# Protocol between Child Protection and Disability Services

Department of Human Services

A Victorian Government initiative

State Government Victoria

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This protocol replaces the protocol between Protective Services and Intellectual Disability Services, August 1993.

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# Foreword

Children and young people who have suffered significant harm require a response that places their best interests at the centre of all decision making.

The purpose of this protocol is to assist Child Protection practitioners and Disability Services staff to strengthen their practice so that the quality of service for children and young people is enhanced.

While this protocol will aid effective communication between Child Protection and Disability Services, it is not meant to replace the need for practitioners to work collaboratively when responding to the needs of children, young people and their families.

Effective processes of communication between Child Protection and Disability Services are critical for the Best Interests Principles to be enacted and to achieve strong engagement with children, young people and their families. This approach requires practitioners to work flexibly and creatively together to develop coordinated and integrated solutions that are timely, respectful and culturally appropriate.

Child Protection and Disability Services will continue to create opportunities to learn from one another, while developing and promoting practice that is holistic to ensure that children, young people and their families receive the best service.

# Endorsement

In accordance with the principles underlying this protocol, we the undersigned, on behalf of our respective areas, agree to this protocol and endorse it to act as the guidelines for our staff to ensure the cooperative framework necessary for the safety and protection of Victoria's children.

**Arthur Rogers**
**Executive Director**
**Disability Services**

**Paul McDonald**
**Executive Director**
**Children, Youth and Families**

# Contents

## A note on the text

In this document, the Department of Human Services Child Protection Program will be referred to as 'Child Protection' and the Department of Human Services Disability Services Program will be referred to as 'Disability Services'. Children and young people will generally be referred to as children. 'Community-based child and family services' and 'Child FIRST' can be regarded as interchangeable terms. The *Children, Youth and Families Act 2005* will generally be referred to as the 'CYFA'. The *Disability Act 2006* is referred to as the 'Disability Act'. The term 'family' is used broadly and does not imply any particular family structure or membership. For example, it includes situations where adults other than the biological parents have the role of primary caregiver, such as step-parents or extended family members.

# 1. Context

Child Protection and Disability Services are separate and distinct programs within the Department of Human Services, which necessarily share a range of common values and professional ethics. Although these are separate programs within the one department, there is a significant crossover where concerns are held that a child is 'in need of protection' within a family and where a family member, child or adult (specifically the subject child or their parent) has a disability. The terms 'in need of protection' and 'disability' are defined in the respective legislation: the *Children, Youth and Families Act 2005* (CYFA) and the *Disability Act 2006*.

The primary purpose of this protocol is to promote a best practice approach to children and their families within this interface between Child Protection and Disability Services.

The Child Protection service system formally includes both secondary and tertiary services within the commonly recognised three-tier child welfare service system model. The Child Protection Program comprises the tertiary end of the service system, with community-based child and family services (as detailed in the CYFA) and other funded services located in the secondary service system. Victoria Police are also an integral part of the formal Child Protection system.

Disability Services provides services for people with intellectual, physical, sensory and neurological disabilities and acquired brain injury. The program works in partnership with families and carers, and with non-government and government service providers to advance the wellbeing and promote the quality of life of people with disabilities.

Child Protection and Disability Services have a shared interest and responsibility in working with vulnerable families with dependent children, where a family member has a disability. While many families with members with disabilities are well able to provide care for all of their family members, children with disabilities can sometimes place additional stresses and demands on families, and parents with disabilities can face additional challenges in their role as parents. Parents and children in these families share a range of common needs with all families and can access services and supports from mainstream services; however, some families require more targeted service responses. Where more targeted service responses are required, community-based child and family services, Child Protection and Disability Services may share responsibility for this group of families in order to provide appropriate support and services from both areas. The client for Child Protection is the child, within the context of the family, while the client for Disability Services can be either the child or the parent. In all considerations, the best interests of the child must always be paramount.

The level of complexity in Child Protection cases is increasing. Evidence shows very high associations of substantiations and re-substantiations with alcohol misuse, substance misuse, family violence and psychiatric illness. Many cases in Child Protection involve families with multiple disadvantage factors, with an average of three parental risk factors for children living in out of home care. While individual agencies have different responsibilities in relation to strengthening families and preventing child abuse and neglect, the best results will occur where agencies work together to deliver the often complex range of responses and supports that are required by vulnerable children and families.

This protocol promotes coordinated, collaborative practices between Child Protection and Disability Services to ensure that responsive and effective supports that improve outcomes for families are provided in these situations.

More specifically, the protocol aims to:

- facilitate a joint understanding of shared clients and the policy and legislative environment in which supports are provided by Disability Services and Child Protection
- clarify the roles and responsibilities of Disability Services and Child Protection
- provide information on how to identify disability and child protection issues and appropriately facilitate access to the supports that respond to the needs of shared clients
- promote effective communication and service coordination between Disability Services and Child Protection
- outline collaborative approaches and processes to working with shared clients as the basis for the development of local protocols by regional staff.

## 1.1 Department of Human Services Values

The Department of Human Services Values outline what the department stands for, the way we expect to treat each other and the way we conduct our business. The Values provide a framework within which Department of Human Services staff should make decisions and take actions in their roles and guides individual and organisational behaviours across the department.

The Values are:

- **Client focus** – we work towards improving the health and wellbeing of our clients and community
- **Professional integrity** – we act impartially, treating all people with dignity and respect
- **Quality** – we always strive to do our best and improve the things we do
- **Collaborative relationships** – we work together to achieve better results
- **Responsibility** – we commit to the actions we take to achieve the best possible outcomes for our clients and community.

## 1.2 Specific policy and legislative framework

The Government's vision is for a Victoria in which every child thrives, learns and grows and is respected and valued to become an effective adult. The community is one in which the safety, health, development, learning and wellbeing of every child is protected and promoted throughout childhood.

All children deserve the opportunity to be safe and achieve their full potential. They should be enabled to:

- be physically and mentally healthy as possible
- gain the maximum benefit from good-quality educational opportunities
- live in a safe environment and be protected from harm
- experience emotional wellbeing
- feel loved and valued and supported by a network of reliable relationships
- become competent in looking after themselves and coping with everyday living
- have a positive image of themselves and a secure sense of identity, including cultural and racial identity
- develop good interpersonal skills and a confidence in social situations.

To achieve this vision, *every child every chance* reforms have been implemented to deliver better outcomes for Victorian children, families and the community. The legislative basis of the reforms is the *Child Wellbeing and Safety Act 2005* and the CYFA. These pieces of legislation have led to a shift in the emphasis in decision making that increases the focus on children's safety, rights and development. The need for stability for children is recognised and there is an additional focus on the impact of cumulative harm on children.

In relation to people with a disability, the government policy is set out through the 2002–2012 State Disability Plan, which focuses on the rights that people with a disability should have to live and participate in the community as citizens of Victoria. In 2006 the Victorian Parliament passed the *Disability Act 2006*, which provides the framework for a whole-of-government and whole-of-community approach to enabling people with a disability to actively participate in the life of the community.

The State Disability Plan states the government's vision for the future as:

> *By 2012, Victoria will be a stronger and more inclusive community – a place where diversity is embraced and celebrated, and where everyone has the same opportunities to participate in the life of the community, and the same responsibilities towards society as all other citizens of Victoria.*

In order to achieve this vision, the government has set three equally important and related goals for supporting the pursuit of individual lifestyles, building inclusive communities and leading the way by developing more inclusive and accessible public services and promoting non-discriminatory practices.

### 1.2.1 *Charter of Human Rights and Responsibilities Act 2006*

The Victorian Charter of Human Rights and Responsibilities is a law that protects the human rights of all people in Victoria. The charter contains 20 rights that reflect four basic principles: freedom, respect, equality and dignity. Of particular relevance to this protocol is the principle of respect, which includes the following elements:

- **Right to life** – this means that everyone has the right to life and includes people having a right to have their lives preserved and protected.
- **Protection of families and children** – this right affirms the fundamental importance of families. It gives families the protection of society and State, and it recognises that children, because they are children, have a right to have their best interests and needs protected.

The charter requires all public authorities, including public servants such as Disability Services and Child Protection practitioners, to act compatibly with the charter and to consider the charter when making decisions. It is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.

The charter recognises that human rights are not absolute. Under the charter, human rights can be limited if such limitation is reasonable and demonstrably justified. Deciding what is reasonable is a matter of balancing the rights of the individual with protection of other public interests in the community. Individual rights may also need to be balanced against each other. The charter provides some guidance in section 7 as to the types of factors to be considered when determining whether any limitations on rights are reasonable. These include:

- **The nature of the right**. What is the purpose of the right and its underlying values? What is the right protecting?
- **The importance of the purpose of the limitation**. Why is the right being limited? What is the policy objective of the limitation? The limitation should address a specific area of substantial public or social concern.

- **The nature and the extent of the limitation**. What are the means or measures used to achieve the purpose of the limitation? In what way and to what extent does the limit interfere with the right?
- **The relationship between the limitation and its purpose**. For a restriction on a right to be reasonable there should be a rational connection between the limitation and the purpose that it aims to achieve. There must also be proportionality between the purpose of the limitation and the means used to achieve the purpose.
- **Whether there is a less restrictive way to achieve the purpose of the limitation**. This is an important factor to consider, although the charter does not require that you must use the least restrictive option. It is sufficient if the means adopted falls within the range of reasonable solutions to the problem confronted.
- **Any other relevant consideration**.

Application of risk and needs assessment and Best Interests planning for children and decisions regarding children will often be a balance of rights of various people – children, parents, siblings and other family. All of these people have rights under the charter, which must be considered. The CYFA dictates that a child's best interests are paramount in making a decision regarding them. This will also include a reference to and application of any charter rights (of children, parents and families) that are relevant to decisions about that child.

Further information on the charter can be found on the DHS Legal Services Branch website and at www.justice.vic.gov.au/humanrights/

### 1.2.2 *Children, Youth and Families Act 2005*

The *Children, Youth and Families Act 2005* (CYFA) updates and replaces the previous *Children and Young Persons Act 1989* and *Community Services Act 1970*. In particular, it is founded on a requirement to promote children's best interests. The CYFA also legislates the field of youth justice.

With regard to the safety and wellbeing of children, the Act contains many features that are entirely new or significantly changed from previous legislation. These can be summarised as:

- common principles to guide practice and decision making
- pathways to connect vulnerable children and families to the prevention and early intervention services they may need
- more flexible Child Protection responses to reports
- a new focus on cumulative harm
- guidelines for keeping vulnerable Aboriginal children within their communities
- strategies for promoting stability in care arrangements and beyond
- a capacity to intervene in cases where children aged over 10 but under 15 years are engaging in sexually abusive behaviours
- powers and orders of the Children's Court
- a framework for registration and quality assurance of community services and carers
- clearly authorised information-sharing mechanisms to promote children's safety, wellbeing and development.

### 1.2.3 *Disability Act 2006*

The *Disability Act 2006* is guided by the principles of human rights and citizenship, and provides substantial reform to the law for people with a disability in Victoria. The Act will ensure that services are of high quality and are accountable to people with a disability who use those services.

In relation to families, the principles of the Disability Act state that Disability Services should:

- consider and respect the role of families and other people who are significant in the life of the person with a disability
- acknowledge the important role families have in supporting people with a disability
- acknowledge the important role families have in assisting their family member to realise their individual physical, social, emotional and intellectual capacities
- where possible, strengthen and build the capacity of families who are supporting people with a disability
- have regard for the needs of children with a disability and preserve and promote relationships between the child, their family and other people who are significant in the life of the child with a disability.

It is important to note that access to Disability Services under the *Disability Act 2006* is by the request of a person with a disability or a person on behalf of a person with a disability. As such, clients of Disability Services access support on a voluntary basis and can withdraw from contact with Disability Services should they choose to do so, providing a significantly different legislative basis and working environment to that which is provided for Child Protection via the CYFA.

## 1.3 Scope

In the context of this protocol, 'disability' is defined as per the Disability Act and in relation to a person means:

(a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which:

  (i) is, or is likely to be, permanent

  (ii) causes substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication

  (iii) requires significant ongoing or long-term episodic support

  (iv) is not related to ageing; or

(b) an intellectual disability; or

(c) developmental delay.

A 'child' is a person under the age of 17 years (or under 18 years if subject to an existing Child Protection Order with continued Child Protection involvement).

This protocol does not address the collaborative working relationships with local Child FIRST (Family Information Referral and Support Teams) and family services that support vulnerable children where there are concerns about their wellbeing and long-term development.[1]

1. Child FIRST services are being implemented across Victoria until the end of 2008.

# 2. Guiding principles

## 2.1 Best Interests Principles

The *Children, Youth and Families Act 2005* (CYFA) sets out a range of principles, which together are termed the 'Best Interests Principles'. These principles are articulated in s10 of the CYFA and extended in s11–14. They are essentially decision-making and action principles which apply equally to Child Protection and community services, with s10 and s13-14 also applying to the Children's Court. Sections 10(1) and (2) are clear and unambiguous in stating:

> *For the purposes of this Act,* ***the best interests of the child must always be paramount****.*
> *When determining whether a decision or action is in the best interests of the child, the need to:*
>
> - *protect the child from harm*
> - *protect his or her rights*
> - *promote his or her development (taking into account his or her age and stage of development) must always be considered.*

Other considerations are clearly subordinate to the above, as articulated in s10(3):

> *In addition to sub-sections (1) and (2), in determining what decision to make or action to take in the best interests of the child, consideration must be given to the following, where they are relevant to the decision or action…*

The section goes on to list a range of factors.

For the purposes of this protocol, action by Child Protection or Disability Services in the best interests of the child includes:

- The child's safety is the primary focus of intervention.
- The child's ongoing wellbeing must be a significant focus of intervention.
- Issues relating to cumulative harm to a child must form part of the overall assessment.
- The child and the child's family must be enabled to access appropriate services in order to ameliorate the long-term effects of abuse or neglect.
- The child and the child's family must be accorded a coordinated and sensitive service response that limits the people/professionals that directly intervene with the child.
- Children are entitled to live in a safe and stable environment. If their safety is violated, they are entitled to a just response.
- Disability Services must report to Child Protection all allegations and situations of physical abuse, sexual abuse, emotional abuse and neglect, where child protection issues are likely to be present.
- Child Protection must report to police all allegations and situations of physical abuse, sexual abuse and serious neglect to a child.
- Child Protection must consult with Disability Services, and involve Disability Services in the Best Interests planning process, where a Child Protection client (child or parent) has a disability.

## 2.2 Collaborative work

Collaboration is defined as a 'joint approach to plan and deliver high-quality services, characterised by working together in an inclusive and participatory manner; effective collaboration occurs when parties create a working relationship premised on trust and respect, shared decision making, adequate time and the application of available resources'.

In this way, collaboration includes active involvement in Best Interests planning for children who are assessed by Child Protection as being in need of protection, including planning for those children who are the subject of a Protection Order issued by the Children's Court.

Collaborative work between Child Protection and Disability Services can improve outcomes for children, young people and families. It can also support Child Protection and Disability Services practitioners in undertaking their work. Some key elements of such collaborative work include:

- a joint understanding including recognition that the best interests of the child must always be paramount and that the widest possible protection and assistance should be given to the parent and child as a fundamental group unit of society
- a common understanding of and respect for different areas of expertise and the related policy and legislative frameworks
- the ability to work together to develop common goals
- a shared commitment to achieve a set of outcomes for a child/family
- consultation occurring at all key decision points
- mechanisms to ensure the roles and responsibilities of different services are clear to the child, family and workers
- appropriately shared responsibility and accountability
- clear, honest and open communication processes
- agreed processes for resolving differences of opinion between workers and the building of positive relationships between services.

Building an environment within which effective collaboration can occur is based on a set of core principles of shared responsibility.

### 2.2.1 The child comes first

The Best Interests Principles within the CYFA (s10–14) enable a unifying framework across service sectors and the Children's Court, and state that 'the best interests of the child must always be paramount'. This principle guides every aspect of collaboration within the Child Protection process and must be placed first if a dispute about roles and responsibilities arises.

### 2.2.2 Collaboration is not optional

The decision to consult Disability Services or Child Protection in relation to a shared or potentially shared client is not at the discretion of the worker or their management. It is in line with obligations under the Victorian Charter of Human Rights and Responsibilities and is required in order to meet the department's obligation under this protocol and to align with Principle 1 above.

### 2.2.3 Joint consultation is not a means to facilitate withdrawal

The initiation of consultation with Disability Services or Child Protection in relation to a shared or potential shared client is not a means to facilitate withdrawal of supports and/or services. In situations where a shared client is identified, it is expected that both services are engaged to participate in the identification and appropriate provision of supports required from both areas.

The lead responsibility for coordination of supports will be undertaken by Child Protection where the child or young person is subject to Child Protection intervention and Best Interests planning processes. In these circumstances, Child Protection will convene the initial meeting and then the responsibility of coordination will be determined at the meeting on a case-by-case basis.

## 2.3 Early identification

Early identification and effective intervention can lessen the initial and long-term effects of child abuse and neglect, and promote recovery of the children and families concerned. Intervention is most effective when there is open and respectful communication, clearly identified procedures and prioritisation of the child's needs.

# 3. Overview of the Child Protection service system

The Child Protection service system in a formal sense includes the Child Protection Program, community-based child and family services as detailed in the CYFA, and Victoria Police. In a broader sense the protection of children from harm is a whole-of-community responsibility shared between the family, the general community, community agencies, professionals working with children and their families, police and government. Each has a significant role to play in ensuring the safety, stability and development of children and in helping to prevent harm from occurring.

This chapter will give a brief overview of the formal Child Protection service system as outlined in the CYFA.

## 3.1 Child Protection

The Department of Human Services has a statutory responsibility according to the provisions of the CYFA in relation to the provision of Child Protection services for all children in Victoria under the age of 17 years or, if a protection order is in place, all children in Victoria under the age of 18 years.

Child Protection works to ensure that children are protected from significant harm within the context of the best interests of the child, when their parent or caregiver is unable or unwilling to provide that protection.

Child Protection provides services to children and their families in order to protect children from significant harm resulting from abuse and neglect within their families. A broad range of services are provided or funded by the Department of Human Services, and these aim to strengthen families so that children and young people can develop within a safe physical and emotional environment. Services are based on the principle that, normally, the best protection for children is within the family. Where a child or young person is assessed as being 'at risk' within the family, Child Protection will – in the first instance and in accordance with the law – take every reasonable step to enable the child to remain in the care of their family by strengthening the family's capacity to protect them.

Where, even with support, a child is not safe within the family, Child Protection will intervene to remove the child and bring the matter before the Children's Court. Until the parents are able to resume their custodial responsibilities, adequate care and protection will be provided as determined by the Children's Court. Where the resumption of care by the parents is not possible, Child Protection will work towards an alternative permanent family care arrangement, or an independent living arrangement, depending on the age and circumstances of the child. A brief overview of the possible stages of intervention following the receipt of a report is described in Appendix 4.

### 3.1.1 Placement and support

Placement and support is an integral component of the Child Protection Program, which provides out of home care services to look after children and young people when a family needs support, in cases of family conflict or if there is a significant risk of harm or abuse in the family home. Support services help the children and young people to cope with their experiences and assist their families to deal with the issues that led to the placement of their child.

The Placement and Support Unit also includes adoption services, which provides counselling and advice for birth parents, assesses prospective adoptive parents and arranges the adoption of infants and children who cannot live at home. These children are placed with adoptive parents to form a new family, which is later legalised by an adoption order. Adopted children may have ongoing contact with their birth parents.

For out of home care, the CYFA requires that consideration be given first to the child being placed with an appropriate family member or other appropriate person significant to the child, before any other placement option is considered. Kinship care now accounts for approximately 60 per cent of new placement arrangements and comprised 33 per cent of all placements as of 30 June 2006.

## 3.2 Community-based child and family services – Child FIRST

The CYFA states the purposes of a community-based child and family service as being:

- to provide a point of entry into an integrated local service network that is readily accessible by families, that allows for early intervention in support of families and that provides child and family services
- to receive reports about vulnerable children and families where there are significant concerns about their wellbeing
- to undertake assessments of needs and risks in relation to children and families to assist in the provision of services to them and in determining if a child is in need of protection
- to make referrals to other relevant agencies if this is necessary to assist vulnerable children and families
- to promote and facilitate integrated local service networks working collaboratively to coordinate services and supports to children and families
- to provide ongoing services to support vulnerable children and families.

Child FIRST (Child and Family Information, Referral and Support Team) has been established to meet this purpose. Child FIRST will ensure that vulnerable children and their families are effectively linked into relevant services.

Child FIRST locations will aim to establish a strong profile within their particular catchment with a particular focus on key professional groups and organisations.

The functions of Child FIRST include:

- ease of access
- provision of information and advice
- initial needs identification and assessment of underlying risk in consultation with Child Protection and other services
- identification of the Aboriginal and Torres Strait Islander status of children and families
- identification of different service responses for families related to the assessment of needs and underlying risks
- active engagement with the child and their family
- determination of the priority of a response and allocation of families to family services, in consultation with Family Services and Child Protection (where required)
- timely responses through provision or oversight of 'active holding responses', involving short-term work with children and families, prior to allocation to family services.

## 3.3 Victoria Police

Victoria Police is the body responsible for dealing with criminal matters that arise in child abuse and neglect cases. Obviously not all cases of child abuse and neglect lead to a criminal prosecution; however, cases of physical abuse, sexual abuse and serious neglect will generally involve an aspect of joint investigation by child protection and police services.

Child Protection and Victoria Police have a separate protocol, which stipulates that all reports received by Child Protection pertaining to physical or sexual abuse or serious neglect must be reported to police for the purpose of conducting a joint investigation if required.

Where child abuse or neglect occurs in a context outside of the family, Child Protection intervention is generally not required (unless the parents are unable or unwilling to protect the child from further harm). These types of concerns should be reported to police.

# 4. Overview of Disability Services

The Disability Services Division is part of the Department of Human Services and aims to improve the quality of life of Victorians living with a disability through supports that enhance independence, choice and community inclusion.[2]

The Division works in partnership with people living with a disability, their families, carers, departmental regional officers and community service organisations to plan and fund a range of supports. These include accommodation, respite, behaviour support services, case management and individual support packages.

There have been significant reforms in the Disability Service sector over the past four years, based on the goals of the *Victorian State Disability Plan 2002–2012*. One of the key priorities identified in the State Disability Plan is to reorient disability supports from the provision of specialised formal highly structured services to the development of programs that are more flexible and responsive to individual needs. This is achieved through the use of an individualised planning approach.

## 4.1 Individualised planning

Planning is an activity which assists people with a disability and their families to identify their goals and aspirations, and work out strategies for achieving them.

The following guiding principles for planning must underpin all planning processes undertaken with a person with a disability. These guiding principles, along with best practice approaches to planning, form the basis of the approach to individualised planning. Individualised planning is about:

- people with a disability directing planning and making their own choices about how they wish to live their life
- the inclusion and participation of people with disabilities in community life
- assisting people with a disability to identify their goals, aspirations and needs, find ways that these can be achieved and identify the supports required
- the exploration of supports that are flexible, wide-ranging and may include – but are not limited to – those that may be available from the existing Disability Services service system
- providing information, opportunities and support for people with a disability to make informed choices about ways to achieve their goals and meet their needs
- planning that is respectful of the views of family members and carers and their role in the life of the person
- family-focused planning and support for children and young people living with a disability
- support for adults with a decision-making disability
- planning that is sensitive to the cultural and spiritual experience of the person
- recognition of the rights and responsibilities of people with a disability as members of the community.[3]

For further information on the needs of shared clients, please refer to Appendix 1. The Disability Services Access Policy and Planning Policy are also available at www.dhs.vic.gov.au/disability

Contact details for Disability Services Intake and Response Teams are provided in Appendix 10.

2. *Disability Services Policy and Funding Plan 2006–09*.

3. *Disability Services Planning Policy 2007*.

## 4.2 Disability Services – supports for children and families

Where the services required to protect and promote the healthy development of a family are not available through the generic support system, Disability Services can provide a variety of responses to support either a parent with a disability and/or a child with a disability.

### 4.2.1 Support Disability Services may provide

Disability Services provides both episodic disability supports, such as respite, and ongoing disability supports such as individual support packages (ISPs) and shared supported accommodation.

Supports and services Disability Services may be able to provide shared clients include:

- respite services for the child with a disability
- education/support for parents with a disability
- individualised packages of support with flexible funding that can be used to directly assist the person with a disability and build family resilience through supporting other family members
- case management for the person or child with a disability, where appropriate, including assistance with planning
- information that is accessible, up to date and objective, and which supports self-management and individual choice by the person with a disability
- assistance to access aids and equipment
- assistance with locating alternative family placements for children with a disability, where required
- advice and assistance in relation to meeting the needs of a child or person with a disability within the generic service system
- behaviour intervention services to address behaviours of concern or meet the need for human relations training, counselling or support
- support for people with an intellectual disability who come into contact with the criminal justice system
- training and outreach support to enable people with a disability to live independently.

### 4.2.2 Support Disability Services may not provide

There are some supports and services that Disability Services is not able to provide.

- Disability Services is not funded as a 24-hour response service and has no after-hours emergency service. Children requiring such a response are reliant on Child Protection or the local hospital for an immediate response, although Disability Services should be consulted as soon as possible the next working day.
- Disability Services is not funded to employ workers trained in supporting clients with high medical support needs. Disability Services should, however, be consulted in relation to social admissions to hospital for children with a disability or children who are cared for by a person with a disability.
- Disability Services has limited capacity for emergency respite or longer term accommodation, and focuses on placements within an alternative family setting. Where a child with a disability is being accommodated within the generic service system, Disability Services should be contacted for advice and assistance to meet the child's support and developmental needs.

- Disability Services is not able to provide assessments of whether a parent with a disability has the capacity to parent effectively. However, Disability Services should provide any relevant information to assist Child Protection in making such a determination.
- Disability Services are provided on a purely voluntary basis, in a spirit of partnership with the client. This means that the provision of services is based on client consent; the client may withdraw from services as and when they wish. Disability Services will do everything possible to facilitate engagement in situations involving child protection concerns and recognises that statutory intervention, particularly Court intervention, does entail a level of compulsion.

## 4.3 Disability Services – priority and demand

In order to access Disability Services, a person must meet the definition of disability under the *Disability Act 2006* and be considered a priority for access to services. In some circumstances, a person with a disability may have needs that could be better supported in the community through the generic service system. It is also acknowledged that there is often a greater demand for Disability Services than resources available; the capacity of the system to respond must also be considered when determining a person's priority for access to services.

To assist in determining a person's priority, the following indicators have been developed and must be used by all disability service providers:

- the need to strengthen or support the role of the family, carer or person's support network
- the need to provide support to ensure the safety and wellbeing of the person with a disability, their family or carer or the wider community
- the existence of multiple disadvantage within the person with a disability's personal, social or community context
- the immediate and potential benefit of the support to reduce the likelihood for more intensive assistance in the future
- the impact on the individual's wellbeing, living situation and quality of life should the disability service be unavailable
- the presence and availability of informal and generic supports to complement the disability services (for example, a small amount of support such as respite may enable informal networks to continue their caring role)
- the status of support provision (for example, whether it is a mandatory requirement as part of a justice plan or condition of an order).

In addition to the priority indicators above, disability service providers who directly allocate resources must consider any specific priority status criteria for access to the Disability Services they are funded to provide.

Access to and allocation of ongoing disability supports is managed through the Disability Support Register (DSR). It should be noted that the DSR is not a waiting list or a measure of future need for people who might need support at a later stage. Resources are allocated to individuals based on their current needs and circumstances. Further information about the DSR can be found in the *DSR Registration Guidelines* February 2008 and *DSR Resource Coordination and Allocation Guidelines* February 2008, which are located at www.dhs.vic.gov.au/disability

Access to services for children under six years of age, should be provided with consideration to whether Disability Services are able to provide the most appropriate support. Support may be better provided by Early Childhood Intervention Services (ECIS), which focus specifically on the needs of children under six years of age and support for them within the context of their families. ECIS can be contacted through Regional ECIS Central Intake Services, details of which are located on the Early Childhood Intervention website at www.ecis.vic.gov.au

Further information about priority of access is available in the *Disability Services Access Policy 2007* and in the *Access Policy Implementation Guide*, which can be found at www.dhs.vic.gov.au/disability

# 5. Reporting concerns about children or young people

## 5.1 Information for professionals working with vulnerable children

A key objective of the CYFA is to create an integrated Child Protection and Family Service system that provides improved supports to vulnerable children, young people and their families. The legislation also introduces a range of new reporting and referral arrangements to replace what was previously known as a Child Protection Notification.

There may be many factors, or combinations of factors, within family life that adversely impact upon children's safety, stability and development. You may already have considered these factors and the following lists are intended to provide some further basic guidance on how to decide whether to refer a matter to Child FIRST or make a report to Child Protection.

### 5.1.1 When to refer to Child FIRST

A referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need, where families exhibit any of the following factors that may impact upon a child's safety, stability or development:

- significant parenting problems that may be affecting the child's development
- family conflict, including family breakdown
- families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- young, isolated and/or unsupported families
- significant social or economic disadvantage that may adversely impact on a child's care or development

### 5.1.2 When to refer to Child Protection

A report to Child Protection should be made in any of the following circumstances:

- physical abuse of a child or non-accidental or unexplained injury (mandatory reporters must report)
- a disclosure of sexual abuse by a child or witness, or a combination of factors suggesting the likelihood of sexual abuse
- emotional abuse and ill-treatment of a child impacting on the child's stability and healthy development
- persistent neglect, poor care or lack of appropriate supervision, where there is a likelihood of significant harm to the child or to the child's stability and development
- persistent family violence or parental substance misuse, psychiatric illness or intellectual disability – where there is a likelihood of significant harm to the child or the child's stability and development
- where a child's actions or behaviour may place them at risk of significant harm and the parents are unwilling or unable to protect the child
- where a child appears to have been abandoned or where the child's parents are dead or incapacitated, and no other person is caring properly for the child.

### 5.1.3 Other factors to consider

Many cases will not neatly fit into these categories and it may be harder to determine whether the level and the nature of any risk is such that the child is in need of protection. The following questions may help resolve the best course of action in such cases.

**What specifically has happened to the child** that has caused your concerns and what is the impact on their safety, stability, health, wellbeing and development?

- How vulnerable is the child?
- Is there a history or pattern of significant concerns with this child or other children in the family?
- Are the parents aware of the concerns? Are they capable and willing to take action to ensure the child's safety and stability and to promote their health, wellbeing and development?
- Are the parents able and willing to use support services to promote the child's safety, stability, wellbeing and development?

**A referral to Child FIRST should be considered** if – after consideration of the available information – you are, on balance, more inclined to form a view that the concerns currently have a low to moderate impact on the child, where the immediate safety of the child is not compromised.

On receiving a referral from a professional or community member, the Child FIRST team will conduct further assessment of the family and may consult an experienced community-based child protection worker who is based in each Child FIRST team. This assessment may lead to the involvement of a local family services organisation. In most circumstances, Child FIRST will inform you of the outcome of your referral.

Where a Child FIRST team or a registered family services organisation forms a view that a child or young person is in need of protection, they **must** report the matter to Child Protection.

**A report to Child Protection should be considered** if – after consideration of the available information – you are, on balance, more inclined toward a view that:

- the concerns currently have a serious impact on the child's immediate safety, stability or development, or the concerns are persistent and entrenched and likely to have a serious impact on the child's development
- the concerns relate to sexually abusive behaviours exhibited by a child aged 10 to 15 years, who would benefit from therapeutic treatment.

Upon receipt of a report containing such factors, Child Protection will seek further information, usually from professionals who may also be involved with the child or family, to determine whether further action is required. In determining what action to take, Child Protection will also consider any previous concerns that may have been reported about the child or young person. In most circumstances, Child Protection will inform you of the outcome of your report.

**If you are still unsure about who to report or refer to**, you should contact either Child Protection or Child FIRST for further advice.

## 5.2 Making a report to Child Protection

The CYFA allows for three distinct types of report to be made to Child Protection:

- a report relating to a concern that a child is in need of protection
- a report relating to a significant concern for the wellbeing of a child
- a report that a child is in need of therapeutic treatment.

### 5.2.1 Report regarding a child in need of protection

**When is a child in need of protection?**

Most children and young people are adequately cared for and nurtured by their family. It is only when the parents or caregivers are unable or unwilling to protect their children against significant harm that Child Protection needs to be involved.

The terms 'abuse', 'neglect' and 'maltreatment' are generic terms used in the community to describe why a child might need protection. For the purposes of the CYFA, a child is in need of protection if any of the following grounds exist:

*(1) (a) the child has been abandoned by his or her parents and, after reasonable inquiries:*

- *the parents cannot be found*
- *no other suitable person can be found who is willing and able to care for the child*

*(b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child*

*(c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type*

*(d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type*

*(e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type*

*(f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.*

*(2) For the purposes of sub-sections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of continuing acts, omissions or circumstances. (CYFA s162)*

For the purposes of this protocol, where – during the course of carrying out their normal duties – a Disability Services staff member forms the belief on reasonable grounds that a child is in need of protection, the staff member **must** make a report to Child Protection regarding this belief and the reasonable grounds for it as soon as practicable.

**Mandatory reporting**

A number of professional groups are identified in the CYFA as mandatory reporters under s182(1). These are:

- primary and secondary school teachers and principals
- registered medical practitioners (including psychiatrists)
- nurses
- police officers.

Nurses and registered medical practitioners employed within Disability Services are mandated.

**Requirement to report**

Section 184(1) of the CYFA requires designated and gazetted professionals to report to Child Protection as soon as practicable if they believe a child is in need of protection:

> *…when, in the course of practising his or her profession or carrying out the duties of his or her office, [he or she] forms the belief on reasonable grounds that a child is in need of protection because the child has suffered, or is likely to suffer, significant harm as a result of physical injury and/or as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type.*

Mandated professionals must report to Child Protection their belief and the reasonable grounds for it as soon as practicable:

*a) after forming the belief*

*b) after each occasion on which he or she becomes aware of any further reasonable grounds for the belief.*

For the purposes of this section, a belief is *a belief on reasonable grounds if a reasonable person practicing the profession or carrying out the duties of the office, position or employment, as the case requires, would have formed the belief on those grounds.*
(CYFA s184(4))

Reasonable grounds may exist where:

- a disclosure is made to the professional by the child that she or he has been physically or sexually abused
- someone else – a relative, friend or acquaintance, sibling or a friend of the child – tells the professional that the child has been abused
- the professional's observations of the child's behaviour, or knowledge of children generally, leads him or her to believe that the child has been abused
- the professional observes signs or indicators of the abuse.

**Failure to report**

Failure by mandated professionals to report a reasonable belief that a child is in need of protection due to the presence of sexual or physical abuse may lead to pecuniary penalties being imposed by a Court (CYFA s184(1)).

### 5.2.2 Report regarding the wellbeing of a child

The CYFA allows for two types of report to be made in relation to significant concerns for the wellbeing of a child. These are outlined as follows:

- s28 of the CFYA states that: '…A person may make a report to the Secretary if the person has a significant concern for the wellbeing of a child…'
- s29 of the CYFA states that: '…A person may make a report to the Secretary, before the birth of a child, if the person has a significant concern for the wellbeing of the child after his or her birth…'

For the purposes of this protocol, where during the course of carrying out their normal duties, a Disability Services staff member forms the belief on reasonable grounds that there is a significant concern for the wellbeing of a child, the staff member **should** make a report to Child Protection; this includes a report prior to the birth of a child. Where the report is classified by Child Protection as a Wellbeing Report, Child Protection may, in turn, make a referral to Child FIRST. It is preferable that, where a Disability Services staff member forms the belief that there is a significant concern for the wellbeing of a child, the staff member make a referral directly to Child FIRST.

### 5.2.3 Report regarding a child in need of therapeutic treatment

Section 244 of CYFA states that:

*'…a child is in need of therapeutic treatment if the child:*

*(a) is of or above the age of 10 years and under the age of 15 years; and*

*(b) has exhibited sexually abusive behaviours…'*

A child has exhibited sexually abusive behaviours when they have used their power, authority or status to engage another party in sexual activity that is either unwanted or where, due to the nature of the situation, the other party is not capable of giving consent (for example, children who are younger or who have a cognitive impairment).

Physical force and/or threats are sometimes involved. Sexual activity may include exposure, peeping, fondling, masturbation, oral sex, penetration of a vagina or anus using a penis, finger or object, or exposure to pornography. This is not an exhaustive list.

For the purposes of this protocol: where, during the course of carrying out their normal duties, a Disability Services staff member forms the belief on reasonable grounds that a child is in need of therapeutic treatment, the staff member **may** make a report to Child Protection.

Where Child Protection receive a report regarding a child in need of therapeutic treatment from a source other than police, Child Protection **must** notify Victoria Police at the point of intake in order to ascertain from police whether or not a criminal investigation is required.

## 5.3 Reporters protected

If a report regarding a child in need of protection or therapeutic treatment is made in good faith, the reporter cannot be held legally liable, *regardless of the outcome of the report* (as stated in s189 of the CYFA):

A report made in good faith '…does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made, and does not make the person by whom it is made subject to any liability in respect of it…'

It is specifically prohibited under s191 of the CYFA to disclose the identity of a person who has made a report to Child Protection, other than to another protective intervener. The identity of the reporter can only be disclosed to a community based child and family service, such as Child FIRST, if the report is classified as a child wellbeing report. Where the report is classified as a protective intervention report, the identity of the reporter must not be disclosed to a community based child and family service. All reporters to Child Protection are protected under s191, regardless of whether or not they are mandated reporters.

In accordance with the legislation, the identity of the reporter will remain confidential, unless:

- the reporter chooses to inform the child and/or family of the report
- the reporter consents in writing to their identity as the reporter being disclosed
- the court decides that it needs this information in order to ensure the safety and wellbeing of the child
- the court decides that, in the interests of justice, the evidence needs to be given.

Similarly, a report or referral in relation to significant concerns for the wellbeing of a child made to Child Protection or Child FIRST in good faith does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made and does not make the person by whom it is made subject to any liability in respect of it (CYFA s40(a)(b)).

It is not general practice for the Children's Court to seek information regarding identification of the reporter. At times the source of the report becomes obvious to the family because of the nature of the concerns raised by Child Protection and this should be discussed at the time of the report. Sometimes it may be possible for the reporter to discuss the report with the family, as this can be a helpful strategy in engaging the family in a resolution of their difficulties and may, in fact, reduce their hostility. In other circumstances, this is not possible or would further endanger a child's safety if the parent had prior knowledge that a report was being made. If there are concerns that there may be repercussions for the reporter from a family, it is advisable to plan a strategy with colleagues or with Child Protection. It is also worth bearing in mind that the notion of mandatory reporting being a reality for teachers, nurses, doctors and other gazetted professionals in Victoria is widely known in the community.

## 5.4 Initial response by Child Protection on receipt of a report

On receipt of a report (other than a report regarding a child in need of therapeutic treatment), Child Protection will conduct an assessment in order to classify reports as being either a Protective Intervention Report or a Wellbeing Report and to determine the most appropriate response.

Where a report is classified as being a Protective Intervention Report, Child Protection will conduct a direct investigation into the subject matter of the report.

Below is a summary table showing the possible outcomes of the direct investigation into a report in respect of a child in need of protection.

| Outcome of investigation | Risk assignment | Response |
|---|---|---|
| Alleged harm/risk of harm is not substantiated | No significant concerns | Close |
| | Significant concern for wellbeing | Refer to Child FIRST/Family Services and close |
| Alleged harm/risk of harm is substantiated | Risk of significant harm – child in need of protection | Issue Protection Application |
| | No further risk of harm | Refer (as necessary) and close |
| | Risk assignment deferred – further protective intervention/assessment | Develop Best Interests Plan |
| Outcome of a period of further intervention and assessment | Risk of significant harm – child in need of protection | Issue Protection Application |
| | No further risk of significant harm | Refer and close[4] |

Where a report is classified as being a Wellbeing Report, Child Protection may provide advice or refer the matter to Child FIRST for action.

Where Child Protection receive a report under s185 of the CYFA, regarding a child in need of therapeutic treatment from a source other than police, Child Protection **must** notify Victoria Police at the point of intake in order to ascertain from police whether or not a criminal investigation is required.

Professional reporters obviously play a critical role in protecting children and should generally receive feedback regarding the report they have made.

4. *every child every chance 'Substantiation and risk assignment' 2007.*

Child Protection intake must make reasonable attempts to contact all professional reporters by phone, to inform them of the outcome of the report, unless there are exceptional circumstances or it is not in the child's best interests. This should occur in a timely manner (usually within two days of the classification of the report).

Information provided to a reporter would generally be restricted to the intake outcome (or classification). The reporter would not generally be informed of the outcomes of any referral, or an offer of assistance or an investigation, unless the child or their parent consents or where the reporter is actively involved in the child's ongoing protection (such as active involvement in the Best Interests planning process).

Where a report is classified as being a Protective Intervention Report, Child Protection will conduct a direct investigation into the subject matter of the report.

## 5.5 Making a referral to Child FIRST

Similar to the provisions for making a report to Child Protection, the CYFA allows for two types of referral to be made to Child FIRST, as follows:

- s31 of the CYFA states that: '…A person who has a significant concern for the wellbeing of a child may refer the matter to a community-based child and family service…'
- s32 of the CYFA states that: '…a person who, before the birth of a child, has a significant concern for the wellbeing of the child after his or her birth may refer the matter to a community-based child and family service…'

Where, during the course of their duties, a Disability Services practitioner identifies a significant concern for the wellbeing of a child, the Disability Services practitioner **should** make a referral to Child FIRST.

Child FIRST will provide a streamlined and visible point of referral, avoiding the need to negotiate across many services to find the right local service. Child FIRST will work closely with other services, to coordinate intake and referral processes (for example, with family violence services and homeless services).

# 6. Information exchange

The CYFA is designed to promote the exchange of information to ensure that professionals work together effectively where children are at risk. The provisions of the CYFA authorise information exchange over and above what is permissible under the *Information Privacy Act 2000* in order to promote the best interests of a child.

Inquiries into child deaths resulting from maltreatment routinely identify a failure to share information as a contributory factor: no single person held all of the available information that may have helped identify the level of risk to the child. The purpose of information exchange authorised by the CYFA is to ensure that the best outcomes for children are achieved.

While this section describes authorised information exchange between Disability Services, Child Protection and community-based child and family services, there are similar provisions enabling information exchange between Child Protection, community-based child and family services and professionals such as doctors, nurses, police, psychologists, community service workers, drug and alcohol counsellors, schools and others.

In addition to the authorisation contained in the CYFA, s39(4) of the Disability Act allows for the release of information concerning a person with a disability to the Secretary DHS, who is the primary delegate of the Child Protection functions under the CYFA.

As a disability service manager or practitioner in Victoria, you have a key role to play in ensuring that vulnerable children are protected and supported. This means that you have a responsibility to share information about a vulnerable child who may need help. This is because sharing information with an agency such as Child FIRST or Child Protection helps to promote a child's safety and development, and gives a vulnerable child and their family access to services they may need.

### What information can be shared?

When information is shared with Child FIRST or Child Protection, it may comprise any information that may help them to make an initial assessment about a child. In the case of Child Protection, information may also be shared that is relevant to the protection or development of a child when Child Protection is investigating a report or during subsequent Child Protection intervention.

With regard to the provision of information by Child Protection to Disability Services, this is able to occur at the request of Disability Services staff with the consent of the family. However, Disability Services is able to access only the information on the file that is also accessible to families.

### What's new in the CYFA regarding information sharing?

New provisions related to information sharing are included in the CYFA.

- A referral to a Child FIRST team can be made if there are significant concerns for a child's wellbeing (this can occur prior to a child's birth, if the concern relates to the wellbeing of the child after their birth).
- Child FIRST or Child Protection may consult when they are assessing and deciding how to best respond to a referral or report they have received.
- The person in charge of a service is authorised to share relevant information with Child Protection when they have decided that a child is in need of protection and are working with the child and family.

**How is the person sharing information protected?**

When a referral to Child FIRST or a report to Child Protection is made, and when Disability Services staff assist Child Protection in confidence with an investigation or intervention:

- their identity will not be disclosed without consent (although they are encouraged to consider disclosing it to help services engage more easily with the family)
- they are legally protected (for example, you cannot be successfully sued)
- they are professionally protected (you cannot incur any formal adverse professional consequences).

**What are Disability Service managers and workers authorised to do?**

A Disability Service manager or worker can:

- make a referral to Child FIRST if there are significant concerns for the wellbeing of a child, or a report to Child Protection if it is believed a child is in need of protection
- be authorised by Child Protection to share relevant information during an investigation.

**What additional authorisations does the person in charge of a disability service have?**

The person in charge of a disability service is authorised to share relevant information with Child FIRST or Child Protection to help them assess a referral or report they have received. The person in charge is also authorised to share relevant information with Child Protection to help them:

- undertake an investigation
- work with, and coordinate services for, a child and their family, where a child has been found to be in need of protection.

Where a child is subject to a Children's Court Protection Order, the person in charge can be required by law to provide relevant information.

**Who is the 'person in charge' of a disability service?**

It is the person who is in charge at the time and on the day that the information is requested and disclosed. If the manager is not on site, this might be the senior worker who is present.

## 6.1 Information-sharing obligations under this protocol

If Child Protection believes on reasonable grounds that a Disability Services staff member has information relevant to the protection or development of a child about whom Child Protection has received a Protective Intervention Report, Child Protection may request the Disability Services staff member to provide that information to Child Protection.

If a Disability Services staff member is asked to provide such information, they **should** provide that information to Child Protection (CYFA s192).

A disclosure of information made in good faith under s192 of the CYFA does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made and does not make that person subject to any liability in respect of it (CYFA s193).

Information exchange between Disability Services and Child FIRST is confined to those situations where a referral has been made to Child FIRST and a response has yet to be determined.

If Child FIRST receives a referral, they may – for the purpose of assessing the risk to a child – consult with Disability Services (CYFA s36).

A disclosure of relevant information made under s36 of the CYFA in good faith does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made and does not make the person by whom it is made subject to any liability in respect of it (CYFA s37(a)(b)). (see Appendix 9)

Relevant information will obviously include specific information about the child. It will also include information about the other members of the child's family, or people living with the child, whose behaviour has an impact on the child. For example, relevant family information might include details of incidents of family violence or substance abuse by the child's parents, where this has an impact on the child.

In addition to the above, the disclosure of information to Child Protection in good faith during the course of the investigation of a report in relation to a child in need of therapeutic treatment does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is given and does not make that person subject to any liability in respect of it and does not constitute a contravention of:

- section 141 of the *Health Services Act 1988*
- section 120A of the *Mental Health Act 1986*.
  (CYFA s212)

A full guide on information sharing is available at: www.dhs.vic.gov.au/everychildeverychance

# 7. Collaborative partnership

As outlined in section 2, collaboration is defined as a 'joint approach to plan and deliver high-quality services, characterised by working together in an inclusive and participatory manner. Effective collaboration occurs when parties create a working relationship premised on trust and respect, shared decision making, adequate time and the application of available resources'. The goal of collaboration is to support effective working relationships to achieve the best outcomes for the child.

## 7.1 Best Interests planning

Best Interests planning is one of the important processes undertaken by Child Protection in partnership with the child (where possible), the child's parents and extended family where appropriate, and other professionals in the child's or family's life. This may include Disability Services.

Best Interests planning is the process by which decisions are made about what actions need to be taken to address the child's needs and risks, in relation to the family strengths and capacities. At appropriate stages formal Best Interests Plans are recoded which lead to case practice directed to achieving the identified goals and objectives.

Where Child Protection is involved with a family in which the subject child or their carer has a disability, it is imperative that Disability Services are actively involved in the Best Interests planning process.

A Best Interests Plan is generally developed in the first instance post-substantiation; that is, where Child Protection has assessed that the subject child is a child in need of protection.

Best Interests planning may involve the development of:

- a Care and Placement Plan – developed if the subject child is placed in out of home care
- various Statutory Case Plans – where a child is the subject of a Children's Court Protection Order (the term 'statutory case plan' simply means that it is required by law)
- a Stability Plan and a Cultural Plan – these are other types of Best Interests Plan that are required by law in certain circumstances.

### 7.1.1 The Care and Placement Plan

When a child is placed in out of home care, a number of people will form a care team. The composition of a care team will vary depending on the specific issues and needs of the child and family. It will always include the Child Protection practitioner, agency placement worker, the child's case manager, the child's carer and parents (as appropriate). Disability Services should form part of the care team for children in out of home care with a disability. The care team prompts all parties involved to consider the things any good parent would naturally consider when caring for their own children.

The care team will help in the development of the Care and Placement Plan, which identifies the child's needs and describes how these needs will be met while the child is in out of home care, including what services will be required to address disability issues. The Plan covers a range of areas: health, emotional and behavioural development, education, family and social relationships, identity, social presentation and self-care skills. The care team is expected to actively participate in regularly reviewing Care and Placement Plans.

The Care and Placement Plan forms part of the overall Best Interests Plan.

### 7.1.2 Best Interest Principles

As noted in 4.1 above, the CYFA includes a range of principles that must be taken into consideration in making any decision or taking any action in relation to a child.

In developing a Best Interests Plan, the CYFA states that Child Protection must follow these principles as far as possible:

- The most important thing is the **best interests of the child or young person**.
- When determining whether a decision or action is in the **best interests of a child**, the need to **protect the child from harm**, to **protect the child's rights** and to **promote the child's development** must always be considered.
- Reunification is promoted as long as it is in the best interest of the child or young person.
- Decisions are based on the child or young person's developmental needs and must maintain family relationships.
- Decisions about the child or young person's safety, stability and development should not be about anything more than the minimum to achieve these.
- Seek full participation of the child/young person and their family.
- Allow and encourage the child/young person and their family to use support people.
- The process must be understandable.
- Consider different perspectives.
- Seek agreement.
- Make decisions as soon as possible.
- Use interpreters.
- Use support people for people from culturally and linguistically diverse backgrounds.
- If the child or young person is Aboriginal, then someone from the Aboriginal community should be part of the decision making, care, supervision, custody and guardianship for the child or young person.

At times it is not possible to be consistent with all of these principles at once. This does not mean that the principles or the decisions are wrong, but rather that some issues are more important than others. In deciding what the most important issues are, the CYFA states that decisions have to be made in the **best interests of the child or young person**.

## 7.2 Children with complex medical needs

With improvements in hygiene and medical technology, child and infant mortality rates have fallen steadily. However, there remain a relatively small number of children with complex medical needs and or with a limited life expectancy. These children and their families are a particularly vulnerable group within Child Protection and the broader service system. Physical and neurodevelopmental disability, combined with complex care needs, contributes to tremendous emotional and practical challenges that families are variably able to meet.

Care of this group of children and their parents is best achieved through a partnership approach between major stakeholders including Disability Services, a range of health services and Child Protection. Child Protection practitioners are not, and not expected to be, experts in the areas of medical diagnosis and complex disabilities. If there are clear and identifiable child protection concerns present, it is expected that Child Protection will consult widely and effectively with other professionals as they investigate and plan for the child with complex medical needs and the family. Professional consultation and

collaboration should occur within a continuum of services including Disability Services, community health centres, maternal and child health services, general practitioners, paediatricians, children's hospitals and other medical specialists.

### 7.2.1 Risk factors for children with complex medical needs

Factors underpinning the risk of abuse and neglect of children with complex medical needs occur across a range of areas of the parent-child relationship, including that:

- Children with disabilities and complex medical needs are statistically more vulnerable to abuse and neglect than other children due to their more likely use of residential care, their physical dependency and their barriers to communication.
- The stigma of having a child with disabilities can lead to the family's isolation and social rejection, resulting in increased risk of abuse.
- Disruptions to parent and child attachment due to hospitalisations and early separations may interfere with the parental role and contribute to a lack of attachment, which is a known risk factor for abuse and neglect.
- Parental denial of the situation may lead to medical neglect and place a child at risk.
- The presence of enormous stress may overwhelm a parent, especially if they lack supports and respite, and can lead to abuse and neglect.
- The presence of other complicating parental factors including violence, mental health issues, substance abuse and intellectual disability.

### 7.2.2 Principles for working with children with complex medical needs

There are several core principles that guide Child Protection work with children with complex medical needs, including:

- Children with complex medical needs require an environment that meets their wellbeing needs and ensures integration with other children without illness as much as possible to enhance their quality of life.
- Children with complex medical needs require early intervention services with a link to a comprehensive medical system.
- Communication and collaboration with community medical and support services are vital to ensure the safety and wellbeing of the child with complex medical needs.
- Protective concerns must be acted upon promptly and thoroughly to ensure the child with complex medical needs remains safe.
- Siblings of children with complex medical needs are also vulnerable and must have their stability, safety and wellbeing needs met.

## 7.3 Statutory and voluntary intervention

Disability Services is a statutory service providing services for people in Victoria who have a disability. The services provided are accessed on a voluntary basis, which means that client consent is explicitly required in order to receive or participate in services funded by Disability Services. In contrast, Child Protection, which is also a statutory service, incorporates within its role a significant component of statutory intervention where client consent is not required. Both programs work within a legislative framework, with clearly defined roles and responsibilities. Collaborative practice is a critical factor in meeting the needs of shared clients.

### 7.3.1 What is consent?

Consent refers to a person's right to make a fully informed choice about what services they will engage with. In this context, it refers to their right to consent to being assessed for eligibility and/or receiving services from Disability Services. Consent also includes the right to withdraw consent at any time.

For some individuals with disabilities, additional assistance is required to ensure that there is a full understanding of the nature of the consent. To make a fully informed decision, a person needs to have:

- awareness of what the decision/choice is
- awareness of more than one option
- awareness of the possible result of each option
- awareness of possible harm to self or others of each option
- the capacity to communicate choice.

## 7.4 Engaging young people and families in voluntary services

A young person or family may be reluctant to engage with voluntary services such as Disability Services for a range of reasons including:

- being labelled as having a disability
- fear of a loss of control
- not understanding the concerns others have for them
- preferring other approaches to dealing with problems, such as using informal supports
- possible stigma attached to being involved in particular services
- not being ready from a developmental perspective.

The best way to address concerns is generally through a worker with whom the family or young person has a positive relationship, who can negotiate a suitable response. It's important to remember the following key points in relation to engaging families or young people:

- People are more likely to access a new service when supported by a worker with whom they have a good relationship. The worker may be present during the appointment if appropriate, but otherwise is available to talk about what happened afterward.
- People need a clear understanding of the role and purpose of the new service in order to make an informed decision regarding accessing the service. Disability Services workers may be best placed to describe the supports available, either to the client or the worker with whom the family or young person has a positive relationship.
- Other services that a client has a good relationship with can provide secondary consultation to the worker or carer if the client is unwilling to access these other services.
- People are often encouraged when the worker they feel most comfortable with talks to other workers, and all concerned seem unified and working towards the child's or family's best interests.

## 7.5 Voluntary services in a statutory framework

In some circumstances, Child Protection may decide that statutory intervention is not required, on the proviso that the family agrees to accept services from another organisation. This may impact on the voluntary relationship between the client/family and the service. However, where this is considered the least intrusive option into family life to address the protective needs of children and young persons, it may be a legitimate response. The aim would be to induce compliance by families to change and reduce the risk to their children.

The message to the parent is that 'this is serious and change needs to occur; however, we will trust you to make this change voluntarily if you agree to receive services to support you in making this change'. From the perspective of Disability Services, however, this challenges the notion of 'voluntary participation'.

A greater challenge to the notion of voluntary participation arises where there is a 'statutory directive' for a child or family to receive services from a voluntary organisation. This is a fairly common characteristic of Child Protection Orders issued by the Children's Court. Special conditions attached to Child Protection Orders in respect of the child and/or the family may include an order to receive services as directed by Child Protection.

Where a Child Protection Order is in place, Child Protection is also empowered to issue a lawful direction to a parent of a child. The direction must be in the best interests of the child.

Problems can arise when the child or family is unwilling to participate and the service being referred to requires that participation occurs on a voluntary basis only.

Where possible, Child Protection practitioners anticipating or seeking to recommend conditions that a child or family member undergo assessment and support by a voluntary service, such as Disability Services, should first:

- Seek the client's views.
- Consult with the relevant service.
- Inform the client of the range of supports and services available through Disability Services.
- Consider options available to address any concerns presenting.
- Consider, on balance, the implications should the client be unwilling to abide by the conditions and seek alternative approaches to addressing concerns as appropriate.

In these situations the key message is that the person to whom a condition of a Child Protection Order applies is responsible for complying with this condition, and the voluntary service should support this as much as possible.

## 7.6 Summary of collaboration at key stages

Disability Services is uniquely placed to provide services and supports to help vulnerable children and strengthen families. They often have close and consistent contact with vulnerable children and their families, both before coming to the attention of Child Protection and after the family's involvement with Child Protection is no longer required.

The role of Disability Services and disability service providers includes:

- providing earlier intervention and prevention services for vulnerable children and their families, which aim to improve outcomes and prevent their move into the Child Protection system
- identifying potential signs of abuse and neglect in children, including where the parent is the client, which may necessitate intervention by Child Protection

- working together with Child Protection and other relevant agencies to achieve shared goals for children and their families, where a child has entered the Child Protection system
- providing ongoing services, where appropriate, to children and their families once Child Protection involvement is no longer necessary to ensure the safety, stability or development of the child.

When a child and their family enter the Child Protection system, the process undertaken contains five key stages: intake, investigation, protective intervention, protection order and closure. Where the child or a family member has a disability and the involvement of Disability Services has been requested, collaborative interaction with Disability Services should occur throughout these stages, although the extent will vary depending on the individual circumstances and action required.

It is important throughout this process that communication is clear, timely and recognises the expertise of workers in their respective fields. Where a difference of opinion is identified, the issue should be addressed promptly and referred to a regional decision-making process involving both Child Protection and Disability Services for resolution as required (see section 8).

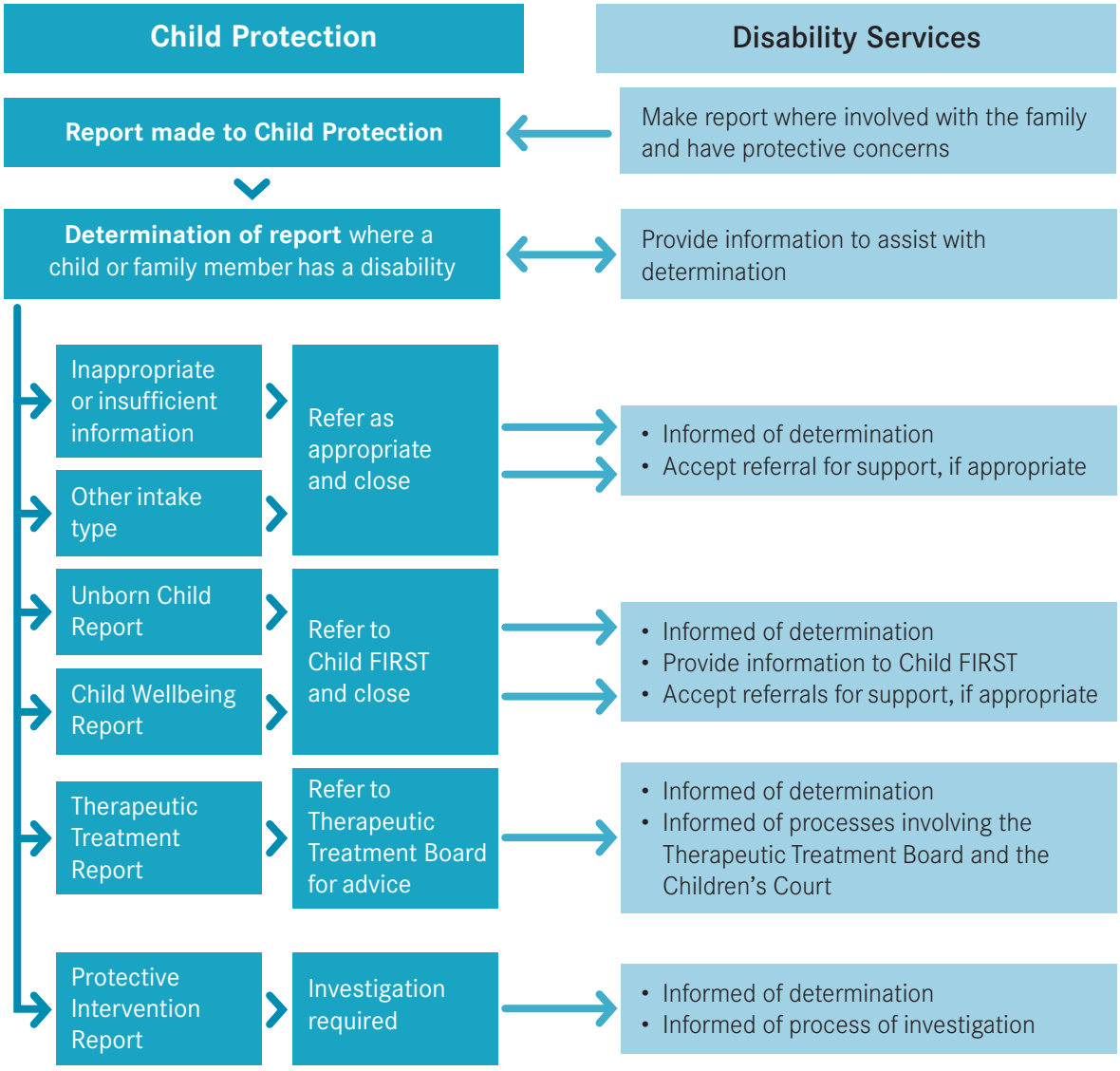
In all elements of the process, the child's best interests are paramount.

### 7.6.1 Intake

Figure 1 outlines the key elements of collaborative interaction between Child Protection and Disability Services during the intake phase.

- Disability Services makes reports to Child Protection, where they become aware of protective concerns.
- Child Protection identifies reports that involve children or family members with a disability (if this is unclear, contact Disability Services for advice).
- Disability Services provides information to inform the determination process (see section 5.5).
- Child Protection informs Disability Services of the determination and their response.
- Child Protection discusses possible referrals for supports available through Disability Services and actions as appropriate.
- In relation to Unborn Child or Child Wellbeing Reports, Disability Services provides information to Child FIRST, discusses possible referrals for supports available through Disability Services and actions as appropriate.
- In relation to Therapeutic Treatment Reports, Child Protection informs Disability Services of subsequent processes involving the Therapeutic Treatment Board and the Children's Court.
- Child Protection informs Disability Services if a further investigation is required and subsequent opportunities for involvement in this process.

## Figure 1: Summary of collaboration - intake phase

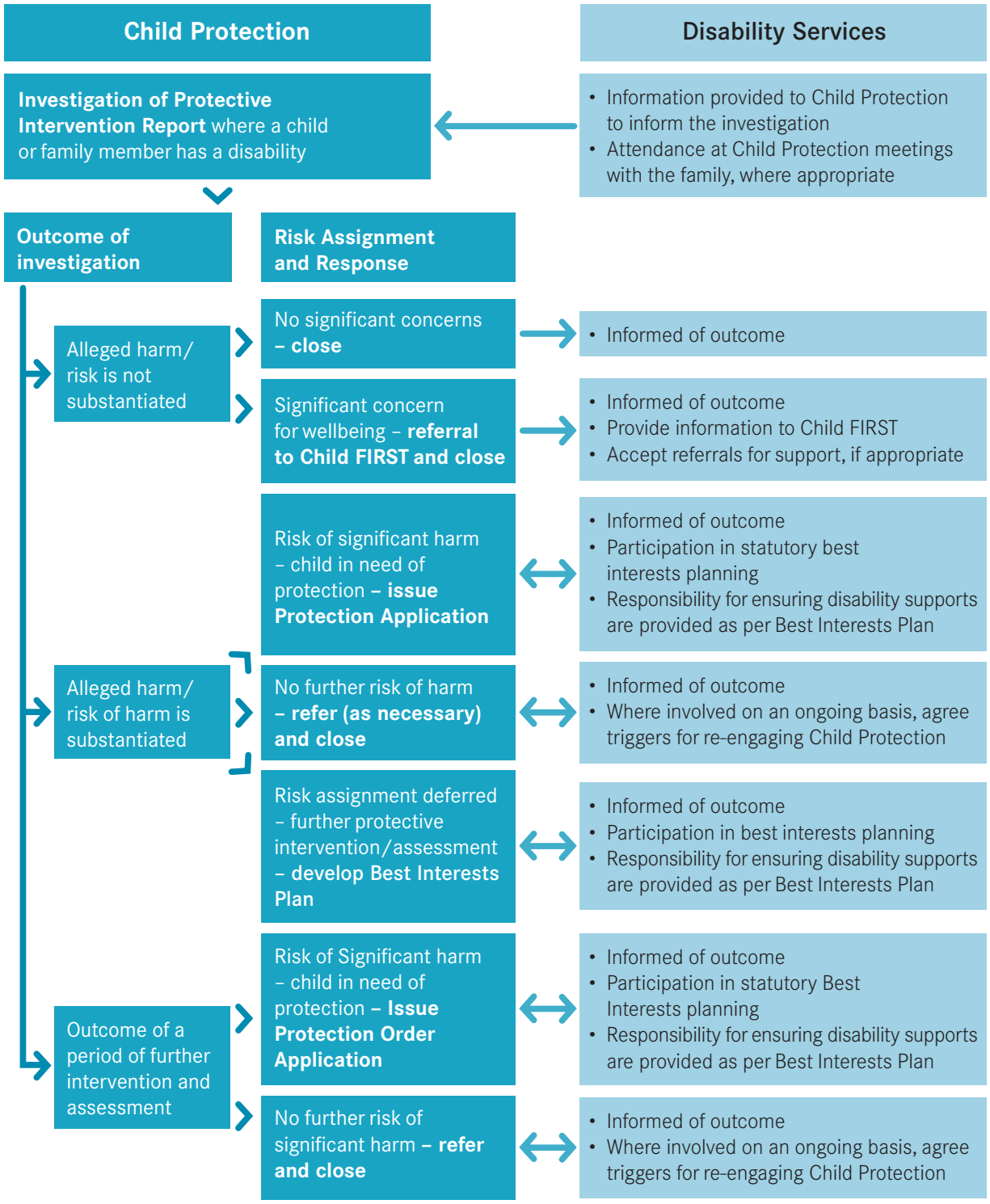


### 7.6.2 Investigation, assessment and protective intervention

Figure 2 outlines the key elements of collaborative interaction between Child Protection and Disability Services during the investigation and intervention phases.

- Child Protection seeks input from Disability Services in situations involving children or family members with a disability (if this is unclear, contact Disability Services for advice).
- Disability Services provides information to inform the investigation and attends Child Protection meetings with the family where appropriate. Where issues related to the disability of the child or of the parent are impacting significantly on the overall functioning of the family and their capacity to care for dependent children, the provision of disability supports and services may assist in maintaining the child safely within the family. Involvement of Disability Services in such circumstances is particularly important, where it is hoped the family will consent to engagement with Disability Services (see section 5.5).
- Child Protection informs Disability Services of the outcome of the investigation, including the risk assigned and the response.
- In relation to significant concerns for wellbeing, Disability Services provides information to Child FIRST, discusses possible referrals for supports available through Disability Services and actions as appropriate.
- Where no further risk of harm is identified (either during initial investigations or after a period of further intervention of assessment) and Disability Services has ongoing involvement with the family, triggers for re-engaging Child Protection must be agreed.
- Where it is deemed that there is a significant risk of harm and the child is in need of protection, Child Protection will issue a Protection Application. Disability Services should be informed of this decision and participate in subsequent statutory Best Interests planning. Disability Services will be responsible for ensuring that the most appropriate support and services are identified and provided for in the plan.
- Disability Services staff must provide evidence for a Children's Court Application, if required as part of the legal proceedings in the Children's Court. Child Protection will always discuss the evidence required with Disability Services. This will be a collaborative process.

## Figure 2: Summary of collaboration - investigation and intervention phases



### 7.6.3 Placement in out of home care

Where a Child Protection Order is made that requires the child to be removed from the care of their parents or caregivers for a length of time, the key elements of collaboration between Child Protection and Disability services include:

- Child Protection should consult with Disability Services in relation to placement options and other services or supports that may be available for the child to assist in meeting their needs during this placement.
- Disability Services should form part of the care team supporting the child.
- Disability Services to assist in the development of the Care and Placement Plan, including identification and provision of services and supports for the child while in out of home care.
- Disability Services and Child Protection will work within the care team to review the Care and Placement Plan and identify any additional supports and services that may be required.

### 7.6.4 Supporting young people to leave care

Where a young person leaves out of home care upon reaching adulthood, comprehensive planning is required to support a successful transition to the new living arrangements. This planning should ideally commence two years prior to the transition or earlier, depending on the needs of the young person. The key elements of collaboration between Child Protection and Disability services at this time include:

- Both Child Protection and Disability Services work with the care team to ensure that the young person has developed the skills and knowledge to move towards independence.
- Disability Services identifies and provides any specialist services or supports that may be required to assist the young person upon leaving out of home care.
- Child Protection will share any relevant information, within the parameters of the CYFA, that may assist Disability Services in supporting the young person upon leaving out of home care.

# 8. Resolving differences

Differences of opinion may occur between Disability Services and Child Protection during the case management of a client or family where a member of the family has a disability. Where such differences occur, they have the potential to impact on the outcomes for the families involved and need to be addressed promptly in a professional and effective manner.

Resolution of differences of opinion should be undertaken in a manner that ensures:

- The child or young person's safety and wellbeing is paramount.
- Differences of opinion are resolved at the most immediate level possible; however, line management should be utilised if initial attempts to resolve differences are not successful.
- Differences are addressed as soon as possible after they arise.

The following model could be used as a basis for resolving differences by workers, where they disagree about the type of action to be taken for a particular client:

- Identify the problem by allowing both parties to state their case (that is, state their position and the rationale behind this position).
- Attempt to work through the dispute to develop a number of strategies to address the disagreement.
- Discuss and negotiate with the other party to achieve the most suitable resolution.
- Agree on an outcome and develop a strategy for its implementation.
- Agree on how strategies will be evaluated and monitored.
- Where a resolution cannot be found, the situation should be 'managed up' within the regional management structure.

The overall aim of this process is to resolve the case specific issues and/or problems. All information should be clearly recorded with:

- an outline of the process taken to resolve the issues
- roles and responsibilities of each service
- further action plans to address issues and maintain the safety and wellbeing of the child or young person.

A log of such differences should be maintained and reoccurring areas of concern should be addressed collaboratively at the regional management level or referred to central programs for cross-divisional policy discussion.

# Appendix 1 Needs of shared clients

Many people in the community are affected by disability, due to physical, sensory, intellectual or neurological impairments or acquired brain injury. Each person's experience of disability is unique and is affected by their own life experience, attitudes of other members of the community towards disability and ease of access to information, services, opportunities and the physical environment.

People with disabilities may require a range of supports including local community services, generic services and specialist services. The aim of these supports is to enable the person with a disability to pursue their lifestyle of choice and to access opportunities for education, employment and leisure and recreational activities. The focus of the disability support system is to provide specialist secondary services that are not available in the generic secondary and universal service system.

People with disabilities vary considerably in the level and complexity of their needs and the supports they require. They may live in families, community and supported accommodation settings. Families with dependent children are part of a larger group of people who may require disability supports and services.

## Families and disability

Many families with members with disabilities are well able to provide care for all of their family members, using networks of informal supports and universal services. These may be further supplemented by formal specialised supports. Many families meet the additional care requirements of children with disabilities without the use of paid carers.

Each family's experience of providing and caring for a member with a disability is unique and is related to factors such as personal resources, perception of disability, availability of informal support, access to universal and specialist services as well as other structural issues that affect all families with dependent children. Many families report and identify many positive aspects of their role and relationship with the family member with the disability.[5]

Research has demonstrated that abuse and neglect in a family where a member has a disability occurs in conjunction with other factors, such as poverty, social isolation, single parenting and so on. Community attitudes to disability may contribute to factors such as social isolation or restrictions on working life, and families may be excluded from accessing universal and generic support services. Disability, in itself (either of the parent or the child), does not lead to abuse; however, it is a factor to consider when assessing risk of harm to a child when a family is experiencing difficulties.

Similar to all families experiencing difficulties in caring for their children, families that include a family member with a disability need to be assessed individually in terms of the vulnerability of the child and the capacity of the parent to protect and care. This should include assessment of support networks and family strengths. Disability, in itself, may not be a significant risk factor in all families.

5. Rosenau, N., 2002, *Families with members with disabilities: Love, money and public policy*, Disability Foundation of Australia.

## Children with disabilities

Research indicates that children and young people with disabilities are more vulnerable to abuse and neglect. Greater physical dependency, communication difficulties and the impact of medication as well as attitudinal aspects of the disability (such as behavioural indicators of abuse misattributed to the disability and limited credibility of the child or young person) are some of the contributing factors.[6] Children with disabilities are more likely to be exposed to a range of workers, increasing their vulnerability to extra-familial abuse.

Abuse and neglect of children with disabilities is likely to be under-reported and there is some research to indicate that professionals and Child Protection practitioners apply lower standards of care when working with children with disabilities.[7]

## Parents with disabilities

Parents with disabilities may face some additional challenges in the parenting role, especially as community attitudes to disability can create barriers to participation and inclusion in society. For this reason, parents with disabilities may require additional support to enable them to fully undertake their parenting role and maintain their families.

It is believed that assessment of parenting capacity and risk issues may be influenced by incorrect beliefs about people with a disability. Parental difficulties may be falsely attributed to the disability rather than the structural issues such as poor living conditions, poverty, limited support or lack of education. Further, parents with a disability may fear the 'removal' of their children by authorities, which could contribute to a reluctance to engage with support services.

Research clearly indicates that parents with learning disabilities have the capacity to learn parenting skills and develop their confidence as a parent, given the right supports and services and provided information in accessible formats. Many parents with a disability, given the appropriate support, are able to provide a level of care that is acceptable by community standards.

## Children living with a parent with a disability

Children who live with parents with a disability or chronic illness are sometimes involved in caring for their parent.[8] The wellbeing of the child may be affected by such factors as continuity of care, family discord, poor general parental skills, social isolation and poverty arising from the parent's disability. The caring tasks may impact on opportunities for the child to participate in schooling and social activities.

6. Office of the Child Safety Commissioner 2004 *Child Death Enquiry – Group analysis, Children with complex medical needs Final Report*, Office of the Child Safety Commissioner, October 2004.
7. Cooke, P. and Standen, P., 2002, 'Abuse and disabled children: Hidden needs…?', in *Child Abuse Review*, Volume 11, pp. 1–18.
8. *A picture of Australia's children*, 2005, Australian Institute of Health and Welfare.

# Appendix 2 Definitions of child abuse

Child abuse is any action, or lack of action, that significantly harms the child's physical, psychological or emotional health and development. Although the abuse types are described separately below, in reality many of the following forms of harm occur concurrently. By definition child abuse is not an accident, but neither is it always the intention of the person to inflict harm or injury.

Child abuse '…may be constituted by a single act, omission or circumstance, or accumulated through a series of continuing acts, omissions or circumstances…' (CYFA 2005 s162(2)).

## Definitions of child abuse

The following definitions are not all-inclusive and are meant as a guide to inform practice.

### Physical abuse

Physical abuse consists of any non-accidental form of injury or serious physical harm inflicted on a child by any person. Physical abuse does not mean reasonable discipline, though it may result from excessive or inappropriate discipline. Physical abuse can include beating, shaking, burning and assault with weapons.

Physical injury and significant harm to a child may also result from neglect by a parent or caregiver. The failure of a parent or caregiver to adequately ensure the safety of a child may expose the child to extremely dangerous or life-threatening situations, which result in physical injury and significant harm to the child. Exposure to extremely dangerous situations can exist where domestic violence is present. Physical abuse also includes fabricated illness syndrome (previously known as Munchausen's syndrome by proxy) and female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female organs for cultural or any non-therapeutic reasons.

### Sexual abuse

A child is sexually abused when any person uses their authority or power over the child to engage in sexual activity. Child sexual abuse involves a wide range of sexual activity and may include fondling genitals, masturbation, oral sex, vaginal or anal penetration by finger, penis or any other object, voyeurism and exhibitionism. It can also include exploitation through pornography or prostitution. Failure to protect a child from sexual abuse may occur from a parent's lack of sufficient capacity to protect the child from such abuse.

### Emotional abuse

Emotional abuse occurs when a child is repeatedly rejected, isolated or frightened by threats or the witnessing of family violence. It also includes hostility, derogatory name calling and put-downs, or persistent coldness from a person, to the extent where the behaviour of the child is disturbed or their emotional development is at serious risk of being impaired.

### Neglect

Neglect includes a failure to provide the child with an adequate standard of nutrition, medical care, clothing, shelter or supervision to the extent where the health or development of the child is significantly impaired or placed at serious risk. A child is neglected if they are left uncared for over long periods of time or abandoned.

### Serious neglect

Under protocols between Child Protection and Victoria Police, Child Protection is required to inform the police where a child has been sexually or physically abused or is suffering serious neglect. The definition for serious neglect is provided below. Serious neglect includes situations where a parent has consistently failed to meet the child's basic needs for food, shelter, hygiene or adequate supervision to the extent that the consequences for the child are severe. For example, where:

- the child's home environment is filthy or hazardous in the extreme and poses a threat to the child's immediate safety or development and is characterised by the presence of animal or human faeces or urine, decomposing food, syringes or other dangerous drug paraphernalia
- the child is provided with consistently insufficient or inadequate food or nourishment for the child's healthy development
- the child has a serious medical condition for which the parent has consistently failed to obtain treatment or dispense prescribed medication
- the parent consistently leaves the child unattended, exposed to or in the care of strangers who may harm the child.

### Medical neglect

Neglect of medical care refers to a situation where a parent's refusal of, or failure to seek, treatment or agree to a certain medical procedure leads to an unacceptable deprivation of the child's basic rights to life or health.

### Family violence

Where there are strong indicators that incidents of family violence are placing children at significant risk or danger, Child Protection must be informed. Family violence is also criminal in nature and liable to prosecution. These forms of violence include assault, aggravated assault, trespass, rape and other offences against the person including offences involving the use of firearms.

### Risk-taking behaviour

While risk-taking behaviour in adolescence is a normal aspect of healthy development, some behaviours demand attention from Child Protection when they carry potentially severe or life-threatening consequences. Examples include severe alcohol or drug use (use of opiates, amphetamines or benzodiazepines; any intravenous drug use); unsafe sexual activity including prostitution; solvent abuse and chroming; and violent or dangerous peer group activity (for example, train surfing).

## The impact of abuse and neglect

The sustained abuse or neglect of a child physically, emotionally or sexually can have major long-term effects on all aspects of a child's health, development and wellbeing. When threatened by overwhelming events, a child's 'freeze, flight, fight' response is activated; biochemical changes occur and they can remain stuck in a dysregulated and hypervigilant state, which impacts on their brain development and future behaviour.

Research into the lasting effects of child maltreatment indicates that neglect is as harmful as abuse and has a cumulative and negative effect on a child's development. Importantly, neglect co-occurring with other forms of maltreatment increases the impact on children exponentially.

Sustained abuse or neglect is likely to have a deep impact on a child's self-image and self-esteem, and on his or her future life. Childhood trauma is directly linked to adult physical and mental health problems. The experience of long-term abuse and neglect may lead to difficulties in forming or sustaining close relationships or establishing oneself in the workforce and to extra difficulties in developing the attitudes and skills needed to be an effective parent.

It is not only the stressful events of abuse that have an impact, but also the context in which they take place. A child's experience of traumatic events is influenced by many factors, including their individual characteristics and the level of stability and support available following the traumatic events, which is why experiences differ between children in response to apparently similar types of events. Relevant factors include the individual child's means of coping and adapting, support from a family and social network, and the impact of any interventions. The effects on a child are also influenced by the quality of the family environment at the time of abuse and subsequent life events. Importantly, the way in which professionals respond has a significant bearing on subsequent outcomes for a child.

## The impact of physical abuse

Physical abuse can lead directly to neurological damage, physical injuries, disability or – at the extreme – death. Harm can be caused to children both by the abuse itself and by the abuse taking place in a wider family context of conflict and aggression. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties.

## The impact of sexual abuse

Sexual abuse has been linked to disturbed behaviour including self-harm, inappropriate sexualised behaviour, sadness, depression and a loss of self-esteem. The severity of impact on a child is believed to increase the longer the abuse continues. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps them to understand the abuse and is able to offer help and protection.

A proportion of adults who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to family violence and instability of care. However, it does not follow that most children who are abused will inevitably go on to become abusers themselves.

## The impact of emotional abuse

There is increasing evidence of the long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Family violence, adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

## The impact of neglect

Children's responses can differ significantly to different forms of abuse and neglect. For example, physically abused infants commonly show high levels of negative affect, while neglected infants demonstrate flattened affect.

The impacts of neglect are again particularly profound in early childhood. Neglect negatively impacts upon the attachment process between parent and child. It leads quickly to an infant being unable to signal basic needs to a parent and a parent's inability to read or respond to the child's signals. Severe neglect of young children is associated with major impairment of growth and emotional and cognitive development.

The more pervasive the neglect, the more harmful it is viewed as being. Cumulatively harmful experiences, whether or not they are ongoing in a child's life, mean maltreated and traumatised children continue to exhibit developmental and learning delays and problems even after the abuse and neglect have ceased and their placements are stable.

Pre-natal and post-natal exposure to psychoactive drugs and alcohol affects the child's brain and body and causes future learning, behavioural, physiological and developmental problems. Specifically, foetal alcohol syndrome causes growth deficits, central nervous system dysfunction, specific facial characteristics and body malformation. Learning and behavioural disorders that result can include attention deficit disorder, speech and language disorders, poor short-term memory, lack of cause-and-effect thinking, poor personal boundaries, anger-management difficulties, poor judgment and no connection to societal rules.[9]

9. McCreight, B. (1998). Recognising and managing children with foetal alcohol syndrome/foetal alcohol effects. In *Attachment Trauma and Healing*. Edited by Levy, T. M. and Orlans, M. Washington: Child Welfare League of America Press.

# Appendix 3 Indicators of harm

Some of the indicators listed in the following lists are only identifiable through medical examinations. Please note that practitioners are not to undertake any physical examinations in order to clarify their beliefs.

## Physical harm – possible indicators

| Physical indicators | Behavioural indicators |
|---|---|
| Bruises or welts on facial areas and other areas of the body, including back, bottom, legs, arms and inner thighs. Any bruises or welts in unusual configurations or those that look like the object used to make the injury: for example, fingerprints or handprints, buckles, iron, teeth.<br><br>Burns that show the shape of the object used to make them, such as an iron, grill or cigarette. Burns from boiling water, oil or flames.<br><br>Fractures of the skull, jaw, nose and limbs, especially those not consistent with the explanation offered or with the type of injury probable/possible at the child's age and development.<br><br>Cuts and grazes to the mouth, lips, gums, eye area, ears or external genitalia.<br><br>Human bite marks.<br><br>Bald patches where hair has been pulled out.<br><br>Multiple injuries, old and new.<br><br>Poisoning.<br><br>Internal injuries. | The child states that an injury has been inflicted by someone else (caregiver or other), offers an inconsistent or unlikely explanation or 'can't remember' the cause of injury.<br><br>Unusual fear of physical contact with adults (for example, flinches if unexpectedly touched).<br><br>Wearing clothes unsuitable for weather conditions (such as long-sleeved tops) to hide injuries.<br><br>Wariness or fear of a parent/caregiver; reluctance to go home.<br><br>No or little emotion when hurt.<br><br>Little or no fear when threatened.<br><br>Habitual absences from school without explanations (the parent may be keeping the child away until signs of injury have disappeared).<br><br>Overly compliant, shy, withdrawn, passive and uncommunicative.<br><br>Fearfulness when other children cry or shout.<br><br>Unusually nervous or hyperactive, aggressive, disruptive and destructive to self and/or others.<br><br>Excessively friendly with strangers.<br><br>Regressive behaviour, such as bedwetting or soiling.<br><br>Poor sleeping patterns, fear of the dark, nightmares.<br><br>Sadness and frequent crying.<br><br>Drug or alcohol misuse.<br><br>Poor memory and concentration.<br><br>Suicide attempts. |

## Sexual harm – possible indicators

Sexual abuse is more likely to be identified through the child or young person disclosing to someone that they have been abused, rather than by physical indicators. Most of the following physical indicators would only be observed through a medical examination.

| Physical indicators | Behavioural indicators |
|---|---|
| Injury to the genital or rectal area, such as bruising or bleeding.<br>Vaginal or anal bleeding or discharge.<br>Discomfort in urinating or defecating.<br>Presence of foreign bodies in vagina and/or rectum.<br>Inflammation and infection of genital area.<br>Sexually transmissible infections (STIs).<br>Pregnancy, especially in very young adolescents.<br>Bruising and other injury to breasts, buttocks and thighs.<br>Anxiety-related illnesses, such as anorexia or bulimia.<br>Frequent urinary tract infections. | The child tells of abuse.<br>Persistent and age-inappropriate sexual activity, including excessive masturbation, masturbation with objects, rubbing genitals against adults, or playing games that act out a sexually abusive event.<br>Drawings or descriptions in stories that are sexually explicit and not age-appropriate.<br>A fear of home, a specific place or a particular adult. Excessive fear of men or of women.<br>Poor or deteriorating relationships with adults and peers.<br>Poor self-care/personal hygiene.<br>Arriving early at school and leaving late.<br>Complaining of headaches, stomach pains or nausea without a physiological basis.<br>Frequent rocking, sucking and biting.<br>Sleeping difficulties.<br>Reluctance to participate in physical or recreational activities.<br>Regressive behaviour, such as bedwetting or speech loss.<br>Sudden accumulation of money or gifts.<br>Truancy or running away from home.<br>Delinquent or aggressive behaviour.<br>Depression. Self-injurious behaviour, including drug or alcohol misuse, prostitution, self-mutilation or attempted suicide.<br>Sudden decline in academic performance, poor memory and concentration.<br>Wearing of provocative clothing or layers of clothes to hide injuries.<br>Promiscuity. |

## Emotional harm – possible indicators

Psychological or emotional abuse may occur with or without other forms of abuse. If a child grows up in a climate of rejection and criticism, they can incorporate a negative self-image, which impedes development and prevents their full potential from being reached. They may develop personality or behavioural disorders, or become an adult filled with self-doubt and internalised rage, unable to form sustained and intimate relationships. There are few physical indicators, although emotional abuse may cause delays in emotional, mental or even physical development.

| Physical indicators | Behavioural indicators |
|---|---|
| Speech disorders.<br>Delays in physical development.<br>Failure to thrive (without an organic cause). | Overly compliant, passive and undemanding behaviour.<br>Extremely demanding, aggressive or attention-seeking behaviour.<br>Antisocial, destructive behaviour.<br>Low tolerance of frustration.<br>Poor self-image.<br>Unexplained mood swings.<br>Behaviours that are not age-appropriate: for example, overly adult (parenting other children) or overly infantile (thumb-sucking, rocking, wetting or soiling).<br>Mental or emotional development lags.<br>Fear of failure, overly high standards, excessive neatness and cleanliness.<br>Depression, suicidal.<br>Running away.<br>Violent drawings or writing.<br>Contact with other children forbidden. |

## Neglect – possible indicators

Neglect includes all instances where a person has failed to take adequate precautions to ensure the child's safety and provide food, clothing and shelter for the child. Many cases of neglect require a welfare and family support response rather than a protective response; however, in cases where neglect has resulted in physical injury or emotional harm or health impairment, it should be considered as abuse.

| Physical indicators | Behavioural indicators |
|---|---|
| Consistently dirty and unwashed. | Begging or stealing food. |
| Consistently inappropriately dressed for weather conditions. | Gorging when food is available. |
| Consistently without adequate supervision and at risk of injury or harm. | Inability to eat when extremely hungry. |
| Consistently hungry, tired and listless, or falling asleep in class. | Alienated from peers. Withdrawn, listless, pale and thin. |
| Unattended health problems and lack of routine medical care. | Aggressive behaviour. |
| Inadequate shelter and unsafe or unsanitary conditions. | Delinquent acts: for example, vandalism, drug and alcohol misuse. |
| Abandonment by parents. Failure to thrive. | Little positive interaction with parent/caregiver. |
| | Appearing miserable or irritable. |
| | Poor socialising habits. |
| | Poor evidence of bonding and little stranger anxiety. Indiscriminate with affection. |
| | Poor or irregular school attendance. |
| | Staying at school for long hours. |
| | Self-destructive. Dropping out of school. |
| | Taking on an adult role of caring for parent. |

# Appendix 4 Overview of the Child Protection process

Child Protection services are based on the legal framework set out in the CYFA. The main principle underpinning the CYFA is that the best interests of the child must always be the paramount consideration. In determining whether any decision or action is in the best interests of the child, the need to protect the child from harm, to protect the child's rights and to promote the child's development must always be considered.

Child Protection intervention is child centred and family focussed, and is limited to only that action necessary to secure the safety and wellbeing of the child.

## Current assessment

Analysis and assessment, along with case planning, is a core process within all Child Protection interventions. This is the process through which a determination is made that a particular child, once reported to Child Protection, is a child 'in need of protection' as articulated in s162 of the CYFA, or other intervention to ensure their wellbeing.

Child Protection practitioners use a professional judgement model, the Best Interests Case Practice Model, which involves the gathering of information, analysis and planning, action and review.

Consideration is given to the vulnerability of the child, the liklihood of future harm if nothing changes and what is needed to ensure the safety, stability and healthy development of the child.

Assessment of cumulative harm is critical to the overall analysis and planning in relation to the child's safety, stability and development.

## Best Interests planning process

Decision making is defined in the CYFA as the '…the process of decision making by the Secretary concerning a child, beginning when the Secretary receives a report under section 28, 33(2), 183, 184 or 185…'

This happens through best interests planning which is underpinned by a set of principles articulated in s10–14 of the CYFA, stating that any decision or action must be made with the best interests of the child being the paramount consideration.

Analysis leading to assessment informs the best interests planning process throughout the life of a Child Protection intervention.

Where a formal case plan is developed, this is referred to as a Best Interests Plan.

## Stages in protective intervention

There are a number of stages in protective intervention that require different courses of action.

### Intake

The function of Child Protection Intake is to receive reports and other statutory requests under the CYFA and to make a determination, using the Best Interests Case Practice Model, to determine what action is required.

In general, Child Protection Intake receives reports related to a concern that '… a child is in need of protection …' These are reports under ss183 and 184 (mandatory reporting) of the CYFA.

Child Protection may also receive a report under s28 and s29 of the CYFA relating to a significant concern for the wellbeing of a child.

When a report is received, Child Protection makes an initial assessment as to the type of report (whether it is a wellbeing report under s28 or s29 of the CYFA or a protective intervention report under s183 or s184 CYFA). For a report to be assessed as a protective intervention report, Child Protection must establish whether the child or young person's described circumstances may fall within the legal definition of 'a child in need of protection'. This process requires a detailed examination of the information and a realistic appraisal of the potential consequences of intervention and non-intervention. Child Protection Intake's primary responsibility is to assess the risks to the child or young person and the level of urgency.

During this process, Child Protection may contact other professionals, as 'information holders' under the CYFA, to gain information to assist with the assessment process. Information holders are authorised to provide information in such circumstances (see section 8 Information Exchange for details).

Child Protection will endeavour to advise professional reporters as to the outcome of the report. Intake workers must take into account that it is important for teachers to be kept informed of the progress of the case, so that appropriate ongoing support can be provided for the student concerned.

## Investigation and assessment

In 'relation to the investigation of abuse and neglect, the CYFA directs that:

> *A protective intervener must as soon as practicable after receiving a protective intervention report, investigate …the subject matter of the report in a way that will be in the best interests of the child.* (CYFA s205(1))

The decision as to whether protective investigation is required is dependent on the intake assessment – that is, do a child's prescribed circumstances mean that a child is in need of protection (as defined in s162 of the CYFA) and that child protection concerns cannot be adequately determined or addressed without direct Child Protection involvement?

The purpose of a protective investigation is to assess the child's safety, ascertain the validity of the allegations, assess the child's needs and make a decision as to the appropriate course of action to promote the child's safety, stability and development.

Where a Protective Intervention Report relates to concerns that a child has been physically or sexually abused, a joint investigation involving Child Protection and Victoria Police is indicated.

Where a case is deemed urgent, investigations will occur within 48 hours. A response to the reporter may occur during this time or shortly after. However, if a case is deemed not to be urgent, the investigative process can take up to 14 days. When a reporter has not had feedback within an agreed time period, or after 14 days, the reporter may contact the Child Protection Intake Manager in the region. The prioritising of cases for investigation is constantly changing. This is because new reports are received on a daily basis and the planning and intervention process usually involves discussions with, and coordination of, a number of people.

## Temporary Assessment Order

Child Protection may make an application for a Temporary Assessment Order (TAO), where (during the course of an investigation into a Child Protection report) Child Protection hold:

> *…a reasonable suspicion that a child is, or is likely to be, in need of protection; and, is of the opinion that further investigation and assessment of the (child's situation) is warranted; and, is of the opinion that the investigation and assessment cannot properly proceed unless a temporary assessment order is made…* (CYFA s228 & s229)

A Temporary Assessment Order will allow Child Protection to investigate reports more thoroughly, where a child's parents are unwilling to cooperate. Section 232 of the CYFA defines eight provisions a TAO may stipulate. These include:

- authorising the Secretary to enter premises where the child is living
- requiring the parent or any person with whom the child is living to permit the Secretary to enter the premises where the child is living
- requiring the parent of the child or any person with whom the child is living to permit the Secretary to interview the child and to take the child to a place determined by the Secretary for that interview
- authorising the medical examination of the child by a registered medical practitioner or registered psychologist (Note that s233 of the CYFA states that the registered general practitioner or psychologist must not examine a child if the child is of sufficient understanding to refuse consent to the examination despite a TAO being in place.)
- directing the parent or any person with whom the child is living to permit the Secretary to take the child for that examination
- authorising the provision of the results of the medical examination to be given to the Secretary
- requiring the parent of the child or any person with whom the child is living to attend an interview with the Secretary and answer questions put to them (Note that CYFA s234 states that a person may refuse to answer a question in an interview authorised by a TAO on the grounds that to answer could incriminate the person or that the information is privileged on the grounds of professional legal privilege. The Secretary must advise the person authorised by the TAO before the interview begins of their rights under this section.)
- giving any other directions or imposing any other conditions that the court considers to be in the best interests of the child.

An application for a TAO can only be made to the Children's Court and may be made by notice under CYFA s228 for a period not exceeding 21 days or, without notice under CYFA s229, for a period not exceeding 10 days.

An application for a TAO without notice can be made if Child Protection is satisfied that the giving of the notice is inappropriate, as would be the case when there is evidence that the family or child may abscond if notice were given or where there is information that evidence could be lost if the child is not immediately assessed.

The Children's Court may make a TAO in conjunction with a warrant authorising police to enter and search according to CYFA s237 (see section 15 for more details).

Child Protection must provide a written report to the Children's Court by the date specified on the TAO setting out details of the action taken under the TAO, the results of the investigation and assessment, and any other information the Secretary considers ought to be provided to the court or that the court directs to be included.

## Substantiation

At the completion of the investigation process, the Child Protection practitioner – in consultation with their supervisor – must make a determination as to whether or not the subject child is 'a child in need of protection' as defined in s162 of the CYFA.

The substantiation decision is a best interests planning decision made on the basis of an assessment process that gathers case information and facts, analyses this information and ultimately makes a professional judgement about the risk to the child. The substantiation decision links the reasons for report and investigation with the further decisions about how to ensure safety, stability and development of the child and address the impact of harm to the child.

In considering the substantiation decision, there are four basic outcomes that may be applied.

**No significant concern**

This outcome is applicable to a case that is not substantiated and where it is assessed that:

- the child has not experienced significant harm as defined in the CYFA
- the child is not in need of protection.

**Significant concern for wellbeing**

This outcome is also applicable to a case that is not substantiated, but where it is assessed that:

- the child is not in need of protection, as defined in the CYFA
- however, there are significant concerns for the wellbeing of the child.

This type of outcome would result in a referral to Child FIRST.

**No further risk of significant harm**

This outcome is applicable to a substantiated case where it is assessed that:

- harm has been experienced by the child that meets the threshold of harm as defined in the CYFA
- there is a parent now willing, and with the capacity, to protect the child.

**Significant risk of harm – child in need of protection**

This outcome is also applicable to a substantiated case, but where it is assessed that:

- harm has been experienced by the child that meets the threshold of significant harm as defined in the CYFA
- there is an unacceptable risk of harm
- the child does not have a parent (or other suitable person) able and willing to protect them

OR

- no actual harm has occurred
- however, there is an unacceptable likelihood of harm
- the child does not have a parent (or other suitable person) able and willing to protect them.

This type of outcome would result in Child Protection issuing a Protection Application in order to ensure the safety and wellbeing of the child.

## Court action

If, during Child Protection intervention, it is assessed that there is an unacceptable level of risk to a child, Child Protection may issue a Protection Application in order to ensure the child's safety. A Protection Application may be issued:

- by notice
- by immediately taking the child into safe custody, with or without a warrant.

## Protection order

The CYFA stipulates a number of restrictions on the making of a protection order. These include:

- s276(1)(b): 'The court …is satisfied that all reasonable steps have been taken by the Secretary to provide the services necessary in the best interests of the child.'
- s276(2)(b): "The court is satisfied …that …all reasonable steps have been taken by the Secretary to provide the services necessary to enable the child to remain in the custody of his or her parent.'

It is only when the conditions in s276 in the CYFA are satisfied that a protection order through the Children's Court is made. Such intervention is an option of last resort. If the Children's Court is satisfied that the child is in need of protection, it may make one of the following orders:

- Interim Accommodation Order
- Undertaking
- Interim Protection Order
- Supervision Order
- Custody to Third Party Order
- Supervised Custody Order
- Custody to Secretary Order
- Guardianship to Secretary Order
- Long-term Guardianship to Secretary Order (in certain circumstances).

On all orders, except Guardianship, parents retain guardianship responsibility (for more details on protection orders, see Appendix 8).

The type of order made will be related to the severity of the child protection concerns and whether there is a need for ongoing statutory intervention to protect the child.

In addition to protection orders, the Children's Court may also issue on application a:

- Temporary Assessment Order, under s231(CYFA)
- Permanent Care Order, under s321 (CYFA)
- Intervention Order, under the Crimes (Family Violence) Act 1987
- Therapeutic Treatment Order, under s249 (CYFA)
- Therapeutic Treatment (Placement) Order, under s253 (CYFA).

## Best Interests (Case) Plan

A Best Interests Plan is a record of decisions made about risk, health and welfare issues relevant to Child Protection's involvement with a child. A Best Interests Plan makes a statement about the overall plan for the child and lists the goals that need to be reached in order to achieve the overall plan, as well as the tasks, timelines and people responsible for undertaking them. A Best Interests Plan must be based upon a comprehensive assessment.

The Best Interests Plan is initially developed where a case is substantiated. At this point in the Child Protection process, the focus of the Best Interests Plan would be to address the safety, stability and development needs of the child.

The Best Interests Plan would be reviewed and updated on a regular basis throughout the life of a case.

The responsibility for preparing a Best Interests Plan rests with Child Protection.

**Best Interests Plan – Statutory Case Plan**

Section 167 of the CYFA states that a case plan must be prepared for every child on a Supervision Order, a Supervised Custody Order, a Custody to the Secretary Order, a Guardianship Order, a Long-Term Guardianship Order or a Therapeutic Treatment (Placement) Order.

In practice, the Best Interests Plan that would have been developed pre-court will be reviewed and updated to meet the legislative requirement of CYFA s167. The Best Interests Plan must be made within six weeks of the court making the order and a copy must be given to the child and his/her parent within 14 days of its preparation.

**Best Interests Plan – Stability Plan/Cultural Plan**

A Stability Plan and Cultural Plan are elements of a statutory case plan.

A Stability Plan focuses on planning for stable long-term out of home care for a child. A Stability Plan must be prepared within the specified time frame detailed in s170(3) of the CYFA, for any child placed in out of home care as a result of a Protection Order or an Interim Accommodation Order.

A Cultural Plan focuses on the best interests of an Aboriginal child placed in out of home care under a Guardianship to Secretary Order or a Long-term Guardianship to Secretary Order, as detailed in s176 of the CYFA.

In practice, the Best Interests Plan will be reviewed and updated as required to meet the legislative requirement of s170 and s176 of the CYFA.

## Case closure

Child Protection case closure occurs when:

- risk of harm is not substantiated during initial investigation
- a Best Interests Plan has been developed, implemented and reviewed, and ongoing Child Protection involvement is not required
- a protection order expires or is discharged, and no alternative order is made
- the young person turns 17 years of age (or 18 years, where a protection order exists)
- Child Protection intervention is no longer applicable: for example, when a family moves interstate.

During the closure phase, Child Protection will work to actively link the child and the child's family to appropriate support services as required.

## Service delivery information

Child Protection provides services to children and their families who are at risk of significant harm.

### Regional Child Protection Program

Child Protection service delivery is organised through a regional structure. There are three Regions which cover the metropolitan area and a further five Regions covering the rest of Victoria.

Each Region has an Intake Team situated at a designated office to accept reports and act on them accordingly.

#### Hours of operation

Normal hours of operation are 8.45 am to 5.06 pm, Monday to Friday, at all Department of Human Services regional offices listed in this document.

### After-Hours Child Protection Emergency Service

The Department of Human Services After-Hours Child Protection Emergency Service (AHCPES) operates outside of the regional offices' normal hours of operation. AHCPES is a crisis service that responds to urgent matters that cannot wait until the next working day. It is not an extension of the daytime activities of Child Protection provided in normal office hours.

#### Hours of operation

A telephone crisis line is available 24 hours a day (**131 278**); however, where possible, calls are referred to the Regional Office during business hours.

The AHCPES operates between 5.00 pm and 8.45 am weekdays, 24 hours on weekends and all public holidays.

# Appendix 5 Out of home care and the care team

Where the risk of harm has been assessed as too great for a child to remain living at home with their parents, Child Protection will need to place a child in out of home care. The type of placement will depend on the needs and behaviours of the child. The majority of children placed in out of home care are subject to Child Protection intervention.

When a child is placed in out of home care, a number of people will form a care team. The composition of a care team will vary depending on the specific issues and needs of the child and family; however, it will always include the Child Protection practitioner, agency placement worker, the child's case manager, the child's carer and parents (as appropriate). Disability Services should form part of the care team for children in out of home care with a disability. The care team prompts all parties involved to consider the things any good parent would naturally consider when caring for their own children.

The care team will help in the development of a Care and Placement Plan. This identifies the child's needs and describes how these needs will be met while the child is in out of home care, including what services will be required to address disability issues. The Plan covers a range of areas: health, emotional and behavioural development, education, family and social relationships, identity, social presentation and self-care skills. The care team is expected to actively participate in regularly reviewing a child's Care and Placement Plan.

The Care and Placement Plan forms part of the overall Best Interests Plan.

## Transition plan and leaving care plan

Under the CYFA, the Secretary of DHS is responsible for providing and arranging services to help people under the age of 21 gain the capacity to make the transition to independent living where the person:

- has been in the custody or under the guardianship of the Secretary, and
- is of an age to, or intends to, live independently on leaving the custody or guardianship of the Secretary.

Transition planning is required for children and young people when a decision has been made that they will leave a placement to return home, go to another placement or move to live more independently. Preparation and planning for leaving care should ideally commence two years prior to a young person's transition from care. For young people with disabilities, however, consideration should be given to assessment commencing earlier and to any specialist input that may be required in order to successfully transition them into independent living.

The care team should ensure that the Best Interests Plan clearly outlines who is responsible for the tasks that are required when a child or young person transitions from placement. For young people with a disability, or children returning to the care of parents with a disability, the plan should address how the appropriate support for the child or young person and their family will be met post-placement, with links into Disability Services as required.

### Leaving Care Model

The Leaving Care Model has been developed to ensure that young people leaving care do not enter adulthood isolated and unskilled, but rather that they have access to the support they need to make the transition. In practice, this means that they are connected to appropriate support networks, their family, community and culture; have the skills and experience needed to lead an independent and good life; and have access to the information, advice and assistance they may need to achieve these aims.

The eligibility criteria applying to young people seeking Leaving Care mentoring and/or post-care support response are:

- young people aged up to 18 years of age making the transition to independent living from residential, home-based or kinship care who are, or were, subject to a Custody or Guardianship to the Secretary Order on their 16th birthday

OR

- young people 18 to 21 years of age who were subject to a Custody or Guardianship to the Secretary Order on their 16th birthday, or after, and subsequently seek assistance.

The model consists of two main parts:

- a stronger, developmentally based focus on preparing children and young people for independence throughout their entire time in care, with particular focus on the two years prior to leaving care
- a service response specifically targeted at post-care services that have the capacity to further strengthen a young person's ability to live independently.

## Voluntary child care agreements

Voluntary child care agreements are legislated under part 3.5 of the CYFA and are used to place children in out of home care where there are identified child protection concerns or risks to children that are not immediate or do not warrant legal intervention. Voluntary placements can only be entered into with the consent of the parents or a young person 15 years or older and where there are no court orders in place. Unlike a guardianship or custody order, the parents retain full guardianship and custody rights and responsibilities. A small percentage of voluntary placements occur where there are no child protection concerns. These placements will not come to the attention of Child Protection. Voluntary placements are used to encourage and assist the child's parents to utilise the necessary services that will allow them to resume the care of the child at a later date.

These placements are ideally with a carer or sometimes within a residential unit, including the services and facilities operated through the Disability Act. Under the CYFA all carers, from both home-based placements and those employed by an out of home care service, must be approved and registered with the department.

There are a number of factors that Child Protection practitioners will consider when determining whether a voluntary placement for a child is appropriate during a child protection investigation. These include:

- Do the parents acknowledge the identified concerns?
- Are they prepared to be fully involved in planning for their child?
- Do the parents (or young person) agree to the placement?
- Can the level of risk be sufficiently managed by a voluntary placement?
- Is there evidence the parent may change their mind and collect their child from the placement, leaving the child at risk?

Voluntary child care agreements may be short term or long term, depending on the circumstances pertaining to the agreement. The department must be notified in writing of each agreement entered into.

Short-term voluntary child care agreements:

- are primarily for the purpose of assisting and encouraging the child or young person's parent to resume care of them
- must consider the wishes of the child or young person in making the agreement
- may only be made for a period not exceeding six months and must be reviewed after the first six months and then annually following this review.

Long-term voluntary child care agreements:

- are intended to add to the range of stable placement options for the child or young person and add stability to their life
- must consider the wishes of the child or young person in making the agreement
- may only be entered into for a maximum period of two years
- must be reviewed after the first six months and then annually following this review.

Where a shared client is identified and investigations or intervention is required, Disability Services will provide information in relation to the client, including Disability Services supports that may be appropriate. Referrals to services and delivery of supports will also be actioned as agreed.

It is important to note, however, that Disability Services are voluntary, unlike Child Protection Services. This difference can necessitate some careful management by both Child Protection and Disability Services workers.

# Appendix 6 Case management

For shared clients it is an expectation that a level of case management will be provided by both Child Protection and Disability Services. This may range from monitoring to providing active case management.

Where a child or young person is subject to Child Protection intervention and Best Interests case planning, Child Protection will convene the initial meeting with Disability Services to discuss a shared approach to the client. The determination of lead responsibility will occur at that meeting on a case-by-case basis.

It is anticipated that both Child Protection and Disability Services will provide a level of case management for shared clients until:

- no significant concerns or further risk of harm are identified
- a referral to Child FIRST is made
- all disability supports are being provided as per the Best Interests Plan.

Where this is the case, the appropriate service or both services may withdraw but only in discussion with any remaining service providers and after agreement of the triggers for re-engagement.

A clear understanding of respective case management roles is required to ensure effective collaboration. The following table outlines the various components of case management from a Child Protection and Disability Services perspective.

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| What is case management? | Case management in Child Protection is the process of assessment, planning, intervention, monitoring and review that aims to strengthen families and decrease risks to children and young people. The case management process commences when a report is made to Child Protection and continues through protective intervention and the implementation of court orders. | Case management involves undertaking a detailed assessment and working with the individual to identify goals and strategies that build on the person's skills and strengths.<br>In most instances, disability supports are provided by community services organisations. |
| Philosophy | • All children should be given the opportunity to reach their full potential and participate in society, irrespective of their family circumstances and background.<br>• While parents are the primary nurturers of a child, society as a whole shares responsibility for children's wellbeing and safety.<br>• Planning and delivery of services should focus on sustaining and improving children's outcomes – the promotion and protection of a child's safety, stability and development.<br>• In all considerations, the best interests of the child must always be paramount. | Disability Services support aims to:<br>• support people with disabilities to pursue their own lifestyles within the community<br>• access generic services that are the same as other members of the community rather than specialist Disability Services<br>• strengthen informal support networks. |

10. Based on the *Protocol between Disability Services and Juvenile Justice* and *Guidelines for workers* July 2005.

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| Assessment | Child Protection will investigate reports where a person believes that a child is at risk of significant harm and in need of protection.<br><br>Where Child Protection assesses that a child is at risk of significant harm, a protection application may be made to the Children's Court.<br><br>Assessment of parenting capacity forms part of the broader assessment process undertaken by Child Protection. Child Protection practitioners can seek expert advice in assessing the capacity of a parent with a disability. It is important to note that such advice is not available through Disability Services. However, a parent's engagement with Disability Services to receive support and/or services would be a factor in assessing parental capacity. | To receive Disability Services, an individual must have a disability as defined by the *Disability Act 2006*.<br><br>Access to services such as case management will depend on the individual's priority for access to services (including consideration of whether generic supports are appropriate) and the capacity of the system to respond. |
| Engagement/ allocation | All reports made to Child Protection are assessed to determine whether there is a risk of significant harm.<br><br>Where Child Protection assesses that sufficient concerns exist to require an investigation of a report, a decision will be made regarding the urgency of the situation and the required response.<br><br>Where a case is deemed urgent, initial visits to the family may occur immediately and must occur within 48 hours. If a protective response is not urgent, the investigation must commence within 14 days. | Allocation of Disability Services support is based on the individual's needs and whether they meet the priority for access indicators.<br><br>Workers will consult with the individual and their family about their needs and goals. |

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| After hours | The After Hours Child Protection Emergency Service (AHCPES) can respond to crisis situations after hours where there is the likelihood of immediate significant harm to the child or young person and the situation cannot be left until the next working day.<br><br>The presence of any of the following factors will increase the likelihood of an after-hours response being required:<br>• The harm or self-harm sustained or threatened is severe.<br>• The risk of recurrence is high.<br>• The child is currently ready to disclose and a delay in responding may jeopardise this.<br>• The disclosure of abuse has precipitated or escalated a family crisis and the risk to the child is increased.<br>• The disclosure of abuse has resulted in the family placing pressure on the child to retract the disclosure.<br>• The child and/or family are likely to abscond as a result of the disclosure.<br>• The child's age, developmental status or emotional state reduces their ability to protect themselves.<br>• The parents or caregivers are unwilling or unable to protect the child from significant harm and no other protective adult can be mobilised to support the child or young person.<br>• An alleged perpetrator has access to the child.<br><br>StreetWork Outreach Services (SOS) provide an after-hours service for vulnerable and 'at risk' young people who are known to Child Protective and are in the Melbourne Central Business District and St Kilda areas. | Disability Services does not have an emergency after-hours service but may have an emergency respite placement available for short-term accommodation in crisis situations.<br><br>In some situations, Disability Services does have contact with AHCPES. In these circumstances, Disability Services can provide information around disability specific supports. |

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| Planning | In accordance with the Best Interests Case Practice Model for vulnerable children and young people, all planning should take account of:<br>• the child's perspective<br>• parent or carer capability<br>• family composition and dynamics<br>• a family's connection to their community and their access to financial and social resources<br>• supports, services and service system responses.<br>The Best Interests and decision-making principles underpin all Child Protection and care practice in Victoria. They must be applied to the Best Interests planning process and be reflected in all decision making throughout the life of the case, from report to closure. Planning goals and actions must be in the best interests of the child. All planning must be directed toward protecting children from harm, protecting their rights and promoting their development.<br>A Best Interests planning meeting must be held to complete a Best Interests Plan and meet statutory planning requirements following a final protection order. This meeting should involve parents, significant family members, other professionals and, where appropriate, the child and the child's current carer.<br>Where a child is Aboriginal, the CYFA outlines additional principles for Best Interests planning for Aboriginal children. A Cultural Support Plan must be developed for Aboriginal children living away from home, which outlines how the child or young person will be supported to participate in cultural events and remain connected to their community and culture. | A person with a disability or a person on their behalf may request the disability service provider to provide assistance with planning. This means people with a disability can access support to think about what they want to do in their life and who can help them achieve their goals.<br>Planning should be undertaken using individualised planning and support principles, which focus on self-determination, community membership and citizenship, and are sensitive to the person's cultural and spiritual experience. The individual should direct the planning process to the greatest extent possible.<br>The role of family member(s) and carer(s) in the person's life should be respected during the planning process. |

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| Intervention/ implementation | Court ordered intervention occurs when the court makes an interim or Protection Order in respect of a child. This means that the child has been found to be in need of protection, in accordance with the provisions of the CYFA, and that departmental involvement is required to ensure the child's safety and ongoing wellbeing.<br>The aim of intervention is to:<br>• reduce the level of risk to the child<br>• promote the safety, stability and development of the child<br>• empower the family to function independent of statutory Child Protection intervention<br>• prepare for the cessation of Child Protection involvement with a family upon the expiration of the Protection Order.<br>• provide long-term and stable care for the child or prepare the young person for independent living, where the best interest plan is not reunification of the child with the family. | Case management intervention means putting plans and goals identified in the planning process into action.<br>Disability Services' role in implementation involves providing information, helping people access other services, organising referrals for services, arranging visits, ongoing liaison, coordination, strengthening informal networks, encouragement and support. |
| Monitoring and review | Best Interests Plans are reviewed by Child Protection to assess the progress of the child and family toward achieving the planning goals and intended outcomes.<br>All children on protection orders must have their Best Interests Plan reviewed each six months and endorsed by the Best Interests planner. Where the child is in out of home care, the care team should be involved in this scheduled review process.<br>The Best Interests Plan can be reviewed at any time, where it is indicated that the effectiveness of the interventions or changes in circumstances of the child and family require reviewing, or when the child or parents request a review. | Disability Services support provision is monitored and reviewed to ensure outcomes are being achieved. Goals and supports are changed as required. |

| Case Management | Child Protection | Disability Services[10] |
|---|---|---|
| Closure | Closure can occur from any phase of Child Protection involvement. The decision to end Child Protection involvement, leading to case closure, can be made for a variety of reasons:<br>• The reported concerns were not substantiated.<br>• The protective concerns have been addressed and the family are better serviced by a community agency or other service.<br>• The family are refusing to engage with Child Protection in conducting an investigation and there is insufficient evidence or information to initiate legal intervention.<br>• A temporary assessment order (TAO) has been granted and the outcome of the assessment is that no further Child Protection involvement is warranted.<br>• The family's whereabouts are or have become unknown.<br>• Child Protection involvement is no longer necessary to ensure the safety, stability or development of the child and the parents or caregivers have demonstrated their capacity and willingness to protect the child from harm and promote the safety, stability and development of the child in the future.<br>• The order is nearing expiration and the protective concerns no longer exist.<br>• The child and/or family are moving interstate or overseas.<br>• The person moves interstate or overseas. | A case may be closed when:<br>• The review process identifies that strategies are in place to achieve all identified goals and no further action is required.<br>• No new needs have arisen.<br>• The person with a disability, guardian and/or primary carer indicates that case management services are no longer required.<br>• The case manager has been unable to make contact with the individual in the past three months – that is, the individual refuses or ceases to cooperate despite extensive engagement strategies that have been put in place. |

# Appendix 7 Children's Court orders

A protection order application can occur in either of two ways:

1. **By notice.** The application is lodged at the Children's Court and the court advises of the date for the court hearing. The practitioner then serves the notice to appear on the child and parents. Shortly before the first hearing of the application, the Child Protection practitioner will file and serve the family with a court report, recommending an appropriate order to be made in the best interests of the child. If agreement cannot be reached as to the appropriate outcome, a further date is set for a full hearing at which the magistrate will consider Child Protection's recommendations and decide whether the grounds for the protection application have been proven and what is the appropriate protection order.
2. **By taking the child into safe custody when it is determined that is is inappropriate to proceed by notice.** Child Protection practitioners will remove the child from the parent's care and attend the Children's Court (office hours) or in some circumstances a Bail Justice (after hours) to apply for an Interim Accommodation Order. Children and young people over six years of age who are subject to a protection application are required to speak with a legal aid solicitor independent of their parent's legal advocate and to attend court. Where a child is over six years of age and is an inpatient, they may not be required to attend court if their medical situation precludes this. This may require confirmation by the relevant hospital medical officer and alternate arrangements may need to be made for consultation by the child with legal aid.

The types of possible Children's Court orders are:

| Order | What the order provides |
|---|---|
| Temporary Assessment Order (TAO) | An order sought where there is a 'reasonable suspicion' that a child is, or is likely to be, in need of protection and the ability to investigate or further assess a report cannot proceed without the order. The court may order a TAO as well as a warrant to authorise police to enter and search premises. It may have conditions attached, such as directing parents to allow Child Protection access to a child. |
| Interim Accommodation Order | Placement of a child on an interim basis:<br>• with a parent<br>• with a suitable person<br>• in an out of home care service<br>• in a secure welfare service<br>• in a declared hospital or a declared parent/baby unit.<br>The order lasts for 21 days and can be extended. Each extension is for a further 21 days. |
| Undertaking | An undertaking enables the court to require the child or parent to do or refrain from doing things specified in the undertaking. The undertaking is usually made for up to six months.<br>The parties to the court proceeding must consent to giving the undertaking, which is made in writing. An undertaking may involve a protection application being proven. The department ceases to be involved once the undertaking is given to the court. |
| Interim Protection Order | This order tests out whether arrangements that have been put in place are sufficient to protect a child from harm. The terms of the order can relate to the child's living and supervision arrangements. The order can last for up to three months and can only be made once a protection application is proven.<br>The order must specify whether the child is to live with a particular person or as directed by the department. It may also place other conditions on a child, parent or carer. This order cannot be extended. |

| Order | What the order provides |
|---|---|
| Supervision Order | This order authorises the ongoing supervision of a child by Child Protection. Parents retain custody and guardianship of the child. It can provide for the child to be placed in the day-to-day care of one or both of the child's parents.<br><br>The order can only be made where the protection application is proven. It can be made for 12 months and, in special circumstances, for up to 24 months. The court can impose conditions on the child or the parents that it considers are in the child's best interests. The order can be extended. Each extension is for up to 24 months. |
| Custody to Third Party Order | This order provides for a person other than the Secretary of DHS or a parent to have custody of the child for a specified period, up to a maximum of 12 months. There is no monitoring of the order by the Department of Human Services.<br><br>The court may impose conditions that it considers to be in the best interests of the child, including a condition concerning access by a parent or another person with the child. This order cannot be extended. |
| Supervised Custody Order | The order provides for a person or people other than the Secretary of DHS or a parent to have custody of the child for a specified period up to a maximum of 12 months. Child Protection supervises the order.<br><br>This order is aimed at facilitating the child being reunified with their parents. Where it is in a child's best interests, the Secretary can direct a child to return to the care of their parents during the order without returning to court.<br><br>The court may impose conditions that it considers are in the child's best interests. The order can be extended. Each extension is up to 24 months. |
| Custody to Secretary Order | This order grants sole custody of the child to the Secretary of DHS but does not affect guardianship, which remains with the child's parents. The Secretary has responsibility for making decisions about the day-to-day care of the child (in out of home care) but major decisions about the child's health, education and travel are made by the child's parents.<br><br>The court may impose conditions that it considers are in the child's best interests. The order runs for up to two years and can be extended. If the order has been in place for less than 12 months, the first extension can only be for a further 12 months. Once an order has been in place for more than 12 months, each extension can be for a period up to 24 months. |
| Guardianship to Secretary Order | The order grants custody and guardianship of a child to the Secretary of DHS. This means that the Secretary is responsible for making all major decisions about a child's life. There is no power for the court to impose conditions on this type of order.<br><br>The order runs for up to two years and can be extended. If the order has been in place for less than 12 months, the first extension can only be for a further 12 months. Once an order has been in place for more than 12 months, each extension can be for a period up to 24 months. |
| Long-term Guardianship to Secretary Order | This order has the same effect as a Guardianship to Secretary Order but lasts until the child reaches 18. It can only be made where a child is over 12 years of age and consents to the order being made. The child must be in a stable placement. The Secretary of DHS must also consent to the order being made.<br><br>If the placement breaks down, or if the young person withdraws their consent to the arrangement, the matter returns to the Children's Court. The department, as part of the Best Interests planning process, reviews long-term guardianship orders annually. |

| Order | What the order provides |
|---|---|
| Permanent Care Order | The order places custody and guardianship of the child with another person. The court may make a permanent care order in respect of a child if the child's parent has not had care of the child for periods that total at least six months, or that total at least six months out of the last 12 months.<br>The order must include conditions relating to ongoing contact between the child and their birth parent(s) but cannot include any other conditions. |
| Therapeutic Treatment Order (TTO) | This order requires the child who is the subject of the order to attend an appropriate treatment program to address their sexually abusive behaviours. It may also have conditions requiring the child's parents or carers to take any necessary steps to enable the child to attend the treatment.<br>Orders are available for a child aged 10 or over, but under 15 years.<br>Therapeutic Treatment Orders can be made for a maximum of one year, with the capacity for a single extension of up to a further one year |
| Therapeutic Treatment (Placement) Order (TTPO) | A TTPO can be made when a TTO has been made and the court is satisfied that it is necessary for the treatment of the child. The TTPO grants sole custody of the child with Child Protection and can include conditions that the court considers in the child's best interests. |

# Appendix 8 Responding to concerns about safety and wellbeing: A guide for Disability Services staff

| **Step 1** Responding to concerns | **Step 2** Gathering information | **Step 3** Forming a belief | **Step 4** Making a referral to Child FIRST | **Step 5** Make a report to Child Protection |
|---|---|---|---|---|
| You are concerned about a child because you have:<br>• received a disclosure from a child<br>• observed warning signs<br>• become aware of other reasons for concern.<br>**Go to Step 5 if:**<br>the concerns relate to a child in need of protection; or<br>the concerns relate to a child in need of therapeutic treatment<br>**Go to Step 4 if:**<br>the concerns relate to a significant concern for the wellbeing of a child.<br>**Otherwise go to Step 2**<br>Remember to:<br>• Record your observations<br>• Consult notes and records<br>• Consult with colleagues | You need to consider doing some or all of the following:<br>• Follow protocols<br>• Speak with the child if appropriate<br>• Speak with the parents if appropriate<br>• Consult with other support agencies<br>• Attend or call a case meeting<br>Are you wondering if your concerns need to be reported to Child Protection?<br>**No:**<br>Continue to monitor and support child<br>**Yes:**<br>Go to Step 3 | Ask yourself:<br>Am I **more** likely to believe there is significant harm for the child or **less** likely to believe there is significant harm for the child?<br>If your answer is that you are **more** likely to believe there is significant harm:<br>Go to Step 5<br>If your answer is you are **less** likely to believe there is significant harm<br>If the concerns relate to a significant concern for the wellbeing of a child:<br>Go to Step 4<br>Otherwise:<br>Continue to monitor and support the child as in Step 2 | See separate contact list for local Child FIRST numbers or Child Protection Office phone numbers.<br>Allow a minimum of 30 minutes.<br>Have notes ready with your observations and child and family details.<br>Consider the level of immediate danger to the child.<br>If you are in doubt about the child's safety and the parent's ability to protect the child:<br>Go to Step 5 | See separate contact list for local Child Protection Office phone numbers.<br>For after hours, call 131 278.<br>Allow a minimum of 30 minutes.<br>Have notes ready with your observations and child and family details.<br>Consider the level of immediate danger to the child. |

# Appendix 9 Summary of information-sharing guidelines

| **Action** | **Is this required by law?** (where not required by law, it may be good practice to do so voluntarily) | **Is this authorised by the *Children, Youth and Families Act 2005?*** | **Is my identity protected by the *Children, Youth and Families Act 2005?**** | **Am I protected from negative legal and professional consequences by the *Children, Youth and Families Act 2005?*** |
|---|---|---|---|---|
| Making a referral to Child FIRST | No | Yes | Yes | Yes |
| Making a report to Child Protection | No | Yes | Yes | Yes |
| Making a mandatory report to Child Protection | Yes | Yes | Yes | Yes |
| Sharing information when you are consulted by Child FIRST or Child Protection | No | Yes | No, but it will be held in confidence upon request | Yes |
| Sharing information with family services when they are providing services to a family | No | No | No | No |
| Sharing information with Child Protection during an investigation | No | Yes | Yes | Yes |
| Sharing information with Child Protection to support ongoing case planning after an investigation | No | Yes | No, but it will be held in confidence upon request | Yes |
| Sharing information with Child Protection on request when a child is subject to a Children's Court protection order | No | Yes | No, but it will be held in confidence upon request | Yes |
| Sharing information with Child Protection when a child is subject to a Children's Court protection order and when you are directed by an officer authorised by the Secretary of the Department of Human Services | Yes | Yes | No, but it will be held in confidence upon request | Yes |

* You are encouraged to allow your identity to be disclosed, even where it is protected by law (when making a referral or report, or assisting an investigation). Your identity will be treated in confidence, if that is your wish, except where disclosure is required by law (for example, if directed by a court).

# Appendix 10 Telephone contacts

## Child Protection

| Metropolitan Regions | | Rural Regions | |
|---|---|---|---|
| **Eastern** | | **Gippsland** | |
| Intake Unit | 1300 360 391 | Intake Unit | 1800 020 202 |
| **Southern** | | **Grampians** | |
| Intake Unit | 1300 655 795 | Intake Unit | 1800 000 551 |
| **North and West** | | **Hume** | |
| Intake Unit | 1300 369 536 | Intake Unit | 1800 650 227 |
| | | **Loddon Mallee** | |
| | | Intake Unit | 1800 675 598 |
| | | **Barwon South Western** | |
| | | Intake Unit | 1800 075 599 |

Child Protection Emergency After Hours Service – **13 12 78**

Statewide freecall number (24 hrs, 7 days a week)

## Disability Services – Regional Intake and Response Services

| Metropolitan Regions | | Rural Regions | |
|---|---|---|---|
| **Eastern** | | **Gippsland** | |
| Telephone | (03) 9843 6312 | Telephone | (03) 5136 2474 |
| TTY* | (03) 9843 6638 | | |
| **Southern** | | **Grampians** | |
| Telephone | 1300 131 079 | Telephone | (03) 9843 6638 |
| | | TTY* | (03) 5333 6815 |
| **North and West** | | **Hume** | |
| Telephone | 1800 783 783 | Telephone | 1300 650 152 |
| TTY* | (03) 9412 2647 | TTY* | (03) 5722 0623 |
| | | **Loddon Mallee** | |
| | | Telephone | 1800 229 822 |
| | | **Barwon South Western** | |
| | | Telephone | 1800 675 132 |

Statewide freecall number – 1800 783 783

Statewide TTY – 1800 008 149

* Telephone typewriter (TTY)


Department of
Human Services