difficult working environment and staff inexperience have continued to negatively impact on the quality of services.

10.5 The major human resource challenge in protective services now facing DHS is to achieve, through workforce planning strategies, a higher professional status for protection workers and increased experience levels accompanied by greater stability within the workforce.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Since assuming the lead child protection agency role in Victoria, the Department has recognised the importance of establishing and maintaining an effective workforce, and to this end has taken positive steps. These include:

  - *A category review involving all direct service positions in 1987. This produced benefits such as a broad-banded flexible category structure, broader qualification requirements, an advantageous market position in terms of remuneration and a clear structure within the service ensuring that the Service is staffed by appropriately qualified personnel;*
  - *Establishment of a dedicated Staff Development and Training Unit, which has delivered a widely acclaimed in-service training program, including a clear focus on management development;*
  - *Development of a set of widely recognised and accepted supervision standards and performance appraisal-based model on best practice objectives;*
  - *International, Statewide and central recruitment, through which the service has gained significant depth in terms of experience and expertise;*
  - *Establishment of key links to education and training providers which have in part led to the establishment of many social work and welfare studies courses by universities, and TAFE colleges across the State;*
  - *Providing many staff with support and opportunities to undertake post-graduate education;*
  - *Providing staff with advanced technological resources;*
  - *Promulgating comprehensive practice, policy standards and procedures;*
  - *Progressively organising the service to provide opportunities for specialisation and job rotation;*
  - *Establishment of "exit interviews" in all regions;*
  - *Undertaking a Staff Tracking Project of newly recruited base grade workers;*
  - *Establishing an advanced de-briefing program; and*
  - *Undertaking a workload review, which led to the establishment of dedicated administrative and case support workers.*

  In addition, the Department is currently developing the following initiatives:

  - *Establishment of a Trainee Child Protection Worker position, which will combine both theoretical learning with on-the-job experience, prior to worker assuming full case work responsibility;*
  - *Establishment of competency-based in-service training, duty statements and performance standards;*
  - *Establishment of a Workforce Planning Working Group with program and regional representation; and*
  - *Development of an improved workforce data collection and analysis system.*

  Given the extent of change experienced by the service, including the introduction of CYPS 1989, "single-track", and mandatory reporting, which has had a major impact upon the supply and demand of child protection workers, the previous and proposed initiatives have had limited success. This mirrors both the experience within Australia and other Western democracies.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services - continued*

Therefore, the Department is proposing to engage a human resource management consultant in order to develop a human resource blueprint for the child protection service. This process will be forward looking and will seek to lay the foundations to improve human resource management within the service.

10.6 In an organisational context, the management of child protection services within DHS comprises:

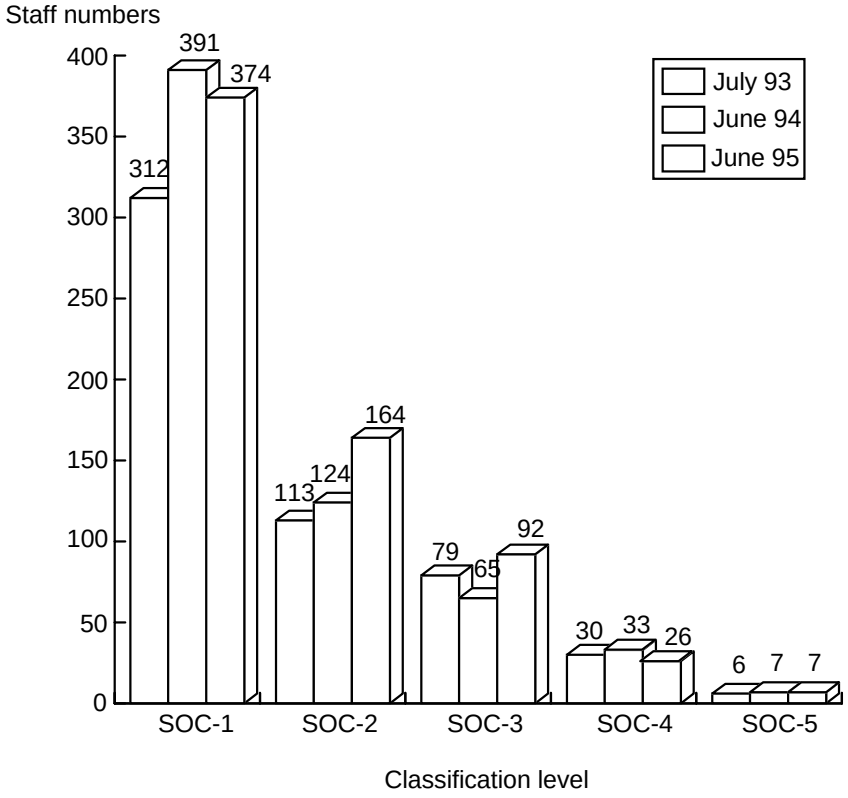
- Head Office sections responsible for Statewide policy formulation, program monitoring, development of preventative strategies and community education programs; and
- operations across 9 regions, comprising in excess of 600 protection workers supported by administration officers and case support workers.

10.7 A regional field workforce comprises teams of base-grade field workers (classified as SOC1s) and advanced field workers (SOC-2s), who are more experienced and have a capacity to deal with a greater workload including the more complex cases. It is departmental policy to have equal numbers of SOC-1s and SOC-2s within its workforce. Teams are headed by a supervisor or team leader (SOC-3), with units of 2 or 3 teams responsible to a unit manager (SOC4) who in turn reports to the regional Protective Services Manager. Operational staffing numbers are based on an average of 12 cases per field worker, with teams of 6 workers to each SOC-3 team leader, supplemented by administration and case support workers.

10.8 DHS operates a discrete After Hours Service for the Metropolitan Region, while services provided after hours in rural regions are resourced from the local protective services workforce.

10.9 Chart 10A shows the staffing breakdown of protection workers within DHS by classification over the period 1992-93 to 1994-95.

CHART 10A
BREAKDOWN OF PROTECTION WORKERS BY CLASSIFICATION, July 1993 TO June 1995



10.10 In line with the recommendations of its internal "Workload Review" in August 1994, DHS has supplemented its protection workforce by the appointment of 40 administrative staff and 15 case support workers to assist protective teams. In addition, DHS has recently established 9 project manager positions, (classified at SOC-5 level in metropolitan regions and SOC-4 in rural regions), with responsibility for regional development of central program initiatives, research projects, community and professional education, and networking with agencies involved in supporting child protection in the community.

WORKFORCE MANAGEMENT CHALLENGES FOLLOWING MANDATORY REPORTING

10.11 As outlined in Part 4 of this Report, notifications of suspected child abuse and neglect increased dramatically in 1993-94 and continued to rise in 1994-95, following the introduction of mandatory reporting. The resultant massive increase in workload forced DHS to significantly expand its child protection workforce from 540 in July 1993 to 663 in June 1995, and to dedicate significant resources to central recruitment programs and the induction needs of the large influx of predominantly inexperienced staff.

10.12 There is little doubt, from the matters identified by audit in other Parts of this Report, that the strategic response by DHS to the very large increase in workload following mandatory reporting was highly commendable. It is also appropriate to recognise the strong work ethic and commitment displayed by protection workers in undertaking an extremely difficult task in often trying circumstances.

10.13 The audit found that protective services had not prepared workforce planning strategies detailing such matters as existing staffing, future staffing requirements and profiles to meet goals, strategic weaknesses and mechanisms to address them. Some regions have begun to develop workforce statements and planning processes and DHS intends to promote these approaches in all regions.

10.14 The absence of such strategies was considered by audit to be a major factor in a range of unresolved issues and workforce problems such as shortage of experienced staff and potential supervisors, matching of workloads to available resources, excessive staff turnover and instability.

10.15 **The major challenge now facing DHS is to achieve, through implementation of appropriate workforce planning strategies, a higher professional status for protection workers and increased experience levels accompanied by greater stability within the workforce.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is in broad agreement with the recommendations in this section and is already taking steps consistent with them. The Department is proposing to tender for an external consultancy to assist with the development of a Child Protection Resource Management Blueprint, and will implement additional initiatives within the constraint of supply and demand workforce factors.

IMPORTANCE OF WORKFORCE PLANNING STRATEGIES

10.16 The importance of DHS developing appropriate workforce planning strategies was reinforced at the time of the audit by the following characteristics of its workforce:

- low experience levels of a large proportion of the workforce, as a result of recent intensive base-grade recruitment, which was illustrated at the time of the audit by:
  - a clear imbalance between base-grade field workers and advanced workers which was not consistent with the stated policy of equal numbers of base-grade and experienced workers; and
  - a shortage of experienced supervisors;
- significant staff turnover and instability; and
- a need for greater flexibility in working arrangements.

Low experience levels in the workforce

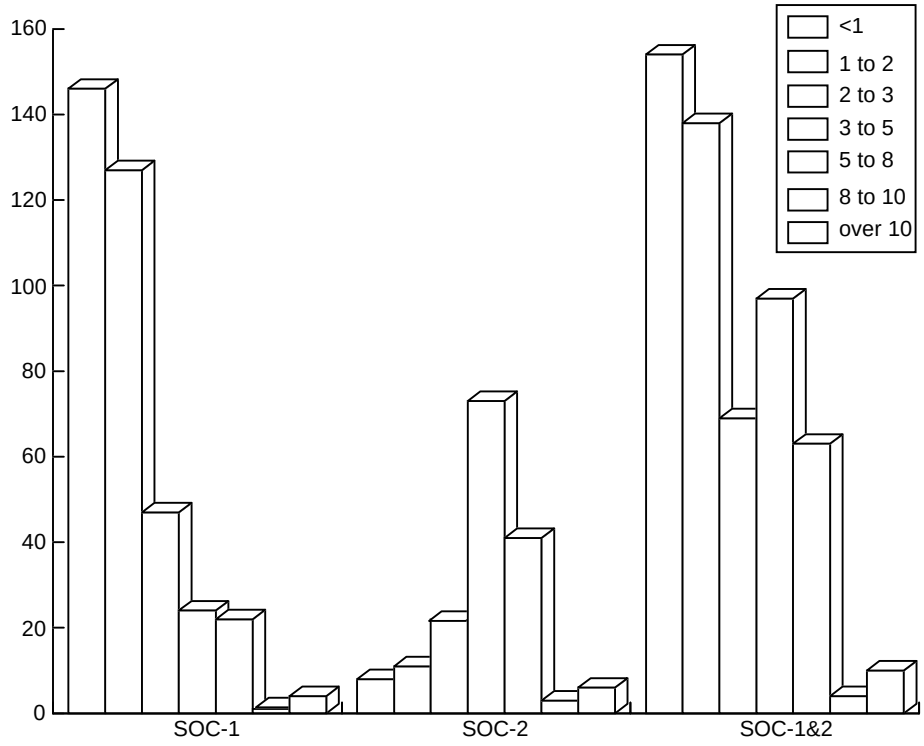
10.17 The work associated with child protection clearly requires substantial experience and personal maturity to achieve the necessary levels of expertise, efficiency and confidence. While a desired experience profile is not articulated in policy, the Department's expectation, as advised to audit, is that, ideally, there should be a spread of experience of 3 to 5 years for base-grade workers and 4 to 6 years for advanced workers.

10.18 The audit examination revealed that many base-grade field workers had less than the preferred experience level, with 73 per cent of these workers having less than 2 years experience in child protection in DHS at 30 June 1995.

10.19 In respect to advanced experienced workers of SOC-2 classification, there was a substantial presence of more experienced workers, with an average working life in child protection of over 4 and a half years (30 per cent with more than 5 years experience). These workers, together with a smaller number of longer experience SOC-1s, represent a valuable core of experienced staff in the child protection workforce.

10.20 However, due to the excessively high proportion of SOC-1 workers, at 70 per cent of field workers, the experience profile of all field workers, SOC-1 and SOC-2, shows a significant shortage of experience, with 55 per cent, 292 of 535 workers, having less than 2 years experience. Chart 10B shows the relevant details.

CHART 10B
EXPERIENCE LEVELS OF FIELD WORKERS IN CHILD PROTECTION
AT 30 JUNE 1995



10.21 Audit found that the situation has begun to improve in the past year. Chart 9A indicates that between 1994 and 1995 the ratio of more advanced workers and supervisors to base-grade workers has increased.

10.22 In addition, audit recognises that the low level of experience in the workforce can be attributable to:

- a past history of high staff turnover;
- the recent expansion of the workforce to meet the increased workload following mandatory reporting, and an increased public awareness of child abuse; and
- the lack of people within the community with child protection experience or similar experience willing to join DHS so that virtually all recruits are at base-grade level.

10.23 The program operates on a strategy of competent professionals working within teams under the guidance of team leaders. Case management strategies are developed in consultation with leaders and other team members, with parameters for the workers' discretion, e.g. in Court negotiations. In general, inexperienced staff are less sure of case parameters and options and authority lines, have less confidence in their own judgement and actions, and require more frequent recourse to the team leader for advice and confirmation. These factors lead to excessive workloads for team leaders, hence reducing supervision capacity and inhibiting skill development in workers.

10.24 Some of the consequences of this scenario are:

- worker credibility, confidence and ability to act independently are reduced, and workers are often perceived, and may perceive themselves, more as subordinates under detailed instruction than as authoritative professionals;
- many field workers experience stress in Children's Court appearances and give the Court the impression that they are unprepared and incapable of presenting effectively; and
- faced with difficult responsibilities and without adequate authority, inexperienced staff become overworked and stressed, may have poor client and community relations, may leave prematurely and be replaced by new recruits, adding further to the experience problem.

10.25 In addition, DHS's practice over the past 2 years of introducing new staff immediately to difficult and sensitive field work, without prior practical experience in many cases has led to reported work problems, poor image, inefficiency and worker stress.

10.26 The major requirements for DHS to improve the experience of its child protection workforce will be to retain staff, both recent recruits and experienced staff, define basic experience requirements and introduce an effective traineeship strategy.

10.27 **In order to demonstrate a greater commitment to its strategy of achieving a highly professional workforce, DHS needs to:**

- **articulate its preferred experience profiles for SOC-1, 2 and 3 levels, covering lengths of service and guidelines on appropriate ranges of experience; and**
- **identify a separate status of "articled" protective workers who "graduate" to become recognised field workers on the basis of proven competency after at least 6 months, with a commensurate salary differential.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

DHS does not accept that new workers are regularly introduced to case management too early. The vast majority of workers receive regional orientation, experience working with senior peers, receive regular supervision, and undertake 15 days central induction within their first 6 months. In addition, all workers are tertiary qualified, predominantly in Social Work, Welfare Work and Psychology, and the large proportion of newly recruited workers have experienced up to 70 days supervised field work placements prior to graduation.

The Department is introducing a trainee child protection position, which will offer 3 month intensive training coupled with fieldwork experience and a commensurate salary differential. This initiative was part of a package of offers made available to staff on 13 June 1996. The training will be competency based.

Implications of significant staff turnover and workforce instability

10.28 DHS has been concerned for several years about the level of turnover and the difficulty in establishing a stable experienced workforce. Key issues under consideration by DHS at the time of the audit were the need to keep newly recruited staff:

- past their initial year of employment in order to become competent workers and return DHS's initial investment in training; and
- past the 3 to 5 year stage to boost the level of experienced, proficient and advanced workers, and potential supervisory staff.

10.29 Audit considered that a good foundation for retaining staff existed within DHS in regard to staff satisfaction and commitment to an important responsibility. Many staff interviewed by audit generally considered their job to be satisfying and worthwhile, appreciated a supportive environment from peers and supervisors, and more recently a high quality induction training program. Unfortunately, this foundation has been adversely impacted by factors which have contributed to a high staff departure rate, including:

- a general feeling of dissatisfaction with the position, focusing on areas such as work levels, stress, interference with personal time, problems with access to cars and parking, and inadequacy of late night security;
- a feeling of poor senior management support, in terms of emphasis on investigation and case throughput at the expense of concern for clients or workers, pressure to close or de-allocate cases and a lack of general management support when criticised in public;

- limited work-based facilities and poor image with service providers; and
- low salaries and a lack of internal and external acknowledgment of the importance and difficulty of the work.

10.30 It was a commonly held view within DHS that the protective services area is used as a first base to gain employment experience and training, which then makes staff attractive to other employers. Many staff interviewed by audit indicated they would leave protective services when an opportunity arose.

10.31 Retention of staff in protective services was lower than for social work staff in other areas of DHS, with a major outflow of staff to other areas of the Department where work was considered to be less demanding. Examination of a sample of staff records over 1993-94 and 1994-95 indicated a 22 per cent departure rate of protection workers compared with 8.5 per cent with other social work staff. A further 12 per cent of protection workers were acting in positions outside protective services.

10.32 Examination by audit in one region revealed that, compared with 12 months ago, 30 per cent of staff had left protective services or were on leave without pay, and after taking into account staff movements to other regions and the After Hours Service, the effective loss to the region was 42 per cent.

10.33 In addition to movements in and out of protective services, there was a high degree of transience and instability in position occupancy, for example:

- A high level of staff temporarily assigned acting responsibilities (34 per cent) - in one region, acting staff exceeded 50 per cent of establishment; and
- Transience in critical SOC-3 supervisor positions caused by successive different acting occupants on short and long-term bases - some staff interviewed by audit had 4 supervisors in one year.

10.34 Audit considered that the excessive staff turnover and workforce instability had contributed to a number of human resource problems for DHS in the provision of protective services, including:

- reduced ability to establish good teamwork;
- inconsistent and sometimes poor staff supervision and development;
- time lost in building a professional workforce;
- continuation of the problems associated with low experience levels;
- wasted training expenditure without return;
- continual need to replace lost knowledge of local situations, agencies and cases;
- the need to fill SOC-2, SOC-3 and SOC-4 positions on an acting basis by staff not deemed to meet criteria well enough to justify permanent appointment; and
- inhibited management and leadership development.

10.35 From an overall perspective, the above factors had an adverse impact on DHS's ability to effectively meet the protective needs of children as commented on in other Parts of this Report, particularly in the area of case management.

10.36 Measures taken by DHS which are aimed at addressing the problems associated with turnover and workforce instability include:

- introduction of an enhanced induction training program;
- regional orientation programs to assist new staff in becoming familiar with their local protective services working environments; and
- revision of the classification structures under which protection workers are employed.

10.37 **To build on its existing human resource strengths, DHS needs to implement a number of workforce planning strategies, including:**

- **quantify achievable goals for job stability, desirable lengths of stay in positions and minimal acting appointments;**
- **a commitment to raising the profile of protection workers to that of a highly skilled, respected workforce, dedicated not only to protecting children but advising families of how their problems could be addressed through welfare and support;**
- **undertake a review of classification structures, remuneration, work values and conditions in comparison with a range of other welfare and professional areas; and**
- **generally build further on the positive aspects of child protection work.**

Need for greater flexibility in working arrangements

10.38 Flexible work arrangements are developing in human resource strategies within both private and public sectors in response to the increasing recognition in the workforce of "family" priorities such as maternity, early child rearing and care of aged relatives. It is now becoming recognised in particular that losses from the workforce arising from these factors are detrimental in terms of replacement costs, skill losses and the loss of potential management skills due to interrupted careers.

10.39 Flexible work arrangements are also valuable from a staff viewpoint in helping staff to manage issues such as balancing work and private commitments, coping with work peaks and troughs, movements in and out of the workforce, continued participation in professional development activities during extended absences from work, and rehabilitation from stress and prolonged illness.

10.40 DHS has established arrangements within its protective services for part-time, work-sharing, temporary and casual work employment. The After Hours Service has a significant number of casual and part-time employees, while over 50 staff in the regional workforce are registered as part-time.

10.41 **In considering the introduction of greater flexibility into its workforce arrangements, DHS will need to take account of:**

- **the high female component which is likely to continue;**
- **the need to retain staff and reduce turnover, one aspect of which is the retention of female officers through their mid-20s to early 30s, which represent the peak ages for family responsibilities; and**
- **facilitating and encouraging staff who have left the workforce to subsequently rejoin.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department accepts the issues identified by audit, and has taken steps to address these issues within the constraints of available resources and government policy. Achievements to date include: flexible employment opportunities; job redesign on the basis of national competency standards; creation and increased number of available experienced practitioner positions (SOC-2); development of "Healthy Workplace" initiatives; introduction of dedicated case support and administrative positions; improved occupational health and safety; and development of a well resourced in-service training program. These initiatives reinforce the Department's commitment to its workforce.

MATCHING OF RESOURCES TO WORKLOAD

10.42 As indicated in an earlier paragraph, the number of workers employed by DHS in protective services has increased markedly over the past 2 years.

10.43 Several factors observed during the audit such as delays in allocating cases and excess workload levels can give rise to an impression that protective services are overworked and under-staffed.

10.44 DHS advised audit that it considered that the protective services workforce was large enough in numbers to cope with work levels, if other issues such as experience levels could be satisfactorily addressed.

10.45 It was not possible for audit to determine the adequacy of the workforce due to the limited information within DHS on the extent of workload and the related capacity of the workforce. While DHS prepares management information detailing individual caseloads, this information records only numeric workloads and does not indicate the complexity of cases, which can vary markedly as to the time needed with individual families and children.

10.46 Several factors can inflate or distort workload levels, including:

- a shortage or uneven distribution of placement and support services such as family support agencies, psychiatric and counselling services adding to the workload involved in placing children and helping families;
- variations in work processes and methodology, knowledge, experience, efficiency and hence capacity;

- the adequacy of preventative strategies; and
- the dependence of workload levels on the specific criteria established by DHS for investigating notifications.

10.47 Audit was informed by several staff that there existed large differences in levels of efficiency across the workforce due to variations in the quality of work practices, including such things as the depth of involvement in cases and the overall quality of case plans. Staff indicated to audit they were expected to be "more efficient" without any guidance on how to achieve increased efficiency.

10.48 DHS needs to address a number of key factors such as staff proficiency, resource availability and adequate performance of other parts of the overall system, including prevention if it is to achieve optimum utilisation of its existing workforce.

10.49 **Initiatives which DHS could consider to build on the capacity of its protective services workforce include:**

- **identifying ways to attract back experienced and capable ex-staff, even for short-term periods;**
- **emphasising to staff, through training, appraisals and supervision, the key notions of efficiency, effectiveness and quality;**
- **introducing training on best practices derived from studies of current work methods;**
- **establishing an employee support unit to review and monitor employee stress, workplace problems and staff turnover, and provide specific support on a consultancy basis to regions; and**
- **considering and adopting means of retaining efficient staff who are currently attracted to the non-government sector or to other departmental programs.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

Recommendation addresses issues that are central to the service's performance and will be addressed in the context of the proposed Human Resource Management Master Plan.

RECRUITMENT ISSUES

Attracting applicants to protective services

10.50 Since Autumn 1994, central recruitment programs within DHS have been successful in attracting more applicants than available placements, and appointing recruits with a wide range of ages and backgrounds who met the Department's qualification requirements. Positive factors attracting applicants to protective services have included:

- an expectation of regular supervision and high quality training;
- recognition of a worthwhile and satisfying occupation;

- positive advice received from some university staff, for example ex-departmental staff lecturing in relevant electives; and
- sound prospects for further career progression following protective services experience.

10.51 On the other hand, audit found that some recently-appointed staff had received predominantly negative impressions at university about working for DHS. A number of students had sought a position in protective services on the basis that selection was a step towards gaining other social work appointments, rather than as the start of a career in this field of work.

10.52 In seeking to attract applicants to protective services, it is essential that a realistic image is projected. Unfortunately for DHS, the image of protective services has suffered from adverse publicity in recent years that, in the Department's view, was not representative of the quality of service provided. Student "placements" with protective services have offered an opportunity for both conveying a fair image of the work and assessing a person's suitability. Audit understands that DHS is considering improvements to the current student placement process to make it more purposeful.

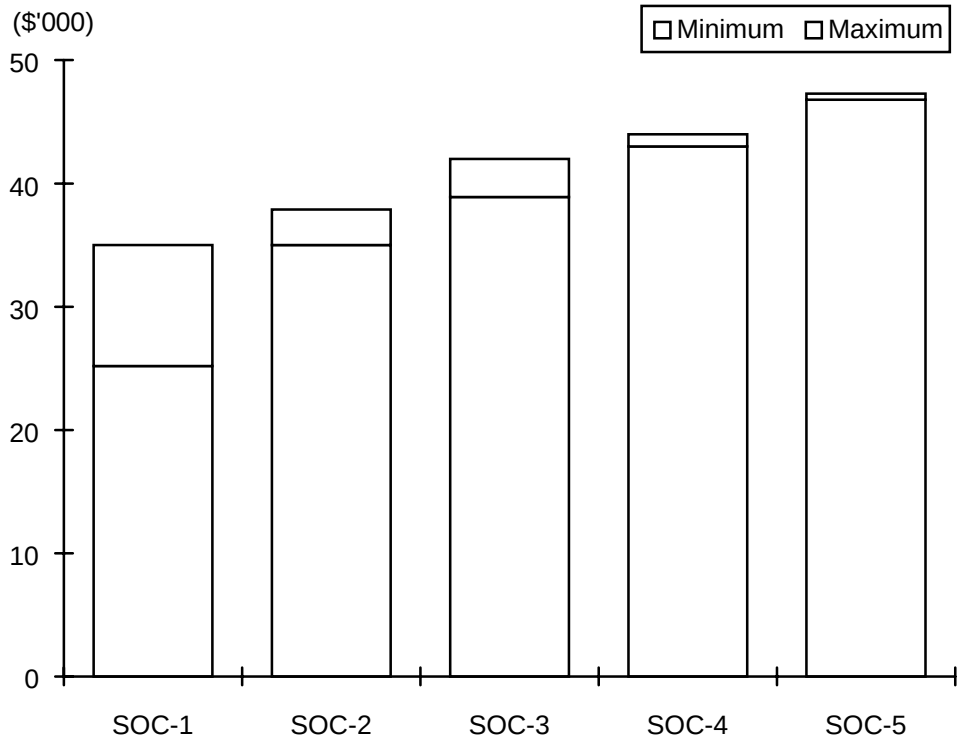
10.53 **In order to improve its image and ensure that good quality students are encouraged to consider protective services as the career of their first choice, or to recruit mature people considering career changes, it is suggested that the Department consider:**

- **surveying the impressions of the community, school leavers, students, staff and other social workers;**
- **developing a positive but realistic image of protective services;**
- **addressing problems in working conditions and negative matters arising from surveys; and**
- **engaging a marketing consultant to advise DHS on recruitment strategies and its image in protecting children.**

Adequacy of classification and remuneration structure

10.54 Classification and salary structures for protection workers at the time of audit had been established following a review in 1987 by the former Public Service Board of Victoria which introduced a 5-level classification structure. Chart 10C illustrates the annual salary scales pertaining at July 1995.

CHART 10C
ANNUAL SALARY RANGES FOR PROTECTION WORKERS, AT JULY 1995



10.55 Issues evident from the chart include:

- the small gap between the salary of an experienced base-grade worker (SOC-1) and an advanced worker (SOC-2);
- a very limited salary range for SOC-2 workers, which has the effect of reducing the professional status of SOC-2s and deterring the development of specialist careers;
- similarly the very small gap between salaries of an experienced SOC-2 and a supervisor (SOC-3) virtually eliminates any salary incentive for staff to be promoted to much more demanding supervisory positions; and
- while the SOC-1 salary range extends from $24 000 to $35 000, the total range of salaries for the higher levels carrying significant responsibility (SOC-2 to SOC-5) was only $12 000 from $35 000 to $47 000.

10.56 While simple salary comparisons are difficult and may be misleading, there were indications that protection workers salaries were poor by comparison with other social work occupations, particularly considering the demands of protective work. This situation is evidenced by the fact that some staff who joined protective services from voluntary agencies identified that they had accepted salary reductions to join DHS.

10.57 There were claims to audit at all levels that staff leaving protective services frequently left for the same salary and less stressful work without statutory responsibilities, often elsewhere in DHS. The personnel statistics identified in an earlier paragraph of this Part of the Report indicate a one way flow of staff exiting from protective services.

10.58 Audit found that there had been no comparative analysis of the value of protective services work in terms of responsibility, complexity, required competencies needed and working conditions with other professions and welfare occupations. In addition, the existing salary framework did not incorporate a performance pay element and therefore did not provide an incentive for individuals to improve their performance.

10.59 During 1995, national competency standards for social workers in child protection, juvenile justice and statutory supervision were agreed by all States, under the co-ordination of the National Community Services and Health Industry Training Advisory Board and its network of State-based Industry Training Boards and Councils. DHS represented Victoria in these developments.

10.60 DHS has subsequently commenced to develop implementation strategies to promulgate competency standards into practices in recruitment, training, selection, work management and promotions.

10.61 **DHS should introduce a performance-based classification and salary structure for its protective services workforce addressing options such as:**

- **recognising and rewarding a significant advancement from an initial traineeship appointment status to recognised operational competency;**
- **introducing alternative specialist and management salary structures, to encourage and reward high quality specialist workers;**
- **recognising the criticality, responsibility and complexity of supervisor (SOC-3) positions by raising the SOC-3 entry salary to well above the basic SOC-2 level;**
- **linking classifications to the national competency standards; and**
- **increasing flexibility in non-salary areas such as leave entitlements, working hours and study support.**

10.62 The Department has informed audit that it is in the process of constructing a new classification and salary structure for protective workers which provides scope for recognising previous relevant experience of recruits, in terms of more appropriate salaries.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department has recently introduced a new classification and salary structure for protective workers. Additionally, Child Protection workers, along with other direct care staff in the Children Adolescent and Family Welfare Division (CAFW), have received an enhanced pay offer to reflect the special role and changing nature of the work undertaken.

  The new structure addresses the majority of the issues raised by audit.

STAFF DEVELOPMENT

10.63 Staff development in major organisations normally includes individual performance appraisals and personal development planning for staff to link their training to organisational and individual needs. Staff development plans define development goals and strategies which may utilise formal training activities, off-the-job training units and other strategies such as secondments, on-the-job training with supervision, particular projects or activities, conference participation and higher duties assignments.

10.64 Key elements of development planning are regular appraisals of staff performance against job expectations and skill requirements, and definition of training needs to serve organisational priorities, individual skill needs and career development.

Scope for strengthening personal development planning

10.65 The operations of protective services provide various opportunities for individual development including:

- the educational and professional development element of supervision;
- higher duties assignments and staff secondments which are often used with a developmental intent; and
- staff rotation systems instigated by some regions to ensure that workers do not remain in high pressure roles such as notification/intake teams for excessive periods.

10.66 Notwithstanding these opportunities, audit found that staff did not have personal development plans and, as a consequence, their development activities were not systematically linked to their needs. Individual training and other developmental activities were generally instigated through staff initiative, with some management input, rather than in response to formal assessment of individual needs from supervision, performance appraisal or career planning.

10.67 Without personal development plans, DHS cannot ensure that staff have training and development programs which are responsive to their specific needs, address their skill deficiencies and support their career development. By not facilitating individual staff development, DHS is also failing to fully realise the potential of its workforce.

10.68 Audit was informed that a number of staff had organised their own external professional supervision at their own expense and others had organised counselling sessions with a child psychologist to provide specialist input to case deliberations.

10.69 **DHS should institute formal, standardised personal development plans, with input from regular performance appraisal. This process could be supported by regular developmental case studies and forums on case management.**

Maximising the value of teamwork

10.70 While it is important to develop individual performance and skills, it is generally recognised that effective teamwork is a crucial success factor in most large organisations. For protective services, it is necessary to consider both "internal" teamwork, covering the collaboration and shared decision making in protective services teams, and "external" teamwork in regard to co-operation with other professionals involved with helping children and families.

10.71 Teamwork is an essential element of child protection work in that:

- evaluating possible strategies and making decisions are actions which are not done on an individual basis but which benefit from the contributions of other members of a team, particularly the SOC-3 team leader and SOC-2 advanced protective workers;
- having a broad knowledge of cases within a team facilitates the involvement of other team members, e.g. in giving advice from similar experience or specialist knowledge, handling emergencies or providing support in Court; and
- there are generally a number of different professionals involved in helping ensure improved child and family development.

10.72 Audit found that the internal team concept was well developed in protective services. Staff generally valued the contribution and support from their teams and peer support was often cited as a key satisfaction area.

10.73 However, a number of weaknesses in team operations in protective services were advised to audit including:

- the excessive proportion of SOC-1s meant that few teams had more than one SOC-2, with some comprising all SOC-1s or acting SOC-2s;
- time available for team consultation was limited;
- SOC-3s devoted most of their time to individual work and casework supervision, with limited time for team building and group consultation; and
- team stability was damaged by staff movements and the volatility of team leader positions.

10.74 In terms of external teamwork, various external professionals, with whom audit had contact, felt they were often not treated as valuable team members by protection workers, particularly in cases involving children with severe problems. Lack of co-operation and feedback was common, and their input was at times disregarded without explanation.

10.75 A major consequence of inadequate emphasis on a team approach is evidenced in the many comments made to audit that protection workers were perceived as isolationist and sometimes arrogant in refusing to consult with other professionals.

10.76 **Improving the quality of teamwork, both within its protective services teams and in their relationships with external parties, should be a key development imperative for DHS.**

TRAINING

Strong features of DHS training in protective services

10.77 The audit identified several strong features of DHS training programs for protective services staff. These features included:

- A high degree of staff satisfaction with central training in terms of the quality of delivery and the learning gained. Induction training was seen as valuable, particularly the current strategy of providing training to new starters 3 months after appointment. In addition, the recently redeveloped residential supervisory and management training program was praised by staff;
- An increasing emphasis on involving senior staff in management training; and
- The close alignment of the central training program with organisational priorities through various mechanisms, including a training reference group and analysis of practice consideration arising from child death reviews.

Opportunities for further improving the delivery of training programs

10.78 Other Parts of this Report have identified areas of operational shortcomings which indicate the need for priority to be given to further training. These areas include core activities such as investigative and note-taking skills, risk assessment, Court presentation, general efficiency of work practices, effective case management skills, customer relations and client communications.

10.79 While several of these areas are addressed in induction training, audit findings in other Parts of this Report suggest that staff should receive more extensive training in these areas during their operational careers. Such training should be reinforced by deliberate application in the workplace and supervisory support and appraisal of work improvement.

10.80 In terms of access to training, while DHS informed audit that it considered staff access to training was satisfactory, an opposite view was expressed by many staff interviewed by audit who claimed that access to training can be difficult or training commitments hard to keep, for reasons such as:

- the scheduling of particular courses only once or twice in a year; and
- an inability to attend training when higher priority work demands arise, e.g. supervision of access by parents to children under Protection Orders at predetermined dates may clash with the training calendar and urgent incidents or Court appearances may unavoidably force the cancellation of prior training plans.

10.81 In addition, audit considered that at an average of under 2 days a year, even allowing for an unquantified level of regional training, training levels were low for field staff considering the complexities of the duties. Audit acknowledges that the ability to provide additional training to field staff has been restricted recently by the need to focus heavily on induction training for large numbers of new recruits. However, this situation should ease in the near future, thus providing opportunities to direct training to existing staff in areas of greatest need.

10.82 **In summary, there are a number of opportunities available to DHS to further build on the sound progress it has made in the provision of training to workers within protective services.**

SUPERVISION SKILLS

10.83 To its credit, DHS has defined comprehensive standards for supervision which it considers to be at the leading edge in welfare work in Australia. These standards include requirements for:

- a minimum of 2 hours uninterrupted individual supervision per week for field workers in the first 6 months of appointment and a minimum of 2 hours per fortnight thereafter;
- formal supervision agreements for all staff, reviewed and adjusted annually or whenever necessary;
- work performance to be assessed at least annually, incorporating some direct observation of performance; and
- formal performance appraisal at the end of 6 months probation.

10.84 Supervision is intended to extend far beyond day-to-day direction of case work into educational, professional and support roles, such as providing role models to staff, assessing stages of development and learning, providing a learning environment and emotional support.

10.85 Many staff advised audit that supervisors gave good guidance on case work, and that case decisions and Court presentations benefited significantly from the experienced input of SOC-3s. The support given by several SOC-3s was praised, e.g. always being available for contact, reporting and discussion for all team members at any hour, including one supervisor who always remained at the office until all staff had finished all client calls, frequently late at night. The impression formed by audit was of a very demanding SOC-3 job and mostly very conscientious caring supervisors.

10.86 However, notwithstanding the advanced nature of the supervision standards, audit found that the standards were not monitored and were often not met in practice, and that, while case work guidance was recognised as valuable, the other elements of supervision were often neglected. Some of the deficiencies in supervision, as perceived by staff were:

- "supervision on the run" sometimes substituted for sessions for uninterrupted supervision;
- supervision was predominantly task oriented in that it was directed towards individual cases, with some supportive but little educative supervision;
- broader insight into practice and theory application was not developed through examination of cases, and a number of staff interviewed by audit had made private arrangements for this type of learning at their own expense;

- supervision was not recorded, there were very few supervision agreements and compliance with standards of time or quality was not monitored; and
- frequent changes in "acting" SOC-3s and "work sharing" at supervisory or management levels caused disruption to supervision.

10.87 The 2 immediate factors ostensibly limiting supervisory capacity were the heavy workloads of supervisors and the general team imbalance in favour of low experience base-grade workers. A supervisor's workload often includes not only legitimate supervisory tasks related to case planning and Court work, but also significant amounts of direct case work including:

- previous caseloads still carried by acting or recently appointed supervisors;
- high levels of unallocated cases awaiting assignment to workers as they become available; and
- back-up responsibility, which can be significant for 6 team members with leave, training and other commitments.

10.88 The pressures to rush supervision and focus on tasks, rather than support, can lead to a lack of a thorough understanding of a case and the implications of different potential strategies, which an adequate in-depth discussion with the supervisor was likely to have provided. As a result, some staff display low authority and confidence, and refer excessively to their supervisors during client contacts and Court appearances, leading to poor image, worker stress and ultimately increased turnover. This problem was also reflected in the often poor standard of Draft Case Plans and Disposition Reports presented to the Children's Court.

10.89 In respect of supervisory competencies, DHS has taken several initiatives to improve supervisory training and the development of future supervisors.

10.90 In discussions with DHS, it was identified that SOC-1 and SOC-2 staff needed to take some responsibility for their supervision and training. Workers also needed to contribute to satisfactory supervision by organising their work to allow time to plan for supervision and keep supervision appointments.

10.91 **In order to maximise the benefits of its advanced standards for supervision of protection workers, DHS should:**

- **institute recording and systematic analysis of formal supervision times and contents;**
- **improve worker skills in work organisation and self-assertion;**
- **reduce the load on SOC-3s through increasing the support role of SOC-2s, in accordance with the new development of SOC-2 role statements;**
- **require SOC-4s to focus on developing the skills of SOC-3s to train and develop SOC-1s and SOC-2s;**
- **institute evaluation of supervision and adopt *staff satisfaction with supervision* as a performance measure for staff of SOC-3 level and above;**

- **develop succession planning to improve future availability of good SOC-3s, involving deliberate observation and development of SOC-2s by SOC-4s; and**
- **increase the number and retention of SOC-3s through strategies such as attracting back ex-staff, improving the flexibility and attractiveness of working conditions and rewards, and managed rotations of staff through other areas of DHS and service agencies.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department has recognised the importance of ensuring high quality supervision since the mid-1980s when it established formal supervision training and supervision standards which audit acknowledges are of a higher standard than in the majority of professions. Staff supervision is a high priority within the child protection service and the Department is committed to its continued improvement.

WORK ENVIRONMENT AND WORK PRACTICES

Work environment: problems and challenges

10.92 Protective services staff expressed concern to audit in regard to many factors which influenced the quality of their working environment. Certain elements of the working environment are controllable, others less so, and some constitute challenges to workers. It is the role of management and supervisors to optimise those elements which give rise to staff satisfaction and assist staff in controlling problem areas and responding to the challenges.

10.93 Major challenges in the working environment were identified as:

- increasing workloads;
- job difficulty, including sensitive client environments and exposure to traumatic incidents;
- an inability to control workload;
- the need to balance personal and work commitments;
- system complexity including interaction with a variety of agencies; and
- few winners or grateful clients.

10.94 Problem areas requiring action included:

- negative external perceptions and prejudices;
- difficulties with the Children's Court;
- shortage of services and inadequate information for new staff in regions;
- interference with personal life and need for spouse/family appreciation; and
- practical grievances on matters such as failure to provide prompt access to cars and parking, or access to the DHS system network after particular hours to record case notes.

10.95 For all staff, a major source of stress was the frequent feeling of inadequate response to client needs due to competing work pressures and lack of practical experience in dealing with many situations.

10.96 The cumulative effect of adverse working conditions contributes to the level of staff turnover, stress which staff carry into private lives, and a commonly held image of protective services as a poor place to work.

10.97 It was encouraging to identify some positive management initiatives on work environments in the regions visited by audit, including, in one region, a significant improvement in staff satisfaction, morale and productivity resulting from changes to management processes and culture

10.98 **The Department needs to take steps to improve its working conditions through:**

- **identifying and promulgating lessons learnt from different regions as to how any poor management practice processes were identified and overcome; and**
- **compiling a list of practical difficulties perceived by staff (if not already available) and ensure management commitment to address them in cooperation with staff.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department accepts that these factors have had a significant impact upon the child protection workforce and have been particularly visible in Victoria during the audit period. Research, however, indicates that these features are present within most other child protection services and are not specific to Victoria.

Scope for improving work practices in protective services

10.99 The DHS 1994 Workload Review resulted in a number of initiatives aimed at improving work practices such as:

- relative standardisation of service delivery models across regions;
- formation of regional and cross-regional groups to discuss and promote practice improvements; and
- separation of work between intake/response teams and long-term/integrated teams.

10.100 Regional management responses to improve service effectiveness and efficiency observed by audit included the establishment of an immediate response team in Eastern Region, process restructures in Western Region and a management restructure and process reorganisation in Northern Region which is recognised as having achieved a dramatic turnaround from a culture of high stress and long work hours.

10.101 Despite the above positive initiatives, audit was informed by various staff that work practices still varied widely across regions and between teams, and that inefficient work practices, including premature de-allocation of stable cases, could contribute significantly to apparently excessive workloads. Areas suggested to audit of opportunities for possible practice improvements included:

- improved case management practice and forward planning;
- more attention by supervisors to the depth of involvement in cases by individual workers;
- the quality, efficiency and standardisation of administrative work elements such as compilation of case notes and reports;
- time management by workers and managers, with management perceptions that a long involvement with some families and children sometimes reflects poor time management;
- maintaining an adequate involvement in stable cases; and
- inadequate knowledge by some case workers of support services available to families and children within a region, which in the longer-term can influence the degree of intervention and subsequent workload.

10.102 Matters identified by audit in other parts of this Report have established that there was considerable scope for improving case management and documentation.

10.103 In view of the dependence of DHS on a committed, hard working workforce and the frequent demands on staff to devote extensive time to difficult cases, great sensitivity is needed in addressing efficiency and productivity issues. However, it is likely that improved, more efficient practices would assist in reducing work demands and hence benefit staff.

10.104 Audit found that DHS has not generally analysed and promulgated different regional initiatives or undertaken an assessment of work practices. In addition, efficient practices in case management and casework have not been used as specific subjects for practice guidelines, training programs or supervision processes.

10.105 **There would be merit in DHS undertaking a wide-ranging assessment of work practices in its protective services. As part of this process, DHS should:**

- **capture, study and disseminate good practice and develop good practice guidelines and training in case planning and management; and**
- **regularly monitor case planning and the quality of case plans and case management.**

Part 11

Deaths of children under protection

OVERVIEW

11.1 Between January 1989 and December 1995, there were 85 deaths of children who were, or had been, involved with protective services. Of these deaths, 20 were subject to official inquiries by the Department of Human Services (DHS). Of the deaths where inquiries were not held, causes of death included natural causes, road accidents and sudden infant death syndrome. Nevertheless, audit considered that in a small number of these cases, inquiries were warranted primarily due to case histories of the children involved.

11.2 Child death inquiries have generally been conducted thoroughly and responsibly by DHS under Ministerial direction, producing wide ranging findings and recommendations which have provided an important input to improving child protection services.

11.3 The quality of the inquiry process was detracted from by long delays in the commencement and reporting of inquiries. The delays were principally due to a lack of urgency and available resources, as well as the time taken to conduct an exhaustive review. Public accountability was further limited through DHS not reporting publicly on all deaths, with only the results of official inquiries being published.

11.4 The Department has established a Victorian Child Death Review Committee with a wide membership of external professional people. This Committee should be of great benefit to DHS in improving public accountability, due to the Committee's general overview of all child deaths, causes and common themes, and the provision of advice to the Minister.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department welcomes audit's acknowledgment of the high standard of the 20 child death inquiries conducted. The Department also welcomes audit's endorsement of the Victorian Child Death Review Committee.

  The decision regarding the need for an inquiry is made after careful consideration of the potential benefits in addition to the findings and recommendations which emerge from established departmental reporting and Ministerial briefing processes. Audit's capacity to make a findings regarding the necessity for a child death inquiry on the basis of case history alone is questionable.

BACKGROUND

11.5 DHS maintains records in regard to all deaths of children who were either current or former clients of the Department. In 1994, a comprehensive computerised database was established to record key information concerning each death.

11.6 Deaths recorded relate not only to those children under Protection Orders at the date of death, but also include children in respect of whom DHS had received a notification, irrespective of whether the notification was investigated or substantiated. Isolated instances have also occurred where notifications had not been received but the child's death was suspected of being attributable to child abuse. Audit was advised by DHS that the very broad definition of recording child deaths adopted by DHS is not practised by other States.

11.7 DHS notifies the Coroner of all deaths of children in whom it has an interest, is represented at any inquest and provides assistance to Coroner's investigations. Child death inquiries are additional to the coronial process and are arranged by DHS, under Ministerial direction, where the causes or circumstances leading to death may reflect upon professional practice by child protection workers. Where available, DHS takes the Coroner's findings into account in its assessment of whether a further investigation is warranted.

11.8 In 1989, a process of official child death inquiries was introduced following public concerns that internal inquiries were deficient in terms of accountability, scope and objectivity. These inquiries are instigated at the discretion of the Minister, and reports are made available to the Minister, key DHS officers and the Parliament.

11.9 The terms of reference for Inquiry Panels is *"to achieve accountability and inform practice and systems"*, namely:

- *identify, as far as possible, the facts related to the death of the client;*
- *examine whether case decisions and actions were reasonable and responsible;*
- *ascertain whether established procedures were followed in case management;*
- *consider whether the role of other agencies and services were appropriate; and*
- *advise the Minister on any issues which require attention by the Department".*

11.10 Each inquiry panel comprises a chairperson, an independent member and a DHS representative. The chairperson may be a departmental or an external appointment dependent on characteristics of the inquiry, such as the need for special skills, involvement of other departments or agencies or any suspicion of mismanagement or system failure which might undermine the objectivity of DHS. Until 1992 the inquiries were chaired by Justice Fogarty. Since then, 5 panels have been chaired by DHS regional directors and 2 chaired independently.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Child death inquiries are distinct from the Coronial process. The Coronial process seeks to establish the circumstances, cause and persons implicated in a death. Child death inquiries aim to review individual practice issues within the context of specific and general departmental policy and procedure with a view to identifying capacity for service improvements.

DECISIONS TO HOLD INQUIRIES

11.11 Between January 1989 and December 1995, 104 child deaths were recorded by DHS, of which 85 concerned children who were deemed as child protection services clients, with the remainder being Juvenile Justice clients. The average age at death was 5.9 years. Table 11A details the number of deaths per year and inquiries conducted or planned for deaths in that year.

TABLE 11A
DEATHS AND INQUIRIES,
JANUARY 1989 TO DECEMBER 1995

Year	*Number of deaths*	*Inquiries planned or undertaken*
1989	9	5
1990	13	5
1991	*(a)* 15	2
1992	6	2
1993	12	2
1994	20	7
1995	10	4
Total	**85**	**27**

(a) In 1991, 5 children subject to a notification died simultaneously in a house fire, while a further 8 died from natural causes, car accidents or sudden infant death syndrome.

11.12 Table 11B details the primary cause of deaths during this period.

CHART 11B
PRIMARY CAUSES OF CHILD DEATHS
BETWEEN 1989 AND JUNE 1995

Cause of death	*Number of children*	*Ministerial or DHS inquiry*
Sudden infant death syndrome	15	-
Natural causes	16	2
Physical abuse	*9*	6
Fire	8	-
Road accidents	8	2
Drowning	8	5
Drug overdose	6	4
Suicide	4	2
Neglect	3	3
Murder	2	-
Other	6	3
Total	**85**	**27**

Initial assessment and report

11.13 The Department's initial process following knowledge of the death of a current or former child protection client involves:

- an immediate report within 24 hours to the Minister and director of the region, including information for a media briefing if relevant;
- registration on the client death database;
- a regional briefing within 72 hours, along with a recommendation whether or not an inquiry is warranted;
- review of the regional briefing by head office before forwarding to the Minister.

11.14 In principle, the process provides a detailed review of all available and relevant information regarding circumstances, along with justification for an inquiry or otherwise for each death. Regional briefings are of critical importance, not only to support any decision on holding an inquiry, but also to provide justification for an inquiry **not** to be held, as occurred with the majority of deaths recorded.

11.15 Audit established that while the immediate reporting requirements were met and regional briefings were undertaken, in some cases detailed regional briefings had not been forwarded to head office for overview and forwarding to the Minister.

11.16 **Regional briefings should be recognised as important in promptly accounting for deaths to the community and to provide early information regarding practice and procedure failures. Standard reporting practices should be implemented, with the central program and training units routinely reviewing regional briefings for practice implications.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department has clarified the standard reporting practices and these are now included in the Protecting Children Manual.

Decision to hold inquiry

11.17 The criteria for a decision to hold an inquiry is based largely on whether there is prima facie evidence of significant practice and procedural failure. The audit of child deaths between 1993 and 1995 established that official inquiries had generally been undertaken where circumstances indicated that further departmental inquiry was required.

11.18 DHS decisions not to undertake child death inquiries were found by audit to be justifiable in most cases in accordance with the Department's stated criteria, e.g. where deaths related to house fires and inherent medical conditions such as brain damage at birth or complications arising with muscular dystrophy. Of 9 cases of death caused by physical abuse, 6 occasioned inquiries. In the other 3 cases the children had not previously been known to the Department and the notifications arose from hospital admissions of these children, with the death suspected of being caused by severe abuse.

11.19 However, audit considered that in a small number of cases where inquiries were not held, the circumstances suggested a need for an inquiry or at least further investigation, on the basis of possible practice deficiencies. An example is detailed as follows:

> *A 15 year old boy died in late 1993 after sniffing butane gas. The boy had been under a Guardianship Order for 6 years, which was allowed to lapse one month prior to his death. During his time in State care, along with his siblings, he was rotated through many placements and despite the fact that the siblings "craved" for long-term security, a permanent placement was never actively pursued by DHS. In his initial years at school he was regarded as a very positive pupil with many talents. Eventually, his behaviour deteriorated and he came to the attention of Juvenile Justice. The case file summary concluded that in addition to a number of significant, unresolved issues in the boy's life, including considerable anger at the Department's inability to take consistent care of him, he met his death by underestimating the dangers of butane sniffing.*
>
> *Although the regional briefing drew attention to the lack of decisive decision making by DHS, the impact of multiple placements and care-givers, and the insistence by the boy, his birth parents and case worker that Guardianship should have been continued, DHS concluded there were no outstanding accountability issues or practice improvements needed and that an inquiry was not warranted.*

11.20 In cases such as the example above, audit considers there is a requirement for detailed internal analysis, as well as public accountability. The Department's practice is to report in its Annual Report to Parliament only the outcomes of official inquiries, rather than detailing all deaths recorded in each year.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department refutes audit's presentation of this case in such a manner as to suggest a failure by the Department to take appropriate action.

  This case was not recommended for formal child death inquiry on the basis that a detailed review of case practice had been completed. This process resulted in several significant findings and recommendation in regard to the primary practice issues of case planning and permanency planning. In view of the above it was determined that no additional benefit would be gained from formal inquiry.

  In addition to the above, the Coronial investigation was completed on 27 June 1994 and found that no person, other than the deceased, contributed to the cause of death.

11.21 **The Department needs to establish a risk-analysis assessment for all client deaths and ensure that any risk control issues are adequately investigated in all cases where an official inquiry is not undertaken.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department considers that it currently takes a sufficiently broad approach in defining who is a client of the service and under what circumstances inquiries are required. Any changes to this approach will be undertaken on the recommendation of the newly established Victorian Child Death Review Committee.

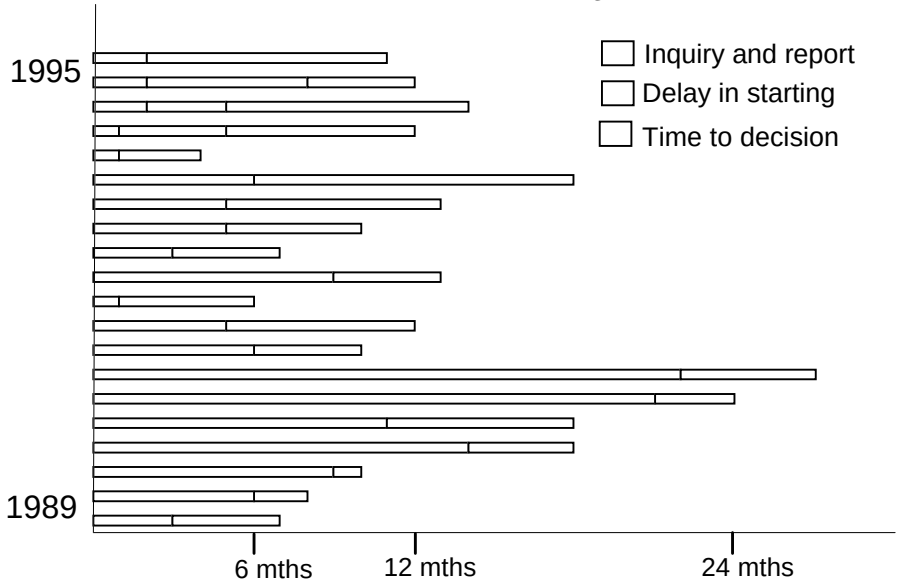
  Most of the circumstances referred to by audit are more appropriately investigated by police assisting the Coroner, who may inform the Department and seek its advice or action in accordance with existing legislative provisions.

  The Child Death Inquiry Panels take a risk-based approach in the assessment of the circumstances leading to a child death. Given the broad range of factors that may be involved, such an approach is not readily facilitated by the application of a risk-based formula as appears to be suggested by audit.

DELAYS IN CONDUCTING INQUIRIES

11.22 Chart 11C, shows that with some exceptions, inquiry reports have generally been finalised substantially after the death, due to the time taken in deciding to hold an inquiry, convening an inquiry panel, undertaking the inquiry and reporting. The total time taken to convene a panel since 1989 has varied from 1 month to nearly 2 years and generally exceeded 5 months.

CHART 11C
TIME TAKEN TO START AND COMPLETE INQUIRIES, 1989 TO 1995



11.23 At the date of audit in September 1995, an inquiry was still being finalised concerning a death which occurred in January 1994. A departmental decision to recommend the inquiry was made in March 1994 and approved by the Minister in September 1994. The panel was convened in October 1994 and held interviews during November 1994. A further 4 inquiries had been recommended by regions and 3 deaths had the potential to warrant inquiries - a backlog of possibly 7 inquiries, with delays extending to 12 months to complete existing inquiries. In a recent case concerning a death in October 1994 by drug overdose, in questionable circumstances, of a youth under a Custody Order, the inquiry recommendation was not made until October 1995, one year after the death and 4 months after the Coronial inquiry had been completed.

11.24 The key cause of delays is the limited staffing allocated to inquiries, which constrains DHS from proceeding with more than one inquiry at a time. This means that even though a decision to proceed is made by the Minister, lengthy delays will continue until staffing becomes available. Other reasons for delays included:

- an apparent absence of urgency in recommending and obtaining approval for inquiries;
- the logistics associated with panel establishment and commencement;
- dual goals of *accountability* and *improving professional practice and systems* where necessary, which extends the length of an inquiry; and
- time taken for the selected chairperson and independent panel member to become available.

11.25 **Audit considers that the time frames to complete inquiries are unduly long, leading to diminished accountability, poor public image of DHS, and delays in DHS benefiting from any lessons to be learnt from practice and procedural failures. The Department needs to:**

- **finalise regional preliminary briefings within one week;**
- **allow for independent monitoring and regular reporting to the Minister on progress on inquiries undertaken;**
- **establish a register of selected independent professionals who could sit on inquiry panels at relatively short notice; and**
- **provide adequate resources for inquiries to proceed and be finalised within specified time frames.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

There have been 3 additional staff appointed to undertake the role of Executive Officer, Child Death Inquiries in order to catch up on the backlog and minimise further delays. The Department has allocated additional resources to minimise delays in the conduct of inquiries. Reporting to the Minister on progress is part of the function of the Victorian Child Death Review Committee.

A register has been established of potential panel members. However, this does not guarantee that the most appropriate people will be available at the time for the particular case, particularly at short notice. This also needs to be understood in the light that the inquiry process is not based on a legislative framework, and that participation in the panels is voluntary.

VALUE OF INQUIRIES TO DHS THROUGH RECOMMENDATIONS FOR PRACTICE IMPROVEMENTS

Generally high quality of inquiries

11.26 Audit established that recent child death inquiries had included a detailed, searching and critical process by DHS. Some inquiries had taken the opportunity to examine all case practices in the case concerned, not simply those which might have had a direct link to the death. This was equally true for inquiries led by an independent chairperson, a regional director or other departmental manager.

11.27 Audit considered that the child death inquiry reports generally demonstrated a high quality review process. The inquiries focused on system deficiencies and improvements needed, rather than personal recriminations, with a view to depersonalising tragic situations for DHS staff.

11.28 When commencing inquiries, panel members are provided with an information kit and a preliminary briefing from DHS. Audit established that although the information kit for panels provided guidelines on methodology and report formats:

- The methodology did not include a risk-based approach, although this is a key element of protective practice. Reports recorded a chronological review of practice developments rather than systematically assessing the risks associated with each case decision and comparing case developments with these decisions; and
- Report standards are broad and reports read by audit varied in presentation, structure and style and differed in the clarity with which they analysed and presented issues and recommendations.

11.29 **Further improvement could be made to the inquiry process through the adoption of a risk-based approach with the inquiry methodology. While appreciating the variety of situations and the need to allow chairperson discretion, a clear set of reporting principles would also enhance the quality of reports.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The guidelines to panel members (1994) indicate that the inquiry report can be set out under a number of headings which do not particularly reflect a chronological format. While the format of reports vary, this is usually a reflection of the nature of issues that needed to be inquired into. The Department maintains that all reports are of an acceptable standard.

  The Department considers that panels currently employ a risk-based approach. This has been clarified through the establishment of reporting principles to guide panels.

Implementation by DHS of inquiry recommendations

11.30 Audit found that child death inquiry reports contained many detailed and wide ranging recommendations in relation to practices, communications, procedures, policies and training. For example, the 1994 Annual Report from DHS detailing 2 child death inquiries contained a wide range of recommendations for improvement, including:

- the need for mechanisms to ensure worker compliance with risk assessment standards and procedures, including checklists and routine monitoring;
- the development of psychiatric services for adolescents in the protection system;
- improving worker access to current information and training on the relationship of domestic violence to child abuse;
- ensuring adherence to supervision standards;
- development by "Drug Services Victoria" of services targeted at transient and *"at risk"* young people whose drug abuse was serious and at times life-threatening, rather than experimental;
- clarification of the role of the specialist "Streetwork" unit of DHS dealing with adolescents;
- compilation and distribution of information on the nature and management of youth suicides;
- access by rural workers to peer support and information sharing opportunities; and
- assistance to workers to critically assess the opinions of other professionals, thereby reinforcing the workers' primary responsibility to protect children at risk.

11.31 After circulation of inquiry reports, the DHS develops a plan for the implementation of recommendations in each report.

11.32 The Department has recently implemented a system to monitor progress with implementing inquiry recommendations, wherever practical. To date reviews have been prepared detailing DHS responses, planned actions and target dates, and progress in regard to the recommendations of the 2 inquiries in the 1994 annual report.

11.33 **Inquiry reports examined by audit identified practice and procedural deficiencies in case management. While DHS is to be commended on the manner in which these deficiencies were acknowledged and corrective action taken, the broader issue is the effectiveness of internal control mechanisms within protective services operations, which allow constant monitoring of performance against practice standards and the early identification of improvements that can be made with case management.**

11.34 **Audit has emphasised elsewhere in this Report the strong need for quality control processes within case management, including regular case audits, and the need for regular performance appraisals of workers to be undertaken. Such measures would assist in preventing future practice deficiencies as well as encouraging practice enhancements. This broad issue of DHS monitoring the quality of case management needs to be considered by the new Victorian Child Death Review Committee.**

Need to enhance public reporting of child deaths

11.35 DHS produced an *Annual Report on Inquiries into Client Deaths*, in December 1994 which described the findings and recommendations of 2 inquiries completed between July 1993 and November 1994. The 2 inquiries involved deaths in May and August 1993, with inquiry reports completed in June and August 1994.

11.36 In contrast, during the same period between July 1993 and November 1994, DHS had recorded 24 deaths of children and young people subject to Protection Orders, notification or investigation, with 8 inquiries conducted. The 16 deaths not warranting an inquiry comprised 5 sudden infant death syndrome cases, 3 deaths in the same house fire, 3 defined medical conditions, 2 accidents and 2 physical abuse cases.

11.37 Audit considers that accountability to Parliament in regard to child deaths was deficient, in that the Annual Report of DHS to Parliament did not record all child deaths or provide information such as an analysis of causes of deaths, client status and reasons why inquiries were not conducted. This is particularly relevant where the Secretary of DHS is either the custodian or guardian of a child.

11.38 **In audit opinion, DHS has a responsibility to report to the Parliament all deaths of children who were subject to notifications of child abuse or were under Protection Orders.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Terms of Reference for the Victorian Child Death Review Committee, include to describe trends and patterns of child deaths; to analyse and comment on any themes which may be emerging through the inquiry process and to identify the prevalence of risk factors which existed in the population of children who had died, and recommend further investigations into particular groups as appropriate.

ESTABLISHMENT OF THE VICTORIAN CHILD DEATH REVIEW COMMITTEE

11.39 To improve public accountability and the quality of reporting of child deaths, in May 1995 DHS recommended establishing a Victorian Child Death Review Committee to provide broader perspectives from consideration of all child death reports and independent advice on the need for, and conduct of, child death inquiries. An appropriate membership of the Committee would be drawn from welfare, medical, legal and judicial organisations, as well as selected individuals.

11.40 The aims of the Committee are to:

- Review investigative reports of all deaths of children who died while current or recent clients of DHS. The Committee would have access to all files and material used to prepare the child death reports, and the ability to request inquiries;
- Advise the Minister of the implications of inquiry findings;
- Describe trends and patterns of child deaths;
- Analyse and comment on any themes emerging from the inquiry process;

- Identify prevalent risk factors and recommend further investigations into particular groups as appropriate;
- Evaluate service and system responses to children and families at high risk and recommend improvements;
- Prepare an annual report to the Minister; and
- Provide advice to the Minister on the Child Death Inquiry (CDI) process.

11.41 As part of its role in monitoring and recognising common themes and trends, audit suggests that the new Victorian Child Death Review Committee (VCDRC) could consider arranging research into why, since 1989, the sudden infant death syndrome has accounted for the deaths of 18 per cent of children recorded in the DHS register of child deaths.

11.42 **The Department envisages that the Committee will strengthen and complement existing processes, and will take a broader perspective of child deaths and the protection of children in general, rather than a narrow focus solely on deaths of protective services clients.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The establishment of the Committee was tabled in Parliament in November 1995 and the chair of the Committee was announced at that time as being Professor Glenn Bowes, Chair for the Centre of Adolescent Health at the Royal Children's Hospital.

The VCDRC held its inaugural meeting on 2 May 1996 which considered the historical context on the CDI process and clarified the role and operation of the Committee. Terms of reference have been circulated and 2 further meeting dates have been established for June and December 1996.

Part 12

Appeals and complaints

OVERVIEW

12.1 The extent of the Department's powers under the *Children and Young Persons Act* 1989, the varying levels of intrusion into lives of families and associated stress, combined with the significant impact on the lives of children resulting from statutory intervention mean that adequate, independent and accessible appeal processes serving families and children are crucial.

12.2 Several avenues of appeal exist, including reviews of case planning decisions, the Administrative Appeals Tribunal and appeals against Children's Court decisions in higher Courts.

12.3 Audit established that formal written complaints were thoroughly investigated by DHS, frequently resulting in further client contact, and in some cases internal acknowledgment of faults followed by remedial actions. However, audit found that:

- Virtually all complaints and appeals come from adults, with virtually none from the children or adolescents. The views of children or young people in any complaints or appeal processes were rarely sought, nor were they independently represented except in appeals in the County or Supreme Courts;
- The utilisation of formal processes for appeal against case planning decisions was very low, partly because the avenues for appeal through the Administrative Appeals Tribunal and higher Courts are relatively inaccessible, costly and can involve significant delays;
- Less formal complaints were generally not fully acknowledged, registered or analysed in a consistent manner, thereby not facilitating input to service improvement; and
- Complaints on specific matters often revealed a general dissatisfaction over DHS involvement in the family or indicated concerns, communication gaps or a lack of understanding of certain factors which should have been addressed earlier.

12.4 The Department's failure to systematically record and analyse client attitudes and outcomes of complaints has helped to contribute to an overall negative image of its protective services, with dissatisfied clients sometimes publicising their views. It has also been a contributing factor in the establishment of pressure groups, mainly by dissatisfied parents which focus on making DHS publicly accountable for its treatment of certain clients.

OVERVIEW - *continued*

12.5 Steps which should be taken by DHS to improve its responsiveness to the concerns of children and families, and help improve the image of its protective services include:

- ensuring that the views and needs of children are adequately heard and independently represented, possibly through the establishment of an Advocate of Children's Rights Officer, as occurs overseas;
- providing easier access to appeals and complaints from all clients, particularly children and young people, with the involvement of external persons where appropriate;
- improving client communications and the regional complaints process;
- undertaking research on complaints and their handling to enable DHS to determine appropriate strategies for visibly providing an objective and impartial complaints process; and
- establishing a more accessible, low cost, external appeals process.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department is committed to improving access and outcomes in its handling of client complaints particularly as it relates to complaints by children and young people, and has recently completed a thorough review of its internal complaints handling process in Child Protection Services. The review considered international and Australian models of complaint handling and specifically examined those of other Australian departments involved in child protection services. It found:

- *no consistent model in use;*
- *widespread use of local management based complaint handling approaches; and*
- *Victoria to be comparatively advanced in terms of access to formal appeals and in participatory case planning processes.*

As a result of this review a range of short and long-term measures are being adopted to address identified deficiencies and improve outcomes for aggrieved clients, including existing avenues for appeal.

The Department has initiated 2 further projects of importance in this area, namely:

- *a project to investigate the means to achieve better outcomes and ensure complaints by children and young people are heard and dealt with effectively; and*
- *a project to produce a Customer Service Video targeted at Protection and Care direct service staff to promote and reinforce the Department's commitment and requirements in this area.*

The Department is disappointed by audit's lack of acknowledgment of the complexities faced by the Department in this area, and the many factors that militate against effective and collaborative complaints resolution in child protection work.

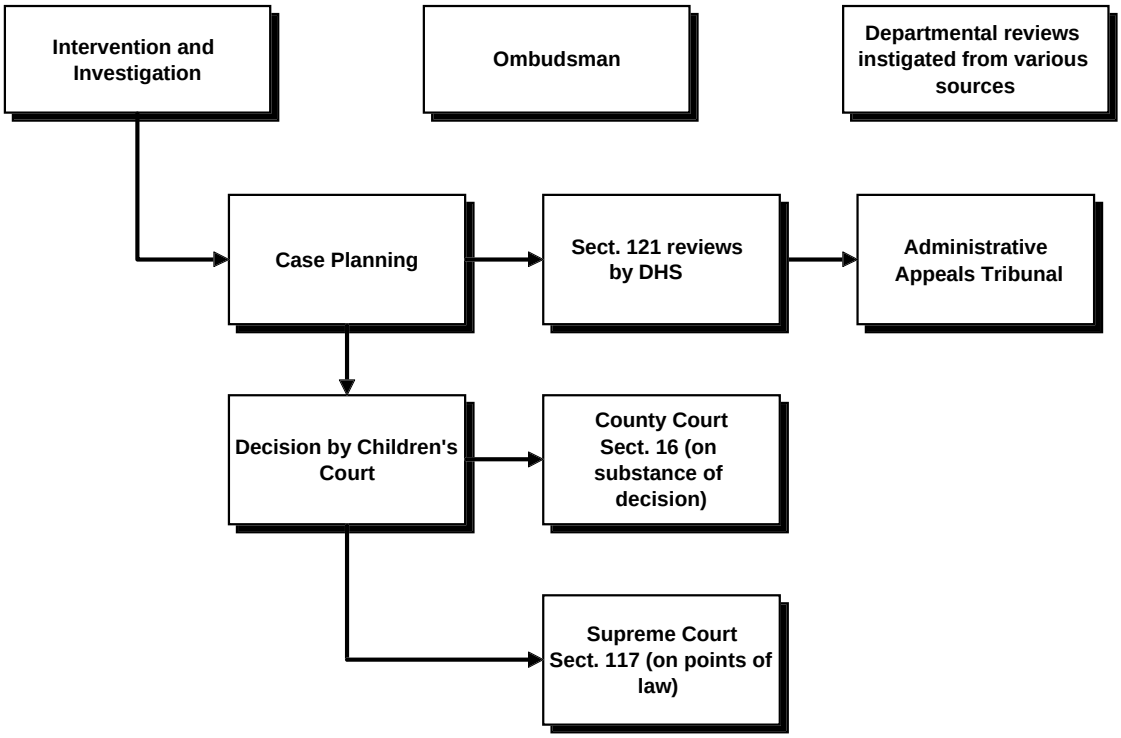
APPEALS AND COMPLAINTS PROCESSES

Background

12.6 Chart 12A illustrates the formal avenues for appeals available to departmental clients, namely:

- the ability to request reviews by DHS of the outcome of case planning meetings, under section 121 of the *Children and Young Persons Act* 1989, with further appeal, if dissatisfied, to a regional director;
- appeals to the Administrative Appeals Tribunal, when section 121 reviews have not resolved disputes; and
- appeals to the County Court against decisions of the Children's Court in granting Protection Orders, and appeals to the Supreme Court on questions of law.

CHART 12A
AVENUES FOR APPEALS AND COMPLAINTS



12.7 Complaints and concerns can be raised in normal dealings with the responsible worker and his or her supervisor, with the opportunity to pursue matters further with unit managers and senior management in the region. Complaints are also often raised by families writing to or telephoning the local Member of Parliament, Minister or the Secretary of DHS.

12.8 The Ombudsman is the major independent avenue of complaint investigations, other than through the Court process.

12.9 Client concerns are handled and resolved through normal client interfaces in the course of duty by protection workers, supervisors and managers in regions, either personally or by telephone or letter. Such contacts are recorded in case notes on client files, not identified as complaints and not recorded in any external systems or indexes.

12.10 Letters to regional management are recorded on regional correspondence files. Concerns raised through other avenues such as telephone calls or letters to parliamentarians, the Secretary or the Minister are directed through the Deputy Secretary, Community Services.

12.11 Around 70 letters of comment or complaint regarding protective services are received annually by the Deputy Secretary of DHS from clients through various external channels and are referred to regional directors for consideration, briefing and response. In the absence of records of telephone complaints, it was estimated that over 200 telephone calls a year are received centrally by the Deputy Secretary, most of which are referred to regional management.

12.12 Written complaints were found by audit to encompass a wide range of concerns, such as:

- the nature of questioning of children (including the number of DHS officers involved), necessity for attendance by police and subsequent (alleged) traumas to the child;
- case management and supervision of children in care, including poor supervision in residential placements and allegations of assault;
- disputes over custody and placement issues and permanent care plans;
- allegations of false or malicious notifications, worker bias, harassment, threatening attitudes and misrepresentation;
- practical arrangements, such as cancellation of access, inconvenient location of DHS offices for supervised access, failure to keep appointments or return phone calls, repeated difficulty in contacting workers and poor communication with mandatory notifiers; and
- resultant harm to children, family strength and parents' reputations from investigations.

12.13 Section 121 of the *Children and Young Persons Act* 1989 requires the Department to establish internal procedures to review decisions made as part of the case planning process. The procedures established by DHS require that reviews be held within 28 days of a formal request and where a review outcome is disputed a further review may be requested by the complainant to be undertaken by the regional director, or a regional director from another region.

12.14 Section 122 of the Act provides for a child, child's parents or other acknowledged interested parties to apply to the Administrative Appeals Tribunal (AAT) for the review of a decision in a case plan or any other decision made by the Secretary concerning the child, including a decision not to make a decision, or a decision relating to the recording of information in the central register. Before a person is entitled to apply to the AAT the person must have exhausted all available avenues for internal review under section 121 of the Act. During 1994-95, only 4 child protection appeals were heard by the AAT.

12.15 The avenues of appeal in respect of rulings by the Children's Court are to:

- the County Court, under section 116 of the Act, in regard to the substance of the decision; and
- the Supreme Court for appeals on points of law, under section 117.

12.16 Appeals to the County Court average around 2 a month, with most being initiated by parents. There are few appeals to the Supreme Court, probably due to cost considerations, including the need of most parents contemplating a Supreme Court appeal to be provided with legal aid. Inability to obtain legal aid would inevitably deter most parents from appealing to the Supreme Court.

SCOPE FOR IMPROVING COMPLAINTS AND APPEALS PROCESSES

Improving DHS handling of complaints

12.17 All contacts between clients and field workers or supervisors involving complaints are documented on case files. Substantial matters raised during these contacts are not readily accessible due to the absence of any form of index. Consequently, DHS cannot determine the extent or substance of client grievances or the success in resolving them other than through an intensive manual process.

12.18 Accordingly, it was not possible for DHS or audit to determine the level of satisfaction or dissatisfaction which has been expressed with protective services, or the success of workers in handling complaints. The level of documented complaints and appeals was small in contrast to the image revealed to audit from service providers and clients, indicating that many complaints may be buried in case files or may be unrecorded.

12.19 Analysis by audit of the nature of written complaints and DHS's responses disclosed a range of underlying causes for complaints to arise, including:

- in some cases, poor staff communications with clients and lack of attention to client grievances at an early stage in the protective intervention process;
- communication gaps - commonly a difference in perceptions of past events and contacts between clients and workers;
- in the case of some parents, a lack of understanding of, or failure to accept, the child's needs and reasons for the chosen care strategy;

- continued inability of some parent(s) to progress in parenting improvements and carry out agreed arrangements; and
- potentially well-founded matters which warranted further investigation.

12.20 In reviewing correspondence between the department and families and other parties, audit observed that parent concerns, particularly those raised through Members of Parliament or directly with DHS management, were investigated thoroughly, frequently resulting in further client contact, and in some cases internal acknowledgment of faults followed by remedial actions. Telephone calls to the Deputy Secretary are generally handled immediately, by connecting the complaint directly to regional management, or by arranging for regions to pursue and resolve the issue. Audit was informed by DHS that this process often results in a prompt response to the client.

12.21 Audit also established that complaints were not systematically analysed to provide input to improving service quality. For example, messages reflecting strong client anger were not directed, where suitable or relevant, into strategies to improve customer relations skills and the Department's image. Conversely, audit also acknowledged that some of the complaints reflected the perverse nature of certain clients DHS was dealing with.

12.22 Many correspondents and telephone callers to the Deputy Secretary had not previously discussed their problem with middle management in the region, and facilitating this often led to resolution. Reasons why issues may not be directed to regional offices in the first instance, and pursued and resolved at the regional level include:

- complaints not having been formally identified and treated as complaints with an emphasis on achieving resolution;
- considerable mistrust by certain families of DHS and protection workers in general, as expressed to audit;
- lack of a clear, designated and credible complaints interface;
- lack of understandings by people involved with protective services, of the regional organisation structure;
- the sparse distribution of DHS offices and relative inaccessibility to many, both in metropolitan and outlying areas of the State; and
- acceptance by regions that the very nature of protecting children will invoke anger by some parents and did not warrant scarce resources being diverted to such issues.

12.23 In mid-1995, in conjunction with the audit review, DHS undertook a *"Review of Internal Complaint Handling Processes in the Protective Services Program"* with the aim of *"... ensuring that they are efficient and effective and are responsive to the needs of clients, the accountabilities of DHS and the concerns of other interested parties".*

12.24 The DHS review identified the need to strengthen and further develop regional complaints handling due to a range of weaknesses, including matters identified in this Report. Areas for improvement identified by the review included:

- the need for consistent capture by DHS of information in relation to complaints to improve the ability to respond to systemic issues and external criticism;
- improved recognition and management of conflict situations;
- provision of easily understood information on complaints and appeals processes to complainants and staff;
- facilitation of direct access to the complaints process by children and young persons;
- improved communication to all parties on the objectivity of the complaints process; and
- articulation of complaint handing principles and standards.

12.25 **The Department needs to:**

- **develop guidelines, training and improved regional procedures to facilitate better client communications and enable the recognition, recording and handling of complaints and grievances, including telephone calls, at the earliest point;**
- **promote and publicise an enhanced public awareness of the regional management structure to facilitate clients pursuing complaints locally;**
- **conduct surveys to gain a clear picture of client satisfaction and determine the level of unvoiced dissatisfaction not currently recognised or addressed;**
- **institute measures to seek and identify client dissatisfaction at an early stage; and**
- **systematically monitor and analyse complaints to assist in addressing faults, with a view to continuously improving practices, guidelines, training, and service delivery.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The reasons listed by audit are speculative and require verification through further research.

The Department is undertaking work in these areas in the context of the recent review of complaints handling in child protection, the project to investigate means by which to better attend to complaints by children and young people, and its development of a multifaceted customer service policy in child protection services.

While it may be fair to say that there is a degree of acceptance that the very nature of protecting children will involve anger by some parents, the Department refutes the notion that this extends to decisions not to invest resources in the resolution of such issues. Rather, it is the case that the Department has to prioritise its work and effort in accordance to its legal responsibility to achieve the protection of the child where this is required in the short-term, over protracted attempts to address what may be insoluble or tactical issues. Audit should be aware of the not insignificant efforts by staff to resolve grievance in the course of their case work and in the case planning process.

Low utilisation of the right to seek regional reviews of case planning decisions

12.26 The effectiveness of the review process, under section 121 of the Act, depends on the quality of the process, satisfaction of the client with outcomes and the success in getting clients to voice their dissatisfaction and seek reviews. This success, in client utilisation, in turn depends on the accessibility and credibility of the system and the knowledge and confidence of clients in it.

12.27 With respect to assessing the quality of the section 121 review processes, the audit examination of a number of regional reviews established that:

- the reviews were generally very detailed and, on occasions, had resulted in changes to case plans, including strengthening the support arrangements for families; and
- a degree of objectivity had been introduced into some reviews by the participation of a regional director or DHS manager from a different region.

12.28 Conversely, audit established that very few reviews resulted in significant change, appellants were not always satisfied with the outcomes and some appellants further pursued their claims through letters to DHS, the Auditor-General, Members of Parliament and the Ombudsman.

12.29 In terms of addressing client concerns, the Department's procedures are to provide all clients with information sheets and to assist them if necessary, to request reviews, in the interests of client relations. While acknowledging the efforts of DHS to promote the rights of appeal, audit also identified that:

- The low level of section 121 reviews undertaken in regions may mean that although case planning decisions and strategies appear to be accepted by most families, the accessibility of the review process may also be an inhibiting factor;
- The information sheet distributed by DHS on complaint avenues may not be effective in ensuring people understand their rights and availability of processes. One voluntary agency had recognised this problem and had developed a more comprehensive and user friendly information package for clients;
- Some clients interviewed by audit indicated ignorance of their rights and safeguards under the Act;
- The section 121 review process is specifically concerned with disputes over case planning decisions and generally requires the expression of preferred alternative strategies by the appellant. The need to think through issues, articulate concerns and describe alternatives may be overly challenging to clients under significant stress, who may be inarticulate and see the appeal process as overwhelming. Protective workers advise clients of their ability to use an advocate and may try to facilitate this, but are not always successful; and

- Continuation by clients of grievances past the formal review process, as detailed in various submissions to audit indicated that the objectivity of the process had not always been accepted. In some cases DHS had been unable to overcome clients' refusal to accept protective intervention or that their parenting had been inadequate. In some of these submissions based on the clients' views and, on occasions, the views of professionals, there did appear to audit to be some concerns about practices adopted by individual workers.

12.30 **It is important for the regional review process to be seen as independent, credible, easily accessible and at minimum cost to the person or family seeking review. This would be facilitated by:**

- **Development of improved communications by DHS to clients of the review process and their rights, supported by evaluation of the effectiveness of communications;**
- **The ability to convene external input to reviews where necessary, possibly involving a panel of independent professionals with child welfare experience;**
- **An advocacy support function independent of DHS, to ensure that all clients have the ability to clarify, articulate and pursue appeals; and**
- **Appeal panels to be seen publicly as independent, although not necessarily always involving members external to DHS. As a matter of practice, all regional panels need to be chaired by a regional director or senior officer from a region other than the region where the review is held.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department acknowledges its role in facilitating access by clients to formal internal and external review mechanisms even within an adversarial legal context. It notes that it currently facilitates and encourages clients to engage appropriate advocacy and support, and does not concur with audit on the need to require all internal reviews to be chaired by out-of-line regional directors, although that practice is currently considered appropriate in some cases. The Department is of the view that there are currently sufficient mechanisms requiring external and independent reviews of its decision-making.

Appeals to the Administrative Appeals Tribunal

12.31 Examination by audit of recent cases submitted to the Administrative Appeals Tribunal (AAT) and discussions with departmental personnel and people operating in the Children's Court revealed that:

- there is some concern over the lack of clarity of the AAT's role, what it should hear and whether it should be concerned with substance or process; and
- pursuit of case planning disputes through the AAT can be a lengthy and costly process, especially if legal aid is not granted to the complainant.

12.32 An appeal to the AAT is the only opportunity for a client to obtain an independent external hearing of a dispute over case decisions, and is only available after avenues of appeal within DHS have been exhausted. The delays, effort and costs involved are likely to inhibit all but the most determined clients.

12.33 **An overall review of client interfaces needs to be undertaken to further clarify the role of the AAT and consider the feasibility of establishing more accessible independent forums at a regional level.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department anticipates that a clearly articulated complaints process conveyed to clients through improved communication and the use of appropriately accessible literature, will highlight the availability of the line management complaints process at the regional level, and the role of the AAT. The Department is currently in the process of reviewing and producing literature for clients, including publication in community languages.

County Court appeals against Children's Court decisions

12.34 Disputes with decisions of the Children's Court can be pursued in the County Court, unless a point of law is disputed, in which case appeal is made to the Supreme Court.

12.35 In connection with appeals to the County Court, DHS considers that stronger evidential standards are applied than are applicable in the Children's Court or intended by the *Children and Young Persons Act* 1989.

12.36 The Department considers that this factor may be partially responsible for it having a poor success rate in appeals to the County Court.

12.37 In his 1993 report on *Protective Services for Children in Victoria*, Justice Fogarty suggested measures to resolve these issues, most notably that the Children's Court be presided over by a County Court judge (thereby removing the County Court as an appellant Court), and that the Family Court would be an appropriate Court of Appeal. The Family Court's involvement in family and custody disputes give it some common activity with the Children's Court and frequent coincidence of cases. In addition, it has access to considerably greater resources for support services and counselling.

12.38 Disadvantages of transferring appeal responsibility to the Family Court include:

- the fundamental difference in roles between resolving marital disputes of legally competent adult parties and determining the best future strategy to protect children; and
- delays of up to a year at the Family Court compared with 4-6 weeks in the County Court whereas a prompt response is important in child protection matters.

12.39 **The potential advantages and disadvantages of transferring appeals to the Family Court of Australia remain a consideration for government, but would be unlikely to occur unless there was national child protection legislation.**

The Ombudsman

12.40 The Ombudsman is the key independent resource for people to pursue their dissatisfaction with the Department's decisions and actions. The ability to complain to the Ombudsman is described on the Department's information sheets. Unlike the formal case review and appeal processes, the Ombudsman will handle any complaint, excluding only matters which are with the Court (sub-judice) or which concern Court rulings.

12.41 The Ombudsman's 1993-94 report recorded that 3 514 written complaints were received in total of which only 131 (4 per cent) concerned child custody and welfare (not including adoption or disability).

12.42 Where complainants have not previously raised their objections with DHS, the Ombudsman advises them to do so, and in 1994-95, 26 of 120 complainants were referred to DHS in this manner. In addition, audit is informed that over 16 000 telephone calls are handled annually by the Ombudsman, although records were not available to permit breakdown of this figure as to calls involving child protection issues.

12.43 Many complainants, particularly telephone callers, sought clarification or confirmation early in the child protection process, from an independent respected party, that DHS has acted appropriately and legally, e.g. in removing a child, or interviewing a child at school.

12.44 The Ombudsman indicated to audit that submissions and telephone calls often concerned communication difficulties which reflect the nature of DHS intervention, as well as great distrust of the Department. Complaints at later stages demonstrate that initial grievances or misunderstandings can be exacerbated by departmental failure to recognise and settle differences earlier in the process thus causing extension and escalation of disputes.

12.45 The Ombudsman is generally able to resolve complaints through accessing files, discussions with DHS and facilitating communication between clients and DHS. A major element in this is the Ombudsman's ability to access information which for confidentiality reasons is not able to be provided to clients or other people, e.g. details of the notification or other reports on case files. The Ombudsman, without infringing confidentiality, is in a position to either reassure the client that DHS has acted justifiably, or bring any problems to the Department's attention.

12.46 **The Ombudsman provides an essential, credible and respected service known for its independence. Ombudsman inquiries have brought attention and enhancements to practice issues. However, many cases referred to the Ombudsman show unresolved grievances to have continued for extensive periods of time which could have been addressed much earlier, through greater consultation and information provision. To resolve this will require management determination to achieve reconciliation and problem resolution and enhanced communication and reconciliation skills, particularly at the supervisor and manager level in protective services.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  A review was undertaken by DHS in 1995 of investigations conducted by the Office of the Ombudsman (Victoria) with DHS.

  A specific finding of the review was:

  > *"In fact, the Ombudsman has generally been a supporter of the Department and has recognised its difficult role in dealing with sensitive and complex human problems; he has only been critical of its actions in 2 per cent of the cases brought under his attention. In 98 per cent of the matters examined by the Ombudsman, the actions of the Department are supported with the usual outcomes being - that the complaint is dismissed, that it is left for the Department to conclude the matter or simply that the Ombudsman is taking no further action".*

  This review indicated that generally, the Department is performing well in its handling of Ombudsman's inquiries. The great majority of cases are concluded without any findings being made against the Department.

  Where deficiencies were found, the Department has been able to remedy problems identified and the Ombudsman has not found it necessary to take further action. The Department proposes to pursue closer liaison with the Ombudsman's office on child protection matters to promote more effective communication for both parties and promote more effective resolution of complaints.

NEED TO FACILITATE INPUT FROM CHILDREN AND YOUNG PEOPLE

12.47 The principal clients of the protective services of DHS are the children and young people in need of protection and care and audit acknowledges that there may be many children for whom the intervention of protective services has been responsible for their removal from abuse, satisfactory upbringing and even saving their lives. On the other hand, input to audit indicates that some children have had numerous changes in placements, multiple care-givers and case managers all adding to their insecurity and disturbed emotions. Some adolescents interviewed by audit felt that the "system" had failed to treat them as individuals and human beings on occasions. The children felt intimidated about making complaints, especially as there was no clearly defined process for making complaints or having an advocate or Children's Rights Officer to assist them.

12.48 While appreciating the difference between *"wishes"* and *"needs"* of children and young persons, audit considers that hearing and addressing the views of children and young people is essential to the success of strategies to protect and care for them.

12.49 Many complaints and appeals studied by audit purported to represent children's interests, alleging investigation trauma and poor care, or disputing Permanent Care Orders, placement arrangements details or wanting the return of children. However, audit considered that appeals and complaints processes were deficient in hearing the views of children in that:

- notwithstanding numerous references to inadequate services being provided by DHS, there were no complaints or appeals directly from children or young people, nor did any of the complaints seen by audit reflect independent input from children;
- fear of family and personal consequences may inhibit children from voicing concerns; and
- children found it very intimidating to complain about their placement services or individual staff.

12.50 In many circumstances it can be appropriate for a parent or guardian to speak on a child's behalf. However, child protection is specifically concerned with questioning child-parent relationships, so that while such input is important, it can be inappropriate as a means of ensuring that the best interests and views of the child are adequately represented.

12.51 Case planning and management aim to address children's concerns and needs, and most case workers endeavour to establish client trust and understanding. However, the children interviewed by audit considered that children in care could be severely inhibited from complaining, by their realisation or anticipation of the results their actions could have in reprisals against themselves or a parent or sibling, or in splitting the family. In reality, although most case plans endeavour to meet the best interests of the child, there will always be occasions where the plans, or certain aspects of plans, are inappropriate, particularly with inexperienced workers. In these situations and where a child considers they are disadvantaged, avenues should exist for a child to officially lodge a complaint without prejudice, and services exist to help the child to do so.

12.52 Without direct, open and fear-free input from children DHS has inadequate information to assess whether problems for certain children exist in relation to particular aspects of the Child Protection Program, including placements, care-givers, supports, case workers or any other issue.

12.53 **Audit considers strategies need to be implemented to ensure that children's views are adequately heard and respected in helping to determine where their best interests lie and whether present arrangements are effective and satisfactory.**

12.54 **Consideration could also be given to the establishment of an independent advocacy service, fulfilling a similar role to Children's Rights Officers in England and Canada. In any event, complaint procedures need to be established and communicated to enable children and young persons to voice their opinions and concerns with clarity and without prejudice or fear of retribution to assist them to achieve the best outcomes for their care.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department is committed to ensuring that children and young people in its care have ready and effective access to a complaints resolution process. It has initiated a project to investigate the relevant issues and develop proposals, including those raised by audit, to achieve better outcomes and ensure that complaints by children and young people are heard and dealt with effectively. Audit's suggestion of an advocacy function would be considered within this context together with associated cost-benefit implications.

  Further, the Department is committed to ensuring that its staff are sensitive to the views and experiences of children and young people, and to ensuring that complaints by children and young people are heard. This is illustrated by the funding of the Victorian Association of Young People in Care (VAYPIC). VAYPIC is a consumer body targeted to support children and young people who are or have been in care and through which they can participate in the planning and provision of care services and policy decision-making. VAYPIC regularly contributes to child protection staff training and other Statewide forums targeted to service delivery staff. Further, VAYPIC has been contracted to seek consumer input on service redevelopment as part of the Secure Welfare Review.

  The Department notes audit's suggestions in relation to the establishment of an Advocate of Children's Rights Officer, and given the lack of detail provided by audit will examine its practical application on the information available, and in the context of its broader work in this area.

Part 13

Prevention and early intervention

OVERVIEW

13.1 In this Part of the Report, prevention is regarded as activities that stop or reduce the incidence of abuse and neglect and facilitate the recognition and treatment of emerging situations before they become notifications. A major benefit of prevention strategies, including early intervention in families, in the longer-term, should be to reduce the number of notifications to Child Protection Services, thus allowing its resources to be focused primarily on protecting children and caring for those who need protection. Effective prevention strategies are seen as the primary mechanisms available to contain the continuing, increasing level of notifications of child abuse received annually by DHS and which are placing the child protection system under continual strain.

13.2 For most children, the main protector is the family. Major safeguards against child abuse and neglect are the integrity and security of families, community support and the network of community activities, universal and specialist services. Of critical importance is the need to identify and provide support and assistance to those families where, in the absence of intensive support, family breakdown is likely to occur and children may become the victims of abuse or neglect.

13.3 Audit concluded that the Department of Human Services (DHS) has a strong commitment to strategies and programs directed toward prevention of child abuse and neglect, including early intervention with families deemed to be at risk. During the past 2 years, DHS has increased its focus on the prevention of child abuse and neglect within the framework of the National Prevention Strategy, through:

- the development of specific prevention and community education strategies by the Child, Adolescent and Family Welfare Program of DHS (CAFW) and the undertaking of joint projects between Child Protection Services and Primary Care; and
- Primary Care programs designed to improve parenting skills and support child development.

13.4 Initiatives to date have included the establishment of Statewide networks, a Positive Parenting strategy and linkage projects between Primary Care and Child Protection services to co-ordinate and improve local early intervention support services.

13.5 Audit established that:

- the development of direct prevention strategies by Child Protection Services, and linkage projects with Primary Care Services are at formative stage;
- the preventative and early intervention effectiveness of DHS's Primary Care Services have not been fully articulated or evaluated within a primary care prevention strategy;
- the significant preventative potential of other primary services lack guidance and direction through a common strategy.

OVERVIEW *- continued*

13.6 It would be beneficial for DHS to take a lead role in progressing the National Prevention Strategy in Victoria. Matters which need to be addressed as part of this process include:

- an overall "primary services" prevention strategy to guide, co-ordinate and harness the preventative potential of government and community organisations and programs dealing with children and families;
- the articulation and progressive development of prevention strategies contained within departmental primary care programs;
- inclusion of prevention objectives within the strategic plans of all relevant DHS programs;
- guidelines and priorities for specific prevention activities for DHS and local communities; and
- overall evaluation of the effectiveness of DHS and other primary care services provided by government in reaching children and families, detecting and addressing early symptoms of problems in families.

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The Department welcomes audit's acknowledgment that it has a strong commitment to child abuse prevention strategies and programs. DHS currently coordinates and guides the direction of prevention in Victoria, using the strategic framework of the National Strategy.

Audit does not make clear how an overall primary services prevention strategy would progress prevention in ways that are not occurring at present.

The process of setting priorities and guidelines for specific activities, and building prevention objectives into existing and new programs is occurring and is an ongoing process. For example, the Department has sponsored a campaign to raise awareness about the dangers of shaking babies. Similarly, the Department has assisted the development of local prevention initiatives through local prevention networks, and intends to utilise a grants scheme to foster local initiatives in accordance with set guidelines.

NATIONAL PREVENTION STRATEGY

13.7 The National Child Protection Council (NCPC) was established in 1991 to bring together representatives of Australian and State Governments and community organisations involved in child protection. The NCPC undertook the role of developing a National Prevention Strategy after recognising that the primary focus in the various States had been to address problems after they had occurred rather than seeking to prevent them in the first instance, and that with the early developmental state of prevention there were numerous benefits to be gained from adopting a national approach.

13.8 The National Prevention Strategy defines 3 levels of prevention:

- *primary prevention programs,* targeted at the whole community with the aim of stopping abuse before it starts;
- *secondary prevention programs,* which target specific sections of the child population considered to be more prone to be *"at risk"* of abuse along with sections of the adult population also considered likely to be *"at risk"* of abusing; and
- *tertiary prevention programs,* to help those who have already been abused.

13.9 The strategy identifies 3 key objectives:

- to identify and change attitudes and behaviours which are harmful to children and to promote attitudes and behaviours which nurture and support children;
- to identify and change factors which contribute to harmful parenting practices and create a community environment which better supports and assists adults in parenting children; and
- to teach children how to form non-exploitative relationships and to develop children's emotional care and personal safety skills.

13.10 Interstate exchange and cooperation in prevention research and activities is supported by the National Child Protection Clearing House which serves as an exchange point for information research and initiatives supporting work in prevention.

Elements of the National Prevention strategy

13.11 The National Prevention Strategy is essentially a framework to structure the development of preventive programs by Australian and State Governments. The framework comprises 4 sub-programs, namely:

- Information and Public Awareness;
- Knowledge and Skill Development;
- Policy and Program Development;
- Local Initiatives and Services.

13.12 Major objectives proposed in these sub-programs include:

- Statewide child abuse prevention networks to be established by State Governments;
- an information package to be prepared by the National Council;
- education programs for children, parents and professionals;
- information and advisory services for children and parents;
- research programs with interchange supported by the National Child Protection Clearing House;
- the inclusion of policy focuses on children's issues in other program areas such as public health and planning; and
- early intervention support services and specific prevention initiatives at an individual State level.

13.13 Recent national preventive activities have included National Child Protection Week, establishment of the National Child Protection Clearing House and a National Kids Help Line.

13.14 The National Prevention Strategy provides a broad framework and allocates responsibilities for a range of activities to Federal and State agencies. Implementation strategies are to be developed by each State following evaluation of existing State processes and initiatives. Victoria endorsed the National Prevention Strategy in 1993, and the development of prevention strategies is now occurring within that overall national framework.

13.15 **It is now important that DHS, when implementing the National Prevention Strategy in Victoria, develops a comprehensive strategic plan as to the specific directions to be taken, drawing maximum benefit from existing services and arrangements.**

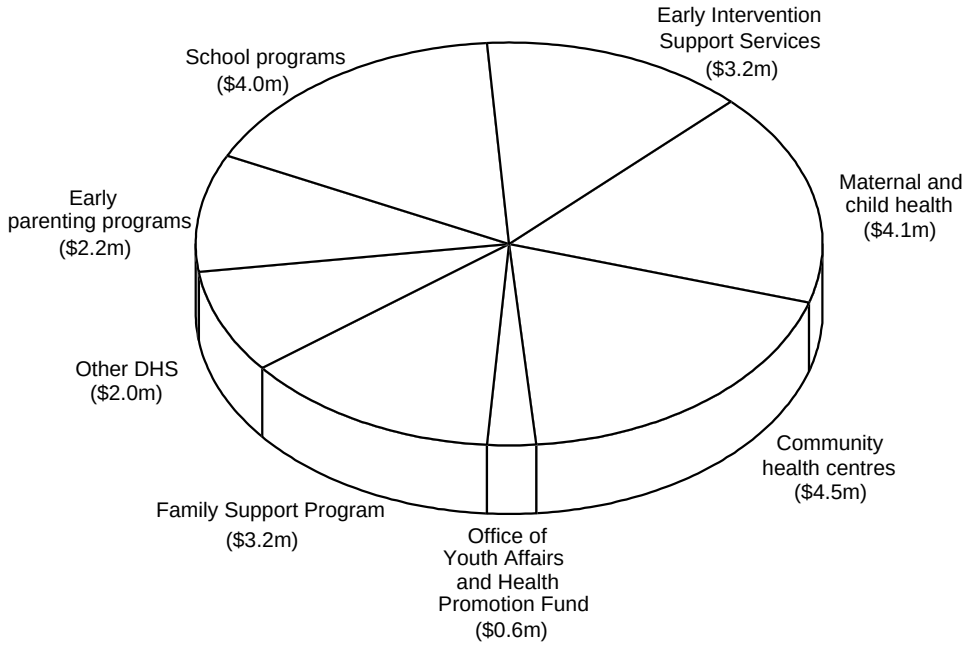
- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The Department believes that the National Prevention Strategy is an appropriate framework for prevention development in Victoria. Victoria has endorsed the national strategy and is implementing it. The Victorian Child Abuse Prevention Reference Group (VCAPRG) has been established by DHS to assist the implementation of the National Prevention Strategy.

Significant Victorian Government expenditure on prevention initiatives

13.16 Existing government programs include a significant level of prevention activity recognised to be within the scope of the National Prevention Strategy, with estimates of annual government expenditure of almost $24 million in 1994-95 including new initiatives totalling $4 million introduced during the year.

CHART 13A
ESTIMATES OF STATE GOVERNMENT FUNDING ATTRIBUTED TO PREVENTION STRATEGIES



13.17 Chart 13A depicts estimates of the extent of expenditure which was deemed to be particularly related to prevention activities in a number of programs. In addition to these programs, Victoria Police operate prevention-oriented education programs, namely *Police in Schools* and *Protective Behaviours* programs.

13.18 New initiatives in Victoria during 1995 included:

- establishment by DHS of senior "Project Manager" positions in each region whose duties include initiating the development of Statewide networks as recommended in the National Prevention Strategy;
- the *Healthy Families* project auspiced by the Health Promotion Foundation involving pilot programs to engage school, family and community, in a primary school setting, to improve parenting skills;
- development of a child sexual abuse prevention package for piloting in secondary schools;
- the Positive Parenting Program introduced by the Primary Care Division of DHS with support material for parents and professionals;
- planning for a mass media campaign on family violence;
- linkage projects between primary care and child protection to improve primary care and early intervention effectiveness in preventing protective notifications;

- early parenting support services including day-stay, in-home support and school linked parenting support services;
- the *"never shake a baby"* campaign; and
- pilot investigation of a *"healthy start"* program by the Berry Street family service.

13.19 **A significant amount of expenditure has been committed to incorporating preventive elements in several government programs in Victoria and in developing new programs. The challenge is to clearly identify the contribution each of the elements makes to the National Prevention Strategy, evaluate their effectiveness in preventing child abuse, modify or cease existing programs where necessary and define what other programs and improvements, if any, are warranted. An evaluative framework also needs to be established for the various prevention initiatives, including setting of goals and appropriate program evaluation measures, which will facilitate a systematic and structured analysis and evaluation of the effectiveness of the initiatives.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Expenditure cited in this section is only an approximation of the actual amount spent on prevention. A range of programs help prevent child abuse. However, the extent to which programs can be said to be preventive varies. Hence, the proportion of the cost of these programs that can be said to be spent on prevention also varies. On current estimates, Victoria is spending over $9 million more than other state and territory on preventive measures, and twice as much per capita than one of the largest states. The Department agrees with the value of program evaluation and with building prevention objectives into program goals. However, audit needs to accept that most of the programs discussed have primary objectives other than child abuse prevention. So program evaluation will in the first instance address the primary objectives of those programs. Where possible and appropriate, evaluation of programs' preventive capacity and effectiveness will be undertaken.

PRIMARY CARE SERVICES OF THE DEPARTMENT OF HUMAN SERVICES

13.20 The principal provider of primary care is the family unit, which nurtures, protects, raises and parents the vast majority of children and supports and maintains individuals in crises. A wide range of general services in Victoria have contacts with children and families and comprise the first and major defensive barrier against child abuse and neglect, through advising and helping parents, families and children, recognising potential problems, providing early intervention and if necessary referral to more intensive services.

13.21 The Maternal and Child Health Service is regarded as central to the primary preventive barrier as the major "universal" service for most young children and their mothers. Other primary services include community health, general medical practice, child care centres and schools, as well as family support services which offer accommodation, counselling, fostering and other care services. The Department encourages networking by different service providers to increase overall effectiveness.

13.22 In 1993, DHS established the Primary Care Division to improve the coordination of services for children and families and promote the development of a Children and Family Service System. Primary care services are characterised as voluntary, self-referral, walk in - walk out and intended to be accessible to, and used by, the majority of families. They include:

- Community health services such as medical, pharmaceutical, allied health and respite services, many of which are provided through community health centres;
- Community support services such as neighbourhood houses and family violence program;
- Children's and family services, including:
  - Pre-school and child care services;
  - Specialist children's services;
  - Family support services;
  - Early parenting programs and support services;
  - Maternal and child health; and
  - School nursing services.

13.23 Major functions of the primary care system in DHS include:

- health promotion;
- early identification, advice and referral to health and social welfare services;
- provision of information and support to families, and care and education for children; and
- provision of support to generic services and referral to specialist services.

13.24 Because of their universal nature, primary care services lack the stigma which is recognised to be associated with "welfare" and "protection" services. Hence it is generally accepted that they provide the most effective platform for family and children advice, support, surveillance, early detection and intervention activities and comprise an effective vehicle for specific prevention programs. The maternal and child health service, in particular, is seen by DHS and the profession to have a strong role in providing support to all mothers during early childhood and in helping to prevent child abuse.

Prevention focus in primary care services

13.25 In June 1993, DHS identified a number of directions for strategic change in primary care services, particularly unit and outcome-based funding strategies, targeting of families with particular needs, clarification of service expectations, and service and program streamlining through co-locating services and improving the linkages between them. In addition, an external evaluation of the effectiveness of school nursing services was planned.

13.26 During 1994 and 1995, a number of strategic initiatives and program changes have been introduced or recommended including:

- the Healthy Futures Program which was intended to clarify the Government's expectations from its funding of maternal and child health services, provide strategic direction to guide the practice of individual nurses and improve the use of services by families with prominent health needs as well as needy groups who did not previously access the service;
- recommendation for a focus on improving parenting skills and support through the Positive Parenting Program and redevelopment of early parenting centres;
- recommended future directions for community health and support including fairer distribution of budget resources based on services provided; and
- the commencement of specialist children's services, established as a merger of allied health and early intervention teams to integrate services for children with additional care needs, and provide family service co-ordination to link families to other services.

13.27 Child welfare and abuse prevention agendas are beginning to be considered in the planning and implementation of primary care program strategies as a result of co-operation between Primary Care and Child and Family Welfare at various levels.

13.28 As an example, protective services managers are involved in reference groups and working parties for the redevelopment of family support programs and Early Parenting Centres. Specific linkage projects between primary care and child protective services have been initiated to pilot improvements in the ability of primary care services to screen and assist families to prevent the development of abuse and neglect.

13.29 Audit acknowledges that DHS has begun to redevelop its primary care services to increase their family support capacity and in doing so is beginning to place greater emphasis on their preventative role. In particular, the parenting initiatives in the Positive Parenting Program and Early Parenting Centres contribute to prevention through enhancing family and social functioning and increasing parenting skills.

13.30 However, in its restructuring of primary care services, DHS has not yet undertaken a systematic review of the preventative aspects of primary care. Prevention perspectives, such as the potential and actual coverage of programs and their ability to identify family functioning problems, have not been addressed in strategies and evaluations for most programs. As an example, the following section on the Maternal and Child Health Service identifies that its effectiveness in prevention needs evaluating and that its capacity for primary screening and early intervention are inherently limited. This indicates the need for the Department to review its primary care services as to the appropriateness and effectiveness of prevention strategies contained in such programs, and the overall preventative effectiveness of all primary care services.

13.31 **The effectiveness of DHS primary care services in helping to prevent child abuse would be further enhanced by:**

- **a strategic evaluation of preventative aspects included in primary care services, including regular collection of statistics on levels of contact with children of different ages and their families;**
- **increased monitoring and assertive outreach strategies to increase the attendance of families, particularly "at risk" families not previously using primary care services; and**
- **developing a better defined child abuse prevention focus in program goals, strategy formulation and implementation planning.**

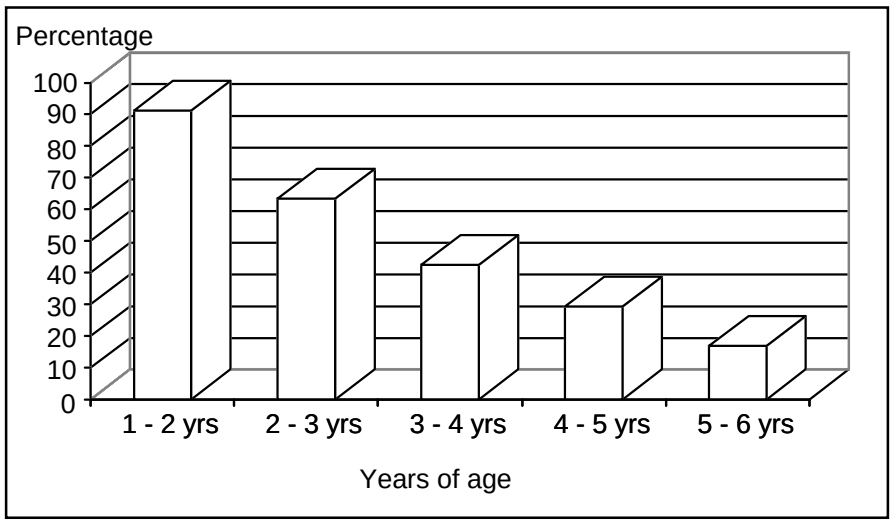
Maternal and Child Health Service

13.32 The Maternal and Child Health Service's principal role is providing health, development and welfare services to mothers and children during early childhood. Maternal and Child Health nurses provide an important service in visiting nearly all new births in the State and providing health and parenting assistance to most families with pre-school children. The Service is operated by local government, and jointly funded by State and local governments, with the State contributing $14.6 million in 1994-95, or just under 50 per cent of the total budget for the Service.

13.33 The Service is regarded as a universal service which targets all children in the State under school age, on a voluntary basis. In 1993-94, over 98 per cent of 64 887 notified births were enrolled in the Service, while stillbirths and early deaths accounted for most of the remainder.

13.34 The level of contacts with children and families drops progressively with increasing age of children. Chart 13B shows the levels of attendance at later ages after initial post-birth contacts, as percentages of the original number of enrolments.

CHART 13B
PERCENTAGE OF ENROLLED CHILDREN CONTINUING TO ATTEND THE MATERNAL AND CHILD HEALTH SERVICE IN 1993-94



13.35 The Service has an important role, and is seen by some health professionals as the linchpin in child and family support and the prevention of abuse and neglect, due to its role in child health and improving family functioning and its contact capacity, initiating family contact for all births and offering ongoing contact for all families for the first 5 years of a child's life. Through contacts and home visits, maternal and child health nurses are well placed to advise parents, observe and help with problems and connect parents to other services.

13.36 As well as the benefits resulting from direct contacts between nurse and client, the Service serves as a base for parent and child groups which can help to reduce stress on mothers through wider contacts for mother and child and providing access to support and advice from others, all of which have welfare and prevention value.

13.37 In recognition of their role in family development and welfare support, training for maternal and child health nurses has been considerably broadened in recent years from a previously more specialised medical focus. The Department is currently working with RMIT School of Community and Child Health Nursing to produce a revised definition of the full role of maternal and child health nurses leading to competency statements which recognise welfare as well as health responsibilities.

13.38 The Department is considering areas of the system where improvements are needed such as increasing the use of multi-disciplinary inputs, improving support to those nurses who are currently very isolated either geographically or functionally, encouraging more access by families in *"at-risk"* groups, and encouraging families to raise problems at an earlier stage to reduce a focus on long-term chronic needs.

13.39 **The Maternal and Child Health Service has developed important welfare capabilities over several years and is increasingly recognised by DHS and others as the front line in preventing child abuse and neglect through parenting support and early recognition of child development concerns.**

Scope for further developing the preventative contribution of the Maternal and Child Health Service

13.40 Evaluation of the Service's inherent preventive capacity would place greater emphasis and more stringent expectations on some aspects related to prevention, including the quality of family contact and the skill of nurses in recognising family problems and early signs of abuse and neglect. However, these components are generally not evaluated and little data is collected about aspects of the Service relevant to prevention.

13.41 In considering these matters, audit recognises that:

- for the majority of families the Service seeks to develop parenting competence and confidence, which would be reflected in a decreasing level of contact, as revealed by Chart 13B; and
- a maternal and child health nurse's knowledge of various factors, such as home conditions and family environment which may indicate risk is usually limited due to infrequent home visits.

13.42 Notwithstanding the above limitations, because the preventative aspects of the Service are not specifically identified or evaluated the Service may not be as effective as a prevention net as it could be. While acknowledging the ability of the Service to develop parental competence and independence, it is likely that the higher percentage of non-users of the Service with older children includes many *"at risk"* families as well as competent, independent highly functional families. For example, family circumstances such as mobility which can contribute to reduced contact, may be factors contributing to increased family vulnerability.

13.43 Audit suggests that the use of the Maternal and Child Health Service in prevention activities cannot be assumed to be sufficient, because those families in greatest need may not use the Service. Usage needs to be reinforced by monitoring and aggressive marketing. Evidence from a different area, to support audit concern, that reliance on voluntary service use can be insufficient to achieve service objectives, is provided by the emerging issue of diminishing immunisation and vaccination levels within the community.

13.44 In the above regard, audit acknowledges the focus in *"Healthy Futures"* on the need to target "at risk" families and families who currently make insufficient use of the Service, and understands DHS's position that with a fixed budget this can only be achieved by encouraging greater independence of competent families. Audit suggests that DHS should follow the NCPC recommendation to increase skills in nurses in identifying high risk parents, and to strengthen the training and assessment of maternal and child health nurses in this regard. The challenge is to increase the Service's success in reaching those most needing it, without endangering either the adequacy of the Service to all families or its general respect and acceptability.

13.45 **Without detracting from the primary purpose of the Maternal and Child Health Service, its effectiveness in helping to prevent child abuse and neglect could be further enhanced through the development of a strategic emphasis on prevention, supported by measures such as:**

- **assessing the extent of initial coverage of the Service, analysing both the known gap and the potential for births not to be notified to the Service such as arrivals from interstate or overseas;**
- **evaluating the effectiveness of the Service in reaching families who need help and developing strategies to bridge the gaps, including assertive outreach strategies for "at risk" families;**
- **developing a profile of non-contact families, what they represent in terms of child care concerns and any correlation with protective interventions;**
- **establishing mechanisms to facilitate continued contact with mobile families, both intra and interstate and all immigrant families with children;**
- **assessing and improving, if necessary, the training of maternal and child health nurses in recognising risk factors within families; and**
- **maximising the confidence in the Service of all parents and children, to encourage the raising of family concerns with the nurse.**

The Healthy Futures strategy

13.46 In 1994 the Government's *Healthy Futures* initiative shifted the funding strategy for the Maternal and Child Health Service from a "subsidy" to "purchase" of services. Guidance for service delivery was provided through a framework of 10 key contact points relating to specific infant health issues and development stages. The aims of *Healthy Futures* include:

- increasing the emphasis on specific contacts with children between 3 and 5 years old related to particular health care concerns;
- increasing the presence of the Service in needy homes and improve the utilisation by families who have been under-utilising the Service; and
- encouraging increased parenting confidence and independence and thus reduce the current heavy service utilisation by some clients.

13.47 Departmental funding to the Maternal and Child Health Service is essentially related to numbers of children in the 0 to 6 age group. Funding of services is calculated on the basis that 65 per cent of the funding is intended to cover the 10 key contact points for all families, including a home visit for all babies soon after birth. The remaining 35 per cent is intended to ensure the capacity to provide:

- at least 4 additional visits for first time mothers;
- an additional 3 hours of contact for 40 per cent of all families who may have particular needs and eight 2 hour group sessions for all first time mothers;
- an outreach service to needy families who would not otherwise use the service;
- additional resources to service mothers from non-English speaking backgrounds, low socio-economic backgrounds and rurally isolated populations.

13.48 In regard to specific prevention provisions, one goal of *Healthy Futures* is to *enhance family functioning.* The detailed development of this goal for each recommended consultation point includes alerting nurses to the potential for abuse and neglect.

13.49 The introduction of Healthy Futures has been publicly criticised by the nursing profession and some users in terms of potential damage and dilution to services and restriction of access to mothers. These criticisms have been supported by external study reports involving surveys of service users. In respect of the effectiveness of the Maternal and Child Health Service in helping to prevent child abuse and neglect, criticisms of *Healthy Futures* were that:

- services to children in their first year are reduced and mothers are limited from getting access as and when they need it;
- there is an increased emphasis on at-risk groups at the expense of universality; and
- it introduces an increased medical health focus in the Maternal and Child Health Service at a time of increasing public emphasis on child protection and care.

13.50 The Department's position is that the strategy articulates key priorities of the Service and reinforces recommended health and development checkpoints, some of which had previously received inadequate attention. The strategy was seen as including improvements to the Service such as the making of appointment times instead of ad hoc arrivals, but does not reduce the provision of services in any form.

13.51 An evaluation of the effectiveness of the Maternal and Child Health Service was not part of the scope of the audit review and therefore audit comment is inappropriate. In any event, DHS maintained that ease of access by families to the Service has not changed, there is a targeted increase in contacts at higher age levels and that the ratio of nurses to new births has not changed.

13.52 In terms of preventing child abuse, Healthy Futures aimed to increase utilisation of the Maternal and Child Health Service by needy families, families potentially at risk of breakdown and families that had not previously used the Service, emphases which should enhance the preventative contribution of the service.

13.53 However, despite the general acceptance of the benefits of the Service in early detection and prevention of child abuse, literature distributed in regard to the *Healthy Futures* program focused on child health and development matters only, with minimal direct references to the value of the Service in prevention.

13.54 Guidance provided on service delivery referred to 10 key contact points with mothers specifically related to infant health issues and child development. Other contacts, outside the minimum of 10, encompassed additional contacts relating to specific categories of mothers. For example, first time mothers need more attention than would more experienced mothers with other children. While not questioning the merits or otherwise of the strategy, audit observed the strategy was undeveloped in regard to the benefit of the Service in terms of detection or prevention of child abuse. Maternal and Child Health nurses are obviously ideally positioned to detect suspected abuse, particularly as statistics indicate that children under the age of 12 months are particularly vulnerable to abuse.

13.55 In audit opinion, the Maternal and Child Health Program does not have a clearly stated strategy in relation to its role preventing child abuse and neglect, nor did Primary Care take the opportunity, in the development of Healthy Futures, to consult with protective services and integrate prevention into the revised service model.

13.56 **There is scope for further improving the contribution of *Healthy Futures* initiative to prevention of child abuse through DHS:**

- **initiating a joint activity between protective services and Primary Care to further establish prevention elements in the *Healthy Futures* strategic framework, in line with the implementation of the National Prevention Strategy;**
- **developing mechanisms to gather data and develop performance indicators in order to evaluate the effectiveness of Healthy Futures against clear agreed objectives, particularly in respect of its impact on the prevention of child abuse and neglect; and**
- **further developing and communicating the family welfare and prevention elements of *Healthy Futures* in consultation with other interested parties.**

❑ ***RESPONSE*** *provided by Secretary, Department of Human Services*

The primary aim of the Healthy Futures funding model, known better as the Maternal and Child Health Program, is to establish a service framework to achieve the Health Goals and Targets for Children and Youth. The Victorian targets have been endorsed nationally, and so the program operates within a national context. The framework articulates a range of activities to be provided for families at each of the key ages and stages of a child's development. Data has shown there is sustained participation in the service. Contact with families into the pre-school year, enhances the service's capacity to support families in their parenting role at a time when, historically, contact with the service reduced.

In addition to the core program, 4 pilot outreach models are currently being developed to provide service to at risk families, with the aim of early identification and intervention through additional support before a crisis arises in order to deflect families from secondary and tertiary intervention. These pilots will be evaluated over a 3 year period.

With the new Healthy Futures funding model now in place for 2 years, evaluation of the effectiveness of the Maternal and Child Health Program to achieve its primary aims is taking place within the limitations of a manual data collection system and the voluntary nature of the service.

Parenting improvement and support programs

13.57 Parenting skills are of major importance in preventing child abuse and neglect, and the NCPC report comments that *"... when parenting is a positive experience, the likelihood of abuse decreases"*. The Department's strategies to improve parenting skills in the community are focused through a range of primary care programs. Recent initiatives by the Primary Care Division to improve parenting capacity and indirectly help to prevent abuse and neglect include the Positive Parenting Strategy and the redevelopment of Early Parenting Centres.

13.58 The Department also funds a range of family support agencies some of which focus on early parenting, provision of support to over 50 parent support groups across the State and parent education and support services in some hospitals, specialised units and community support services.

13.59 The Departments strategies in improving parenting skills are important initiatives which are also expected to make a valuable contribution towards limiting child abuse and neglect. In order to maximise this contribution, the implementation of these strategies should establish linkages between protective services and primary care so that families experiencing difficulties which are brought to the attention of protection workers are encouraged to utilise Early Parenting Centres and to participate in the Positive Parenting Program.

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  The overall purpose of Early Parenting Centres is to enhance parenting competence and confidence, enabling parents to nurture and protect their children. One objective of the current redevelopment of EPCs is to ensure they are accessible and relevant for all vulnerable families.

  In order to ensure that EPCs continue to service the needs of Protection and Care clients, discussions are taking place between CAFW and Primary Care to ensure that in a redeveloped service model, services continue to be provided for those families most in need.

  The Positive Parenting Program (PPP) is an initiative which has the primary goal of enhancing the health, development and emotional wellbeing of all children in the community. The PPP is not primarily an abuse prevention program. However, once fully implemented, through the provision of positive parenting practices, the PPP has the potential to reduce the prevalence of child abuse.

  The Department is currently arranging for the distribution of PPP materials to protective service workers for their work with families. Linkages between Primary Care and Protection and Care will be further extended as the program develops.

Community Health and Community Health Centres

13.60 Community Health Centres are the principal focus for provision of DHS's Community Health Program of medical, pharmaceutical, allied health, respite and other services. Other elements of the Department's Community Health Program relevant to preventing child abuse and neglect include:

- innovative health services for homeless youth programs;
- women's health and sexual assault programs; and
- family support and counselling services with some prevention focus.

13.61 There are at present 78 Community Health Centres operating in municipalities across Victoria. The Department is working to rationalise and improve the distribution of centres in line with the recent local government reorganisation and with the aim that there will be at least one centre per municipality, and possibly multiple sites within some municipalities, depending on geographical factors.

13.62 Community health centres can make a significant contribution to prevention because they are available to all members of the community and have the advantages of being health-based as well as generalist, hence allowing the purpose of contact to remain confidential. As a complement to the Maternal and Child Health Service, the centres have the additional value of providing services which are appropriate to older children and other family members. However, the ability of centres to contribute to the prevention of child abuse is not specifically addressed in policy guidelines, documentation or directives provided by DHS to centres.

13.63 **Audit recommends that Child Protection Services and Primary Care co-operate to extend the general policy and strategy for prevention in the primary care sector into specific policy, strategies and program guidelines related to the prevention of child abuse and neglect, for community health centres and community health services. In time, the effectiveness of the centres in contributing to a universal safety net for preventing child abuse and neglect will need to be appraised.**

- ***RESPONSE*** *provided by Secretary, Department of Human Services*

  Community health centres are service outlets which provide a wide range of services, funded by a number of programs, to the local community, or targeted to particular priority groups, such as low income earners. The Community Health Program funds a specific profile of services, including information provision, health education, allied health, nursing and counselling. These services can contribute to a broad community support system for families and thereby assist in the reduction of child abuse.

Role of schools in prevention strategies

13.64 Many health and welfare professionals consider schools to be the obvious "universal service" for children aged between 6 and 17 years, because of the requirement for all children to attend school to at least the age of 15 and the extent of contact between teachers and students. In recognition of this contact, teachers are mandated notifiers.

13.65 The Department of Education considers that the school system is not a welfare or protective service, and is prevented from being a "universal service" by the limitation of contacts with children to school terms, hours and premises. However, the Department of Education recognises that personal and family problems potentially limit individual educational prowess and that alertness for and responsiveness to them are an important element of effective teaching. In teaching students, schools may identify family problems through learning difficulties of children which could indicate or provide early warning of abuse and neglect. Although it is not appropriate for teachers to directly follow-up welfare concerns in the home, all schools are intended to have student counselling and welfare support provisions through which concerns may be referred to DHS or an appropriate care service.

13.66 The manner and extent of provision of student care functions, previously organised through school support services and welfare co-ordinators, are now determined according to the individual needs of each school within policy guidelines of *Schools of the Future* which has devolved budget management and service strategy to schools.

13.67 Particular provisions of *Schools of the Future* for student support programs, which aim to encourage children to remain at school to complete their schooling, include:

- provision of student support services in accordance with the needs of each school, with specific fund allocations subject to accountability mechanisms;
- requirements and guidelines for schools to develop *Codes of Student Conduct*, inclusive of procedures for maintaining safe and supportive school environments;
- the *Students at Risk* program which focuses on support for students at risk of leaving school before completing year 12, and students whose achievements or behaviour are adversely affected by circumstances such as family dysfunction, including severe disabilities, violence, substance abuse or homelessness;
- a number of programs such as the *peer support* and *pro-social adolescent behaviours* programs, anti-violence guide to positive relationships and drug education support; and
- a range of *alternative program settings* which provide different learning environments and strategies to suit the needs of students who are experiencing educational difficulties in the normal school environment.

13.68 Schools are also a basis for several health, welfare and prevention strategies and activities, including school nursing services and other related programs. In addition, initiatives such as the *Homes* project and the *Healthy Families* project have focused on engaging community and parents in schools to improve the quality of family functioning and parent-child relationships.

13.69 **A range of provisions have been incorporated the *Schools of the Future* Program in relation to student welfare. It would be beneficial for the Department of Education to participate with DHS in developing the Victorian implementation of the National Prevention Strategy.**

SPECIFIC PREVENTION INITIATIVES BY THE DEPARTMENT OF HUMAN SERVICES

Pilot prevention projects

13.70 In most investigations undertaken by Child Protection Services, child abuse is not substantiated, although a need for welfare support for the family may be recognised.

13.71 While many of these notifications may have been warranted by the circumstances, a reduction in notifications primarily involving welfare concerns as distinct from suspected child abuse, would bring significant benefits by enabling protective workers to devote more attention to high risk protection cases. DHS, in 1994, initiated a number of pilot regional projects within the National Prevention Strategy framework to investigate:

- why protective notifications were made in situations where a primary care response would have been more suitable; and
- how the referral of families to support services, where welfare issues were apparent rather than protective concerns, could be improved.

13.72 Initial findings of the projects identified service gaps in the 0 to 6 age group as a focus for further activity. The projects are addressing:

- the development of assertive outreach approaches and increased service accessibility, appropriateness and integration to increase the percentage of families voluntarily using the Maternal and Child Health service;
- the enhancement of parental confidence, independence and ability to make appropriate use of primary care services and family support networks;
- the need for long-term intensive participation in families *"at risk"* with a view to improving parenting strategies; and
- the identification of high risk factors and groups to be targeted more determinedly in service utilisation.

13.73 In addition, a proposal has been made for a pilot "diversion" project to consider the feasibility of diverting notifications before protective involvement by establishing, within a service agency, a joint agency/DHS unit to take referrals at the point of notification. Families would be referred on to protective services only where serious protective issues existed, otherwise appropriate welfare or counselling support services would be provided.

13.74 The Department's initiative in introducing the pilot projects is an important step towards further improving the effectiveness of the primary care system in assisting in prevention activities.

13.75 **The Department has taken seriously the need for prevention strategies to be developed in the context of the National Prevention Strategy and pilot projects of the type described above will assist substantially in helping to achieve the strategy's National objectives. The pilot projects will also serve to identify the type of client services needed most in order that DHS can better focus grants provided to non-government agencies contracted to provide these services.**

Departmental funding proposals for new prevention initiatives

13.76 The Department has identified a number of further opportunities to enhance prevention, in connection with which project funding applications were submitted to the Community Support Fund in 1994-95 and 1995-96.

13.77 Projects funded through the Community Support Fund in 1994-95 included $1.3 million for *"Support to families to deal with family and parenting crises"*. This resulted in the development of range of parenting support services, namely:

- 7 early parenting day-stay services to provide parenting skill development for families in the general community who are experiencing difficulties or crises caring for infants up to 2 years old;
- 9 early parenting, in-home support services to enhance the parenting skills knowledge and experience of parents of children aged up to 4 years, with identified needs; and
- 9 school-linked parenting support services which identify and provide assistance with parenting skills for identified families with children attending school.

13.78 Further initiatives for which funding was sought in 1995-96, but were deferred by the Community Support Fund committee, included:

- developing new models for the delivery of health and welfare services to the growing proportion of children and adolescents with mental disturbances (such as depression, attention deficit disorder and psychosis);
- development of specialist services to support families of children with specific problems, including disabilities; and
- exploring innovative approaches to family violence prevention and early intervention, including a referral service for men and a Family Violence Prevention Training Unit.

13.79 Projects such as these demonstrate a strong awareness by DHS of strategic priorities for prevention and have the potential to contribute significantly to reducing child abuse and neglect. However, audit observed that the projects were initially presented as individual submissions in response to a funding opportunity and do not currently comprise part of a comprehensive documented research and development program.

13.80 **While recognising the value of the above projects in prevention of child abuse, the submission of such projects should be made within the context of an overall strategy for prevention, with funding proposals being prepared on the basis of priority needs within such a strategy based upon detailed research into client needs.**

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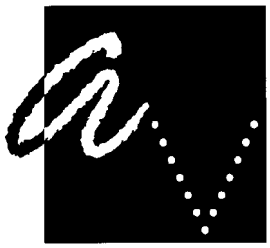

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