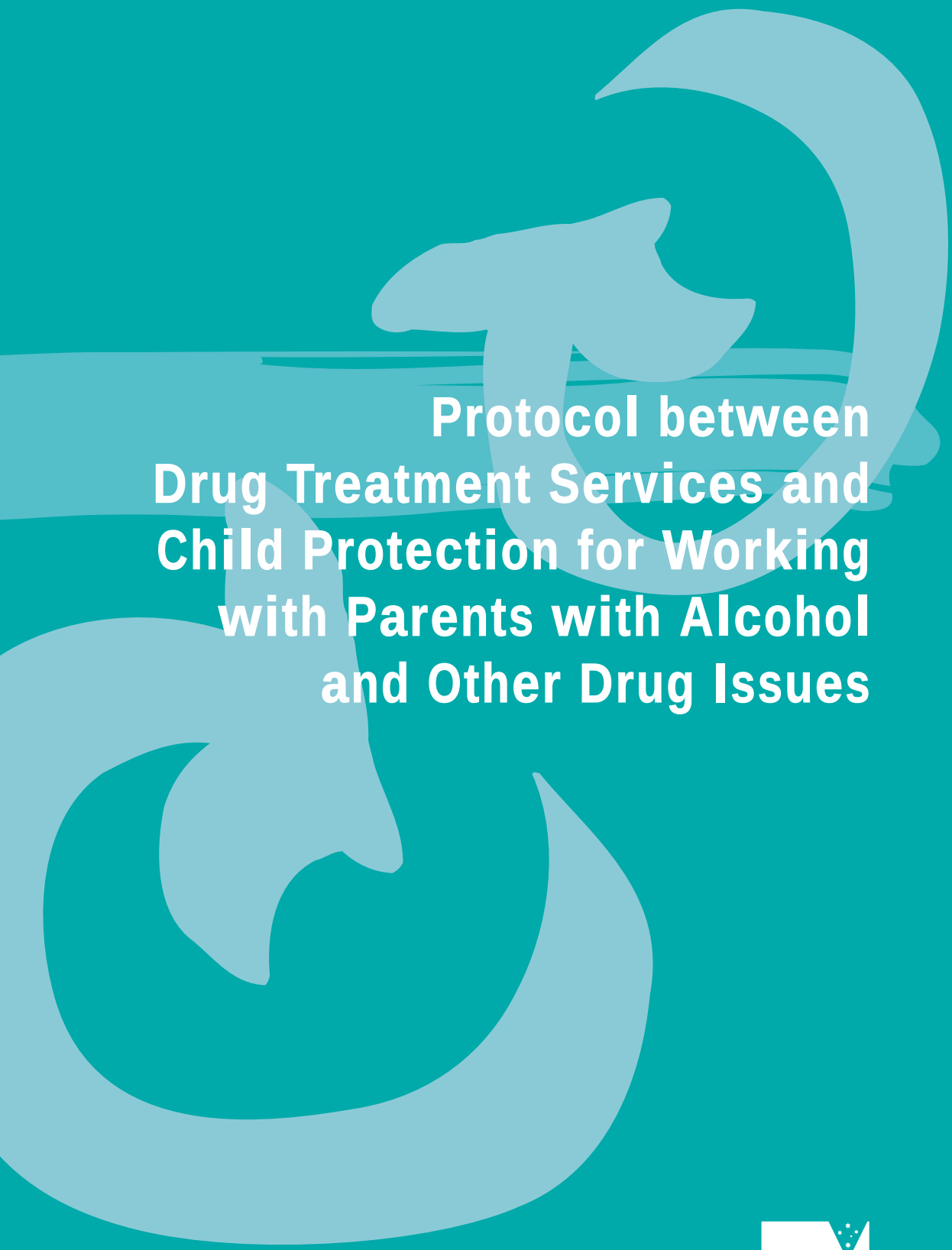

Protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and Other Drug Issues

Victoria
The Place To Be

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Department of Human Services
August 2002

Published by Community Care Division
Victorian Government Department of Human Services
Melbourne Victoria

Also published on www.dhs.vic.gov.au/commcare

August 2002
(1160202)

This protocol replaces the Protocol between Protective Services (H&CS), Drug Services Victoria (H&CS) and the Victorian Association of Alcohol and Drug Agencies (VAADA) published by the then Department of Health and Community Services (H&CS), Victoria, November 1993.

Foreword

Child Protection and drug treatment services have a shared interest and responsibility in working with vulnerable families. Parents with problematic alcohol and other drug use form a large percentage of the families with whom Child Protection work and many of the adult clients of drug treatment services are parents.

There are numerous examples of excellent working relationships between drug treatment services and Child Protection. These relationships have taken time to build and maintain. Staff have learned about each other's role, constraints, and imperatives in order to gain confidence and trust in one another. However, there are also differences that characterise the Child Protection and drug treatment service systems. These differences are seen in the approach to, and methods of, service delivery.

For Child Protection, the primary goals are the child's safety and wellbeing. The child is the defined client, although the focus of activity is the entire family. Child Protection may coordinate a number of services aimed at ensuring and promoting the child's safety and wellbeing. When balancing children's needs and parents' needs, the Child Protection mandate directs workers to place the needs of the child first.

For most alcohol and other drug (AOD) treatment programs, the user of the alcohol or drug is the primary client. Service design and provision centres on their needs. While family relationships and other life issues are assessed, and services, particularly counselling, may be family inclusive, the client's relationship with the substance is more likely to be the focus of clinical intervention. A number of Victoria's drug treatment services have family focused programs where children and other family members may be clients. With the client's permission, children can be included in therapeutic activities and workers may offer assistance with parenting.

Central to the challenge of providing alcohol and other drug treatment to parents is that problematic AOD use is typically a chronic, relapsing condition. Recovery can be a long-term process. Children, however, have a right to a safe and stable home in which to grow. Their physical and psychological development cannot be put on hold. Balancing these factors represents a key issue for all workers.

Many parents with problematic AOD use are able to make arrangements that minimise the impact on their children, thus obviating the need for Child Protection involvement.

For others, however, the children's safety is so compromised that Child Protection must be involved.

Teachers, nurses, police and doctors are mandated under the *Children and Young Person's Act (1989)* to report child physical and sexual abuse. A significant proportion of alcohol and drug workers also have mandated qualifications. Whether legally mandated or not, many of those who work with parents are becoming increasingly knowledgeable about, and skilled in, identifying the impact of parental problematic AOD use on children. Alcohol and drug workers are more confident in reporting their concerns about children.

Similarly, Child Protection workers are offered a variety of training opportunities to address problematic AOD use. A number of Regions have developed innovative ways of regularly consulting about these issues, including scheduled case discussions with local drug treatment services. Child Protection workers are becoming increasingly knowledgeable and skilled in understanding how problematic alcohol and other drug issues impact on parents' capacity to meet their children's needs.

This protocol deals with common scenarios and practice issues, such as confidentiality and sharing of information, different styles of case management, disputes and complaints. Staff from Child Protection and alcohol and drug treatment agencies, guided by the protocol, can resolve these issues, both generally and on a case-by-case basis. Establishing joint outcome plans is recommended; particularly the identification of short term and long term goals that will allow both agencies to work with the client on identifying progress and managing relapses.

Our two disciplines have come a long way in understanding each other's service priorities and developing ways to work together more effectively. With drug treatment and Child Protection services together devising well coordinated service delivery plans, parents are better supported to provide a safe environment for their children.

The intention of this protocol is to develop stronger collaborative service delivery to clients, leading to better outcomes for children and their families. It will assist the development of mutual understanding and cooperation between both our service systems. While providing clear direction on key points of contact, the protocol allows for service improvement and innovation in these two service sectors and we look forward to these developments.

Paul McDonald
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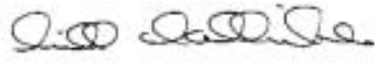

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Acknowledgements

This Protocol was co-written by Child Protection and Juvenile Justice and Drugs Policy and Services, the Victorian Department of Human Services. A Reference Group, which met from December 2001 to March 2002, provided valuable input.

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1. Introduction

1.1 Protocol

Not all parents and caregivers with alcohol and other drug (AOD) issues harm their children. Some parents with relatively severe problems are able to recognise the impact on their children and put in place arrangements to ensure their care and safety. However a significant percentage will need assistance or assertive intervention from service providers to ensure the children's safety.

Approximately half of all child abuse and neglect cases investigated by Child Protection in Victoria involve some degree of problematic AOD use by the child's parents.

Particular risks for infants include:

- Addiction to the substances their mothers used while pregnant;
- Foetal alcohol syndrome;
- Risk of malnourishment, injury and death. For example a substance affected adult sleeping with a young baby can inadvertently smother the baby.

Infants and children who reside in households in which AOD are a problem may suffer harm in a variety of ways.

- A parent's overriding involvement with AOD may leave the parent emotionally and physically unavailable to the child.
- A parent's mental functioning, judgment, inhibitions, and / or protective capacity may be seriously impaired placing the child at increased risk of all forms of abuse and neglect.
- A parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs.
- Excessive responsibility placed on young children to care for themselves and / or younger siblings.
- Parent may spend the household budget on alcohol and drugs, depriving the child of adequate food, clothing, housing, and health care.
- A child's health and safety may be seriously jeopardised by criminal activity associated with the manufacture and distribution of illicit drugs in the home.
- Consistent exposure in the home may contribute to the child eventually developing AOD problems.

Early identification of the problem and early intervention are essential. All professionals who work with parents and children need to understand the indicators and dynamics of AOD misuse, routinely probe for the problem in families, and be prepared to work in collaboration with other service providers

to assist the family when the problem is suspected or confirmed. In this way they contribute to the best possible outcome for both parents and children via a community-based case plan.

This requires examining one's own attitudes about the limitations of one's role as a service provider in a specific service type. It is the responsibility of all members of the community to contribute to the protection of children and young people from physical, sexual or emotional abuse or neglect.

Professionals who come into contact with parents with severe problematic AOD use, either directly or indirectly during the performance of their duties, are in a key position to ensure that any abuse or neglect of the children is identified and responded to as early as possible and that parents are offered support in their parenting role and treatment for their AOD problems.

1.2 Aims of the Protocol

This protocol aims to:

- Promote and strengthen professional, collaborative relationships between drug treatment services and Child Protection.
- Promote the practice of alcohol and drug workers notifying Child Protection if they believe that a child or young person is being, or is at risk of being, physically, sexually or emotionally abused or neglected.
- Promote the practice of Child Protection consulting with drug treatment services regarding drug and alcohol information, referral and treatment.
- Ensure that Child Protection workers understand the role and functions of drug treatment services.
- Ensure that alcohol and drug workers understand the role and functions of the Child Protection Service.

1. 3 Principles Underpinning this Protocol

The principles underpinning this protocol are:

- Families generally provide for children's safety and wellbeing. If families are unable to provide safety from harm for a child or young person, professionals working with the family must seek to ensure the child's safety.
- The safety and wellbeing of children whose parents have problematic AOD use is more likely to be ensured when their parents are provided with appropriate and effective drug treatment intervention.
- Where child safety is not compromised, information exchange between a drug treatment service and Child Protection should occur with the knowledge and consent of the adult client.
- The needs of parents and their children should be considered in a broad, holistic manner by both the Child Protection worker and the alcohol and drug worker to ensure that family functioning as a whole is maximised.
- Effective service delivery to families is dependent upon drug treatment services and Child Protection working collaboratively, cooperatively and with a clear understanding of each other's roles and responsibilities.
- Meeting the needs of children assists in reducing the impact of intergenerational transmission of the negative consequences of parental problematic alcohol and other drug use.

2. The Protocol

2.1 Making a Notification to Child Protection

Who Can Make a Notification

Any person in the community can make a notification to Child Protection.

Certain professions are listed in the *Children and Young Persons Act 1989* as being **required** (or mandated) under the Act to notify Child Protection that a child is at risk of physical or sexual abuse.

The following professions are legally required to make notifications under what is commonly referred to as mandatory reporting legislation; other professions have not been officially gazetted (the official parliamentary process necessary to formally enact legislation):

- Doctors
- Nurses
- Police
- Teachers (primary and secondary)
- School Principals

However, all professionals working with families share in the responsibility of protecting children who are being physically, sexually or emotionally abused or neglected.

Alcohol and other drug workers must be flexible in responding to concerns about the welfare of children and be prepared to work collaboratively with family support and Child Protection. Responding to concerns about children and families is not easy. Sharing the responsibility is much more effective than acting individually.

Definition of a 'Child or Young Person'

A 'child or young person' is defined in Victorian law as being someone **aged 17 years or under**.

Forming a Belief

The concept of 'forming a belief' is a thinking process, where a person is more inclined to **accept** rather than **reject** that there is risk of significant harm for the child or young person. You might ask yourself: '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?**' If you are **more likely to believ**e, then you have 'formed a belief'.

An alcohol and drug worker may come to form a belief that a child is at risk of abuse or neglect by gathering evidence over time or on initial contact with the child and/or adult.

It is the Child Protection workers' job to investigate and prove significant harm, so other professionals need only to have 'reasonable grounds for belief'. If it does not jeopardise the child's immediate safety the worker should convey the concerns to a more senior staff member in order to seek support for making a notification and to discuss the best form of response.

Reasonable Grounds

If a drug treatment service or alcohol and drug worker holds a belief on reasonable grounds that a child or young person may be or is at risk of significant harm, the service has the responsibility to inform Child Protection of this belief and can do so without the consent of the adult client. Where the risk of harm relates to physical or sexual abuse, mandated professionals must report the matter.

'Reasonable Grounds' is a defined term in the Children and Young Persons Act. It includes "matters of which a person has become aware" and "any opinions based on these matters".

'Reasonable grounds' can best be described as the behaviours, observations, facts and information that lead to 'forming a belief'.

For example, there may be reasonable grounds when:

- Your knowledge of the parent's circumstances, presentation or behaviour leads you to believe that they have abused or neglected their child or the child is at risk of abuse of neglect.
- A child says that they have been abused or harmed.
- A child tells you that they know someone who has been abused or harmed.
- Someone else, such as a relative, friend, acquaintance or sibling of the child, tells you that the child has been abused or harmed.
- Your observations of the child's behaviour or development lead you to believe that the child has been abused or harmed.
- Signs of physical, sexual, emotional abuse or neglect are recognised.

Significant Harm

Significant harm is a compilation of events, both acute and long standing, which interact with the child's ongoing development and interrupt, alter or impair physical and psychological development.

The Children and Young Persons Act identifies a number of grounds, the existence of which indicates that a child is in need of protection. These grounds are specifically set out in s.63 as follows:

s.63. ***When is a child in need of protection?***

For the purposes of this Act a child is in need of protection if any of the following grounds exist—

(a) the child has been abandoned by his or her parents and after reasonable inquiries—
  (i) the parents cannot be found; and
  (ii) 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.

Child Protection will be looking for three factors:

- The degree of severity of the situation
- The risk of harm to the child
- The capability and / or willingness of the parents to protect the child from harm.

Ways of Notifying

Consideration should be given to how the notification to Child Protection is made.

In situations where a child's immediate safety is at risk, the notification must be made immediately and possibly without consultation with, or the consent of, the parent or a more senior worker within your organisation. The safety of a child should not be compromised. Examples of notifications which should be made expediently include:

- When a small child is discovered unattended at home or in a car.
- If a parent presents as seriously affected by alcohol or other drugs and has the sole care of a child whose safety would be compromised in the care of that adult.
- When a child discloses sexual abuse or serious physical abuse.
- When concerns for the child are serious and concerns exist that the parent may abscond if the parent is aware a notification is to be made.

However, better outcomes for protective intervention are likely to occur if the alcohol and other drug worker can be direct with the parent about their concerns for the child and inform the parent that they plan to make a notification.

Notifications can be made in a number of ways. These include:

- Contacting the regional Child Protection Intake Team (see appendix for details)
- In emergencies, calling the **Central After Hours Child Protection Service 13 12 78** (after 5.00 pm, before 9.00 am and on weekends and public holidays).
- Contacting Child Protection with the parent present when the call is made.
- Requesting a meeting with a regional intake worker, with or without the parent present, to discuss the protective concerns and make a notification.

The Intake worker will request the following information:

- Name and age of child (date of birth if available).
- Name of parents.
- Alcohol and other drug worker's name and relationship to the family.
- Address of child and parents.
- Nature of concerns about the child.
- Knowledge of immediate safety issues for the child.
- Knowledge of any other agencies or workers involved with the family.
- Cultural characteristics such as ethnicity, interpreter requirements, Aboriginality.

Additional information asked of an alcohol and drug worker who makes a notification may include:

- The nature and duration of the parental problematic alcohol and other drug use.
- The alcohol and drug worker's impressions of the impact of the parental alcohol and other drug use on the child or children.

Also negotiated may be:

- The ongoing role of the alcohol and other drug worker with the family.
- A case conference to further explore concerns and plan intervention.

The alcohol and other drug worker can expect the following from the Intake Child Protection worker:

- Feedback on the appropriateness of the notification.
- Advice on whether the notification will be directly followed up with the family (directly investigated).

- Advice on strategies in relation to concerns notified if the matter is not to be directly investigated by Child Protection.
- Confirmation of the nature of any ongoing liaison between the two services.

Child Protection will inform the alcohol and drug worker who makes a notification to a Child Protection Intake Team, the outcome of that notification (whether it is to be directly investigated or not) as soon as possible, and within five working days.

Notifications—No Further Action

In 2001–02, 65 per cent of notifications made to the Child Protection service in Victoria were managed without investigating the concerns directly with the family. It should be noted that many children are notified more than once. Concerns which may not be deemed to warrant a direct Child Protection investigation at the first notification, may at the second or third be sufficiently concerning, or escalating, for a direct investigation and assessment of the concerns.

Workers in the Child Protection Intake Teams can offer notifiers advice and suggestions in relation to concerns notified when a notification is not formally investigated.

If the notification is not accepted, the Child Protection worker shall provide the notifier with the reasons as to why this is the case.

Notifier's Protection

Section 67 of the Children and Young Persons Act 1989 specifies that Child Protection must not disclose the name of the person making the notification to anyone else without the written permission of the notifier. An exception to this is when the court decides it needs the information in order to protect the safety and wellbeing of the child, or that in the interests of justice the evidence needs to be given. However, it is highly unusual for the Children's Court to seek identification of the notifier.

Notifying Unborn Children at Risk

Child Protection accepts notifications on unborn children and may work with the family prior to the birth of the child. A community safety plan can be developed antenatally, potentially preventing the need for Child Protection involvement once the child is born.

Specialist Infant Protective Workers (SIPWS), located in each Region, play a pivotal role in this assessment and coordination of services.

Specialist advice and treatment regarding pregnancy and alcohol and other drug use is available from the Women's Alcohol and Drug Service, Royal Women's Hospital. The Women's Alcohol and Drug Service accept referrals for assessment from Child Protection for pregnant women with alcohol and other drug use issues at any stage of pregnancy and up to 48 hours postnatally.

Case Conferences

A professional can call a case conference to which Child Protection and other relevant professional, community or family members can be invited.

Case conferences may be considered in a range of circumstances. For example:

- A pregnant adolescent with problematic AOD use.
- Parents whose use of AOD had previously minimally impacted on the children, however, the repercussions of the parent's dependency are beginning to adversely affect the children's wellbeing and safety.
- A parent who has a range of complex needs, such as mental heath problems, housing issues, alcohol and other drug problems and young children.
- A discussion of guardianship issues if parents are unable or ambivalent about caring for the child and where other relatives or caregivers are temporarily caring for the child.

Recording of Child Protection Notifications

All calls made to Child Protection Intake Teams where sufficient identifying information is provided, are recorded on the Client and Service Information System (CASIS).

CASIS is the computerised data management program all Child Protection workers use to manage information in relation to the families with whom they work.

Working with Indigenous Families

When an Indigenous child is notified to the Victorian Child Protection program, the protocol between the Department of Human Services Child Protection Service and the Victorian Aboriginal Child Care Agency (VACCA) states that Child Protection will consult with VACCA on all notifications of Indigenous children (including young people) and investigation decisions, including notifications that do not proceed to direct investigation.

Indigenous community alcohol and drug workers are located in Aboriginal Co-operatives across the state. Co-operatives provide a range of health, welfare, housing, employment and social support services to the local Indigenous community. Services are culturally sensitive and gender and age appropriate. The Indigenous alcohol and drug workers assess clients' needs; provide assistance to access alcohol and other drug programs and information and education about the effects of alcohol and drugs. Some workers provide counselling.

If an Indigenous community alcohol and drug worker (or any key worker) makes the notification or is closely involved with the family, they may negotiate to be present at the initial assessment.

These workers operate within a harm minimisation approach, by focusing on reducing the harm to both the individual and the community from AOD use.

Other Indigenous services include alcohol and drug resource centres (previously known as sobering-up centres) that provide accommodation of an average of 48 hours, and Recovery and Residential Rehabilitation Centres for those who wish to address their alcohol and drug usage. Some co-operatives provide needle exchange programs.

Information about these services is available from Direct Line Tel: 1800 888 236.

2.2 A Request from Child Protection to a Drug Treatment Service for Information, Consultation or Advice in Relation to a Current or Previous Client of the Drug Treatment Service

Child Protection may be notified about children or young people whose parents are current clients or previous clients of a drug treatment service. As part of their assessment the Child Protection worker may seek information from the drug treatment service in relation to the assessment and/or treatment of that parent.

With Client Consent

Child Protection workers will usually discuss with the adult client their intention to seek information from the client's drug treatment service. The Child Protection worker will endeavour to seek the consent of the individual before contacting the drug treatment service.

Drug treatment services may ask for a copy of written consent from the client before giving information to Child Protection. Child Protection should fax the adult's written consent to the drug treatment service with the written request for information and type of information required.

Without Client Consent

There are two situations in which Child Protection may seek information from a drug treatment service without the consent of the adult client.

(i) If, during the course of a Child Protection investigation, a parent with problematic alcohol or other drug issues, refuses to give consent to child protection to speak with their alcohol and drug worker, and if the information is considered important to the assessment of the child's safety and wellbeing, the Child Protection worker will inform the client that they will seek the information directly from the drug treatment service.

The Child Protection worker can inform the client that a protocol exists between Child Protection and drug treatment services which supports alcohol and drug workers providing relevant information to Child Protection, during the course of an investigation.

Where there is conflict between the ethical principle in relation to client confidentiality and the responsibility of drug treatment services or alcohol and drug workers to ensure that children and young people are not harmed, **the safety of the child/young person is paramount**.

Section 67 of the Children and Young Person's Act states that:

> The giving of information to a protective intervener during the course of the investigation of the subject-matter of a notification under Section 64 (1) does not constitute a contravention of the Health Services Act.

Information given to Child Protection without the consent of the client will be limited to that which is necessary to enable Child Protection to investigate, assess risk, and ensure the immediate safety of the child or young person.

Except in situations where a child is at immediate risk (see section on making a notification), the alcohol and drug worker will not breach a client's confidentiality without prior consultation with a clinical supervisor of the drug treatment service. It is preferable that senior alcohol and drug clinicians respond to Child Protection.

For security and privacy purposes, the alcohol and drug treatment service may request receipt of a faxed request from Child Protection indicating what information is required and why the information is needed. The information should be discussed with a senior clinician before being provided and a file note recorded.

(ii) In the course of an investigation, Child Protection may contact a drug treatment service in order to add information to a notification received from another source. For example, a neighbour or relative of a child may make a notification to Child Protection in which allegations are made about parental drug and alcohol use and child abuse. The Child Protection Intake Team may then contact the alcohol and drug treatment service to seek information on that parent's contact with the service. In these instances, the parents have not been told that a notification has been made.

When balancing the protective concerns as outlined in the original notification with the information received from the drug treatment services and other professionals who may have been contacted, Child Protection may decide not to proceed further with an investigation. In these instances, the family will not be informed that Child Protection has received a notification about a child in their care.

The alcohol and drug treatment service, can, if it believes it is appropriate, inform the family that Child Protection has contacted them.

2.3 A Request from Child Protection to a Drug Treatment Service for Consultation or Advice in Relation to Family Members Who Are Not Clients of a Drug Treatment Service

At any point in the assessment period, a Child Protection worker may require advice from a range of professionals to assist with developing an intervention to address the child's safety and wellbeing issues.

A Child Protection worker who has received a notification from another professional or member of the community may contact an alcohol and drug worker for information and advice. The Child Protection worker may wish to gather information on the range of treatment options available. They may also seek the expertise of the worker about the particular alcohol and other drug use issues without making a referral to that service.

The alcohol and drug worker will ask questions regarding the general presenting problems and the client's history of AOD use, if known. For example, type of drug/s used, frequency of use, route of administration, duration of use, average daily intake, any previous drug related problems such as overdose or withdrawal, whether the substance use is of concern to the client and its impact on the family. The alcohol and drug worker can give information, advice and referral options.

For information and advice from experienced alcohol and drug workers on alcohol and other drug issues and referral options, Child Protection workers can contact:

- Drug and Alcohol Clinical Advisory Service (DACAS)
  Phone: 9416 3611 or 1800 812 804 (free call, regional Victoria)
- Local drug treatment services.

2.4 Case Management

2.4.1 Case Management in Child Protection

Once a notification has been accepted for further investigation, Child Protection assumes a case management role.

Although other services (such as drug treatment services) may be responsible for specific tasks in relation to the child's safety and wellbeing, Child Protection retains ultimate responsibility for attending to the safety and wellbeing issues relating to the child or young person.

The role of the alcohol and drug worker in relation to the Child Protection intervention may include:

- Attendance at case conferences.
- Participation in case planning as necessary.
- Liaison with Child Protection and other involved services in relation to the family's wellbeing.
- Attendance at court with client if requested.
- Provision of written or verbal assessments of the parent's alcohol and other drug use and its impact on general functioning.

On occasions, a case conference may be held at the intake stage. This is to determine whether a notification requires further action, who should take that action, and clarify the seriousness of protective concerns. Families can be invited if appropriate. Alcohol and drug workers should be informed of their role in the meeting, its purpose and who will be attending.

If the alcohol and drug worker cannot attend the scheduled meeting, relevant information should be provided to Child Protection prior to the case conference and feedback given by Child Protection as to the outcome.

Liaison Meetings

If problematic AOD use is a significant protective concern during the course of a Child Protection investigation, the Child Protection worker is likely to require ongoing feedback from the parent's alcohol and drug worker to help them assess the safety and wellbeing of the child, on a case by case basis.

The Child Protection worker may need to speak with the drug and alcohol worker on a regular basis to ascertain the parent's current treatment and response to that treatment. To ensure the parameters of this interchange are clear, the Child Protection worker and alcohol and drug worker should discuss how this information exchange is to be conducted.

It is recommended that an initial meeting with the client, the Child Protection case manager and the alcohol and drug case manager be convened by Child Protection if it is expected that the drug treatment services will be asked to:

- Provide written or verbal assessments of the parents' history of alcohol and other drug use and its impact on general functioning.
- Monitor and provide feedback to Child Protection on the parent's current alcohol and drug use.

This meeting should:

- Clearly outline the protective concerns.
- Outline the reasons why information about the adult's AOD use is essential to a comprehensive assessment of the child's safety and wellbeing.
- Clarify roles and responsibilities so that any future contact between the two services and the adult client is clear.

While a Child Protection worker may, as part of their broader assessment, ask an alcohol and drug worker their observations of the impact of the parental AOD use on their clients children, it is not appropriate for Child Protection to expect an alcohol and drug worker to assess the parenting capacity arising from the parents' AOD use.

Case Planning in Child Protection

Once it is assessed that a notification requires further investigation, and concerns in relation to the child are substantiated, Child Protection develops a comprehensive and coordinated case plan to protect the child / young person. Case planning is an ongoing process throughout the involvement of Child Protection that aims to:

- Assess and define the level of risk to a child or young person.
- Determine the developmental needs of the young person and how these can be met.
- Work with the family to ensure that the child is safe.

28 Day Protective Planning Meeting

Once a notification is accepted for direct investigation, a protective planning meeting is held within 28 days of the initial involvement of Child Protection. Priority is given to the development of a plan that aims to manage the risk to the child or young person through the family's existing support network and within the community. The roles and responsibilities of support services in implementing the protective plan are negotiated and documented during the planning meeting.

The 28 day Protective Planning meeting is chaired by a Senior Child Protection Worker who will ensure that 'Results of the Meeting', detailing agreed upon roles and responsibilities of various members of the family's service network in implementing the plan, are provided to all participants.

Child Protection is able to remain initially involved with a family **for a period of up to three months** once protective concerns are substantiated. During this period, the family may be linked into various support services with the aim of securing the child's safety.

The goal of Child Protection involvement during this period is, wherever possible, to strengthen and empower families to provide care for their children within the community without the need of further statutory involvement from Child Protection. Further involvement by Child Protection after the three-month period will usually result from an application to the Children's Court and a request that a child be placed on a protective order.

Role of Alcohol and Drug Workers in Children's Court matters

As well as being authorised to accept and investigate notifications of child abuse and neglect, Child Protection workers can issue a Protection Application to bring the matter before a magistrate in the Family Division of the Children's Court. During hearings at the Children's Court, the magistrate receives a report from the Child Protection worker. This report to the Court outlines the safety and wellbeing issues in relation to the child or young person. The report will also highlight the family's strengths and capabilities.

The author of any report to the Court must inform any person being interviewed that the information they provide may be included in any report given to the Court (s.40).

Professionals, including alcohol and drug workers, who know the child and family may be required to participate in the Children's Court proceedings. This involves preparing a written report to be submitted to the magistrate and can involve the professional being called by the Department of Human Services as a witness at the court hearing.

Professionals preparing reports are most likely to be called to provide both written and verbal evidence in cases where the child or family is contesting the matter. When preparing a report, professionals should keep in mind that they may be required to attend court even though the matter may end up not being contested.

There are three main situations in which a professional may be involved in proceedings of the Family Division of the Children's Court:

- When a Protection Application has been lodged. If the magistrate finds that the child is at risk, the protection application is proved and an order to protect the child is made. If the protection application is not proved, the case will be dismissed.
- Breach of an existing order. The magistrate determines whether the conditions of the existing order have been breached. If a breach is proved the magistrate decides on a new order.
- Final hearing of an Interim Protection Order. This usually occurs when a matter that has been undergoing further assessment or monitoring in the community returns to the Children's Court.

Reports to the court become a document of the Children's Court and will be read by the magistrate, the legal representatives for both the Department of Human Services and the child and family. The child and family will also usually read the report. The report must not be disclosed to anyone else without the consent of the court or the child or the parent.

Professionals are encouraged to inform families that a report is being written by them for a Children's Court hearing. Families may react in a range of ways including with anger to the presentation of this information in court and may feel that trust has been betrayed. Professionals are therefore encouraged to be as open and honest with families as possible in relation to any child protection concerns they may have. Giving evidence in opposition to families views may make professional witnesses reluctant to say what they really believe. These concerns are valid, however remember that Children's Court action is taken to protect the child, and as such, professionals have a responsibility to present the facts to the court openly and honestly. The magistrate ultimately makes the final decision – professional knowledge and assessment provides the opportunity for all relevant information to be considered.

More information for professionals on presenting evidence for the Children's Court is available in the DHS publication, Effective Court Practice: A Guide for Professionals. This publication is available from regional Child Protection offices.

Case Management Post Court Order

When the Children's Court places a child or young person on a protection order, a case plan must be prepared within six weeks. A meeting may be held to facilitate preparation of the plan.

The meeting, at which a written case plan is usually formulated, involves the family and members of a family's support and service network. Alcohol and drug service workers may attend case planning meetings as part of the family's service network. Depending on the circumstances, separate meetings may be held with service providers and family members. A copy of the case plan will be sent to all professionals involved in the care of the client and possibly others, with the client's knowledge.

Statutory Case Plan Meetings

Once a case plan has been established, it is subject to regular review. Reviews of the case plan can be held as part of the scheduled review process, in response to changed circumstances that may impact significantly on the level of risk to the child, or at the request of the family.

2.4.2 Case Management (Care Coordination) in Drug Treatment Services

Alcohol and drug treatment agencies funded by Drugs Policy and Services Branch are mandated to contribute to the reduction of AOD-related harm to the individual and the community by providing alcohol and drug services as specified in their Department of Human Services Funding and Service Agreement. Services are funded to provide coordination and continuity of care for clients. The alcohol and drug worker will arrange for the client to receive a range of appropriate services and liaises with service providers involved.

Where an alcohol and drug treatment agency is providing clinical services, the individual receiving the service is the primary client and all services must comply with privacy legislation to protect their clients' confidentiality. **The Children and Young Persons Act overrides privacy legislation.** Families and significant others are involved with the client's consent and to the level s/he wishes. Some services have specialist family programs.

Where the Privacy legislation is incompatible with other legislation, the Privacy legislation has no force. This includes the Children and Young Persons Act, the *Alcoholics and Drug Dependent Persons Act 1968* and the *Health Act 1958.*

In order to ensure the coordination of all aspects of a client's management, individual treatment plans are formulated, in conjunction with the client, which identify key issues and manage the efforts of professionals and agencies involved in the client's care.

Alcohol and drug workers in drug treatment services focus on supporting clients through personal counselling and sometimes are the primary worker/therapist for clients. The needs and aspirations of the user are prominent and there is a collaborative approach to developing the individual treatment plan. Once written plans are drawn up, they are reviewed regularly in the service's case management supervision meetings.

The treatment process in alcohol and drug services is one of negotiation, not prescription. The ultimate goal is directed towards client empowerment, habit control and harm minimisation. The case management process may involve a series of episodes of treatment. As clients are vulnerable to relapse, follow-up is often required with varying degrees of intensity, and the plans need to be flexible.

The alcohol and drug worker is the person responsible for attending case planning meetings with the client's Child Protection worker and contributing to the Child Protection case management process concerning care of the child/children. **The alcohol and drug worker will take account of the Child Protection plan in the client's individual treatment plan.**

A significant percentage of individuals referred to drug treatment services for treatment have dependent children. A proportion of these adults experience difficulties maintaining adequate care of their child or children and many of these clients have Child Protection involvement prior to an assessment by a drug treatment service.

The alcohol and drug case manager will advise their clients that Child Protection will need to be informed of the goals, interventions and support network in the alcohol and drug treatment plan and the client's progress.

2.5 Disputes/Complaints

Any dispute or complaint in relation to an operational issue should be dealt with in the first instance between the regional Child Protection worker and the alcohol and drug worker. The aim of the contact will be discussion and resolution of the concern.

If the workers concerned cannot resolve the problem the following should occur:

- Depending on the nature of the complaint, contact will be made either verbally or in writing to the direct worker's line manager or clinical supervisor.
- If the problem is still not resolved, the regional Child Protection Manager and the relevant senior manager from the alcohol and drug treatment service will discuss the matter.
- If the problem remains unresolved, then the Regional Director of the relevant Child Protection program and the Director, Drugs Policy and Services Branch will decide on a course of action to resolve the problem.

2.6 Training

Staff of Child Protection and drug treatment services agree to cooperate in relation to training in order that services gain a mutual understanding of each other's philosophies, policies and methods of operations. As part of such cooperation between agencies, opportunities for workers from each service to observe the operations of the other service may be negotiated to meet the training and professional development needs of staff in the respective services.

3. Overview of the Drug Treatment Service System

The drug treatment service system referred to in this document is comprised of organisations funded by the Department of Human Services for the provision of AOD treatment, education and prevention services.

The Victorian Government provides the community with AOD treatment through a purchaser-provider model. This means that, rather than providing the services itself, the Government purchases these services from a range of independent agencies, for example, not for profit religious organisations, community health centres, hospitals and others.

Types of Services Funded

Drug treatment services provide a range of community-based services for adults and young people, including residential and non-residential withdrawal services, residential rehabilitation, supported accommodation, counselling, consultancy, continuing care, peer support groups and specialist methadone services (see Framework for Service Delivery p 20).

Some alcohol and drug services have special programs targeted at families. These include:

- Ante and post natal support.
- Family counselling and family therapy.
- Specialist residential rehabilitation for families.
- Alcohol and drug supported accommodation for women and children.
- Domestic violence programs.
- Parent support.

Information about these services can be obtained from Direct Line (see referral to alcohol and drug services p 21 for details).

Services are targeted at people with serious problems resulting from their use of AOD.

Alcohol and drug workers are drawn from a range of disciplines and backgrounds, predominantly social work, social welfare, nursing, psychology and youth work.

Harm Minimisation

As in all health services, there is diversity in philosophies and special interests of agencies to match client preferences, but the principle of harm minimisation is fundamental to the approach of all funded drug treatment services.

Harm minimisation aims to achieve the best possible AOD use control outcomes suitable to the capacity and circumstances of the affected individual. There may be occasions where the elimination of a client's AOD use is not attainable in the short term.

Problematic AOD use is a chronic relapsing condition that makes ceasing the use of the substance very difficult for some people.

Harm minimisation aims to reduce the adverse health, social and economic consequences of problematic use of AOD to the individual, the family and the wider community.

Drug Treatment Services Legislation

Legislative provision for the establishment and operation of drug treatment services are in the following Acts:

- **Health Services Act 1988, Section 26**
- **Alcoholics and Drug Dependent Persons Act, 1968.**

The Alcoholics and Drug Dependent Persons Act does not compel people with problems with alcohol and drugs to accept treatment. Treatment facilities are not secure and alcohol and drug workers have no powers to detain a client who wants to leave.

The Forensic Service System provides a range of alcohol and drug education and treatment options, parole and community-based orders with AOD treatment conditions. Clients may be attending treatment as a result of pre-sentence diversion into treatment, in prison alcohol and drug education and treatment, or parole conditions. On release, although offenders are not 'committed' to treatment, considerable incentives are applied to motivate the person to attend community drug treatment services.

For treatment to be effective, the individual must be willing to attempt to cease or reduce AOD use and agree to cooperate with treatment.

A rapport based on trust between the client and alcohol and drug workers is essential for engagement and effective treatment. This necessitates fully informing the client of intended courses of action and seeking their consent and collaboration in the planning and implementation of their treatment and the sharing of information.

Framework for Service Delivery

Drug treatment services aim to:

- Prevent / reduce / contain the harm related to AOD use as it affects clients, their family and the community.
- Assist the client in addressing the issues related to their harmful AOD use.
- Provide a flexible individualised treatment plan and service provision that responds to the client's changing AOD use behaviour. The focus is on careful planning and monitoring, and appreciation of incremental gains.

Victoria's Framework for Drug Treatment Service Delivery

Regional Services

Young People

- Outreach
- Counselling Consultancy and Continuing Care
- Withdrawal
- Supported Accommodation
- Peer Support
- Aboriginal Services
- Residential Rehabilitation
- Day Program

General Adult

- Withdrawal
  - Residential
  - Home-based
  - Outpatient
  - Rural
- Substitute Programs
  - Methadone
  - Buprenorphine
- Counselling Consultancy and Continuing Care
- Residential Rehabilitation
- Supported Accommodation
- Peer Support
- Aboriginal Services
- Mobile Overdose Response
- Continuity of Care
- Extended hours
- Methadone Outreach
- ABI Resource Workers

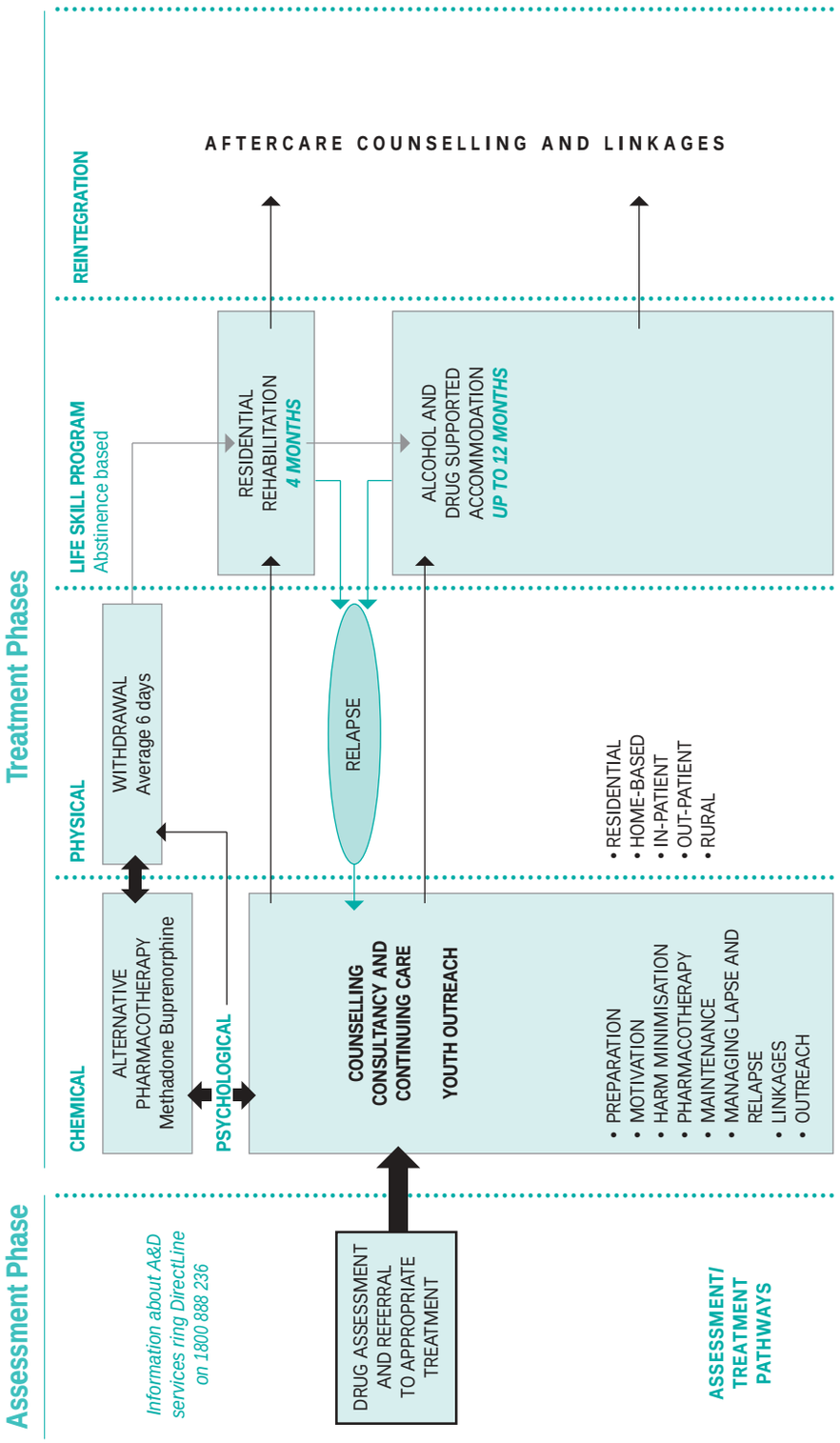
Statewide Services

- Youth Substance Abuse Services
- Ante and Post Natal Support
- Family Residential Rehabilitation Program
- Family Drug Information and Support Telephone Helpline
- Parent Support Program
- Dual Diagnosis
- Homeless Persons A&D Program
- Treatment Programs for Offenders
  - Community Offenders Advice and Treatment Service (ACSO/COATS)
  - Police Illicit Drug Diversion
  - FOCiS
  - RODW
  - Court Diversion
    - CREDIT Bail Program
    - Deferred Sentencing
    - Children's Court Clinicians Program
  - Sentencing Options
    - CBO
    - ICO
    - CCTO
    - DTO
  - StepOut Post Prison Release Service
  - Welfare
  - Juvenile Justice/Child Protection
  - CHAD Nurses

Legend

FOCiS –	Drug Education for First Offenders Services	ICO –	Intensive Corrections Order
RODW –	Rural Outreach Division Worker	CCTO –	Combined Custody Treatment Order
CREDIT –	Court Referral Evaluation and Drug Intervention Treatment	DTO –	Drug Treatment Order
CBO –	Community Based Order	CHAD –	Custodial Health and Alcohol and Drug

Drug Assessment and Treatment Phases



Referral to Drug Treatment Services

A Child Protection worker can make a referral directly to the appropriate alcohol and drug treatment agency.

Detailed and up-to-date information on Victorian alcohol and drug services can be obtained by phoning:

Direct Line Tel: 1800 888 236.

Direct Line provides accurate information about AOD, treatment services and community agencies to health workers and liaises with the Dual Diagnosis Teams and Psychiatric Assessment Teams to assist with psychiatric and drug induced psychosis matters.

For clinical advice contact:

Drug and Alcohol Clinical Advisory Service DACAS Tel: 9416 3611

or 1800 812 804 (free call – regional Victoria)

Updated information on the range of alcohol and drug services is available at the drug treatment services website http://www.dhs.vic.gov.au/phd/dts/index.htm.

The *Trace Directory: A Directory of Alcohol and Drug Services in Victoria* is available through Turning Point Alcohol and Drug Centre Inc. 54-62 Gertrude Street Fitzroy.

Description of Regional Alcohol and Drug Services

There are 12 service types that form the basis of the Victorian regional drug treatment services system:

Counselling, Consultancy and Continuing Care

Counselling, consultancy and continuing care services provide a range of services and supports appropriate to the needs of clients who have AOD use problems. Services provided may include assessment, treatment and consultancy, referral and ongoing case management.

A range of professionals, including social welfare workers, health professionals, psychologists, general practitioners, consultant physicians and psychiatrists, deliver services. These services ensure that continuity and quality of care are provided.

Youth Alcohol and Drug Outreach Services

An outreach service provides assessment, support and ongoing case coordination to young people up to the age of 21 years whose use of licit and illicit drugs causes significant physical, psychological and social harm.

Home-Based Withdrawal Service

An experienced nurse, in association with a medical practitioner, provides the service.

A family member or friend at home provides support through the home-based withdrawal process in cases where the withdrawal syndrome is of mild to moderate severity and the client has a support person available. This service may be provided as part of the rural withdrawal support service either in conjunction with a brief hospital stay or as a complete treatment.

Residential Withdrawal Service

Residential withdrawal services provide alcohol and drug withdrawal to young people and adults through a community residential drug withdrawal service. The treatment emphasis is on a short length of stay.

Outpatient Withdrawal Service

Outpatient withdrawal services are provided to clients who have a withdrawal syndrome which can be appropriately managed without admission to a residential service. The service provides a series of intensive individual outpatient consultation over a short period, followed by ongoing counselling and support to complete withdrawal.

Rural Withdrawal Service

In rural Victoria, general practitioners and health services are often utilised for the treatment of withdrawal symptoms. Rural withdrawal services combine a short hospital stay (where required) with a period of home-based withdrawal.

Residential Rehabilitation

Residential rehabilitation services provide a 24-hour staffed residential treatment program of an average of three months duration. They will provide a range of interventions that aim to ensure lasting change and to assist reintegration into community living.

Residential rehabilitation services are provided from a community-based setting, such as a house or houses located in a residential area.

Alcohol and Drug Supported Accommodation

Supported accommodation provides short term support (one to 12 months) in a safe, drug-free environment to clients who require assistance in controlling their alcohol and drug use. Women's drug and alcohol supported accommodation includes dependent children who also require accommodation and support from the service.

Koori Community Alcohol and Drug Workers

The Koori community alcohol and drug worker undertakes a number of program development activities based on a harm minimisation approach.

These include health promotion, information provision, education activities, development and maintenance of community linkages, referrals, counselling interventions, the provision of advice to generalist services, liaising with relevant programs and fulfilling an advocacy role on behalf of the service user.

Koori Community Alcohol and Drug Resource Services

Koori community alcohol and drug resource services provide an alternative to incarceration for Koori persons who are found to be alcohol and drug affected in public. It provides short-term accommodation of an average of 48 hours in a safe non-threatening environment, which is focused on meeting the needs of the individual and continuity of care through appropriate referral processes.

Peer Support

Peer support provides mutual support and information by individuals with personal experience of alcohol and drug use for individuals who may be having, or who have had, difficulties associated with their alcohol and drug use.

Specialist Methadone Service

While methadone/buprenorphine is generally administered through general medical practitioners, the need for specialised services occurs where there are associated complex medical, psychiatric or psychological problems. Specialist methadone services incorporate medical, counselling and case management services in order to stabilise clients for a return to less intensive community-based treatment. In general, these services only accept clients referred by GPs.

Description of Statewide Alcohol and Drug Services

The Youth Substance Abuse Service (YSAS)

This service is provided for young people, between the age of 12 and 21, who are traditionally 'hard to reach', at risk of being excluded from their existing networks and who have established dysfunctional drug use. It operates Outreach Teams in seven locations with a flexible funding pool, runs an eight bed, short term residential treatment facility and provides training in youth alcohol and drug issues to specialist and generalist workers statewide.

Ante and Postnatal Support

The Women's Alcohol and Drug Service, Royal Women's Hospital (formerly Chemical Dependency Unit) accepts women with AOD issues at any gestation and up to 48 hours postnatal. Following assessment the woman will either remain with Women's Alcohol and Drug Service for ongoing pregnancy care or be referred to an appropriate service. The service also has an educational program available to providers throughout Victoria, which aims to equip all health professionals with skills in caring for pregnant women with AOD issues. Referrals are made by contacting the duty worker between 8.30am and 5.00pm Monday to Friday.

Family Residential Rehabilitation Service

The family residential rehabilitation program, provided by Odyssey House, is directed to drug-addicted parents and has qualified preschool teachers and a fully operational child care / preschool centre. Both custodial and non-custodial parents are assisted in parenting and family skills. Although the children are not regarded as clients, they play an integral role in their parents' rehabilitation program.

Family Drug Information and Support Telephone Help Line

This 24-hour service 1800 888 236 provides access to drug and alcohol counselling, information and referral to services anyone in the community.

Parent Support Program

Parent support programs are therapeutic programs, facilitated by alcohol and drug professionals for adults who are in a parenting role to young people under the age of 21 with problematic substance use.

Dual Diagnosis Teams

Four specialist substance use and mental illness treatment teams are located with major metropolitan health services that are currently providing mental health and drug treatment services. These teams also support specialist dual diagnosis workers in rural health centres.

The Dual Diagnosis initiative is based on providing training, secondary and tertiary consultation to all organisations delivering mental health or alcohol and drug services, and direct treatment to a small number of clients who have both a mental illness and problematic substance use.

Acquired Brain Injury Resource Workers

Acquired brain injury (ABI) resource workers provide secondary consultation to health workers in management of clients with ABI and AOD issues and provide direct AOD counselling to a small number of clients with this dual disability.

Specialist Alcohol and Drug Treatment and Therapeutic Workers

The five Specialist Alcohol and Drug Treatment and Therapeutic Worker Positions will provide secondary consultation and support for child protection clients and staff in out of home care residential facilities, adolescent community placement and secure welfare. The positions will be auspiced by existing Drug Treatment Agencies with experience in working with young people.

Although the specialist workers are based in metropolitan regions, they will have some capacity to service a small number of high profile clients in their corresponding rural region / s.

The five Specialist A&D Treatment and Therapeutic Worker Positions are a pilot project and will operate for a 13-month period commencing on the 1st June 2002

Forensic Services

As part of the Turning the Tide strategy on drugs, Drugs Policy and Services has funded a range of forensic community treatment initiatives to assist offenders with community-based orders by targeting AOD treatment options.

These treatment options attempt to tackle AOD problems from a health perspective and recognise the importance of making public drug treatment services available to community-based offenders.

Community Offenders Advice and Treatment Service

The Victorian Offenders Support Agency Inc. (VOSA) provides the Community Offenders Advice and Treatment Service (COATS). As a result of referrals from the courts, COATS undertakes an assessment, provides an alcohol and drug treatment plan and purchases any necessary treatment from community-based alcohol and drug treatment agencies for parolees and offenders who receive community-based dispositions or a Combined Custody and Treatment Order (CCTO). In exceptional cases, COATS can undertake pre-sentence assessments for the court, particularly where the court is considering a CCTO.

The Intensive Post Prison Release Drug Treatment Service (Stepout)

The Intensive Post Prison drug treatment service, Stepout, provides in-prison assessment and, where appropriate, intensive counselling and case management to people on release from prison who are high risk or for whom a further period of counselling and support will consolidate the outcomes of treatment received in prison.

The Drug Education for First Offenders Service

The Drug Education for First Offenders Service (FOCiS) provides drug education sessions for first offenders in possession of small quantities of illicit drugs (other than cannabis) who give the court an undertaking to attend such education.

Court Referral Evaluation and Drug Intervention Treatment (CREDIT)

This is a program that refers offenders with AOD issues to appropriate drug treatment services as a condition of their bail.

Drug Diversion Program

The National Illicit Drug Strategy Drug Diversion Initiative provides the option of a caution for persons picked up by the police for using and possessing small amounts of illicit drugs other than cannabis. A condition of the caution is that the offender attends a drug treatment service for assessment and appropriate treatment.

CHAD Nurses Program

The CHAD Nurses Project is a joint Department of Human Services-Victoria Police project and extends the alcohol and drug treatment / withdrawal program to offenders held in Category A police cells across the State. The project comprises five nurses who complement five nurses in the Custodial Medicine Unit, Victoria Police.

The CHAD nurses provide a timely and accessible health service to people held in police custody who have a demonstrable drug problem and who require drug treatment / withdrawal or substitute pharmacotherapy services whilst they are in detention.

4. Child Protection in Victoria

The Role of the Child Protection Service

The Child Protection Service has a particular role prescribed by the Children and Young Persons Act 1989.

It has responsibility for those children who are at risk of significant harm, and their families.

The Child Protection Service provides child-centred, family-focused services to protect children and young people from significant harm as a result of abuse or neglect within the family unit. It also ensures that children and young people receive services to deal with the impact of abuse and neglect on their wellbeing and development.

The Child Protection Service is based on the principle that the best protection for children is usually within the family, however, the child's safety and wellbeing is of paramount consideration.

The function of the Child Protection Service is to:

- Receive notifications from people who believe on reasonable grounds that a child is in need of protection.
- Provide advice to people who report such concerns.
- Investigate matters where it is believed that a child is at risk of significant harm.
- Refer children and families to services that assist in providing the ongoing safety and wellbeing of the children.
- Take matters before the Children's Court if the child's safety cannot be assured within the family.
- Supervise children on legal orders granted by the Children's Court.

4.1 Identifying Child Abuse and Neglect

Professionals who work with children and young people should:

- Be aware of the warning signs and be open to noticing them.
- Have clear organisational protocols and procedures, know them and use them.
- Provide mutual support between staff members.
- Have good links with relevant external welfare and Child Protection agencies.

Types of Harm

'Abuse', 'neglect' and 'maltreatment' are generic terms used to describe situations where a child might need protection. Child abuse is an act or omission by an adult that endangers or impairs a child's physical or emotional health and development.

From a Child Protection perspective, the term 'harm' is often used to focus on the **effects** on the child, rather than the **actions** (abuse) of the adults. This distinction becomes important when undertaking an assessment of the child's ongoing safety and wellbeing and the parents' capacity to protect the child.

Indicators of Harm

A professional working with children may observe a number of indicators or a single indicator. One single indicator can be as significant as the presence of a number of indicators.

It is also important to be aware that the **presence** of an indicator listed below does not always indicate that a child **is** being abused; and the **absence** of indicators listed below does not indicate that the child is **not** being abused.

Physical Harm

Physical 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 which look like the object used to make the injury, for example, finger or hand prints, buckles, iron, teeth.

Burns which show the shape of the object used to make them, such as an iron, grill, cigarette, or burns from boiling water, oil or flames.

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 stage.

Cuts and grazes to the mouth, lips, gums, eye area, ears, external genitalia.

Human bite marks.

Bald patches where hair has been pulled out.

Multiple injuries, old and new.

Poisoning.

Internal injuries.

Behavioural Indicators

The child states that an injury has been inflicted by someone else (parent or other), or offers an inconsistent or unlikely explanation, or 'can't remember' the cause of injury.

Unusual fear of physical contact with adults (for example, flinches if unexpectedly touched).

Wearing clothes unsuitable for weather conditions, (such as long-sleeved tops) to hide injuries.

Wariness or fear of a parent / caregiver, reluctance to go home.

No or little emotion when hurt.

Little or no fear when threatened.

Habitual absences from school without explanations (the parent may be keeping child away until signs of injury have disappeared).

Overly compliant, shy, withdrawn, passive and uncommunicative.

Fearfulness when other children cry or shout.

Unusually nervous or hyperactive, aggressive, disruptive and destructive to self and / or others.

Excessively friendly with strangers.

Regressive behaviour, such as bed-wetting or soiling.

Poor sleeping patterns, fear of dark, nightmares.

Sadness and frequent crying.

Drug or alcohol misuse.

Poor memory and concentration.

Suicide attempts.

Sexual Abuse

In older children and young people, 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 observing physical indicators. In babies and young children, the physical indicators are observed mostly through a physical examination.

Physical Indicators

Injury to the genital or rectal area, such as bruising or bleeding.

Vaginal or anal bleeding or discharge.

Discomfort in urinating or defecating.

Presence of foreign bodies in vagina and / or rectum.

Inflammation and infection of genital area.

Sexually transmitted diseases.

Pregnancy, especially in very young adolescents.

Bruising and other injury to breasts, buttocks and thighs.

Anxiety related illnesses, such as anorexia or bulimia.

Frequent urinary tract infections.

Behavioural Indicators

The child tells of abuse.

Persistent and age-inappropriate sexual activity, including excessive masturbation, masturbation with objects, rubbing genitals against adults, playing games which act out a sexually abusive event.

A fear of home, a specific place, a particular adult.

Excessive fear of men or of women.

Poor or deteriorating relationships with adults and peers.

Poor self-care / personal hygiene.

Arriving early at school and leaving late.

Complaining of headaches, stomach pains or nausea without a physiological basis.

Frequent rocking, sucking and biting.

Sleeping difficulties.

Reluctance to participate in physical or recreational activities.

Regressive behaviour, such as bed-wetting or speech loss.

Sudden accumulation of money or gifts.

Truancy or running away from home.

Delinquent or aggressive behaviour.

Depression.

Self-injurious behaviour, including drug / alcohol abuse, prostitution, self-mutilation, attempted suicide.

Sudden decline in academic performance, poor memory and concentration.

Wearing of provocative clothing or layers of clothes to hide injuries.

Promiscuity.

Neglect

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, emotional harm or a health impairment, it should be considered as abuse.

Physical Indicators

Consistently dirty and unwashed.

Consistently inappropriately dressed for weather conditions.

Consistently without adequate supervision and at risk of injury or harm.

Consistently hungry, tired and listless, falling asleep in class.

Unattended health problems and lack of routine medical care.

Inadequate shelter, and unsafe or unsanitary conditions.

Abandonment by parents.

Failure to thrive.

Behavioural Indicators

Begging or stealing food.

Gorging when food is available.

Inability to eat when extremely hungry.

Alienated from peers, withdrawn, listless, pale, thin.

Aggressive behaviour.

Delinquent acts: vandalism, drug and alcohol abuse.

Little positive interaction with parent/caregiver.

Appearing miserable or irritable.

Poor social skills.

Poor evidence of bonding, little stranger anxiety.

Indiscriminate with affection.

Poor or irregular school attendance.

Staying at school long hours.

Self-destructive.

Dropping out of school.

Taking on adult role of caring for parent.

Emotional Harm

Psychological or emotional abuse may occur with or without other forms of abuse. If a young person 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 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

Speech disorders.

Delays in physical development.

Failure to thrive (without an organic cause).

Behavioural Indicators

Overly compliant, passive and undemanding behaviour.

Extremely demanding, aggressive, attention-seeking behaviour.

Anti-social, destructive behaviour.

Low tolerance of frustration.

Poor self-image.

Unexplained mood swings.

Behaviours that are not age-appropriate, for example, overly adult (parenting other children, or overly infantile (thumb sucking, rocking, wetting or soiling).

Mental or emotional development lags.

Fear of failure, overly high standards, excessive neatness and cleanliness.

Depression, suicidal.

Running away.

Violent drawings or warnings.

Contact with other children forbidden.

4.2 Victorian Risk Framework

The Victorian Risk Framework (VRF) provides a consistent and standardised model for the assessment of significant harm to children, and guides Child Protection workers in the key activities of information gathering, analysis and judgment. The VRF includes Specialist Assessment Guides such as *Assessing Parents who Substance Abuse.*

Risk Factors Warning List

Research and experience has found that combinations of the following factors are commonly associated with heightened risk to children or young people. Any one factor, however, is only meaningful for a particular family when its occurrence can be demonstrated as affecting the safety of the child or young person. The purpose of the Risk Factor Warning List within the VRF is to signal a warning to the worker, and any identified risk factor must be explained within the worker's subsequent Risk Analysis. The following Risk Factors Warning List demonstrates the complexity and thoroughness that is applied to making decisions about the safety and wellbeing of children.

	Risk Factors
Child and Young Person	**Child** under 2 years **Evidence** of physical abuse/shaking **Born** drug dependent **Difficulty** feeding, sleeping, cries a lot **Currently** underweight **Premature** **Chronically** ill child **Developmental** or other disability **History** of multiple separation/placements **No** stable day program **No** effective guardian/homeless **Mental** health issue **Recent** significant behaviour change **Violent** behaviour **Offending** **Sexual** offending **Unsafe** or age-inappropriate sexual activity, including prostitution **Substance** abuse problems **History** of self harm/suicide (talk or attempt)
Opportunity for Harm	**Alleged** perpetrator has access to child **Imminent** exposure to harm **No** protective adult present **Young** person not self-protecting **Pattern and History** **Any** prior Child Protection notifications **Escalating** concern or contact with Child Protection **Other** child removed, or died in parent(s)' care **Carer(s)** have physically abused any child (past/present) **Carer(s)** have a history of sexual assault of children **Carer(s)** have any history of violence
Beliefs and Relationships	**High** criticism/low warmth family **Carer(s)** have poor understanding of needs of infant/child **Carer(s)** use excessive or inappropriate discipline **Carer(s)** describe or act toward child predominantly negatively **Carer(s)** failed to cooperate satisfactorily **Carer** views concerns less seriously than Child Protection **Young Person** views concerns less seriously than Child Protection
Parenting Factors	**Carer** under 20 at birth of first child **Carer** under 20 now **Carer(s)** abused as child(ren) **Carers(s)** have intellectual disability **Carer** not biological parent **Carer(s)** have current alcohol/drugs use **Carer(s)** have history of alcohol/drugs use **Carer(s)** have history of sexual assault of adults **Carer(s)** have current mental health issues **Carer(s)** have history of mental health issues **Carer(s)** have self esteem issues, depression **Carer(s)** is/has been victim of domestic violence **Carer** is/has been perpetrator of domestic violence **Carer(s)** have poor health **Carer(s)** transient/homeless **Current** financial difficulties
Isolation or Supports	**Family** is socially isolated **Young Person** is socially isolated **Family** is severely fragmented **Family** is chaotic **Family** have not engaged with offered services in past **Young Person** has not engaged with offered services in past

Child Protection – Contact Details

If you are making a notification to a regional Child Protection service, please use the Intake Unit numbers.

For all other enquiries please contact the appropriate regional office.

Metropolitan Regions

Eastern

Intake Unit	1300 360 391
Box Hill	(03) 9843 6000

Northern

Intake Unit	(03) 9471 1644
Fitzroy	(03) 412 5333
Glenroy	(03) 9304 0799
Preston	(03) 9479 6222

Southern

Intake Unit	1300 655 795
Cheltenham	(03) 9581 2222
Dandenong	(03) 9213 2111
Frankston	(03) 9784 3100

Western

Intake Unit	1300 369 536
Footscray	(03) 9275 7000

Rural Regions

Gippsland

Intake Unit	1800 020 202
Bairnsdale	(03) 5152 6244 or (03) 5150 4500
Leongatha	(03) 5662 4311
Morwell	(03) 5128 9400
Sale	(03) 5144 4166
Warragul	(03) 5624 0600

Grampians

Intake Unit	1800 000 551
Ballarat	(03) 5333 6669
Horsham	(03) 5381 9777
Stawell	(03) 5358 4374

Hume

Intake Unit	1800 000 227
Benalla	(03) 5761 1222
Seymour	(03) 5793 6400
Shepparton	(03) 5832 1500
Wangaratta	(03) 5722 0555
Wodonga	(03) 6055 7777

Loddon Mallee

Intake Unit	1800 675 598
Bendigo	(03) 5430 2333
Mildura	(03) 5022 3111
Swan hill	(03) 5032 0100

Barwon South-West

Intake Unit	1800 075 599
Geelong	(03) 5226 4540
Portland	(03) 5523 1600
Warrnambool	(03) 5561 9444

24-hour Central After Hours Child Protection Service – 13 12 78

State Government Victoria
Department of Human Services