



Youth Firesetting Support Guide

A resource for parents and practitioners concerned about fire risk behaviour in a child or young person.





YOUTH FIRESETTING SUPPORT GUIDE: NAVIGATION AND INFORMATION

Description of this tool and other services

Caregiver Information

Understanding fire risk behaviour

As a caregiver, what can I do?

The young person is a client of DHS (Youth Justice, Child Protection and/or Disability Services)

More information about DHS

Are you involved or seeking services (not DHS)

Are you concerned about other problems (not fire risk behaviours, e.g. behaviour problems) and seeking assistance or information?

Child & Youth Public Mental Health

Youth, parent and family other support services

Helplines

Other services

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DESCRIPTION OF THE TOOL

WHAT IS THIS TOOL?

This tool will provide you with information about:

- ▶ fire risk behaviours
- ▶ services that can help
- ▶ fire-related charges
- ▶ consequences of burns.

Who is it for?

This resource is for practitioners and caregivers who are concerned about a young person's fire risk behaviour.

How can it help?

You are here because you are concerned about your child's fire risk behaviours or you are a practitioner who is working with a family that is concerned about this problem. This tool may help you understand fire risk behaviours and direct you to services that can help.

Services for families can be difficult to understand. For some services, certain criteria are required to gain entry to that service. If you do read information about a service, please ensure that you also read the eligibility criteria provided in each section.

This document contains a large number of highlighted links. After following a link, you can return to the previous location by pressing Alt-Left Arrow.





FIRESETTING IN THE COMMUNITY



IF YOU LIVE IN A BUSHFIRE PRONE AREA, PLEASE READ THIS INFORMATION

About 50% of Bushfires are believed to be deliberately or recklessly lit.

Bushfire arson has a devastating impact on the community. If you suspect that a fire has been deliberately lit, please click [here](#) for information. You can also call crime stoppers on 1800 333 000. Your report will remain confidential.



CAREGIVER INFORMATION



INFORMATION FOR PARENTS, GUARDIANS AND CARERS

You are here because you are concerned about a child's fire risk behaviour. If you are involved with a service (such as DHS or child youth public mental health service) then discuss this issue with your case worker or **allied health professional**.

If you are concerned about the child's wellbeing please refer to the information on **Child FIRST** and contact **Child FIRST Intake**.

Is your child showing an interest in fire?

Many people have an interest in fire and they do not intend to harm or cause damage. Misuse of fire can be very dangerous and any fire can easily get out of control. If this happens, young children are not likely to have the skills to put it out.



UNDERSTANDING FIRE RISK BEHAVIOUR

It is common for young people to be interested in fire, and if left unchecked, this can progress to fire risk behaviour.

Fire interest

Very young children will be interested in the colour and movement of the flame. They often show interest by asking a lot of questions about fire and expressing fire themes in play (pretending to be a firefighter).

Strong interest in fire may lead to fireplay or firesetting.

It is important to take notice of your child's interest in fire and the Juvenile Fire Awareness and Intervention Program (JFAIP) may be able to assist. Call JFAIP on 1300 309 988.

Fireplay

Fireplay can include experimenting with fire to see what fire can do. The child often finds ignition sources (matches and lighters) in the home and they may light available materials (eg. papers and twigs).

Firesetting

Firesetting is when a child misuses fire repeatedly. Some behaviour can include searching for materials, deliberately damaging or destroying property and using flammable materials to make the fire bigger.

If your child is firesetting you may need to call an allied health professional or your case worker.

What are the signs of fire risk behaviour?

Some of the signs that a young person is misusing fire are:

- ▶ Matches and lighters are disappearing
- ▶ Matches and lighters are found in the child's belongings
- ▶ You discover burnt matches or paper
- ▶ There are burn marks on toys, carpet or household items
- ▶ The child is showing a lot of interest in fire (asking a lot of questions).



Why do young people set fires?

Young people often cannot give you a reason for their misuse of fire; they may deny or blame someone else.

Common reasons young people provide for misusing fire are:

- ▶ Boredom
- ▶ To see what would happen (curious) or
- ▶ For fun/amusement.

More serious reasons for childrens' misuse of fire that may not be as obvious:

- ▶ To get attention
- ▶ Peer pressure
- ▶ Because they are angry or frustrated and find it difficult to communicate this
- ▶ To get power over a situation (eg. revenge).

If you suspect more serious reasons for a young person's firesetting you may need to contact an [allied health professional](#) or your case worker.

Young people may continue to light fires repeatedly because:

- ▶ They have not been caught for a long time and therefore they continue to do this
- ▶ There has not been any consequences
- ▶ They get something out of it (rewarded by attention from peers or family)
- ▶ They have easy access to matches and lighters and are not being supervised — **these are two things that caregivers can control.**



When firesetting may be a deeper problem

Some signs that your child or teenagers' firesetting is a problem are:

- ▶ Lighting fires or a strong interest in fire at a very early age (eg. 2 or 3 years old)
- ▶ Teenager firesetting can indicate emotional or psychological issues
- ▶ Setting fires to many and a variety of objects (eg. lighting papers and toys and twigs and bedding),
- ▶ Setting fires in many different places (eg. lighting fires in the home, the backyard, the park and the school) or
- ▶ Setting fires to harm self or another (eg. setting clothes alight while wearing them or trying to hurt someone).

This kind of misuse of fire can indicate a deeper problem that you may need to discuss with an allied health professional.

AS A CAREGIVER, WHAT CAN I DO?

Caregivers have an important role in guiding their child towards fire safety and a **JFAIP** practitioner may be able to assist. Being concerned and teaching your child to be safe with fire is just as important as teaching your child to cross the road safely.

What to do if you see signs of fire risk behaviour:

- ▶ Pay attention
- ▶ Do not assume it is just curiosity and something your child will grow out of
- ▶ Do not ignore it and try not to over react
- ▶ Talk to your child about fire safety and the risks of their behaviour
- ▶ Seek help.

One of the reasons children continue to light fires is because they do not think there will be any consequences. It may be useful to talk to an allied health professional about ways to create fire safety rules, ways to reward fire safe behaviour, appropriate consequences and what to do if these rules are broken in the family home.

Fire safe Behaviour – how to keep your family fire safe

- ▶ **Lock away ignition sources.** Locking away matches and lighters is just as important as locking away medicines, cleaning fluid and other dangerous household products.
- ▶ **Lead by example.** Positive role modelling is the most effective method of developing fire safe behaviour (this includes the way you use fire and the concern you place on fire safety in the home).
- ▶ **Ensure that children are supervised at all times around fire and heating appliances.**
- ▶ **Explain why fire is a tool – not a toy.** Fire is used for cooking and heating. Fires can quickly get out of control and they can kill.
- ▶ **Build knowledge about fire and fire safety** and teach personal safety strategies through **JFAIP**.
- ▶ **The family takes responsibility for fire safe behaviour** (e.g. child shows the caregiver that the matches were left out). The caregiver puts them away and rewards the child for safe fire behaviour.

- ▶ **Explain consequences of unsafe fire use** (fire is dangerous and it can kill; **consequences of burns**, and **legal consequences**).
- ▶ **Create and maintain rules about fire** (and having consequences if these rules are broken).

Fire competence

Fire safe behaviour needs to be actively taught by an adult. Without guidance, children are at risk of not learning a safe, responsible attitude towards fire which leads to fire competence.



Your next steps

1. Lead by example and maintain a fire safe environment

- ▶ have working smoke alarms installed in your home
- ▶ prepare and practice a home escape plan
- ▶ limit access to ignition sources by locking them away in a secure place
- ▶ store flammable liquids and combustible materials properly
- ▶ increase supervision
- ▶ recognise fire hazards (e.g. faulty appliances).

2. Contact your local Fire Service

The fire service can provide advice and assistance regarding young people's fire risk behaviour, specialised fire service education programs (e.g. **JFAIP**) and fire safety.

3. Contact an allied health professional

A health care professional can assist if you have any concerns with emotional or psychological issues and can also assist in the development of fire safety family rules and consequences if these rules are broken.

What is an allied health professional? An allied health professional is a person who is qualified to work with families and young people. This term is used to describe professionals who can have a background in social work, youth work, psychology, psychiatry, medicine or nursing. These professionals work with various services that can include: **Child and youth public mental health and other services.**



INFORMATION FOR ALLIED HEALTH WORKERS

HOW TO SUPPORT PARENTS/CARERS OF YOUTH WHO MISUSE FIRE



There are four sections in this information brochure. Please talk to the caregiver about:

- ▶ The **caregiver information** and check for their understanding
- ▶ The facts and statistics about firesetting
- ▶ How families can be assisted and supported
- ▶ Coping with re-occurrences.

[Click here for additional information on youth firesetting](#)



STEP ONE: PLEASE READ THROUGH CAREGIVER INFORMATION

Check for their understanding of:

1. The difference between fire interest, fire safe behaviour and fire risk behaviour?

Check the caregivers' understanding of the differences between fire interest, fire safe behaviour and fire risk behaviour. Explain to the caregiver that if left unchecked fire risk behaviour can progress to fireplay and firesetting.

Sample questions to ask the parent/carer:

- ▶ Why do you think your child is engaging in fire risk behaviours?
- ▶ Can you recall a progression from fire interest to engaging in fire risk behaviours?

2. The signs of fire risk behaviour

Refer to the “**caregiver information**” regarding “signs of fire risk behaviour”.

Sample questions to ask the parent/carer:

- ▶ Have you seen any signs of fire risk behaviour? If so, what signs have you observed?

3. Why young people set fires, continue to light fires and when firesetting is a deeper problem?

Refer to the “**caregiver information**” regarding “Why young people set fires, why do they continue to light fires and when firesetting is a deeper problem”.

Sample question to ask the parent/carer:

- ▶ Why do you have concerns?
- ▶ What have you tried in the past to stop the fire risk behaviour?
- ▶ What do you think the young person is getting out of the fire risk behaviour?
- ▶ Do you understand how fire risk behaviours are learnt?



STEP TWO: TALK TO THE CAREGIVER ABOUT SOME FACTS AND STATISTICS ABOUT YOUTH FIRESETTING

Prevalence

Studies have found that fire interest is very common in young people. These studies have found that roughly 40–50% of children have played with fire at some stage.

Victoria Police data has indicated that approximately 40% of fires (that they become aware of) are lit by young people under 18 years.

The reported number of fires set by young people may not be accurate as fire risk behaviours are often done in private and can go undetected for some time.

Risk Factors – General information for Professionals

Please outline with the caregiver some of the research findings related to risk factors associated with youth firesetting.

Demographic

Generally a low socio economic family

Gender

It is more common that boys misuse fire, with most studies reporting a 9:1 (boys to girls) ratio.

Age

The most common age for misuse of fire is 9–10 years old, although fireplay has been reported as early as 2–3 in some studies.

Individual factors – psychological/behavioural factors, fire specific factors and family factors.

Psychological/behavioural factors

- ▶ Diagnosed mental health issues (firesetting is closely associated with Conduct Disorder – can be as high as 60% – and secretive antisocial behaviour)
- ▶ Behavioural problems (aggressive behaviours)
- ▶ Academic difficulties
- ▶ Social problems (is bullied or bullying others)
- ▶ Experiencing a stressful event as a trigger to the fire-setting (e.g. death or divorce).

Fire specific factors

- ▶ Intense curiosity or strong interest in fire
- ▶ Role models that misuse fire such as caregivers or older siblings.

Family factors

- ▶ Parents may have mental health issues, substance abuse problems or criminal issues
- ▶ Family problems
- ▶ Parenting issues (experiencing problems in managing the young person's behaviour).



STEP THREE: ASSISTING AND SUPPORTING FAMILIES WHO LIVE WITH A YOUNG PERSON WITH FIRE RISK BEHAVIOUR.

It is important to reassure the caregiver and motivate them to keep the young person safe. You as a practitioner can support the caregiver by guiding them through the 9 steps to family safety.

Recommend the caregiver calls **JFAIP** for assistance.

Explain to caregiver that fire risk behaviours are learned

The family home is an important setting for learning fire safe behaviours.

Caregivers can keep the young person safe by:

- ▶ Creating a safe home environment (particularly around securing access to ignition sources e.g. matches and lighters)
- ▶ Creating rules around fire (and having consequences if the rules are broken)



- ▶ Providing good supervision
- ▶ Being a good role model for safe use of fire
- ▶ Understanding the child's triggers to the fire risk behaviour.

What can caregivers do if they start to see the signs of fire risk behaviour?

Explain to caregivers that if they notice that their child is misusing fire:

- ▶ Pay attention to this
- ▶ Talk to your child
- ▶ And seek help.

Nine tips for keeping your family safe (check the caregivers understanding of each)

1. Storage of lighters, matches and flammables

Studies have found that young people mostly use matches and lighters found in the home to light fires. Explain to caregivers that one of the best things to do to stop fire risk behaviour is locking away ignition sources such as matches and lighters in a secure place. Just as important as locking away medicines and cleaning fluids, flammable liquids and combustible materials must be stored properly.

If young people cannot find matches and lighters immediately they will have to search for them. The act of searching may serve to stop this initial impulse to light a fire (they may get bored and find something else to do). It is important to emphasise to caregivers that they can secure ignition sources by:

- ▶ Having only one lighter or box of matches
- ▶ Knowing where the matches and lighters are at all times – keep them on you or lock them away
- ▶ Locking flammable liquids away so that children have no access to them

Sample questions to ask:

- ▶ Where do you think your child obtained the ignition sources?
- ▶ How do you secure matches, lighters and flammable liquids in your home?
- ▶ What will you change to ensure safe storage of matches, lighters and flammable liquids?

2. *Providing good supervision*

Young people frequently misuse fire when they are unsupervised, bored and have nothing to do. Good supervision and having planned activities for young people may stop any fire risk behaviour. Along with securing ignition sources, good supervision is the best and most realistic step towards stopping a young person's fire risk behaviour. It is important to monitor their play and enquire about supervision in other young people's homes. As watching and monitoring a young person can be difficult, having a fire safe home and limiting opportunity to ignition sources can reduce fire risk behaviour especially during sleeping times.

Help the caregiver identify the links between the:

- ▶ absence of supervision,
- ▶ absence of planned activities,
- ▶ presence of peers who engage in antisocial behaviour and fire involvement.

3. *Positive role modelling*

Young people learn fire safe behaviour from their parents, carers, family, friends, television and media. You can model safe behaviours by:

- ▶ How you use fire
- ▶ The importance you place on fire safety e.g. having working smoke alarms, preparing a home escape plan, recognising and fixing fire hazards immediately
- ▶ By being consistent in delivering a fire safe message (i.e. have clear rules about fire and follow through with the consequences if your child breaks these rules)
- ▶ Monitoring TV or internet use.

Inappropriate guidance for fire risk behaviour:

- ▶ Rewarding them for fire risk behaviour e.g. giving them a lot of attention
- ▶ Modelling fire risk behaviour (e.g. adults who flick lighters or do fire tricks)
- ▶ Teaching your child that fires are calming and soothing in times of stress.



Sample questions to ask:

- ▶ Do you think role modeling is a factor to your child's misuse of fire?
- ▶ Can you think of an example of how your behaviour impacts on your child?
- ▶ If you were to use fire inappropriately, what message would that send?

4. Explain why fire is a tool not a toy

Explain to the caregiver that being concerned and teaching their child to be safe with fire is just as important as teaching them to cross the road safely. This can be used as leverage when working with a family that is experiencing this problem.

In your discussion with caregivers about how fire is a tool you can emphasise that:

- ▶ Keeping your child safe is a priority
- ▶ Fire is used for cooking, heating and some workplace activities
- ▶ We do use fire for celebration but it is under adult supervision

- ▶ Many young people can die or are injured through fire risk behaviour.

5. Building knowledge about fire e.g. knowing the fire triangle, recognising the signs of fire and understanding fire hazards

Contact [JFAIP](#).

6. Building knowledge about fire prevention and preparedness e.g. working smoke alarms, "home escape plan", "Stop, Drop, Cover & Roll", "Crawl down low and go go go", and calling 000.

Contact [JFAIP](#).

7. Consequences of fire (fire is dangerous – it can kill; consequences of burns, and legal consequences).

Explain to the caregiver that it is important that the young person understands the big picture of fire risk behaviour. If a young person starts a fire – it can kill or hurt someone. Some points you may want to address are:

- ▶ Burns survivors have described how frightening this experience is
- ▶ Scars last forever



- ▶ There is physical and emotional trauma (not only experienced by the burns survivor but all family members)
- ▶ There is a financial impact
- ▶ The treatment for a burn can be long and painful
- ▶ There can be **legal consequences and penalties** for young firesetters.

Sample questions to ask:

- ▶ What are some of the consequences of misusing fire?
- ▶ What is most concerning to you?
- ▶ What consequences have you discussed with your child?
- ▶ Do you think your child understands the consequences?

8. Create and maintain rules about fire (and having consequences if these rules are broken)

Creating and maintaining rules

It is important for caregivers that they do not assume that fire risk behaviour is just curiosity or something that the young person will grow out of. Discuss with the

caregiver about how to create and maintain appropriate consequences for fire risk behaviour ensuring that consequences are:

- ▶ Consistent
- ▶ Predictable (planned, so that both the caregiver and the child both know what the consequences will be)
- ▶ Meaningful to the young person
- ▶ Fit the misbehaviour.

Sample questions to ask:

- ▶ What are some of your existing family rules?
- ▶ What works about those rules? What doesn't work?
- ▶ Does your family have rules about the use of matches/lighters?
- ▶ Why is it important?
- ▶ Are the rules different for adults and children?
- ▶ Should your child be permitted to use matches/lighters?

What about smoking?

Availability of ignition sources may be hard to control if family members, or the young person themselves, smoke.

Brainstorm with the caregiver how family members in the home can keep track of their lighter/matches if they smoke. Explain to the caregiver that it's important to have only one lighter and to store this safely.

Have consequences if rules are broken

Research has indicated that one of the reasons young people continue to light fires is because they do not think there will be any consequences.

Help the caregiver make a plan about the rules and consequences for misusing fire. Explain that it is important to:

- ▶ Have firm safety rules
- ▶ Decide on consequences for breaking the rules and rewards for fire safe behaviour
- ▶ Discuss these rules, consequences and rewards with the young person
- ▶ Follow through with the consequences if the young person breaks the established rules.

Sample questions to ask:

- ▶ What are some of the effective consequences you have used in the past?
- ▶ Why is yelling/screaming not effective?
- ▶ Why is hitting not effective? What message does it send?
- ▶ What about doing nothing and ignoring?
- ▶ What kind of consequences might help stop your child from lighting fires?
- ▶ If there was reoccurring of misuse of fire, what consequences would you use?

Managing reactions to risk behaviour

Caregivers may find fire risk behaviour alarming because of the safety risks. This is a normal feeling because fire risk behaviour can be frightening and concerning, however both overreacting and under reacting are not effective. Punishing the young person too harshly, using scare tactics, or dismissing (ignoring) the behaviour can lead to continual fire risk behaviour.

Behavioural contracts can be used and this can outline (1) rewards for being fire safe over nominated periods (i.e. 3 months or 6 months) and (2) consequences for misusing fire again.

9. Understanding the young person's triggers to fire risk behaviour can assist you with managing high risk times

It is important to understand what was happening to the young person before the fire event(s). Discussing with the caregiver the fire event(s) will assist to identify trends in order to develop a behaviour management plan.

Sample questions to ask:

- ▶ Where was the young person?
- ▶ What was the young person doing?
- ▶ Who was the young person with?
- ▶ How was the young person feeling?
- ▶ Where was the caregiver?

STEP FOUR: HOW TO COPE WITH RE-OCCURRENCES OF FIRE RISK BEHAVIOUR?

The young person may continue to light fires, you can help the caregiver prepare by reassuring they should:

- ▶ Revisit your plan that is in place
- ▶ Review your rules in place and the behavioural contract
- ▶ Followed through with the agreed consequences
- ▶ Reflect on your reaction to the re-occurrence. How did you react?
- ▶ Reflect on the reasons for the re-occurrence
- ▶ maintain a fire safe environment
 - ▶ Have working Smoke Alarms installed in your home
 - ▶ Prepare and practise a home escape plan
 - ▶ Limit access to ignition sources by lock away in a secure place
 - ▶ Store away flammable liquids and combustible materials properly
 - ▶ Increase supervision
- ▶ Contact **JFAIP**.

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) has 7 divisions and 8 regions and 3 core divisions that service families. These include: **disability services**, **child youth and families** and **housing and community divisions**.

This tool will provide detailed information on the following DHS services of:

- ▶ **Child Protection**
- ▶ **Youth Justice**
- ▶ **Disability Service.**

You can also go to <http://www.dhs.vic.gov.au/contact-us>

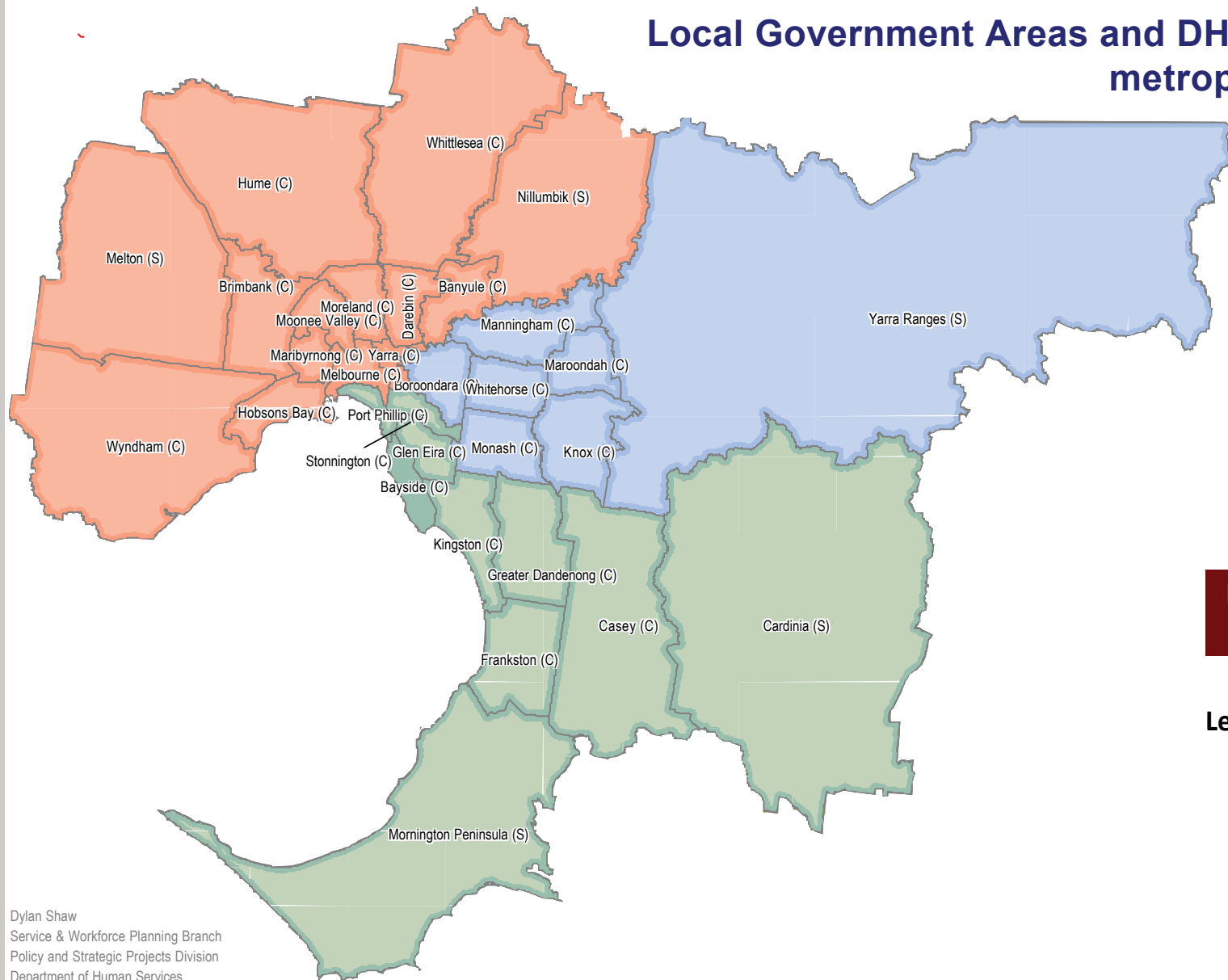
Click here to find **contact numbers for Child Protection**. Please call the central number of **1800 783 783** for Disability Services (or TTY: **1800 08 149** or email: disability.services@dhs.vic.gov.au)

To access Youth Justice services the young person needs to have been **charged with an offence** and have a Youth Justice case worker.





Local Government Areas and DHS Regions, metropolitan area



It is important to call the region in which you live to get services.

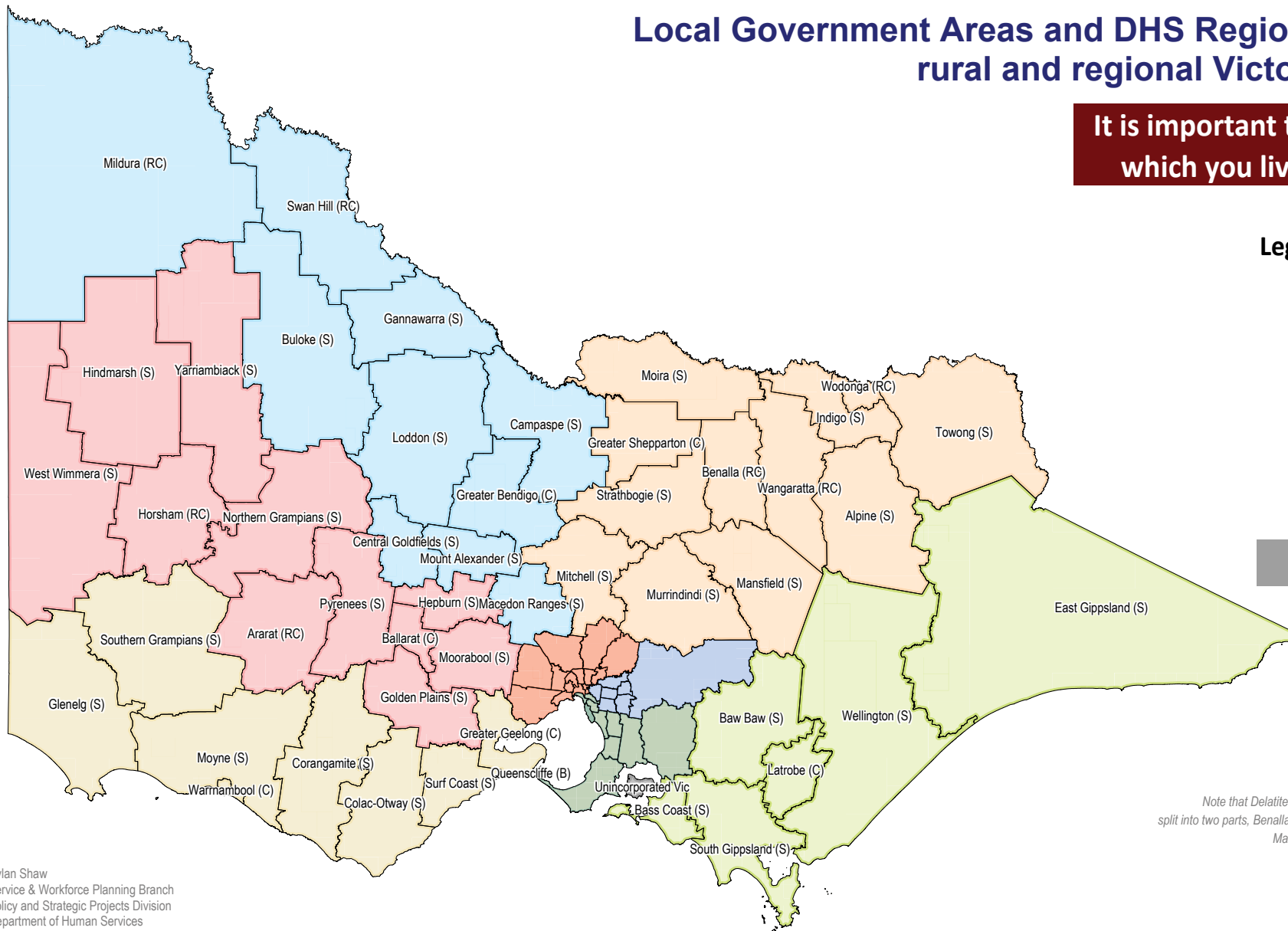
Legend (Hover to view contact details)



Local Government Areas and DHS Regions, rural and regional Victoria

It is important to call the region in which you live to get services.

Legend (Hover to view contact details)



Note that Delatite Shire has split into two parts, Benalla (RC) and Mansfield (S).

Dylan Shaw
Service & Workforce Planning Branch
Policy and Strategic Projects Division
Department of Human Services

March 2004



FIRE-RELATED OFFENCES AND LEGAL CONSEQUENCES

Type of fire-related offence	Act	Penalty
Criminal damage by fire (arson)	Crimes Act Section 197(6)	Maximum of 15-years imprisonment
Attempted criminal damage by fire	Crimes Act Section 321M (Attempts)	Maximum of 10-years imprisonment
Cause false fire alarm to be given	Summary Offences Act 12.1	1 st offence: \$100.00 fine and/or up to 2-months imprisonment. 2 nd offence: 3-months imprisonment.
Criminal damage by fire-endanger life	Crimes Act 197 (A)	Maximum of 25-years imprisonment.
Intentionally and/or recklessly cause a bushfire	Crimes Act 197 Section 201A	Maximum of 15-years imprisonment.
Light a fire during a prohibited period (Within 1.5 kms of a public land or park)	Forest Act 63.2 A	\$50 and/or up to 1-year imprisonment.
Light a fire during a prohibited period (on public land or park)	Forest Act 63.1	\$100 and/or 2-years imprisonment.

Type of fire-related offence	Act	Penalty
Light a fire during a prohibited period with intent (on or within 1.5 kms of public land or park)	Forest Act 66	Not more than 10-years imprisonment.
Light fire in Open Air: During period of fire danger	CFA Act – Section 37	\$50 and/or not more than 12-months imprisonment.
	CFA Act – Section 39 (a, b, c, d)	\$50 and/or not more than 12-months imprisonment.
	CFA Act – Section 39 C	Not less than one year but not more than 20-years
Causing fire in the country area of Victoria in extreme conditions	CFA Act – Section 39 A	Not less than 3-months but not more than 3-years imprisonment.
Prohibition of high risk fire activities	CFA Act – Section 39E	\$50 and/or 12-months imprisonment.
Light fire on total fire ban day	CFA Act – Section 40.4	\$100 and/or up to 2-years imprisonment.
Failure to comply with a direction to extinguish a fire	CFA Act – Sections 48, 1 (a, b) and 2.	\$50 and/or up to 12-months imprisonment.

CONSEQUENCES OF BURNS

The lifelong consequences of a burn injury makes it one of the most devastating injuries a child can sustain. Scar tissue does not stretch like normal skin and children will sometimes require surgery to accommodate growth.

This often means many visits to hospital for surgery and/or therapy to maintain physical function and for scar management. If a child is burnt as an infant, they could face more than 50 operations by adulthood.

Please click to find information regarding what requires [referral to a burns unit](#).

Psychosocial problems

The psychosocial difficulties encountered by patients after a burn injury may include:

- ▶ Problems managing pain, itching and discomfort
- ▶ Problems with post-traumatic stress including anxiety, nightmares, flashbacks
- ▶ Avoidance, emotional numbing
- ▶ Mental health difficulties such as delirium, depression, anxiety
- ▶ Grief and loss issues
- ▶ Functional problems of mobility

- ▶ Social problems
- ▶ Body image issues.

Burns Management

Each year, over 5000 patients present to Emergency Departments throughout Victoria with burn injuries. Approximately 400 of these injuries are transferred to the states' two specialist burns services at the Alfred and Royal Children's Hospital for specialist care. The **Alfred Hospital** has a specialised burns unit that cares for Adults. The **Royal Children's Hospital (RCH)** specialises in burns care for Children.

Other useful websites

www.anzba.org.au

www.vicburns.org.au

YOUTH JUSTICE

Youth Justice is responsible for the statutory supervision of young people in the criminal system. Only the court can impose a sentence requiring a young person to accept supervision by a Youth Justice case worker.

For young people displaying fire-risk behaviours:

Young people entering Youth Justice are assessed to determine their offending risk and related criminogenic needs. Formal supervision and case management are provided and this can also include referral for targeted offence specific intervention. Such intervention can be provided by a range of services including **Adolescent Forensic Health Service (AFHS)** for metropolitan Youth Justice clients, **Malmsbury Health Service** for young men aged 18-20 years in custody, and **Rural Specialist Sessional Services** for Youth Justice clients in rural regions.

Case workers can also refer to the caregiver and professional information included in this resource to assist their client.

Within the Department of Human Services, Youth Justice is responsible for the statutory supervision of young people in the criminal justice system. Youth Justice promotes opportunities for rehabilitation and contributes to the reduction of crime in the community by providing programs and resources to assist young people to develop knowledge, skills and attitudes to manage their lives effectively without re-offending.

The objectives of Youth Justice are to:

- ▶ Where appropriate, support diversion of young people charged with an offence from the criminal justice system
- ▶ Minimise the likelihood of reoffending and further progression into the criminal justice system through supervision that challenges offending behaviours and related attitudes and promotes pro-social behaviours
- ▶ Work with other services to strengthen community-based options for young people enabling an integrated approach to the provision of support for the young person that extends beyond the court order
- ▶ Engender public support and confidence in the Youth Justice service.



Youth Justice Service Contacts and [website](#)

Head Office Youth Services and Youth Justice Branch	Ph: (03) 9096 7507
Head Office Youth Justice Custodial Services Branch	Ph: (03) 9096 8231
Youth Justice Custodial Services are responsible for the operation and management of Youth Justice Centres these include:	
Melbourne Youth Justice Centre	Ph: (03) 9389 4200
Parkville Youth Residential Centre	Ph: (03) 9389 4400
Malmsbury Youth Justice Centre	Ph: (03) 5421 3100

Eligibility

Young people aged between 10-20 years who have offended and who are placed on a court order supervised by Youth Justice.

Who can refer?

Only the courts can impose a sentence requiring a young person to accept the supervision of Youth Justice. Most youth justice clients aged 10-17 years are sentenced through the Children’s Court, but at times appear in the

Supreme Court for very serious offences. Victoria also has a ‘dual track’ system whereby 18-20 year olds can receive a custodial sentence through adult courts to a youth justice centre instead of an adult prison.

Statutory Service

Under statute, the ***Children, Youth and Families Act 2005*** is the principal legislation for the Youth Justice service. This legislation provides the framework for Youth Justice, Child Protection and Family Services in the Department of Human Services, together with the constitution for the Children’s Court of Victoria as a specialist court dealing with matters relating to young people. Other legislation relevant to the statutory operation of Youth Justice includes:

- ▶ Sentencing Act 1991
- ▶ Crimes Act 1958
- ▶ Bail Act 1977
- ▶ Sex Offenders Registration Act 2004
- ▶ Magistrates Court Act 1989
- ▶ Criminal Procedures Act 2009.

If the court finds a young person guilty of an offence, the court imposes a **sentencing order**, which is issued

hierarchically in accordance with the offending behaviour. Refer to the diagram showing the Victorian Children's Court sentencing orders hierarchy under the Children, Youth and Families Act 2005, with lower tariffs depicted in blue not supervised by Youth Justice. Note that entry to Youth Justice and statutory supervision begins at Probation Orders and the use of custody is preserved in legislation as a last resort.

Young people on a statutory order supervised by Youth Justice are assigned a case manager and together develop a Client Service Plan (CSP). The CSP helps the youth work through the order successfully. Ensuring the requirements of the court order are followed is also achieved through regular supervision, case management, assessment of needs, specialised programs for offending behaviour, referral to appropriate support services, and advocacy and support for the youth.

Youth Justice Interventions

Youth Justice aims to appropriately divert young people from entering or progressing further into the criminal justice system and provide better rehabilitation of high risk offenders. Youth justice also supports young offenders in custody by delivering pre-release, transitional and post-release support programs to reduce the young person's risk of re-offending.

If bail is an option:

- ▶ The Children's Court may offer the Intensive Bail Supervision Program that provides support to young people aged 10-18 who are at immediate risk of remand.
- ▶ The adult courts can request that Youth Justice provide Bail Supervision and progress reports for young adults aged 18-20. This is a diversion from a more intensive adult justice outcome.
- ▶ During business hours Police can contact the regional **Youth Justice unit**.
- ▶ After hours, Youth Justice have a Central After Hours and Bail Placement Service (CAHABPS) which provides a single point of contact for police in matters where



police and/or a bail justice are considering remand of a young person outside business hours.

Central After Hours Assessment and Bail Placement Service (CAHABPS)

Monday to Friday 5.00 pm – 3.00 am

Saturday and Sunday 9.30 am – 3.00 am

Office: 1300 139 767

Pager: 132 222 (quote pager number 322 586)

Pre-Sentence Report

At the request of the Court, a sentence can be deferred for up to four months. In this period, Youth Justice will provide a Pre-Sentence Report to the court which may also result in referrals to support services. These reports include information on a young person's circumstances and usually include recommendations regarding sentencing.

Youth Justice Group Conference (YJGC)

The Children's Court can order a Youth Justice Group Conference (YJGC) when considering Probation or a Youth Supervision Order. Based on restorative justice principles, a YJGC brings together the young person and

their family, the victims and the police. This intervention aims to raise the young person's understanding of the impact of their offending.

A community based sentence

The court can impose a community based sentence (Probation, Youth Supervision and Youth Attendance Orders) that requires a young person to be supervised by a Youth Justice Unit.

Custodial sentence

Young people convicted of serious offences can be sentenced to a Youth Justice Centre Order where a youth is detained for a specified time at either:

- ▶ Parkville Youth Residential Centre (10-14 year olds)
- ▶ Melbourne Youth Justice Centre (15-17 year olds)
- ▶ Malmsbury Youth Justice Centre (18-20 year olds)

Staff

The majority of Youth Justice staff are social workers or youth workers.

Partnerships

- ▶ Other programs in the Department of Human Services, including **Child Protection** and **Disability Services**
- ▶ Contracted services, including **Adolescent Forensic Health Service** and **Rural Specialist Sessional Services**
- ▶ **Youth Justice Mental Health Initiative (YJMHI)**
- ▶ Community Health Non-Government Organisations
- ▶ Community Mental Health Services including **Child and Adolescent Mental Health Service**.





Youth Justice Unit Contacts

Youth justice units are a state wide regional service providing supervision to young people on statutory orders residing in the community

EAST DIVISION

- Box Hill PH: 03 9843 6481
- Shepparton PH: 03 5832 1500
- Wangaratta PH: 03 5722 0555
- Wodonga PH: 02 6055 7777
- Seymour PH: 03 5793 6400

NORTH DIVISION

- Preston PH: 03 9479 0379
- Bendigo PH: 03 5434 5555
- Mildura PH: 03 5022 3111

WEST DIVISION

- Footscray PH: 03 9275 7353
- Geelong PH: 03 5221 4466
- Warrnambool PH: 03 5561 9444
- Ballarat PH: 03 5333 6530
- Horsham PH: 03 5381 9777

SOUTH DIVISION

- Dandenong PH: 03 8710 2700
- Frankston PH: 03 9784 3280
- Bairnsdale PH: 03 5150 4500

- Sale PH: 03 5144 9100
- Morwell PH: 03 5136 2400
- Leongatha PH: 03 5662 4311
- HEARING OR SPEECH IMPAIRED**
- National Relay Service PH: 1800 555 660

RURAL SESSIONAL PSYCHOLOGISTS

Youth Justice clients in rural regions are a smaller and more widely dispersed population than Youth Justice clients in metropolitan regions. Hence Youth Justice have adopted an area-based, flexible service purchasing model to address the specialist service access and availability problems faced by rural Youth Justice clients. Under this funding model, rural regions purchase forensic specialist services on a case-by-case, sessional basis from local practitioners, usually psychologists. Reasons for referral to Youth Justice Rural Specialist Sessional Services can include court-ordered special conditions, such as treatment for anger management and specific offences, such as arson.



SENTENCING ORDER HIERARCHY

There are some orders that are not supervised by Youth Justice and supervised by Youth Justice (i.e. Community and Custodial Orders).

Orders for offending behaviour are displayed in a sentencing hierarchy from the lowest to highest. Please refer to [Sentencing Orders Hierarchy](#) and [Children, Youth and Families Act 2005](#).

If the Court finds a young person guilty of an offence, the Court may:

1. Without conviction:
 - ▶ **Dismiss the charge**
 - ▶ Dismiss the charge and order the young person to give an **undertaking**
 - ▶ Order the young person to give an **accountable undertaking**
 - ▶ Place the child on a **good behaviour bond**.
2. With or without conviction:
 - ▶ Impose a **fine**
 - ▶ Place the child on **probation**
 - ▶ Release the child on a **youth supervision order**.

3. Convict the child and:
 - ▶ Make a **youth attendance order**
 - ▶ Order that the child be **detained in a youth residential centre**, or **Youth Justice centre**.

Orders not supervised by Youth Justice (unsupervised orders) and other court disposals

1(a) Dismiss charge [CYFA Act 2005 Section 360]

A Dismiss Charge is issued when the court does not have enough evidence to proceed. This charge does not go on a child's record.

1(b) Undertaking [CYFA Act 2005 Section 363]

An Undertaking is a promise made to the court and the charge(s) is dismissed by the court. This promise agrees that a child/parent/carer will do (or not do) certain things in the best interests (or welfare) of a child. An example of this may be that the young person attends counselling for a specified problem (e.g. an intervention for fire setting). The maximum period for an Undertaking is six months. A Non-accountable Undertaking cannot be breached.

1(c) Accountable Undertaking [CYFA Act 2005 Section 365]

Similar to a Non-accountable Undertaking but an Accountable Undertaking may be breached.

1(d) Good Behaviour Bond [CYFA Act 2005 Section 367]

A Good Behaviour Bond is a charge that is postponed — as a child has promised in writing:

- ▶ To be of good behaviour
- ▶ To abide by any special conditions given by the court.

1(e) Fine [CYFA Act 2005 Section 373]

A fine requires a young person to pay a sum of money in respect of an offence.

ORDERS SUPERVISED BY YOUTH JUSTICE

If a child is issued a supervised order a Youth Justice worker is assigned to monitor and supervise the young person and develop a Client Service Plan to assist the young person complete the order successfully.

Community Orders

1(f) Probation order [CYFA Act 2005 Sections 380-386]

Probation is an order where a child is required to be supervised for a specified period of time. In addition, special conditions may be attached to the child's sentence. In Victoria, Probation Orders are commonly twelve months duration.

1(g) Youth Supervision Order [CYFA Act 2005 Sections 387-395]

A Youth Supervision Order (YSO) is an order for youths aged 10-17 years who require more intensive supervision and who may be required to comply with special conditions imposed by the Court. A YSO cannot exceed eighteen months.

1(h) Youth Attendance Order [CYFA Act 2005 Sections 396-409]

A sentencing order by which a child or young person aged between 15 and 17 is required for a specified period to attend a youth attendance project for a maximum of 10 hours per week (a maximum of three attendances) of which no more than four hours may

be spent in community service activities. A Youth Attendance Order is a direct alternative to a custodial sentence.

Custodial Orders

1(i) Youth Residential Centre Order [CYFA Act 2005 Sections 410-411]

Parkville Youth Residential Centre is for youths aged 10-14 years who have been found guilty of an offence and the Court is satisfied that a community based sentence is not appropriate. This order cannot exceed two years (through the Children's Court) or three years (through the County or Supreme Court).

1(j) Youth Justice Centre Order [CYFA Act 2005 Sections 412-413]

A Youth Justice Centre Order is imposed on youth aged 15-17 years who have been found guilty of an offence and the Court is satisfied that no other sentence is appropriate. A Youth Justice Centre Order cannot exceed three years. Whilst in custody, the youth is allocated a Youth Justice worker to assist the youth through the sentence. There are three youth custodial centres in Victoria:

- ▶ Parkville Youth Residential Centre
- ▶ Melbourne Youth Justice Centre
- ▶ Malmsbury Youth Justice Centre.

Note that Section 32 of the Sentencing Act 1991 legislates that some 18 to 20 year olds can receive a custodial sentence to a youth justice centre instead of an adult prison if the Court believes that the young person has reasonable prospects for rehabilitation, or is particularly impressionable, immature or likely to be subjected to undesirable influences in an adult prison. This is commonly referred to as the 'dual track' system.



THE ADOLESCENT FORENSIC HEALTH SERVICE (AFHS)

The Adolescent Forensic Health Service (AFHS) is a program of the Centre for Adolescent Health, Royal Children's Hospital, Melbourne for young men and women aged 10 – 21 years involved with Youth Justice. Young people must have a Youth Justice case worker and fulfill eligibility criteria to access this service. This service is for metropolitan Melbourne areas only and available for those in custody.

For young people displaying fire-risk behaviours:

There is no standardised protocol for the treatment of youth firesetters. However, AFHS offers individualised treatment that will include: offence analysis (e.g. looking at the offence cycle), cognitive behaviour therapy, problem solving, building skills (i.e. coping skills) and treating underlying mental health issues (i.e., anxiety, depression, Attention Deficit Hyperactivity Disorder - ADHD).

Clinicians can also refer to the caregiver and professional information included in this resource to assist their client.

Adolescent Forensic Health Service Contact Details

900 Park Street, Parkville Victoria 3052

Telephone: 9389 4424

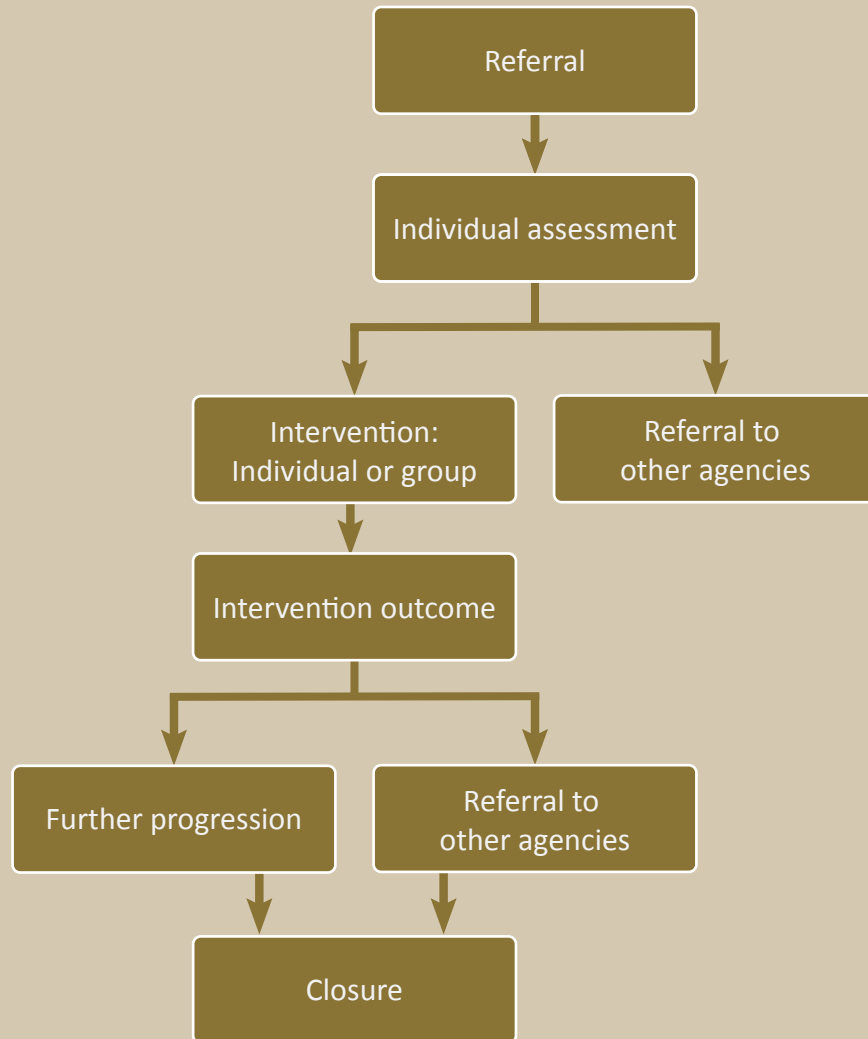
Eligibility

Young men and young women aged 10 – 21 years who are involved with the Youth Justice System can be eligible for AFHS if they assessed as having mental health issues and are at risk of re-offending.

Who can refer?

Referrals of young people to AFHS services are made by Youth Justice case managers.

AFHS referral pathway



The treatment service

AFHS runs programs from two Youth Justice Centres:

- ▶ Parkville Youth Residential Centre (PYRC) which houses young men aged 10-14 years and young women aged 10-21 years and
- ▶ The Melbourne Youth Justice Centre which houses young men aged 15-18 years.

AFHS provides services to young people both in custody and on community-based orders. This can include:

- ▶ Addressing offending behaviour and mental health problems
- ▶ Conducting risk assessments
- ▶ Advocating for Youth Justice clients in the health sector.

AFHS skillfully manages the complex behaviours that youths present with, including antisocial, serious and persistent offenders with mental health problems. They provide the following core programs, including:

- ▶ Male Adolescent Program for Positive Sexuality (MAPPS) which is a program for young people who have been found guilty of sexual offences.

- ▶ Violence Prevention Program which is a program for young people whose offences are of a violent nature
- ▶ Primary health care which includes comprehensive medical and nursing services encompassing alcohol and other drug treatment
- ▶ Mental health care services which are specialised in adolescent forensic assessment and clinical counselling
- ▶ Health promotion and education which provides information sessions, workshops and programs aimed to reduce health related risk-taking behaviours and improve health and wellbeing.

Clinicians are co-located in DHS offices within the metropolitan region however the service is not funded in regional or rural locations.

Staff

The types of professionals that work at AFHS are: adolescent physicians and GPs, mental health and clinical nurses, psychiatrists, psychologists, social workers and drug and alcohol counsellors.

Partnerships

- ▶ **Youth Justice**
- ▶ **Youth Justice Mental Health Initiative**



YOUTH JUSTICE MENTAL HEALTH INITIATIVE

Only Youth Justice case workers can initiate a referral to an YJMHI clinician. The role of the YJMHI is primarily consultation, education and training. There are six statewide YJMHI positions.

For young people displaying fire-risk behaviours:

There is currently no standardised treatment protocol for youth firesetters. This service however will aim to provide consultation around assessment, treatment and offending behaviour for Youth Justice clients.

Youth Justice clients may be eligible for an offence-specific intervention through their Youth Justice case worker.

The Youth Justice Mental Health Initiative (YJMHI) aims to:

- ▶ Improve access for young people involved with the Youth Justice program to ensure an appropriate level of mental health treatment and care
- ▶ Enhance capacity of Youth Justice staff and mental health staff to respond to young people involved with

the Youth Justice program who require mental health services.

The YJMHI forms a key aspect of the vulnerable youth outreach element of the redesigned **child and youth mental health service** system. This YJMHI offers an opportunity to address some of the barriers that young people involved with the Youth Justice program face in receiving appropriate mental health treatment and care.

The YJMHI will also enable service enhancement by building on existing Youth Justice health services in order to provide a more comprehensive and targeted mental health care response to young people involved with the Youth Justice program.

YJMHI clinicians

To achieve the above aims, the YJMHI has established:

- ▶ Four community positions, one in each of Eastern, Southern and North and West Metropolitan Regions (2009-10) and one community position in the Hume Region (2010-11)
- ▶ A coordinator position within Forensicare, which provides a coordinating function for the initiative and

supplements mental health services within Victoria's Youth Justice custodial centres (2010-11)

- ▶ One Aboriginal YJMHI position which enables greater, targeted mental health support to young Aboriginal people involved with the Youth Justice program (2010-11).

Outcomes

The following outcomes are expected from the YJMHI:

- ▶ Earlier identification and intervention in development and episode at all levels of severity of mental health, and in co-occurring mental health and substance misuse problems for young people involved with the Youth Justice program
- ▶ Improved access to appropriate levels of mental health care for young people involved with the Youth Justice program
- ▶ Improved social functioning, educational engagement and life chances for young people involved with the Youth Justice program
- ▶ Improved understanding and responsiveness of youth justice staff to the needs of young people with mental health concerns

- ▶ Improved understanding and responsiveness of mental health staff to the needs of young people with forensic issues.

Key features

The YJMHI provides the following services:

- ▶ Primary and secondary consultation to Youth Justice staff on issues related to mental health
- ▶ Secondary consultation to mental health service staff on needs of young people involved with the Youth Justice program with forensic issues
- ▶ Provision of education and training to mental health and youth justice staff on relevant topics
- ▶ System and network development, including actively seeking the engagement of the mental health service system to facilitate improved access to treatment services for young people involved with the Youth Justice program
- ▶ Establishment and maintenance of effective referral pathways into the mental health service system for young people involved with the Youth Justice program



- ▶ Brief focused treatment or ‘mental health’ case management of a small number of for young people involved with the **Youth Justice** program.

Target group

The target group for the YJMHI is young people involved with the Youth Justice program that have mental health problems or mental illness or are at risk of mental illness and where their behaviour is characterised by high prevalence disorders such as mood and/or anxiety disorders, psychosis, or a history of involvement with area mental health services.

Young people within this target group will require assistance to link in with area mental health services, **Headspace**, a general practitioner or local health services provider, or navigation of the mental health service system including advocacy with mental health services.

Exclusions

The **Adolescent Forensic Health Service** (AFHS) will provide forensic assessment and intervention for young people aged 10-21 years who are involved with the Youth Justice program and are serious and persistent offenders, are mandated by the courts to forensic intervention programs, and have mental health issues directly relating to offending behaviour.

Referral process

Referrals to the YJMHI are initiated by the regional Youth Justice worker as part of the case planning process.

Further information

For further information on the policy and program aspects of the Youth Justice Mental Health Initiative, please contact Usha Mudaliar (usha.mudaliar@health.vic.gov.au) or Tina Gee (tina.gee@dhs.vic.gov.au)

For further information on the operational aspects of the Youth Justice Mental Health Initiative, please contact the Youth Justice Mental Health Clinician at the relevant health service.



Contact details

YJMHI Coordinator Forensicare, Community Forensic Mental Health Service	Ph: 9947 2500
YJMHI Clinician, Eastern Health, Child and Adolescent Mental Health	Ph: 9895 3333
YJMHI Clinician Orygen Health	Ph: 9342 2800
YJMHI Clinician Goulburn Valley Health	Ph: 5832 2322
YJMHI Clinician Southern Health, Early in Life Mental Health Service	Ph: 9594 6666





CHILD PROTECTION

If you are concerned about a child who may be in need of immediate protection, or you think a child is at significant risk of harm – Call Child Protection Intake.

Reports to Child Protection are strictly confidential.

For young people displaying fire-risk behaviours:

Referrals to **Take Two** or **Child and Youth Mental Health Service** may be considered to address youth firesetting.

If the young person is also a client of **Youth Justice**, they may be eligible for an offence-specific intervention.

Case workers can also refer to the caregiver and professional information included in this resource to assist their client.

Child Protection intake numbers

DHS Regions	Telephone
EAST	
Box Hill	1300 360 391
Hume (Wangaratta, Wodonga, Seymour, Shepparton)	1800 650 227
SOUTH	
Dandenong	1300 655 795
Gippsland	1800 020 202
NORTH	
Preston	1300 664 977
Bendigo	1800 675 598
WEST	
Ballarat	1800 000 551
Geelong	1800 075 599

The role of Child Protection

The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them.

The main functions of Child Protection are to:

- ▶ investigate matters where it is alleged that a child is at risk of harm
- ▶ refer children and families to services that assist in providing the ongoing safety and wellbeing of children
- ▶ take matters before the Children's Court if the child's safety cannot be ensured within the family
- ▶ supervise children on legal orders granted by the Children's Court
- ▶ provide and fund accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need.

Child abuse is defined by the **Children, Youth and Family Act (2005)** (Section 162) as the non-accidental misuse of power by adults over children. This can involve an act (or failure to act) which has endangered or impaired (or is likely to endanger or impair), a child's physical or

emotional health and/or development. Abuse can fall into four overlapping categories:

1. physical abuse
2. sexual abuse
3. emotional/psychological abuse
4. neglecting to provide basic medical (or health) treatments that could (or has) significantly effected a child's developmental needs.

Additional definitions of abuse can be found at the [DHS website](#).

Who can make a report?

Any person who believes on reasonable grounds that a child needs protection can make a report to the Child Protection Service Intake Service. Some professionals including doctors, nurses, police and school teachers are legally obliged to report suspected child abuse. Reports to Child Protection are strictly confidential and the identity of the reporter is protected (*Child Youth and Families Act 2005 Section 191*).

Please refer to – A step by step guide to making a report to Child Protection.



The intake process

During the intake phase the Child Protection worker may assess if a child or young person is at significant risk of harm. This is done by obtaining information from any available sources. Where necessary, the matter may proceed to further investigation to assess if a child or young person is at risk of harm. The outcomes of the intake process can be:

1. no further action required
2. referral to **“Child FIRST”**
3. further investigation required.

Treatment

Child Protection provides specialist support services to children and adolescents in need. In accordance with Child Protection best principles and practice, all children under the age of 18 are assigned a case manager and receive a holistic assessment. The best outcomes for the family are paramount. This may include a referral to a specialist clinician or service, such as **Child and Youth Mental Health Service** or **Take Two**. Therapeutic services provided by Take Two are only available to children and young people who are clients of the Child Protection service.

Staff

Child Protection staff include social/welfare workers and psychologists.

Partnerships

Child Protection works with most agencies, including a range of government departments and other community-sector organisations.



CHILD FIRST

Child and Family Information, Referral and Support Teams (Child FIRST) is funded by **DHS** and is delivered by a variety of service providers. The primary concern of Child FIRST is the wellbeing of a child.

If you are concerned about a child's wellbeing, contact **Child FIRST Intake**.

Reports to Child FIRST are strictly confidential

For young people displaying fire-risk behaviour:

- ▶ Depending on a child's circumstances, they might be referred to a specialist clinician or service (i.e. Child and Youth Public Mental Health Service or another community mental health service).
- ▶ Case workers can also refer to the caregiver and professional information included in this resource to assist their client.

[Please click here for additional information.](#)

Making a child wellbeing referral

Any person, community or family service who believes on reasonable grounds that there are significant concerns about a child, can make a referral to Child

FIRST intake service. The referrer's identity remains anonymous, however permission to share the identity of referrer with the family can significantly assist the ongoing engagement with the family by Child FIRST and Family Services. In the majority of referrals, those who voluntarily consent to participate in Child FIRST experience the best outcomes.

The intake process

Intake is an assessment process that will determine risk and the most appropriate agency to provide assistance. To enable Child FIRST to find the best service and outcomes possible for the family several agencies may be consulted. These agencies may include:

- ▶ Child Protection
- ▶ another community-based child and family service
- ▶ service agencies (including other government sectors and services like disability, health, psychiatric, and drug or alcohol)
- ▶ information holders (key professionals such as: police, principals and teachers, doctors and nurses, psychologists, child care, and drug and alcohol counsellors).

The role of Child FIRST

Child FIRST prioritises the needs of the child, family or youth referred to the service. The service is for families who have complex needs/risks that negatively effect the child's development and wellbeing. The function of Child FIRST is to support families in effort to prevent difficulties from escalating to a level that would require entry to **Child Protection**.

Some families are assisted by information and advice only, however for most families a cycle of assessment, planning and action will commence. Child FIRST will engage with the child/young person and family to begin this process. Once a plan is in place for how best to support the child's healthy development and improve parenting capacity, Child FIRST will arrange for a family services agency to support the family. Part of the role of the family services agency is to facilitate connections with other appropriate services (i.e. universal services, drug & alcohol, mental health, housing or family violence services).

Staff

Child FIRST staff include social and welfare workers.

Partnerships

A Child and Family Services Alliance is established in each Child FIRST catchment. The alliance includes partners from:

- ▶ **DHS** Family Services Partnerships
- ▶ **Child Protection**
- ▶ funded family services (including Aboriginal family services).

TAKE TWO

Take Two is a state-wide developmental therapeutic service for children and young people in the Child Protection system. Take Two acknowledges that care alone is not sufficient to help children and young people recover from the trauma of family violence, abuse and neglect.

The service also provides training, research and consultancy and is funded by the Department of Human Services. Please [click here](#) for additional information.

To be eligible for the Take Two service you need to be referred from the DHS child protection service via the Client Relationship Information System (CRIS) system.

For young people displaying fire-risk behaviours:

- ▶ There is no standardised protocol for the treatment of youth firesetters. However, Take Two will undertake an assessment and offers individualised treatment and referral to appropriate services.
- ▶ Clinicians can also refer to both the caregiver and professional information included in this resource to work with clients.

Take Two website	www.berrystreet.org.au
Richmond (Head Office)	1 Salisbury Street Richmond Vic 3121 03 9429 9266 03 9429 5160 e: taketwo@berrystreet.org.au

Eligibility

Children or young people who have been referred by DHS Child Protection and who:

- ▶ have been abused or neglected
- ▶ are exhibiting, or at risk of, developing severe emotional or behavioural disturbance, are eligible for the service.

Treatment service

Take Two works intensively with the distressed child or young person and their carers, families and teachers to help make sense of their painful experiences and learn to trust others. The service provides a comprehensive assessment, and from this an individualised treatment plan is collaboratively developed with the client.

Staff

Take Two therapeutic services are delivered by a range of clinicians and therapeutic specialists.

Partnerships

Take Two is a partnership of child and family services, mental health, academic and Indigenous services. It is a Berry Street program in partnership with La Trobe University Faculty of Health Science, Mindful Centre for Training and Research in Developmental Health and the Victorian Aboriginal Child Care Agency (VACCA).





DHS DISABILITY

Contact Intake and Response on:

Tel: 1800 783 783

TTY: 1800 008 149

Email: disability.services@dhs.vic.gov.au

To be eligible for disability services the young person needs to have a registered disability as per the *Disability Act 2006*. This is a voluntary service, however if the disability client is charged with an offence, the court may impose a condition (bond of service) that mandates certain treatments.

For young people displaying fire-risk behaviours:

The case worker will work with the family to address behaviours of concern, such as fire-risk behaviours. The case manager may also facilitate a referral to **JFAIP** so that the client receives fire safety education and may also refer to the **Behaviour Support Service (BSS)**.

Case workers can also refer to both the caregiver and professional information included in this resource to work with clients.

If the young person is both a client of Disability and Youth Justice, they may be eligible for an offender-specific intervention. Please contact your Youth Justice case worker.

The Department of Human Services (DHS) provides and funds services for people with a registered disability across the lifespan. The department aims to support people living with a disability to

- ▶ realise their goals and aspirations
- ▶ improve their quality of life
- ▶ enhance their independence, choice and community inclusion.

Eligibility criteria

This service is offered to people with a registered disability (over the lifespan).

Intake service

Intake and Response provides information and advice, assistance with referrals to generic and disability-specific services and short-term support. It is also the initial point of contact for people requiring ongoing disability support.

The referral pathway is through the Disability Client Services **Intake and Response Service** (Tel: 1800 783 783). **Click here** for the nearest DHS office in your region. Referrals can come directly from the child or young person, their family, carers, direct support staff and service providers.



What will the department's Disability Intake and Response service need to know?

They will ask you a range of questions to determine eligibility, as well as more general questions about your circumstances and why you are requesting disability supports now. They will also ask you about any supports you may already be using, including funded and informal supports, such as help from family members.

If your needs can be better met by a community service, they will provide you with contact information for the service. If you need specialist disability support, they will explain the next steps to you, which may include assessment and a referral to a planner or case manager who will work with you to explore a range of ways your needs can be met.

Disability client services

Disability Client Services provides a range of **support and services** to people with a disability and their families including:

- ▶ needs assessment
- ▶ eligibility assessments
- ▶ service planning
- ▶ individual planning

- ▶ assistance in the home and community
 - ▶ accommodation support
 - ▶ case management
 - ▶ specialist behavioural intervention
 - ▶ outreach services
 - ▶ family and carer support.

Support

People with a disability, their family and carers can request disability support. For information on disability support you can contact your **regional DHS office**.

Specialist Disability Services

Specialist disability supports are available to assist people with a disability who require case management, therapy, or behavior support. Specialist supports are also available for people with a disability who are involved in the criminal justice system.

Office of the Senior Practitioner

The **office of the Senior Practitioner** may also be involved in the clients overall care-plan, if the person with a disability is subject to restrictive interventions or compulsory treatment.

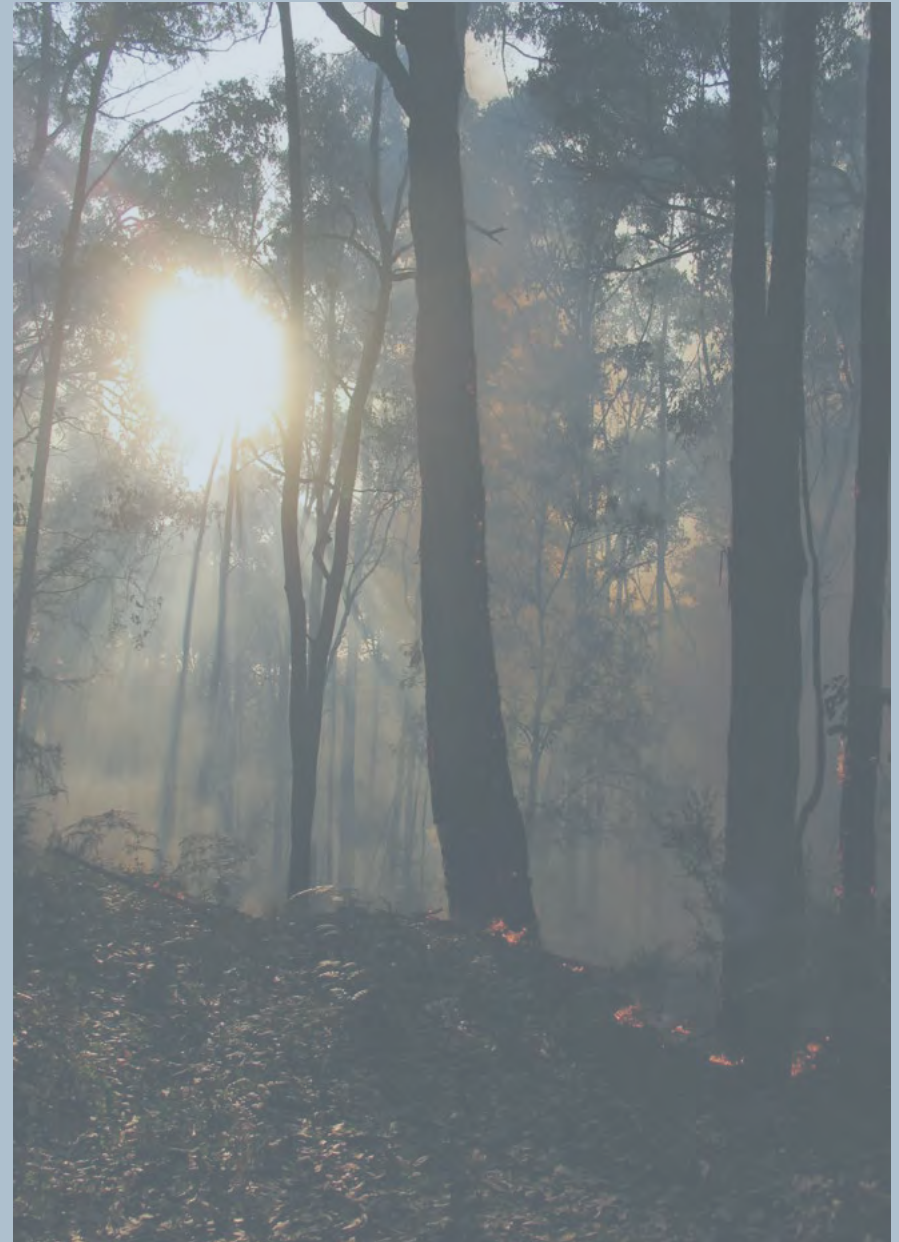


Staff

Disability staff are mostly qualified social workers.

Partnerships

- ▶ Department of Human Services
- ▶ Non-Government Organisations.



OFFICE OF THE SENIOR PRACTITIONER

The Senior Practitioner is responsible for ensuring the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with. The role of the Senior Practitioner is to evaluate and monitor the use of restrictive interventions in disability services, develop guidelines and standards, provide education and information to disability service providers, develop links to professionals and academic institutions to facilitate knowledge and training in clinical practice, and conduct research around the use of restrictive interventions and compulsory treatment.





BEHAVIOUR SUPPORT SERVICES (BSS)

Contact Intake and Response:

Telephone: 1800 783 783

TTY: 1800 008 149

email: disability.services@dhs.vic.gov.au

BSS is an episodic service for young people who have a **registered disability** and are displaying behaviours of concern.

For young people displaying fire-risk behaviours:

BSS does not run a specific fire setters' program but endeavours to maintain a working knowledge in the area and will partner specialist fire setting treatment services where appropriate. However, the service is individualised and can include:

- ▶ Behavioural assessment
- ▶ Positive behaviour support intervention
- ▶ Problem solving
- ▶ Coping skills
- ▶ Referral to the **JFAIP** where relevant

Case workers can also refer to both the caregiver and professional information included in this resource to work with clients.

Eligibility Criteria

Persons with a registered disability according to the **Disability Act 2006** between the ages of 6 years and over are eligible to access the Behaviour Support Service (BSS).

Behaviours of concern

The BSS supports people whose behaviours impact negatively on their quality of life and those who support them. Behaviours of concern are defined as “Any behaviour that is a barrier to a person participating in and contributing to their community (including both active and passive behaviours) that undermines, directly or indirectly, a person’s rights, dignity or quality of life, and poses a risk to the health and safety of a person and those with whom they live or work” Positive Practice Framework: A guide for behaviour support services practitioners, Department of Human Services, 2011). These behaviours may include self-injury, harm to others and behaviours which limit the person’s access to environments and opportunities.



Referral pathway and intake service

The referral pathway is through the Disability Client Services **Intake and Response Service** (Tel: 1800 783 783). [Click here](#) to find your closest regional DHS Office. Referrals can come directly from the child or young person, their family, carers, direct support staff and service providers.

Treatment service

BSS is an episodic service, not an ongoing service. BSS attempts to reduce the negative impact of these behaviours on the individual and others. This includes focusing on the person achieving their person-centred and quality of life goals. Services include:

- ▶ assessment of (or assistance in assessing) the function of a person's behaviour, in consultation with the client, caregivers and relevant others
- ▶ development of (or assistance with developing) support programs which focus on the behavioural and quality of life needs of the person
- ▶ support of the person and relevant others in the implementation phases of the support program

- ▶ provision of consultancy, training or education services to clients, families, support staff and service providers.

BSS services may be to the individual directly, their supports (including family) or to disability support services in a tertiary level. Services vary in their length according to the client's specific needs.

Staff

BSS staff have qualifications in a range of disciplines including psychology, mental retardation nursing, speech pathology, special education teaching, and disability studies.

Existing formal relationships

BSS Clinicians work in partnership with other DHS Disability Services, Child Protection, Youth Justice and Housing Departments (where relevant). Clinicians also work with non-government organisations including case management services, day services, and accommodation services including supported residential services.



REGISTERED DISABILITY

According to the *Disability Act 2006* “disability” in relation to a person means:

- (a) A sensory, physical or neurological impairment or acquired brain injury or any combination which is:
 - (i) likely to be permanent; and
 - (ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and
 - (iii) requires significant ongoing or long term episodic support; and
 - (iv) is not related to aging; or
- (b) an intellectual disability; or
- (c) a developmental delay.

An acquired brain injury is not defined in the Disability Act 2006 but is considered to be any type of brain damage that occurs after birth. It can include damage sustained by infection, disease, lack of oxygen or a blow to the head. Intellectual disability in relation to a person over the age of 5 years, means the concurrent existence of:

- (a) Significant sub-average general intellectual functioning; and
- (b) significant deficits in adaptive behaviour

- (c) each of which became manifest before the age of 18 years.

Developmental delay means a delay in the development of a child under the age of 6 years which is:

- (a) attributable to a mental health or physical impairment or a combination of mental and physical impairments; and
- (b) manifested before the child attains the age of 6 years; and
- (c) results in substantial functional limitations in one or more of the following areas of major life activity –
 - (i) self-care
 - (ii) receptive and expressive language
 - (iii) cognitive development
 - (iv) motor development; and
- (d) Reflects the child’s need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services which are of extended duration and are individually planned and coordinated.



DISABILITY FORENSIC ASSESSMENT & TREATMENT SERVICE (DFATS)

Contact Intake and response:

Telephone: (03) 9280 2761

Clients are eligible for services if they have a registered disability and are in the criminal justice system who are 18 years or older. In some cases, young offenders will be eligible for DFATS.

For young people displaying fire-risk behaviours:

There is no specific protocol for youth firesetter. However, there is an individualised treatment plan and that may include:

- ▶ Cognitive Behavioural Therapy (CBT) and psycho-educational interventions that are provided for Disability Services clients aged under 18
- ▶ additional social/life skills group work is available for young clients aged 18 and over, as required
- ▶ assessment from the Dual Disability Clinic and consultancy services from a Forensicare consultant forensic psychiatrist for young clients aged 18 years or more who may have a co-morbid psychiatric illness.

Clinicians can also refer to both the caregiver and professional information included in this resource to work with clients.

The Disability Forensic Assessment and Treatment Service (DFATS), formerly known as the Statewide Forensic Service, is funded by the **Disability Services Division** and managed by North and West Metropolitan Region.

DFATS is a statewide disability forensic service that delivers time-limited treatment, support and residential services for people with a disability who display high-risk anti-social behavior and are involved (or at risk of being involved) in the criminal justice system.

Eligibility criteria

Clients need to be eligible for services under **Disability Act (2006)** who are 18 years or older. In certain cases, young offenders who have an intellectual disability and are involved in the **Youth Justice** custodial system, and have committed serious crimes may also receive services from DFATS.



Referral pathway and intake services

The referral pathway is through the client's regional Disability Service case manager.

Only disability service case managers can refer a person to DFATS for assessment and service provision. The first step in the referral process is to call the DFATS intake line (on Ph: 9280 2761) to discuss the referral. After this discussion the DFATS worker will indicate whether a referral is needed via Client Relationship Information System (CRIS) or if verbal advice will be provided only. If a referral via CRIS is needed, the Disability Client Service (DCS) worker will ensure all required information is included on the CRIS referral. It is important to note that referrals cannot be made on CRIS without an initial discussion with the DFATS Forensic Services team.

If a Youth Justice worker is interested in initiating a referral to DFATS for a young person (who is not already a client of Disability Client Services) then they need to contact the Disability Client Services' Intake and Response team (on Ph: 1800 783 783) to arrange a service request. This will require the consent of the young person. The young person will then be allocated a Disability Client Service worker who will investigate the DFATS referral.

Treatment services

Depending on the offence, young offenders may be able to be supported with intensive interventions in custody. If the young offender is not in a custodial setting, they can still receive support from DFATS via secondary consultation.

Secondary consultation

DFATS are able to provide advice to disability case workers and Youth Justice staff in relation to a young person with a disability who has engaged in serious offences (e.g. sexual, violent or arson offences). This consultation may be in relation to assessment, program development, intervention strategies and implementation.

Training

DFATS offers clinical training to staff in:

- ▶ relapse prevention
- ▶ working with different offence groups
- ▶ risk assessment.

Assessment

If appropriate, DFATS will undertake a forensic assessment of a young person and provide treatment recommendations based upon functional analysis and interpretation of the offending behaviour.

Community-based programs

The DFATS Program Support Team can provide individual or group therapy and psycho-educational programs.

Staff

DFATS comprises a broad skill mix of multidisciplinary staff including: senior management, case management, consultant psychiatrists, clinical staff, direct support officers, administrative and facility staff.

Formal partnerships

Broader DHS service domains, including

- ▶ Child Protection and Youth Justice
- ▶ Corrections Victoria
- ▶ Forensicare
- ▶ Victoria Police
- ▶ Office of the Public Advocate.





FORENSICARE – COMMUNITY FORENSIC MENTAL HEALTH SERVICE (CFMHS)

Intake and response:

Telephone: (03) 9947 2500

www.forensicare.vic.gov.au

CFMHS works with adults who have a serious mental illness and have offended, or are at high-risk of serious offending.

For young people displaying fire-risk behaviours:

While assessment and treatment services at CFMHS are typically for adults aged 18 years and over, referrals for clients aged under 18 years may be accepted on a case by case basis, primarily through the Problem Behaviour Program. Often Forensicare will work in conjunction with other services who are involved and the treatment. The treatment is offence specific offered on an individual basis by a specialist psychologist with input from psychiatry as necessary. This treatment can include:

- ▶ a specialised risk assessment and/or risk management plan
- ▶ skills building
- ▶ emotional regulation
- ▶ addressing risk and background factors and criminogenic needs
- ▶ cognitive behaviour therapy
- ▶ counselling
- ▶ ongoing support from a consistent therapist.



What do they do?

The Community Forensic Mental Health Service (CFMHS) works primarily with adults who have a serious mental illness and have offended, or are at high risk of serious offending. The service also provides specialist assessment and treatment for people who present with a range of serious problem behaviours. CFMHS comprises a range of programs including the Mental Health Program (MHP), Problem Behaviour Program (PBP) and Court Services. Assessment and treatment services are provided primarily through the MHP and PBP, as outlined below.

Who can refer?

Referrals are taken by the intake worker and can be received from Adult Area Mental Health Services, Community Health Services, private practitioners, Community Corrections, Non-Government Organisations (NGOs) and self-referrals (as appropriate).

Referrals are discussed and prioritised at a weekly intake meeting to determine suitability, and once accepted; referrers are contacted with an appointment date and time.

It should be noted that where a referred client has charges pending that the referral may not be accepted until the court matter is resolved. Similarly, if a referral is made on the basis of seeking a report for the purposes of court, CFMHS does not provide such reports unless requested by the court or Adult Parole Board (APB).

Assessment and treatment services

Mental Health Program

The MHP provides primary, secondary and tertiary consultation for people who have a serious mental illness and have offended, or are at risk of serious offending. Within the MHP, there is also the Community Integration Program (CIP) which assists people with serious mental illness in their transition from prison back into the community, as well as offering a short-term intensive outreach service to Adult Area Mental Health Services in their care of high risk clients. This service is offered following an assessment of the client.

Problem Behaviour Program

The PBP provides psychiatric and psychological consultation and treatment for people with a range of problem behaviours associated with offending, and for whom services are not available elsewhere. These behaviours include fire-setting, stalking, threatening, violence, and problematic sexual behaviour including problematic sexual thoughts.

In general, treatment offered by CFMHS is typically individually based, however group-based intervention is offered for certain issues (e.g. anger management).

Staff

The staff at Forensicare include: forensic specialist psychiatrists, clinical and forensic psychologists, psychiatric nurses, social workers and occupational therapists

Existing formal partnerships

- ▶ broader DHS service domains
- ▶ Corrections Victoria
- ▶ Victoria Police
- ▶ Office of the Public Advocate.



CHILD AND YOUTH PUBLIC MENTAL HEALTH

To access Child and Youth Public Mental Health go to the website <http://health.vic.gov.au/mentalhealth/services/child/index.htm> to find out your local area and then call the intake number provided on the website.

Child and youth public mental health has been commonly called Child and Adolescent Mental Health Services (CAMHS) however; in some areas the service has a different name. This is a free public mental health state-wide service in Victoria.

For young people displaying fire-risk behaviours:

There is no standardised protocol for treating youth firesetters. However, the clinician will undertake a full assessment and develop an individual service plan if the client is eligible for this service.

Clinicians can also refer to both the caregiver and professional information included in this resource to work with clients.

Government-funded clinical services include 21 adult specialist mental health services Adult (MHS), 17 aged persons mental health services, 13 child and adolescent

services (CAMHS), Orygen Youth Health and an increasing number of youth services statewide. As part of ongoing reform and service improvement endeavours, CAMHS and Adult MHS are working together to deliver a new 0-25 response – Child and Youth Mental Health Services (CYMHS), that aims to provide seamless care across this important age range. Two streams – services for children (0-14) and young people (12-25) are being configured.

Not all child and youth public mental health services will be the same and they will frequently offer different services and programs in different areas. People can access different services depending on where they live. Below is the list of service names and locations of community-based clinics:

Who can refer to this service?

Referrals can come directly from the person, their family, carers, direct support staff and service providers

Who is this service for?

Child and youth public mental health provides a range of assessment and treatment options for children and

young people. Mostly, the problems that this service treats are complex (see below) and may involve a team of professionals (see below).

What types of problems?

The types of complex problems may include: behaviour and emotional problems (sadness, anxiety or anger), relationship problems (bullying, problems with friends, and family conflict), abuse or trauma, attention, school refusal, social or play, suicidal ideation, hearing voices or seeing things that no-one else thinks are real, delusions, confused and disorganised, and mood swings.

Intake – what will happen when you contact this service?

Parents/Guardians, schools, paediatricians, GP's, health professionals, young people and community agencies commonly call the service. When you call the intake number of the child and youth public mental health service in your area, the professional who takes your call will assess the needs of the young person. The type of information you will be required to talk about includes:

- ▶ where you live
- ▶ main concerns
- ▶ any current mental health diagnosis

- ▶ previous counselling
 - ▶ medication
 - ▶ your GP or Paediatrician
 - ▶ who is in your family
 - ▶ family history of mental illness
 - ▶ home situation
 - ▶ daily functioning
 - ▶ developmental history
 - ▶ school history
 - ▶ social functioning
 - ▶ involvement with child protection
 - ▶ any history of abuse
 - ▶ drug and alcohol use.

The intake professional will offer consultation and will allocate cases to a case manager who meets the criteria of the service (see who is this service for?). For people who do not meet the criteria the intake professional will support you in accessing the correct service for the child or young person you are calling about.

Treatment services

The young person and family will be appointed a case manager who will be the single point of contact and will coordinate all aspects of the young person's care-plan.

The case manager may also recommend another place that may also be able to help. Your case manager will:

- ▶ get to know the young person and family
- ▶ provide or organise a full mental health assessment to develop the individual service plan. (The assessment may also lead to additional special assessment if required, e.g. cognitive or speech and language assessments)
- ▶ work with you to develop an individual service plan
- ▶ provide an specialised treatment (based on your individual service plan)
- ▶ work towards a discharge plan.

Staff

The types of professionals that work at child and youth public mental health are:

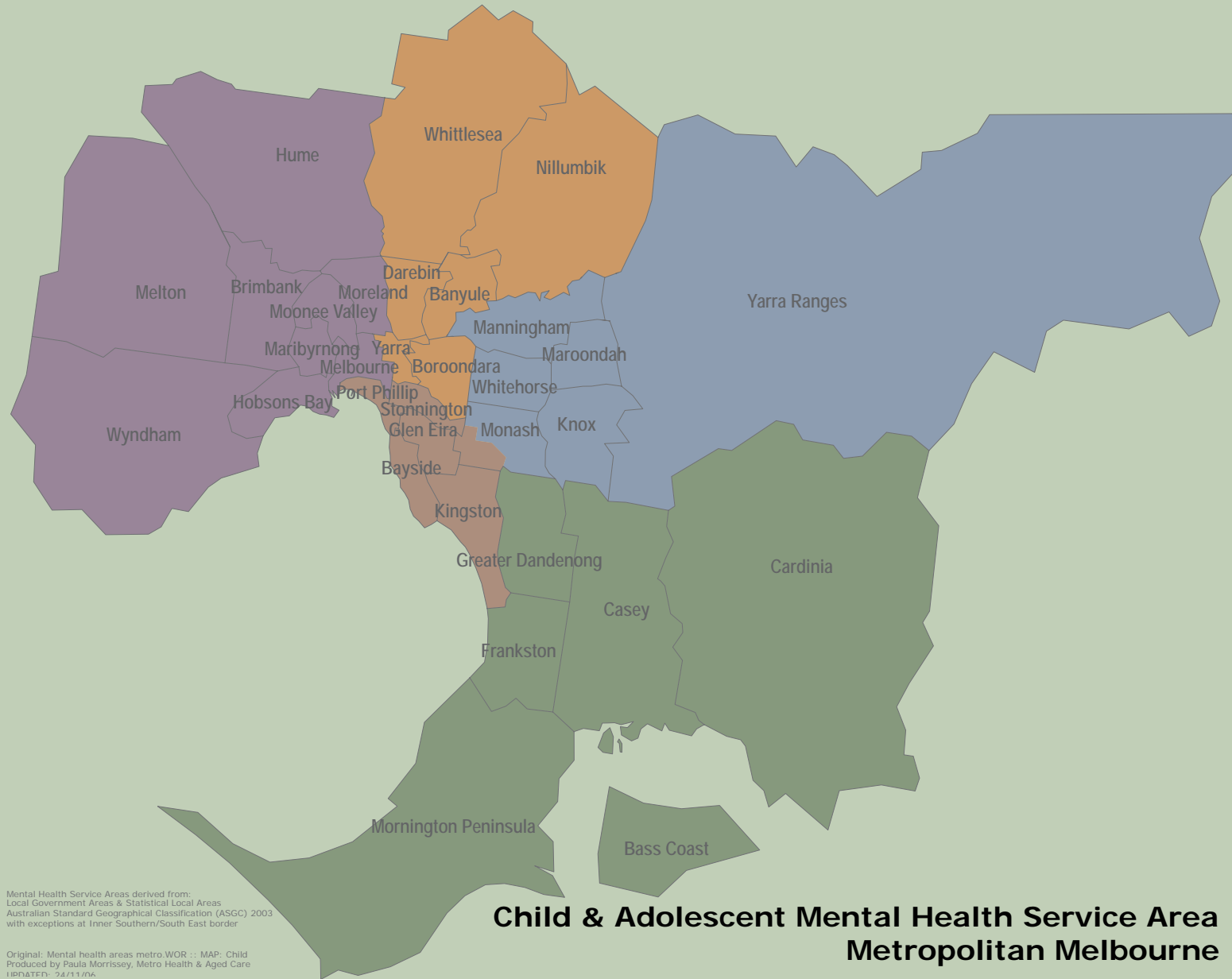
- ▶ mental health nurses
- ▶ occupational therapists
- ▶ psychologists
- ▶ psychiatrists
- ▶ social workers
- ▶ speech pathologists
- ▶ clinicians in training.

Partnerships

CAMHS has partnerships with a variety of agencies both in the government and non-government sector.



CHILD AND YOUTH PUBLIC MENTAL HEALTH



Legend (Hover to view contact details)

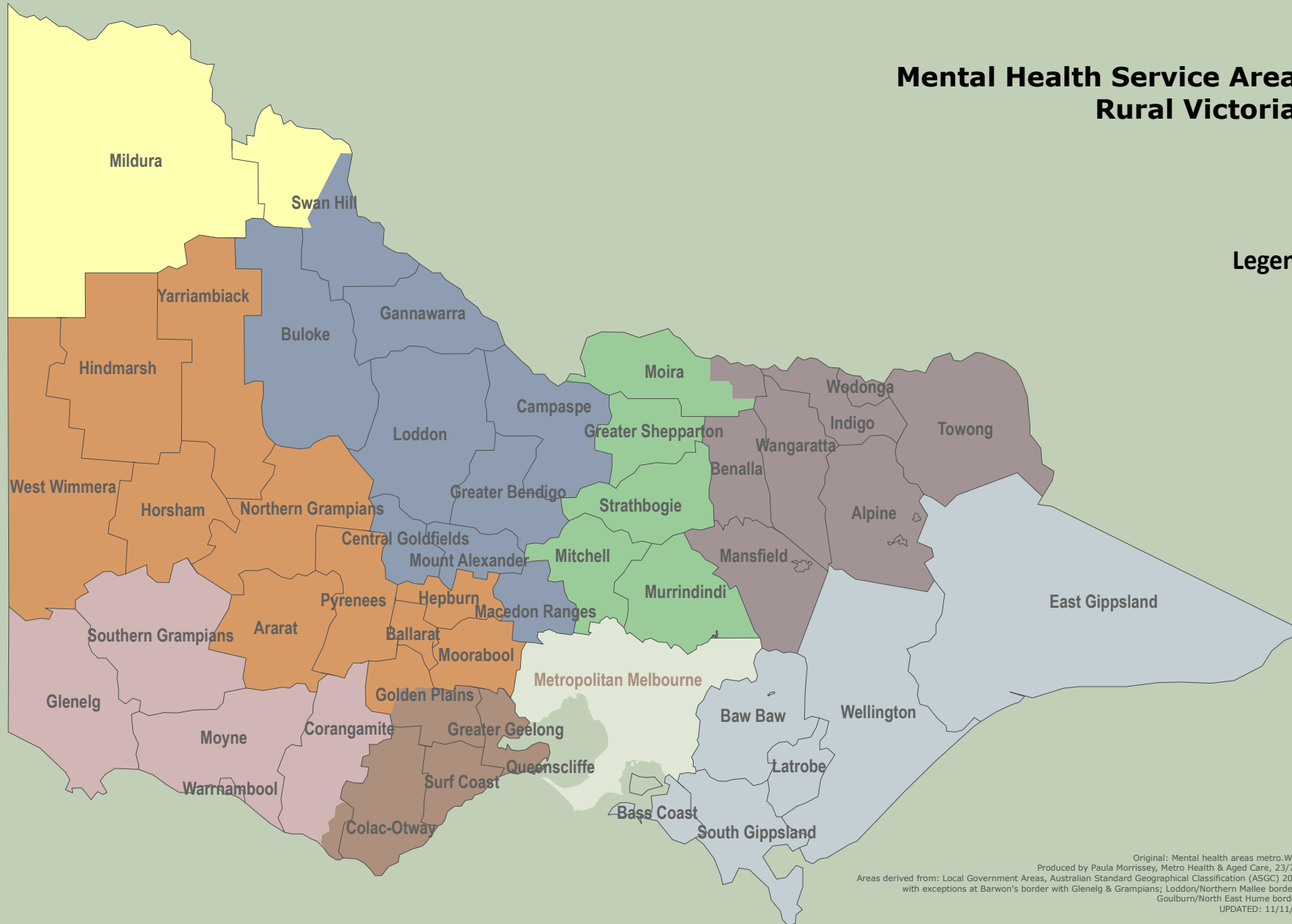
Mental Health Service Areas derived from:
Local Government Areas & Statistical Local Areas
Australian Standard Geographical Classification (ASGC) 2003
with exceptions at Inner Southern/South East border

Original: Mental health areas metro WOR :: MAP: Child
Produced by Paula Morrissey, Metro Health & Aged Care
11/06/2014

Child & Adolescent Mental Health Service Area Metropolitan Melbourne



Mental Health Service Area Rural Victoria



Legend (Hover to view contact details)

Original: Mental health areas metro.WOR
 Produced by Paula Morrissey, Metro Health & Aged Care, 23/7/3
 Areas derived from: Local Government Areas, Australian Standard Geographical Classification (ASGC) 2003
 with exceptions at Barwon's border with Glenelg & Grampians; Loddon/Northern Mallee borders;
 Goulburn/North East Hume borders
 UPDATED: 11/11/05



YOUTH SUPPORT SERVICE (YSS)

YSS is free, confidential and voluntary.

Referrals to the Youth Support Service can only be made by police.

YSS is an early intervention designed to divert young people away from the youth justice system.

For young people displaying fire-risk behaviours:

The YSS uses a systems and strengths-based approach to address the underlying causes of offending and risk taking behaviour. This will include identification of offending and risks and assisting the young person to develop strategies to reduce risks and harms.

Individual support planning is also undertaken, in consultation with the young person, their family and other relevant services. This includes the provision of supported referrals/linkages and case review that are integral features of the YSS model.

Case workers can also refer to both the caregiver and professional information included in this resource to work with clients.

YSS is a client-centred, holistic, developmentally appropriate, family sensitive and culturally inclusive service in Metropolitan Melbourne (North, South, East and West) and regional areas (Geelong, Latrobe Valley, Ballarat, Shepparton, Bendigo and Mildura).

Eligibility Criteria

The Youth Support Service is an early intervention program and targets young people who:

- ▶ are aged from 10 and under 18 years
- ▶ had recent (in last 3 months) contact with Victoria Police
- ▶ are not currently case managed by Youth Justice or Child Protection
- ▶ are not subject to a deferral of sentence or on supervised bail
- ▶ are willing to participate and voluntarily engage with the YSS.



Treatment services

YSS is an early intervention service and has capacity to work with young people for up to six months. Service will include a holistic assessment, development of an individual support plan and support to action the plan.

Staff

At YSAS, a team of 23 youth workers deliver the YSS across metro Melbourne and Latrobe Valley. (Please note this service is also offered in a number of other regional areas by a variety of community service organisations).

Formal partnerships

The YSS has a formal partnership with Victoria police.





JUVENILE FIRE AWARENESS AND INTERVENTION PROGRAM (JFAIP)

Phone: 1300 309 988

Email: jfaipoffice@mfb.vic.gov.au

Website: www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Juvenile-Fire-Awareness/JFAIP-Program-Profile-.html

The Juvenile Fire Awareness and Intervention Program (JFAIP) is a free, confidential program delivered state-wide by specifically trained operational firefighters. The program is jointly delivered by CFA and MFB. The purpose of JFAIP is to assist family and carers by educating children and teenagers (aged 5-17 years old) to reduce the fire risk behaviour and improve fire safe behaviour. Firefighters work one-on-one with the young person and their family at their home (or a convenient location).

For young people displaying fire-risk behaviours:

JFAIP is a fire safety educational program. Best outcomes for young people are when JFAIP is paired with an allied health intervention. [Click here](#) for information to help you understand the young person's fire-risk behaviour.



Eligibility

JFAIP accepts referrals from parents or a third party (with the carer’s permission) such as the Fire Service, DHS, Victoria Police, Children’s Court, Schools and allied health professionals.

Participation in the program is voluntary except where referred by the Children’s Court as a condition of their sentence. The program is about helping the young person, not judging them for any past behaviour.

JFAIP can help modify fire risk behaviour

A young person’s social, emotional and intellectual development may benefit through the intervention provided by the program. Whether the child is displaying fire curiosity, fireplay or firesetting, the approach to dealing with the behaviour may require a combination of fire safety education paired with allied health professionals (for example DHS, psychologist, social workers or family welfare agencies).

The fire safety education component involves a fire-fighter with the support of the young person’s parent/carer working to modify the fire risk behaviours. This is done by raising awareness of fire hazards and

risks, responsible fire safe behaviour and developing a fire safe environment.

The Juvenile Fire Awareness and Intervention Program

JFAIP provides fire safety education including: personal fire safety strategies, understanding the consequences of misusing fire, taking responsibility for fire safe behaviour and that fire is a “tool and not a toy”. The program is tailored towards the age and maturity of the young person and severity and frequency of the fire risk behaviour. A key strength of the JFAIP program is that it is delivered by an operational fire-fighter who can draw on their knowledge, experience and credibility that assists to build rapport with the child and family.





YOUTH, PARENT AND FAMILY OTHER SUPPORT SERVICES

Government websites

Service	Contact	Provider
State Government Mental Health	health.vic.gov.au/mentalhealth/services/child/index.htm	Information on child and adolescent mental health services
Department of Human Services	www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families	Information on programs such as Adoption, Child Protection, Placement & Support, Family Services, Family Violence, Sexual Assault, Youth Justice and Youth Services.
Mental Health Advice Line	health.vic.gov.au/mhal/ Ph: 1300 280 737	Provides one source for expert advice, information and referral on any mental health issue.
Better Health Victoria	www.betterhealth.vic.gov.au	Provides an A-Z guide on physical and mental health.
Youth Government website	www.youth.gov.au	Provides a hub of information for young people and links to important sites.
Child and Youth Health (CYH)	www.cyh.com	Child and youth health website with very user friendly information about many aspects of health including for parents.



Helplines

Service	Contact	Provider
Lifeline	13 11 14	Lifeline is a 24 hour crisis/suicide prevention line
Parentline	13 22 89 8am-midnight, 7 days a week	Provides information, advice, referral and counselling to assist parents. This is an early intervention/prevention line (not crisis support).
Raising Children	raisingchildren.net.au	Parenting resources (newborns to teens)
Kids Helpline	Freecall: 1800 55 1800, website: kidshelp.com.au	Kids Helpline is Australia's only free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25.



Other Services

Service	Contact	Provider
Headspace	www.headspace.org.au	Headspace is the National Youth Mental Health Foundation that helps young people aged 12 to 25 access a range of services. These services include: GPs, psychologists, psychiatrists, counsellors, occupational therapists, youth workers, and education and employment specialists.
Anglicare	www.anglicarevic.org.au	Anglicare offers a number of services in Metropolitan Melbourne and the regional areas of Gippsland and North-East Victoria. Program delivered by the service aim to help strengthen families and communities.
The Salvation Army	salvos.org.au	The Salvation Army provide a wide range of services for people of any age in need. Some of these services include: youth support, assistance in crisis, telephone counselling and professional counselling.
Wesley Care	Web: www.wesley.org.au Phone: 1300 493 753 or 9662 2355	Wesley provides a broad range of community services in Victoria which address disadvantage, whilst advocating on a state and national basis for a just society.
CatholicCare	www.ccam.org.au	CatholicCare provide programs and services for children, youth and families in the broader community. Provides early intervention strategies to kids aged 6-18 years through programs that provide school counselling, school reluctance or school refusal. Some services are free. If fees are charged, it is determined on level of income.



YOUTH, PARENT AND FAMILY OTHER SUPPORT SERVICES

Uniting Care	VICTAS Contact Numbers	Provides a variety of services for children, young people, families, people with disabilities and older people. They also provide a free adolescent program for young people aged 12 to 17 who are at risk of significant harm or a been involved with Child Protection or DHS. Uniting Care provides free home support and case management for complex or parenting issues. [Uniting Care will not see clients if DHS are involved].
Victorian Aboriginal Child Care Agency (VACCA)	Web: vacca.org Email: vacca@vacca.org Ph: 8388 1855	All of these programs seek to promote strong connection to Aboriginal culture, promotion of Aboriginal child rearing; child and family safety; and wellbeing, such as assisting children meet their developmental milestones; and address family issues such as family violence, parental attachment and other issues.
BADAC (Ballarat and District Aboriginal Co-operative Ltd)	badac.ballarat.net.au Ph: 5331 5344	Provides a rural VACCA service (See VACCA)
Lakidjeka ACSASS	Child Protection & VACCA	This program provides an Indigenous perspective on risk and decision making to Child Protection. While all major decisions rest with Child Protection the program advocates that a child/young person's best interests include strong connection to Aboriginal culture, community and family.

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Youth Support Service
Adolescent Forensic Health Service
Metropolitan Fire Brigade
Victoria Police

ACRONYM LIST

AFHS	Adolescent and Forensic Health Service	ELMHS	Early in Life Mental Health Service
ACSASS	Aboriginal Child Specialist Advice and Support Service	Child FIRST	Child Families Information, Referral and Support Teams
BADAC	Ballarat and District Aboriginal Cooperative Ltd	GP	General Practitioner
BSS	Behaviour Support Services	JFAIP	Juvenile Fire Awareness Intervention Service
CAHABPS	Central After Hours Assessment and Bail Placement Service	MHP	Mental Health Program
CAMHS	Child and Adolescent Mental Health Service	MHS	Mental Health Service
CFMHS	Community Forensic Mental Health Service	MFB	Metropolitan Fire Brigade
CFA	Country Fire Authority	MAPPS	Male Adolescent Program for Positive Sexuality
CIP	Community Integration Program	NGO	Non-Government Organisation
CRIS	Client Relationship Information System	OSP	Office of Senior Practitioner
CSP	Client Service Plan	PYRC	Parkville Youth Residential Centre
CYFA	<i>Child Youth and Families Act 2005</i>	PBP	Problem Behaviour Program
CYH	Child and Youth Health	VACCA	Victorian Aboriginal Child Care Agency
CYMHS	Child and Youth Mental Health Services	YJGC	Youth Justice Group Conference
DCS	Disability Client Service	YJMHI	Youth Justice Mental Health Initiative
DFATS	Disability and Forensic Assessment & Treatment Service	YSO	Youth Support Officer
DHS	Department of Human Services	YSS	Youth Support Service
		YSAS	Youth Support and Advocacy Service



Youth Firesetting Support Guide

Supplementary Information



HELP CATCH BUSHFIRE ARSONISTS BEFORE THEY STRIKE.

If you observe any suspicious behaviour, call **Triple Zero (000)** immediately.

If you suspect someone of bushfire arson, call **Crime Stoppers** confidentially on **1800 333 000**.

If you are suspicious of a person or a vehicle, write down the following details:

For vehicles:

- registration
- make
- model
- colour
- any damage to vehicle

For individuals:

- age
- height
- hair colour
- build
- facial hair
- clothing
- ethnic appearance

HELP CATCH BUSHFIRE ARSONISTS BEFORE THEY STRIKE.



**Seen Something?
Know Something?
Say Something.**

Call Crime Stoppers
confidentially on 1800 333 000

Call Triple Zero (000)
in an emergency



VICTORIA POLICE

PREPARE. ACT. SURVIVE.
FireReady Victoria

YOU ARE IN AN AREA OF BUSHFIRE ARSON RISK.

What is bushfire arson?

A bushfire caused by a person intentionally or recklessly.

Arson is a serious crime

The maximum penalty for arson causing death in Victoria is 25 years imprisonment. The maximum penalty for intentionally or recklessly causing a bushfire is 15 years imprisonment.

If you see something

Victoria Police and Crime Stoppers urge the community to report suspicious behaviour by calling **Triple Zero (000)**.

If you know something

People who commit bushfire arson are not always strangers, they often live and work in local communities. If you have concerns about a member of your family, a friend or colleague, they might need help.

Say something

If you do know something, say something. You can provide information to **Crime Stoppers** confidentially on **1800 333 000**.

ABOUT 50% OF BUSHFIRES ARE BELIEVED TO BE DELIBERATELY OR RECKLESSLY LIT.

Source: Advancing Bushfire Arson Prevention in Australia, Monash Sustainability Institute (2010).

BUSHFIRES RUIN LIVES. REPORT AN ARSONIST.

Bushfire arson has a devastating impact on the community. It has the potential to injure or kill people, cause significant financial loss, and destroy property as well as the environment.

Operation Firesetter

Victoria Police, as part of Operation Firesetter, will be conducting highly visible patrols to prevent and apprehend arsonists.

Investigations into suspicious fire activity and bushfire arson persons of interest will also be undertaken.

Operation Firesetter is a state-wide coordinated initiative that will intensify during periods of high fire danger.



ALLIED HEALTH PRACTITIONER GUIDE TO YOUTH WHO MISUSE FIRE: RISK FACTORS AND GOOD PRACTICE INTERVENTION GUIDELINES

(Informed by the PhD thesis *Perspectives of effectiveness: What works in a juvenile firesetting intervention program?* Written by Dr. Kate McDonald, PhD)



Prevalence and Cost

- Arson is estimated to cost the Australian community \$1.6 billion a year. Most arson is committed by young males (youth up to 20 years; Stanley & Kestin, 2010).
- Prevalence of firesetting rates is unclear, particularly in Australia. This is because the behaviour is: underreported, frequently minimised by parents (considered curiosity and something the child will outgrow) and covert in nature. The other issue is that there is no central repository or coordinated effort to gather this data (Fineman, 1980; Kolko, 2002a & Stadnolick, 2000).

What is fire involvement?

- Youth firesetting is child or adolescents' unsanctioned misuse of fire. The motives of misuse of fire have been described in many ways such as: curiosity-driven, experimental, accidental, cry-for-help, unmotivated and in rare cases pyromania (prevalence rate of 0-8%; APA, 1994).
- Gaynor (1991) describes different levels of fire involvement, including: fire interest, fireplay and firesetting. Fire interest may be common in young children (aged 3-5). Fire interest is often expressed when children ask "what makes it burn?" or incorporate fire themes into their pretend play. This interest may progress to fireplay or firesetting.
- Gaynor (1991) also differentiated fireplay and firesetting. Fireplay is described as a single unplanned episode of igniting available materials (i.e., paper) and where the child reacts by either putting it out or calling for help. She describes firesetting as recurrent, planned incidents that often involve flammable or combustible materials that are targeted towards another person, property or animal and where the child reacts by watching the fire burn or running away.

Demographic, individual and family factors associated with the onset and continuation of youth firesetting

Demographic

- Interest in fire can occur as early as 2 or 3 years of age (Kafry, 1980; Nurcombe, 1964).
- Age of onset of firesetting is earlier than other antisocial behaviours (Jacobson, 1985; Root, et al., 2008; Stickle & Blechman, 2002). This often means that there is often a more severe course of firesetting (Root et. al, 2008). Based on a meta-analysis of 22 studies, the mean age of firesetting is 10 years (Kolko, 1985).
- Firesetters are more likely to be male. Researchers commonly report a 9:1 (male vs female) ratio (Kolko, 1985; McDonald, 2011).
- There is an association between low socio-economic status and firesetting/arson (Kolko & Kazdin, 1990; 1991b, 1994; Stratchan, 1981; Stanley & Kestin, 2010).

Severe course of firesetting is defined as: an earlier onset of fire involvement, more frequent and varied firesetting, higher recidivism rates, and greater emotional and behavioural problems. This can lead to heightened aggression, early arrests and chronic offending (Jacobsen, 1985; Stickle & Blechman, 2002).

Individual

- The current thinking is that firesetting is motivated by anger and curiosity (Kolko & Kazdin, 1991a, 1991b; Kuhnley, Hendren & Quinlan, 1982; Mackay et al., 2006; Sakheim & Osborn, 1991).
- Firesetters present with both fire-specific (i.e. curiosity and interest in fire) and general behavioural/clinical and family risk factors (i.e. poor parenting or externalising behaviours; Fineman, 1995; Root et.al, 2008).

- The most common co-morbid disorder is Conduct Disorder (60-70%; Sakheim & Osborn, 1999). The second most common diagnosis is Attention Deficit and Hyperactivity Disorder (ADHD; Kolko and Kazdin, 1989a).
- Firesetters do not commonly present with internalising behaviours (i.e., guilt or depression; Fineman, 1980; Heath, Hardesty, Goldfine & Walker. 1983; Kolko & Kazdin, 1994).
- Many firesetters have social difficulties, including: poor relationships with their peers, inadequate social skills, an inability to form close relationships and have been bullied or bullied others (Kafry, 1980; Kolko, 1999; Nishi-Strattner, 2005; Vandersall and Wiener, 1970; Wooden & Berkey, 1984)
- A predisposing factor for firesetting could be exposure to a stressful event (such as divorce, death or loss; Fineman 1995, Kolko & Kazdin, 1992; Mackay et al., 2006; Patterson, 1982).
- Many firesetters have academic difficulties (Kaufman, Heins & Reiser, 1961; Vandersall & Wiener, 1970; Wooden & Berkey, 1984), but the link between firesetting and intellectual disorders is unclear (due to limited studies). However, some researchers have indicated that there are a high proportion of people with intellectual disabilities (ID) that light fires (Gaynor, 1991; Nishi-Strattner, 2005 and Taylor, et. al, 2006).

Disability and firesetting

Youth with intellectual disabilities can present as a challenge for services (Taylor, Thorne, Robertson & Avery, 2002). Treatment and interventions strategies for youth firesetters with ID's may require a different focus and methods than other firesetter populations, including:

- managing the environmental risk
- creating an individual treatment for the person
- having behavioural contracts
- high motivator incentives
- visual cues
- having the structure of routines (boundaries)
- getting parents on board with the treatment
- addressing the person's quality of life, personal and environmental issues

Challenges in working with firesetting clients who have a disability can be:

- The level of cognitive capacity, lack of insight, understanding of consequences, impulse control, learning new skills, engagement, social deficits, obsessive interest (particularly with autistic behaviours), and getting parents on board.
- Things tend to fall-down in ongoing treatment recommendations when there is no follow-on and the person is not supported to apply the treatments into real life situations.
- Disability services can only work with the client to a certain point. The client may need more intensive psychotherapy and counseling

Considerations

- It is critical that a behaviour support plan is consistently delivered because it enhances the persons' ability to understand the impact of their behaviour. The material should be presented in a visual way, broken-down into chunks of information, brief and more frequent sessions (repetition).
- One of the risks is that drawing attention to the firesetting can increase the person's propensity to light fires. There also may be pleasure in the Shock Value which makes it difficult to put treatment into play.

Family

- The parents of firesetters often experience psychopathology, including: schizophrenia, psychotic disorders, depression, substance abuse problems, criminality, abusive behaviours, and/or personality and antisocial disorders. (Bumpass, Fagelman, & Brix, 1983; Fine & Louie, 1979; Kolko & Kazdin, 1986; 1990; Lewis & Yarnell, 1951; Stewart & Culver, 1982).
- Child firesetters may grow up in families that are dysfunctional. This may include: poor parenting practices, abuse, harsh punishment, and poorer parent-child relationships (Gruber et al., 1981; Kazdin & Kolko, 1986; Kolko & Kazdin, 1986,1992; Kolko, 1985; Macht and Mach, 1968; Sakheim & Osborn, 1986, 1991; Sakheim et al., 1985; Vandersall & Wiener, 1970).
- Abuse was found to predict a more severe course of firesetting behaviour (Root et. al, 2008).

Recidivism and high-risk firesetting

Roughly one in four young people who misuse fire will be a recidivist (Kolko, 1985). McDonald's (2011) study found the following factors associated with recidivism as:

General behavioural risk factors:

- Greater externalising and behavioural disturbance
- Social deficits
- Family dysfunction (i.e., poorer parenting practices)

Fire-specific risk factors:

- "A-typical" curiosity (fascination) with fire
- Earlier onset of fire interest
- Greater fire history
- Lower fire safety knowledge scores
- Exposure to models (fascinated and misuse fire)

These findings are consistent with other international studies (Fineman, 1995; Root et al., 2008). The strongest predictor of recidivism in McDonald's (2011) study was negative behaviour (i.e. aggression), greater fire history and an early fire history onset. The recidivist children's fire history was 3 times greater than non-recidivists. Recidivists also had an earlier onset of firesetting (5 years and 8 months) compared with non-recidivists (8 years and 9 months).

Other research findings on firesetting recidivism

- It has been found that covert antisocial behaviour and interest in fire (or involvement) are the strongest predictors of recidivism (Kolko et. al, 2001b) Thus, the assessment process needs to explore these two factors in some depth. For instance, fire involvement can be assessed by looking at age of onset, frequency, severity (damage caused), versatility (what was the ignition source, where the fire was lit and what was ignited) and who was involved (any accomplices). The Toronto Arson Prevention Program (TAPP-C) uses a fire involvement questionnaire that evaluates these factors and yields a score (Mackay et. al, 2004).
- Childhood interest in fire was reported as the most robust predictor or adult arson (Rice & Harris, 1991). This is an important variable to explore when assessing and treating a firesetter.

- Kennedy Vale, Kahn & McAnaney (2006) found that past involvement with fire was the best single predictor of recidivism.
- Externalising (acting out) behaviour is a general behavioural/ clinical factor that is associated with recidivism (Adler, et. al 1994; Kolko, Hershell & Scarf 2006; Root et. al, 2008). This is a key factor that needs to be included in the screening/assessment of youth firesetters.

Screening

A standardised and reliable screening tool is required because it determines the intervention level needed (Oregon State Fire Marshall, 2009).

More community awareness, better screening processes in both allied health and fire services using reliable and valid tools that assess both fire-specific and general behavioural/clinical or family factors are essential for case formulation, treatment planning and monitoring processes (Kolko & Kazdin, 1989a, b; Mackay et al., 2006). This can include:

Fire-specific factors

- Age of onset
- Firesetting history
- Attraction to fire (preoccupation/curiosity)
- Versatility of firesetting
- Damage
- Modeling (collaborators)

General behavioural factors

- Externalising behavioural problems
- Antisocial behaviour / social deficits
- Covert antisocial behaviour (e.g., secretly lighting fires).

Intervention and Good Practice

Good practice intervention for youth firesetters is a fire-specific psychological Cognitive Behavioural Therapy (CBT)-and Parental Management Training (PMT)-based intervention (delivered by allied health) that is complimented by Fire Safety Education (FSE -delivered by firefighters; Mackay et al., 2004; McDonald, 2011).

- Without intervention, programs have reported a 50-80% recidivism rate (Massachusetts State Police, P.Z., personal communication; 26 May 2007).
- Fire knowledge and fire safety skills are generally targeted by most fire safety education (FSE) programs that emphasise low-level skilled-based intervention strategies (incorporating behavioural training, some basic behavioural modification strategies, and basic parenting training; Cole, et al, 2006).
- The aim of intervention strategies is to (1) reduce recidivism, and (2) build skills in the firesetter (i.e., skills in: coping strategies, assertiveness, managing states, problem solving) and the family (i.e., parenting skills).
- Restricting access to fire sources, combined with adequate supervision, is perhaps the most realistic and effective procedure for preventing future firesetting (Humphrey, Kopet & Lajoy, 1995; TAPP-C – S. M., personal communication, 1 June 2007; Wilcox, 2006).
- *Tips for Caregivers* is a practical and useful guide for parents around securing ignition sources (Humphreys, Kopet & Lajoy, n.d.).

Guidelines for Good Practice

The traditional approach to treating youth firesetters in Australia has been fire safety education (FSE) programs that are delivered by trained firefighters in the fire services with an option to refer to allied health services. In recent times, many FSE programs

in Australia have received referrals for higher risk clients. For instance, the source of referrals to the Victorian JFAIP has changed; frequently capturing children and young people with greater mental health, social and developmental problems. Due to this, revisions of the model and good practice guidelines have been identified and listed as:

Underpinning guiding principles

- An underlying philosophy that youth firesetting is a community problem.
- Multidisciplinary - working together collaboratively with partners can draw the skills, knowledge and skills of multiple professionals. This also ensures that they are working within roles, limitations and skills.
- Evidence-based intervention that is offence-specific (i.e., firesetting specific)
- Based on the evidence that the sole intervention of FSE is appropriate for low-risk clients, but a multi-agency approach is required for high-risk clients.

Engagement strategies

- Accessibility in the community (i.e., low-income families or culturally and linguistically diverse families).
- Engagement and rapport-building strategies (i.e., has innovative age appropriate materials, regular review and modification of materials, has screening tools that emphasis rapport, and the program is structured – emphasising accountability and responsibility).

Program Components

- Standardised protocols that guide the delivery and content of the program, monitoring and evaluation.
- Program components of: a screening component, a standardised FSE component (delivered by firefighters), assessment and an evidence-based intervention that is CBT-and PMT-based (delivered by allied health professionals), monitoring and evaluation components.
- Demonstrates evidence of effectiveness (i.e., pre- and-post assessments could measure the following: knowledge about fire safety, curiosity and attraction to fire, behavioural change- Child Behaviour Checklist, and recidivism).

Relationships and networks

- A relationship with allied health professionals that provide referral options and continuity of care (Bumpass et al., 1985; Kolko, 1988; Mackay et al., 2004; Oregon State Fire Marshall, n.d; Palmer et al., 2007; Pinsonneault et al., 2002; Sharp, Blaakman, Cole & Cole, 2006, Schwartzmann, 2002; Webb, et al., 1990).

FSE component and the role of the firefighter

Firefighter practitioners deliver the standardised FSE, a vital component of treatment of all youth firesetters regardless of age, risk or motive.

Firefighters will also play an important role in the intervention because commonly they are the first person to receive the firesetter referral. Thus, they are the first step in the crucial process of building rapport, screening (using reliable tools) and making observations of the youth firesetter within the context of the multidisciplinary team.

Curriculum content of FSE

Content for each developmental stage generally includes:

- assessment of the child fire safety knowledge and awareness
- a home safety audit
- fire safety education
- understanding the nature of fire

- consequences of unsafe fire use
- teaching of appropriate fire use
- education of personal fire safety strategies
- taking responsibility for safe-fire behaviour.

Allied health component and their role

Allied health practitioners often utilise CBT, PMT or family therapy generally as treatment strategies for young people and their families. However, youth firesetters may not be receiving a targeted offence specific intervention (Pierce & Hardesty, 1997; Sharp et al., 2006). Good practice programs have found that CBT-and PMT-based techniques that are fire-specific are most effective.

Rationale for CBT- and PMT-based intervention

- Firesetting frequently occurs in the context of other disruptive or antisocial disorders and CBT therapies for this population have been endorsed as more effective and more likely to facilitate behaviour change than other less directed therapies (Kazdin, Esveldt-Dawson, French, & Unis, 1987).
- Evidence has concluded that CBT and PMT have been shown to be effective with children with disruptive disorders. PMT strategies are thought to augment CBT strategies with youth firesetters (Mackay et al., 2004).

Some useful CBT-based strategies with youth firesetters include:

- self-safety boundaries (fire-safety)
- improving problem-solving techniques
- exploring beliefs about fire (i.e., examining fire and media and/or omnipotence)
- analysis of thinking errors
- identification of emotions and learning self-management skills in relation to firesetting behaviour
- assertiveness training
- making better choices about friends (peer pressure)
- exploring consequences of the fire (legal, financial, and personal costs)
- relapse prevention (L. NS., personal communication, 13 June 2007; S. M., personal communication, 1 June 2007; Mackay et al., 2004).

PMT-based strategies that are delivered by allied health professionals are also effective and can include:

- securing ignitions (planned searches for matches and lighters)
- accepting boundaries set by parents
- teaching parents positive and negative reinforcement strategies
- discussion of family rules.

Many of these strategies are used in programs that represent good practice. The Toronto Arson Prevention Program for Children (TAPP-C) and Oregon Juvenile Firesetting Intervention Networks (Oregon JFIN) are considered best practice because they are well-organised, evidence-based and have demonstrated effectiveness (i.e., low recidivism rates and an increase of skills in the firesetter and family- e.g. increase in problem solving skills and parenting skills).

Multidisciplinary Approach

Evidence-based analysis in the United States has concluded that the most effective way to reduce recidivism and build skills in youth firesetters is within a multidisciplinary program (Sharp et al., 2007). Multidisciplinary approaches target both fire-specific and general behavioural dysfunction risk factors, are best practice and are based on collaboration with several agencies that are concerned with and involved in the firesetting problem (Gaynor & Hatcher, 1987; Kolko, 2002b; Okulitch & Pinsonneault, 2002, Webb et al., 1990). Successful intervention with firesetting behaviour requires the ability to coordinate an array of services (Henderson, Mackay & Peterson-Baddali, 2006; Stadolnik, 2000).

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The Australian and New Zealand Burn Association has identified the following injuries as those requiring referral to a burn unit:

- Burns greater than 10% Total Body Surface Area (TBSA)
- Burns of Special Areas - Face, Hands, Feet, Genitalia, Perineum and Major Joints
- Full Thickness burns greater than 5% TBSA
- Electrical burns
- Chemical burns
- Burns with an associated inhalation injury
- Circumferential burns of the limbs or chest
- Burns at the extremes of age - children and the elderly.
- Burn injury in patients with pre-existing medical disorders which could complicate management, prolong recovery or affect mortality
- Any burn patient with associated trauma

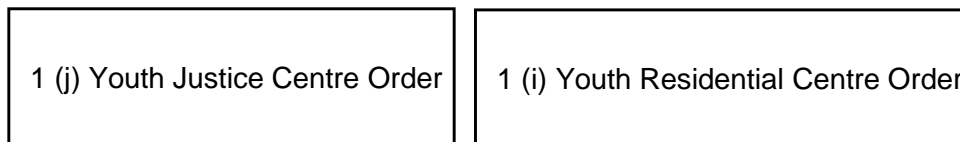
Sentencing Orders Hierarchy

Children, Youth and Families Act 2005, Victoria

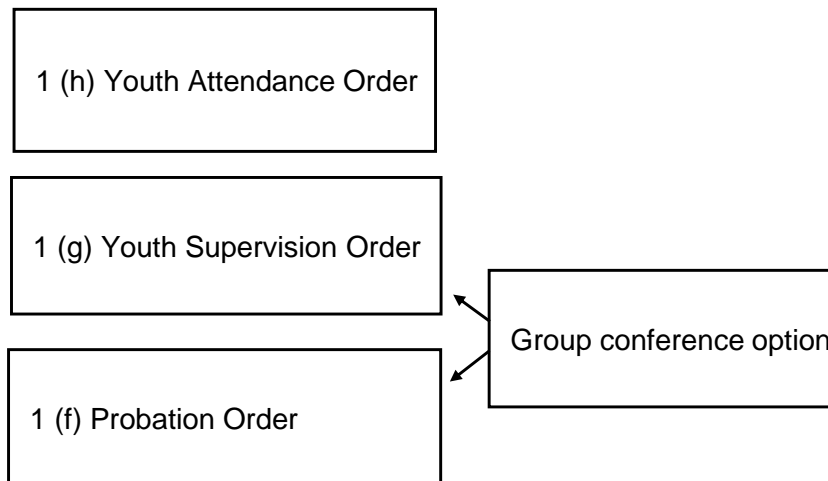
Section 360 Sentencing orders

Orders supervised by Youth Justice

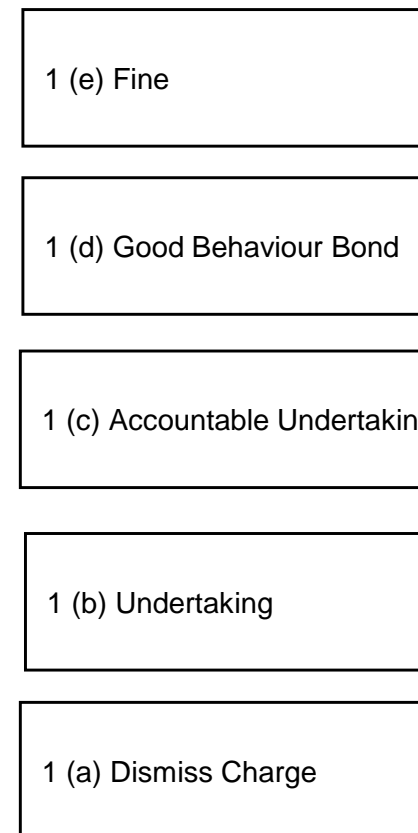
CUSTODIAL



COMMUNITY



Unsupervised orders



Section 361 Sentencing hierarchy

The Court must not impose a sentence referred to in any of the paragraphs of section 360(1) unless it is satisfied that it is not appropriate to impose a sentence referred to in any preceding paragraph of that section.

A step-by-step guide to making a report to Child Protection or Child FIRST

Protective concerns

You are concerned about a child because you have:

- received a disclosure from a child about abuse or neglect
- observed indicators of abuse or neglect
- been made aware of possible harm via your involvement in the community external to your professional role.

At all times remember to:

- record your observations
- follow appropriate protocols
- consult notes and records
- consult with appropriate colleagues if necessary
- consult with other support agencies if necessary

STEP 1	RESPONDING TO CONCERNS	STEP 2	FORMING A BELIEF ON REASONABLE GROUNDS	STEP 3	STEP 4	MAKE A REPORT TO CHILD PROTECTION
	<ol style="list-style-type: none"> 1. If your concerns relate to a child in need of immediate protection; or you have formed a belief that a child is at significant risk of harm*. Go to Step 4 2. If you have significant concerns that a child and their family need a referral to Child FIRST for family services. Go to Step 3 3. In all other situations Go to Step 2. <p>* Refer to Appendix 2: Definitions of child abuse and indicators of harm in the Protocol – <i>Protecting the safety and wellbeing of children and young people</i></p>	<ol style="list-style-type: none"> 1. Consider the level of immediate danger to the child. Ask yourself: <ol style="list-style-type: none"> a) Have I formed a belief that the child has suffered or is at risk of suffering significant harm? YES / NO and b) Am I in doubt about the child’s safety and the parent’s ability to protect the child? YES / NO 2. If you answered yes to a) or b) Go to Step 4 3. If you have significant concerns that a child and their family need a referral to Child FIRST for family services. Go to Step 3 	<h3>Child Wellbeing Referral</h3> <ol style="list-style-type: none"> 1. Contact your local Child FIRST provider. <ul style="list-style-type: none"> • See over for contact list for local Child FIRST phone numbers. 2. Have notes ready with your observations and child and family details. 	<h3>Mandatory/Protective Report*</h3> <ol style="list-style-type: none"> 1. Contact your local Child Protection Intake provider immediately. <ul style="list-style-type: none"> • See over for contact list for local Child Protection phone numbers. • For After Hours Child Protection Emergency Services, call 131 278. 2. Have notes ready with your observations and child and family details. <p>* <i>Non-mandated staff members who believe on reasonable grounds that a child is in need of protection are able to report their concerns to Child Protection</i></p>		

Contact Numbers

Department of Education and Early Childhood Development

METROPOLITAN REGIONS	
Eastern	(03) 9265 2400
Northern	(03) 9488 9488
Western	(03) 9291 6500
Southern	(03) 9794 3555
RURAL REGIONS	
Barwon South Western	5225 1000
Gippsland	5127 0400
Grampians	5337 8444
Hume	5761 2100
Loddon Mallee	5440 3111

Office for Children and Licensed Children's Services:

METROPOLITAN REGIONS	
Eastern	(03) 9265 2400
Northern	(03) 9412 5333
Western	(03) 9275 7000
Southern	(03) 9096 9555
RURAL REGIONS	
Barwon South Western	5225 1000
Gippsland	5127 0400
Grampians	5337 8444
Hume	5761 2100
Loddon Mallee	5440 3111

Important information for government schools

Principals of Victorian Government schools must report all incidents to the Emergency and Security Management Unit on **03 9589 6266**.

Victorian Government schools should contact the Student Critical Incident Advisory Unit (SCIAU), Student Wellbeing Division, for advice and support when responding to allegations of student sexual assault or inappropriate sexual behaviours.

The SCIAU can be contacted on **03 9637 2934** or **03 9637 2487**.

Victorian Government School Principals should refer to the flowchart – *Responding to Allegations of Student Sexual Assault Compulsory Actions for Principals* at:

<http://www.education.vic.gov.au/healthwellbeing/safety/childprotection/childprotection.htm>

Department of Human Services Child Protection

METROPOLITAN REGIONS		METROPOLITAN REGIONS	
Intake Unit		Regional Office	
Eastern	1300 360 391	Box Hill	(03) 9843 6000
North and West	1300 664 977	Preston	1300 664 977
		Footscray	1300 360 462
Southern	1300 655 795	Dandenong	(03) 9213 2111
RURAL REGIONS			
Intake Unit		Regional Office	
Barwon South Western			
	1800 075 599	Geelong	(03) 5226 4540
Gippsland	1800 020 202	Traralgon	(03) 5177 2500
Grampians	1800 000 551	Ballarat	(03) 5333 6530
Hume	1800 650 227	Wangaratta	(03) 5722 0555
		Wodonga	(02) 6055 7777
Loddon Mallee	1800 675 598	Bendigo	(03) 5434 5555

After hours Child Protection Emergency Services (AHCPEs)

Statewide number for all emergency child protection matters outside of normal business hours (24 hours, 7 days a week):

131 278

Victoria Police 000

Catholic Education Offices

Catholic Education Office, Melbourne	(03) 9267 0228
Catholic Education Office, Ballarat Diocese	5337 7135
Catholic Education Office, Sale Diocese	5622 6600
Catholic Education Office, Sandhurst Diocese	5443 2377

Independent Schools Victoria (03) 9825 7200

Other

Victorian Aboriginal Education Association, Inc.	(03) 9481 0800
Victoria Police Sexual Offences and Child Abuse Unit	(03) 9247 6666
Centre Against Sexual Assault	1800 806 292
Gatehouse Centre, Royal Children's Hospital (for specialist counselling and medical assistance)	(03) 9345 6391
Child Safety Commissioner	(03) 8601 5884
Victorian Aboriginal Child Care Agency	(03) 8388 1855

CHILD FIRST

Local Catchment Area	Contact
Barwon South Western	Greater Geelong, Queenscliff, Surf Coast 1300 551 948
	Colac – Otway, Corangamite 5232 5500
	Warrnambool, Moyne, Glenelg, Southern Grampians 1300 889 713
Gippsland	East Gippsland 5152 0052
	Wellington 5144 7777
	La Trobe, Baw Baw 1800 339 100
	South Gippsland, Bass Coast 5662 5150
Grampians	Northern Grampians, West Wimmera, Hindmarsh, Yarrambat, Horsham 1800 195 114
	Ararat, Pyrenees, Hepburn, Ballarat, Golden Plains, Moorabool 1300 783 341
Hume	Wodonga, Towong, Indigo 1800 705 211
	Alpine, Benalla, Mansfield, Wangaratta 1800 705 211
	Greater Shepparton, Strathbogie, Moira 1300 854 944
	Mitchell, Murrindindi 1800 663 107
Loddon Mallee	Greater Bendigo, Campaspe, Central Goldfields, Loddon, Macedon Ranges, Mount Alexander 1800 260 338
	Buloke, Goonawarra, Swan Hill, Mildura 1800 625 533 1800 MALLEE
Eastern Metropolitan	Yarra Ranges, Knox, Maroondah 1300 369 146
	Monash, Whitehorse, Manningham, Booroondarra 1300 762 125
North and West Metropolitan	Nillumbik, Whittlesea, Banyule, Yarra and Darebin (03) 9450 0955
	Brimbank, Melton 1300 138 180
	Hume, Moreland 1300 786 433
	Hobson's Bay, Maribyrnong, Melbourne, Moonee Valley and Wyndham 1300 786 433
Southern Metropolitan	Casey, Cardinia, Greater Dandenong (03) 9705 3939
	Aboriginal children and families (Casey, Cardinia and Great Dandenong) (03) 9794 5973
	Frankston, Mornington Peninsula 1300 721 383
	Kingston, Bayside, Glen Eira, Stonington, Port Phillip 1300 367 441

Child FIRST

continued from front page

Where a Child FIRST team forms a view that a child or young person is in need of protection they must report the matter to Child Protection. This would be done in consultation with Community-Based Child Protection. Child FIRST will inform you of the outcome of your referral and in most cases will invite you to be included in the assessment, planning and action to support the child and family.

How to make a referral to Child FIRST

Each Child FIRST site will publicise its phone number locally. You may also wish to refer to the following web link for contact details.

http://www.cyf.vic.gov.au/family-services/home/_nocache

Will a referral to Child FIRST be confidential?

In most cases, better outcomes for the child, young person and family are achieved when a referral is made with their consent and participation. If making a referral to Child FIRST on behalf of a child, young person or family without their knowledge, you will be asked if you are willing to have your identity disclosed to the family if Child FIRST contacts them. You may choose to have your identity remain confidential; however, you should consider the impact of this on the ongoing engagement with the family by Child FIRST and Family Services.

If you would like to receive this publication in an accessible format, email: everychildeverychance@dhs.vic.gov.au

Child and Family Services Alliances

To support the effective operation of Child FIRST, a Child and Family Services Alliance is established in each Child FIRST catchment.

The Child and Family Services Alliances include partners from Child FIRST, all funded family services (including Aboriginal family services), Child Protection and the Department of Human Services Family Services Partnerships. In catchments where an Aboriginal family service does not exist or does not have capacity to be actively involved in the Alliance, the Alliance will demonstrate how it is consulting with the Aboriginal community on Alliance activities.

More information:

For more information, fact sheets and supporting documents, see the every child every chance website: www.cyf.vic.gov.au/every-child-every-chance

Supporting documents:

- *Children, Youth and Families Act 2005 Part 3.2 – Concern about Wellbeing of a Child*
- A strategic framework for Family Services 2006
- Reporting concerns about children or young people: a guide for professionals
- Information sharing guidelines
- Best Interests principles: a conceptual overview
- A Best Interests framework for vulnerable children and youth
- Best Interests Case Practice Model Summary Guide

You may also want to contact your regional Community Partnerships Unit Manager or Family Services team for further information.

Child FIRST – what do I need to know?

Child FIRST (Child and Family Information, Referral and Support Teams) have been established in designated sub-regional catchments across Victoria to provide a community-based referral point into Family Services.

The maps [overleaf] show the 24 sub regional catchments across the state.

When should I refer to Child FIRST?

A referral to Child FIRST may be the best way of connecting vulnerable children, young people and their families to the services they need to protect and promote their healthy development.

Families requiring the support of Family Services generally have complex needs, which can adversely impact on a child's development if appropriate supports and interventions are not provided in a timely manner. Significant concerns about the child's wellbeing and development are highlighted by how often issues are occurring, how serious the issues are and most importantly how the issues are affecting the child's development.

Who provides Child FIRST?

Child FIRST is staffed by Family Service practitioners, with experience in assessing the needs of vulnerable children, young people and families. In addition, Community-Based Child Protection staff facilitate collaboration between these community-based intake services and Child Protection, providing advice to Child FIRST and Family Services about the engagement of families with complex needs and the identification of significant risk factors, and ensuring timely Child Protection involvement if a child is at risk of significant harm.

Child FIRST and/or Family Services may also need to seek the professional advice of the Community Based Child Protection worker on specific case related matters. The ability to consult is a key component of the legislation which aims to promote and support the partnership, interface and operation of Child Protection and registered community based child and family services.

Community Based Child Protection – how will it work?

Community Based Child Protection supports every Child FIRST by facilitating collaboration between Family Services and Child Protection.

This is done through:

Facilitating referrals from Child Protection to Child FIRST; provision of consultation and advice on specific cases to Child FIRST and Family Services in the subregional catchment; provision of advice to the Child FIRST catchment Child Protection staff regarding making referrals to Child FIRST; participation in local professional and community education initiatives and identification of cases within Child Protection requiring enhanced referral.

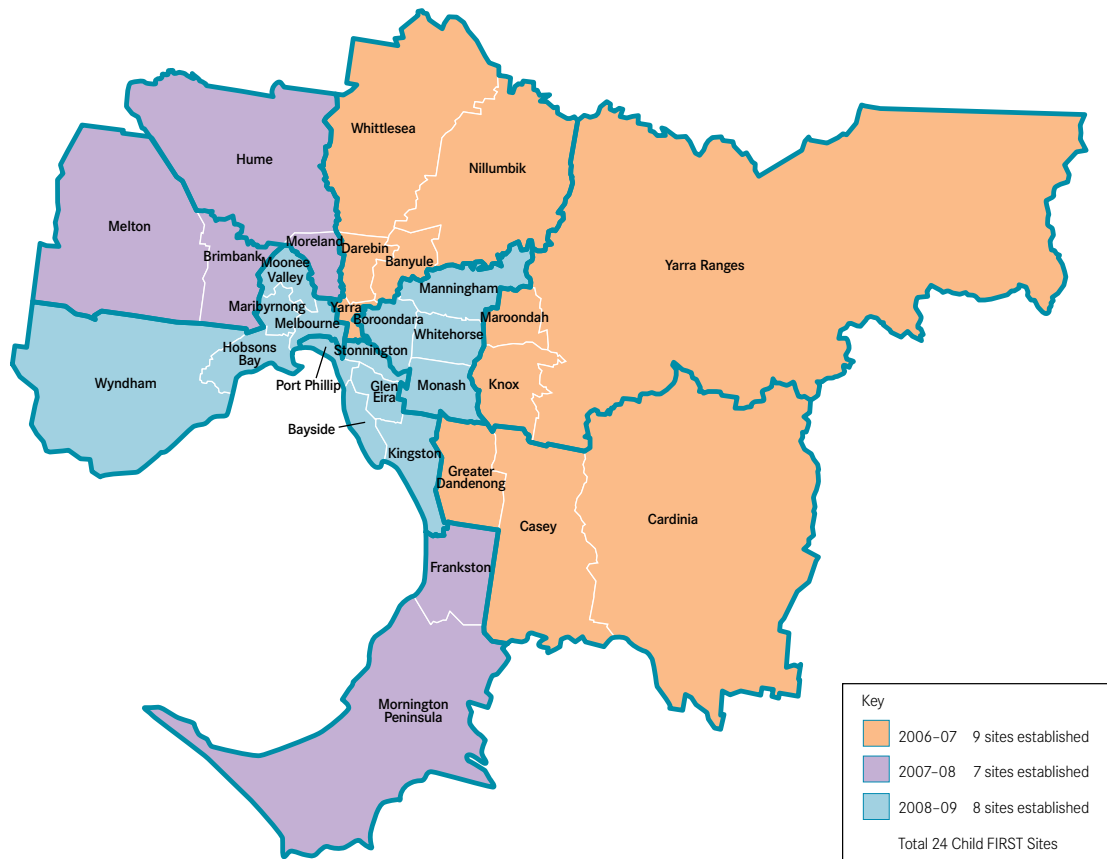
What happens when I make a referral to Child FIRST?

Child FIRST will discuss with you the initial needs of the child, young person and family that you have concerns for to determine the most appropriate response. Services will be prioritised to families on the basis of need, to prevent difficulties escalating to a level that will significantly impact on the child's development and consequently lead to entry into Child Protection.

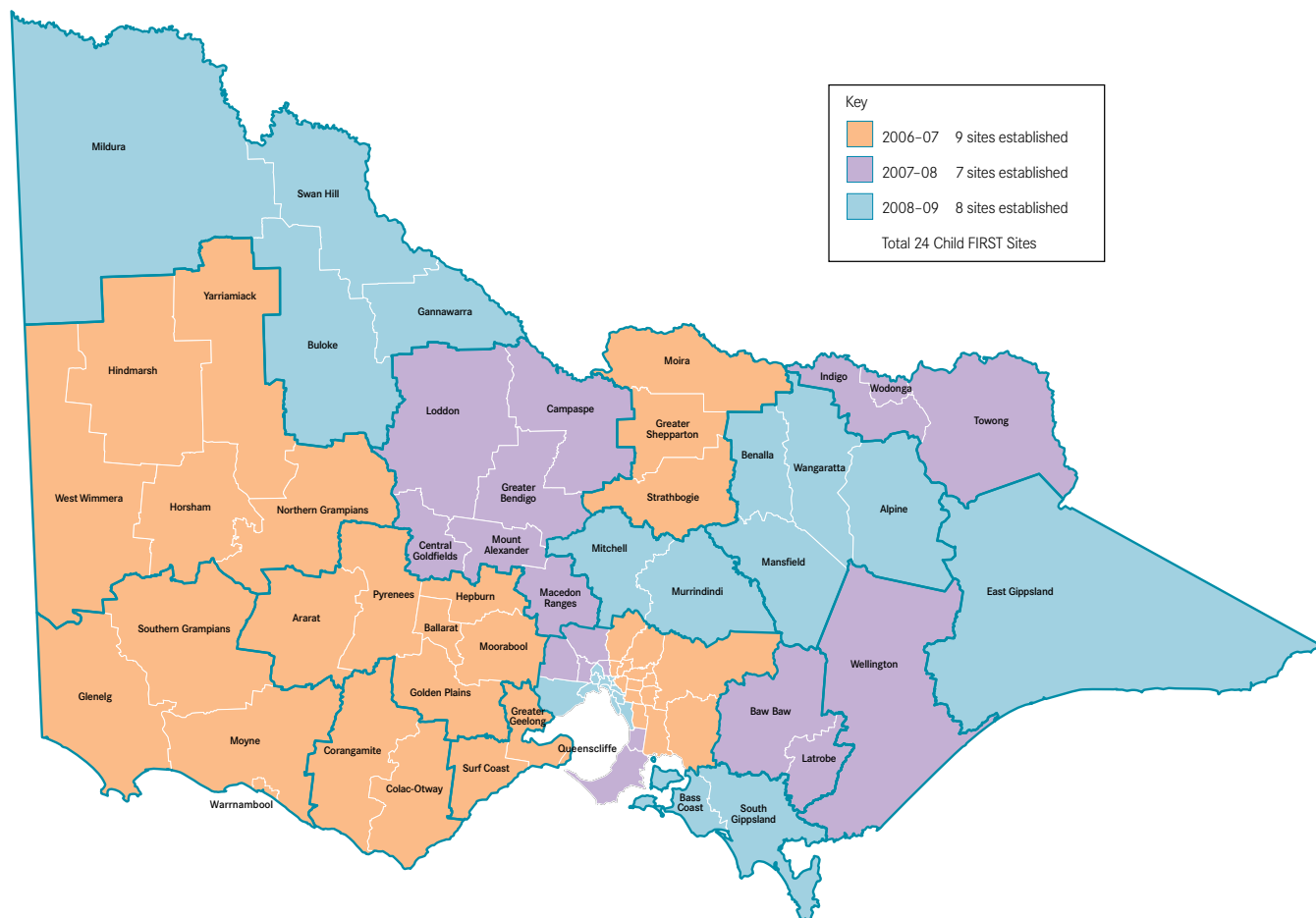
Some families may be assisted by the provision of information and advice only, however, for most families referred to Child FIRST, a cycle of assessment, planning and action will commence. Child FIRST will engage with the child, young person and family to begin the process. Once a plan is in place for how best to support the child's healthy development and improve parenting capacity, Child FIRST will arrange for a Family Services agency to support the family. Part of the role of the Family Services agency is to facilitate connections with other appropriate services, eg universal services, drug & alcohol, mental health, housing or family violence services.

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Victorian Child and Family Information, Referral and Support Team (Child FIRST) Sites 2006–2009



Victorian Child and Family Information, Referral and Support Team (Child FIRST) Sites 2006–2009



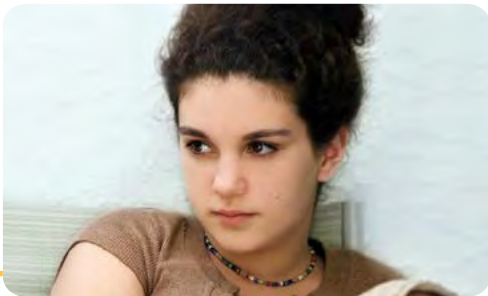
Service, Quality, Research & Training

The Take Two Program is a partnership with:

- Berry Street, an experienced child and family service organisation;
- Austin Health, Child and Adolescent Mental Health Service an experienced provider of child and adolescent mental health services;
- La Trobe University Faculty of Health Science, an experienced research institution;
- Mindful Centre for Training and Research in Developmental Health, an experienced training institution; and
- Victorian Aboriginal Child Care Agency (VACCA)

These organisations help Berry Street to develop and monitor the quality of services provided by Take Two. Take Two is an accredited health service with the Australian Council of HealthCare Standards.

The Take Two Practice Development and Training Team Provides training to a range of services and networks regarding development, attachment and trauma and can be contacted on 03 9429 9266



Contact Details

Privacy Statement

1. Information is collected by the Berry Street Take Two program for the purposes of assessment and therapeutic intervention of our clients.
2. Berry Street works closely with the Department of Human Services and other services, such as health, welfare and education services. Information may be collected from and shared between these services to assist the support and care of children, young people and their families.
3. If we don't receive this information it is harder for us to assist children, young people and their families.
4. It is our practice to seek written consent as soon as practicable to collect and, where relevant, share this information.
5. Information may be shared with the Take Two research team and La Trobe University for the purposes of research and evaluation but no identifying information will be published.
6. All your information is treated with the strictest confidentiality and stored securely by Berry Street.
7. You can request access to any information we hold about you by contacting our Privacy Officer on 03 9429 9266.

Berry Street Central Office

1 Salisbury Street, Richmond Vic 3121

Tel: (03) 9429 9266

Fax: (03) 9429 5160

Reg No: A0030034E

Email: taketwo@berrystreet.org.au

Web: www.berrystreet.org.au



www.berrystreet.org.au



What is Take Two?

Take Two is an intensive therapeutic service for children who have suffered trauma, neglect and disrupted attachment. It is a statewide service in Victoria funded by the Department of Human Services. Take Two aims to provide high quality therapeutic services for children of all ages and those important in their lives. It also aims to contribute to improving the service system that provides care, support and protection for these children.

There are Take Two teams in rural and metropolitan areas as well as some statewide teams such as the Aboriginal team and in Secure Welfare. In some regions Take Two is also involved in partnership with therapeutic foster care, therapeutic residential care services and Family Coaching services.

Who works at Take Two?

Take Two employs psychologists, social workers, nurses and other mental health workers who know how to respectfully work with infants, children, young people along with their families and carers.

Take Two also employs researchers and trainers to build and share knowledge.



Who are our clients?

Take Two works with children from 0 to 18 years old who are clients of DHS Child Protection Services, as well as their families and carers.

Our clients are usually referred by the Child Protection or Contracted Case Managers via a standard referral procedure. Others are encouraged to discuss potential referrals with the case manager.



How does Take Two help?

When an infant, child or young person is referred, Take Two is careful to get a thorough understanding of what is happening for the individual and everyone involved in their care.

From assessment, a therapeutic intervention is developed and goals are discussed with the client and those who care for them. The intervention can involve working directly with the child or young person by themselves, with the parent or carer or with others. Regular liaison with other workers is an important part of Take Two's intervention plan. Take Two also works behind the scenes with some services where it provides consultation, training and guidance.

How do we know Take Two is helping?

Take Two regularly reviews progress towards goals with clients, carers and other workers by both discussion and the use of short questionnaires that are completed by clients, parents, carers and workers. Take Two also uses outcome measures to see if progress is happening for the child. If a plan is not working, all those involved can assist in improving it. If anyone wishes to give us feedback, make a complaint or compliment, or offer suggestions for improvement we are keen to hear these. The Berry Street Service Charter lists ways in which these can be made.



Research

The research strategy within Take Two is supported by La Trobe University and includes evaluation of the program as well as broader research questions about the nature and developmental needs of the client group, work involved and how to support positive change. The research team is actively involved in research partnerships at a local and statewide level and can be requested to undertake research in related areas on behalf of other organisations.

For example, research circles are being established in different areas to facilitate discussion regarding the interface between practice and research regarding trauma and attachment. Those interested in being involved can contact the Take Two research team on 03 9429 9266.

Department of Human Services, Disability Intake and Response Service

If you need more information about community supports and services for people with a disability, their families and carers in your local area, contact your regional Department of Human Services Disability Intake and Response Service between 9am and 5pm, Monday to Friday.

For direct connection to your regional Disability Intake and Response Service call 1800 783 783

Alternatively, if you know which Department of Human Services region you live in you can contact your local Intake and Response Service using the following details:

Eastern Metropolitan Region

Phone: (03) 9843 6312
Fax: (03) 9843 6575
TTY: (03) 9843 6638
Email: Eastern.Disability@dhs.vic.gov.au

Northern Metropolitan Region

Phone: (03) 9412 2741
Fax: (03) 9412 5466
TTY: (03) 9412 2647
Email: Northern.Disability@dhs.vic.gov.au

Southern Metropolitan Region

Phone: 1300 131 079
Fax: (03) 9585 1590
Email: Southern.Disability@dhs.vic.gov.au

Western Metropolitan Region

Phone: 1300 360 462
Fax: (03) 9275 7240
TTY: (03) 9689 2369
Email: Western.Disability@dhs.vic.gov.au

Barwon South Western Region

Phone: 1800 675 132
Fax: (03) 5226 4566
Email: Barwon.Disability@dhs.vic.gov.au

Gippsland Region

Phone: (03) 5136 2474
Fax: (03) 5136 2411
Email: Gippsland.Disability@dhs.vic.gov.au

Grampians Region

Phone: 1800 670 143
Fax: (03) 5333 6505
TTY: (03) 5333 6815
Email: Grampians.Disability@dhs.vic.gov.au

Hume Region

Phone: 1300 650 152
Fax: (03) 5722 0577
TTY: (03) 5722 0623
Email: Hume.Disability@dhs.vic.gov.au

Loddon-Mallee Region

Phone: 1800 229 822
Fax: (03) 5430 2302
Email: Loddon.Disability@dhs.vic.gov.au

If you would like an interpreter, telephone the Translating and Interpreting Service on 13 14 50 and ask to be connected to the relevant regional number.

If you are deaf, have a hearing impairment, or complex communication needs telephone the National Relay Service on 13 36 77, or the Speech to Speech Relay Service on 1300 555 727 and ask to be connected to the relevant regional number.

Contact your regional Disability Intake and Response Service on 1800 783 783 or visit www.disability.vic.gov.au

Disability Information and Support

Who can I contact?



General supports and services are available for people with a disability, their families and carers through many local organisations including:

- Local Councils/Shires
- Community Health Centres
- Neighbourhood Houses
- Recreation and Leisure Services

Disability support agencies can offer more specific assistance including:

- Assistance in the home or in the community
- Recreation options
- Accommodation options
- Other more specialised services

To find out more information about community supports and services for people with a disability, their families and carers in your local area you can contact:

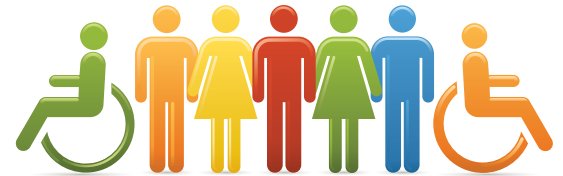
- Your local Council/Shire
- The 'Disability Online' website at:
www.disability.vic.gov.au
- A relevant disability support agency
- Your regional Department of Human Services Disability Intake and Response Service using the contact details in this brochure

We use different languages and formats



Your privacy is protected

Disability support programs



Information for people needing support

What supports are available for adults and children with a disability?

A person with a disability, as a member of the community, can access a range of general services including community health, early childhood and education services, sport and recreation, employment, maternal and child health services and other community services. People can contact their local government or community health service to explore these options.

The Department of Human Services (DHS) also funds a range of specialist disability supports that are available to people with a disability and their families, to help the person with a disability actively participate in the community and reach their full potential.

These supports fall into two categories:

- Short-term supports – such as respite services, behaviour supports, case management and therapy, and
- Ongoing supports – such as individual support packages and shared supported accommodation.

Specialist disability supports may be provided directly by the Department of Human Services or by community service organisations funded by the department.

Who can access disability supports?

People with a disability, their family or carers can request disability supports.

You can request disability supports if:

- you have a disability,
- the disability impacts on your mobility, communication, self-care or self-management
- your support request meets specific requirements related to the service you are seeking.

It is important to remember that disability supports may not always be suitable. For example, a person with a chronic health issue may have their needs better met through Health Services.

To make an enquiry about disability support, you or a person who supports you can contact the Department of Human Services' Disability Intake and Response service (see contact details over page).

What will the department's Disability Intake and Response service need to know?

They will ask you a range of questions to determine eligibility, as well as more general questions about your circumstances and why you are requesting disability supports now. They will also ask you about any supports you may already be using, including funded or informal supports, such as help from family members.

If your needs can be better met by a community service, they will provide you with contact information for the service. If you need specialist disability supports, they will explain the next steps to you, which may include assessment and a referral to a planner or case manager who will work with you to explore a range of ways your needs can be met.

Do I get a say in what kind of supports I receive?

The Department of Human Services uses a self-directed approach to disability supports. This means you and your family will be supported to plan what you need to meet your goals and decide how the supports will be managed.

How do I access short term supports?

The department's Disability Intake and Response service can assist you to get the short-term supports you need. These supports may be provided directly by the Department of Human Services or by community service organisations funded by the department.

There is a high demand for disability supports and allocation is prioritised based on each individual's circumstances and need. This would include the existence of multiple disadvantage, the likelihood that immediate support will reduce the need for more intensive supports, the need to strengthen the role of the family, carer or support network, and the impact on the individual's wellbeing and living situation if supports are not provided.

How do I access ongoing supports?

The Disability Services Register (DSR) is a database of all people who are requesting ongoing disability supports. The Disability Services Register enables the department to allocate supports in a fair and efficient manner when resources (funding or vacancies) become available.

For more information on how to register for ongoing supports please refer to the Disability Services section of the Department of Human Services website – www.dhs.vic.gov.au/disability or contact your regional Department of Human Services office.

How long will it take me to get an ongoing support?

There is a high demand for disability supports and allocation is based on priority of need. So any request for disability supports are considered along with all other requests. Therefore it is not possible to specify when a support will become available in advance.

The allocation of support is based on need and does not relate to the length of time you have been on the Disability Services Register; as it is not a waiting list.

Where can I find out more?

For more information on Disability supports you can contact your regional Department of Human Services office.

Telephone: 1800 783 783 or TTY 1800 008 149 between 9.00am–5.00pm
Monday to Friday.

Visit: www.dhs.vic.gov.au/disability

If you would like to receive this publication in an accessible format, please phone 1300 650 172 using the National Relay Service 13 36 77 if required.

About the *Disability Act 2006*

From 1 July 2007, the *Disability Act 2006* ('the Act') is the new legislation for people with a disability in Victoria. It replaces the *Intellectually Disabled Persons' Services Act 1986* and *Disability Services Act 1991*.

The Act provides for:

- a stronger whole-of-government, whole-of-community response to the rights and needs of people with a disability, and
- a framework for the provision of high quality services and supports for people with a disability.

The Act can be viewed on the Victorian Legislation and Parliamentary Documents website in the Victorian Statute Book section (www.legislation.vic.gov.au).

Understanding people's rights under the Act

The Act requires that people with a disability be given information that explains their rights.

For example, when a person starts to use a disability service, the disability service provider must give them information about the services to be provided and their rights under the Act.

The information given to a person under the Act must:

- use the language and type of communication they are most likely to understand
- where possible, be both explained to the person and given in writing.

If the person with a disability cannot understand the information, it can be given to another person of their choosing, who can assist them with understanding their rights.

Being included in the community

The Act has three key areas that focus on the inclusion and participation of people with a disability in the community:

Victorian Disability Advisory Council

The Victorian Disability Advisory Council provides advice to the Minister for Community Services on issues that affect people with a disability across all government services.

The Victorian Disability Advisory Council is a way for people with a disability to have a say in decision making on whole-of-government policy issues.

Most Council members must be people with a disability and they must come from a range of different backgrounds.

Disability Advisory Council

www.dac.vic.gov.au

1300 880 043

State Disability Plan

The *Victorian State Disability Plan 2002–2012* emphasises the importance of people with a disability being included and participating in their local communities.

The Act says that the current plan will continue until a new plan is required in January 2013.

Disability Action Plans

A Disability Action Plan is a plan to:

- reduce barriers for people with a disability as community members
- make it easier for people with a disability to use services available to all Victorians.

The Act says that all public services—government departments, statutory authorities and statutory corporations—must have a Disability Action Plan. Statutory authorities and statutory corporations will be identified before the Act commences.

Public services must report on their Disability Action Plan every year, to make sure the plans are put into practice.

Access to disability services

The Act states that people who have a physical, sensory or neurological impairment, an acquired brain injury, intellectual disability or developmental delay may access disability services.

The Act changes the way people access disability services, by allowing for a simpler and more consistent system for all people with a disability.

The Act says a person with a disability, or a person on their behalf, may request services from a disability service provider. This may be the Department of Human Services, or another disability service provider.

If a person is refused services because the disability service provider does not think the person has a disability, the person can request the Secretary of the Department of Human Services ('the Secretary') to decide whether they have a disability.

If the Secretary decides that the person does not have a disability, the person may ask the Victorian Civil and Administrative Tribunal (VCAT) to make a decision.

The Act does not change the Disability Support Register requirements for people who want to access some ongoing services, such as accommodation in community residential units.

Planning for people

The Act has guiding principles for planning, which include that planning should:

- be individualised
- be directed by the person with a disability
- consider and respect the person's family and other people who are important to the person with a disability
- be underpinned by the right of the person with a disability to have control over their own life.

The Act outlines a process for planning, which includes that:

- A person with a disability (or a person on their behalf) may ask a disability service provider to assist them with planning.
- People who receive ongoing disability services must have a support plan.
- A support plan must be reviewed at least once every three years, but can be reviewed earlier if requested.
- People with an intellectual disability who request a service must be offered assistance with planning.

Now the Act has commenced, any existing plans will continue until they are reviewed. When a person's plan is reviewed, the new planning processes will start.

Strengthening rights in residential services

A residential service is accommodation with staff support provided by a disability service provider.

The Act includes rights and duties for people living in residential services and obligations for disability service providers.

Disability service providers must provide a residential statement to a person with a disability when they start living at a residential service. The residential statement must include the type and cost of the service and other information such as a person's right to make a complaint.

The Act has duties for disability service providers, including making sure there is a balance between the rights of a person and the safety of all people living in the residential service.

The Act outlines duties for people living in the residential service, such as paying fees and keeping their room free from fire and safety hazards.

The Act protects the rights and privacy of people living in a residential service by providing guidance about when a disability service provider can enter a person's room.

Community residential units

The Act has extra requirements for community residential units in relation to fees and what needs to happen if people who live in the service need to move.

If a person is given notice of a fee increase, or notice to move permanently from the community residential unit, the person can apply to VCAT to review the decision.

Residential institutions

The Act outlines reasons for when a person with an intellectual disability may be admitted to a residential institution.

If a person is admitted to a residential institution, they can apply to VCAT for a review of this decision.

Managing money

The Act says a disability service provider cannot manage the money of a person with a disability using their service.

However, a residential service may manage a limited amount of money for a resident in specific circumstances.

Providing better complaint and review systems

The Act provides for better and clearer complaints and review systems.

Disability service providers

The Act says that disability service providers must:

- have a clear process for managing complaints about their services
- make sure that people who use their service know how to make a complaint
- report every year to the Disability Services Commissioner about the number of complaints they receive and how they managed these complaints.

Disability Services Commissioner

The Act creates Victoria's first Disability Services Commissioner, who will work with people with a disability and disability service providers to resolve complaints.

The Disability Services Commissioner will be independent of government and disability service providers and will report annually to Parliament.

Any person can make a complaint to the Disability Services Commissioner about disability services. The Disability Services Commissioner can also investigate complaints and has broad powers to look into complaints across a wide range of issues.

The Act makes it clear that it is an offence to threaten or intimidate a person who has made a complaint to the Disability Services Commissioner.

Disability Services Commissioner

www.odsc.vic.gov.au

1800 677 342

Victorian Civil and Administrative Tribunal (VCAT)

Under the Act a number of decisions can be made or reviewed by VCAT. This increases protections for people with a disability, who will be able to apply for review of certain decisions by a disability service provider.

VCAT is able to accept, modify or change the decision of the disability service provider, depending on the situation.

Victorian Civil and Administrative Tribunal

www.vcat.vic.gov.au

(03) 9628 9911

Providing high quality services

The Act has a number of mechanisms to improve the quality of disability services:

Registration

The Secretary may register a service provider as a disability service provider, if they can meet the requirements of the Act when providing a service to people with a disability.

The Secretary must keep a register of disability service providers, which can be viewed by the public.

Standards and performance measures

The Act will make sure services are of high quality and accountable to people with a disability, by ensuring standards and performance measures for disability services are set and monitored.

The Act states that the Minister must determine standards to be met by disability service providers. It is an offence if a disability service provider does not comply with these standards.

The Act states that the Secretary must specify performance measures in relation to the standards. The Secretary may monitor how disability service providers are meeting the performance measures.

If a disability service provider does not meet the performance measures, conditions of their funding or any other requirement of the Act, the Secretary has the power to take action.

Community visitors

Community visitors are volunteers who are able to inspect and make inquiries in relation to residential services. The Act outlines how community visitors are appointed and what they can do when visiting a residential service.

If a person living in a residential service asks to see a community visitor, the disability service provider must notify the community visitors within 72 hours.

Community visitors can, through the Community Visitors Board, provide reports to the Minister for Community Services. Community visitors can also refer a matter to a more appropriate person such as the Disability Services Commissioner.

Office of the Public Advocate

www.publicadvocate.vic.gov.au

1300 309 337

Protecting the rights of people subject to restrictive interventions and compulsory treatment

A small number of people with a disability are subject to restrictive interventions (such as restraint or seclusion) or to compulsory treatment, due to the harm they pose to themselves or others. The Act provides strong requirements to ensure that the rights of these people are protected.

Senior Practitioner

The appointment of a Senior Practitioner is a key part of the Act to ensure that people's rights are protected when these practices are used. The Senior Practitioner will also ensure that appropriate standards are met in relation to these practices.

The Senior Practitioner has extensive powers and can investigate and direct disability service providers to either stop or undertake a practice.

Senior Practitioner

www.dhs.vic.gov.au/disability
(03) 9096 8427

Restrictive interventions

The Act has specific requirements for the use of restraint and seclusion.

The Act says that restraint and seclusion cannot be used unless the following criteria are met:

- The disability service provider is approved to use restrictive interventions.
- The use of restraint or seclusion is included in a behaviour management plan.
- A person who is independent of the disability service provider has explained the use of restraint or seclusion to the person with a disability and that the person has the right to seek a review of the decision by VCAT.
- The behaviour management plan has been given to the Senior Practitioner.

The Senior Practitioner is responsible for monitoring the use of restraint and seclusion.

The Senior Practitioner may also monitor or set guidelines about the use of other restrictive interventions.

Compulsory treatment

The Act provides regulation of two types of compulsory treatment for people with an intellectual disability: criminal and civil.

Criminal

Residential treatment facilities provide compulsory treatment for people who have a criminal order which allows for treatment in these facilities.

The Statewide Forensic Service is identified in the Act as a residential treatment facility and the Act provides new protections for people who have treatment in this service.

These include that:

- the person must have a treatment plan
- the treatment plan must be reviewed by VCAT
- the Senior Practitioner must monitor the treatment of people in these facilities.

Civil

The Act creates a new civil order, a Supervised Treatment Order. This order applies where a person:

- has an intellectual disability
- is living in a residential service
- has restrictions on their freedom, because there is a great risk of them causing serious harm to another person.

The Act provides protection for the rights of these people, by ensuring that:

- treatment plans must be developed
- an application must be made to VCAT for a Supervised Treatment Order
- the Senior Practitioner must supervise the Supervised Treatment Order
- the person can apply to VCAT for review of the order at any time.

For more information

Disability legislation website: www.dhs.vic.gov.au/ds/disabilityact

Email: disability.legislation@dhs.vic.gov.au

Telephone: 1300 366 731 (during business hours)

TTY: (03) 9096 0133 (for people who are deaf or have a hearing, speech or communication impairment)

UnitingCare Victoria and Tasmania

Providing a network of care in your community



Feeding the hungry (Photograph by Stacey Merlin, Sunraysia Daily)



Counselling and support for families in crisis



Drug and alcohol rehabilitation



Support for people with a mental illness

Gippsland		
UnitingCare Gippsland	Bairnsdale: 03 5152 9600 Sale: 03 5144 7777 Leongatha: 03 5662 5150	Early Years Services, Family, Youth, Children, Financial Counselling, Disability Services, Aboriginal, Independent Living Units, Emergency Relief, Op Shop

Loddon Mallee		
Bendigo UnitingCare Outreach	Bendigo: 03 5443 4972	Emergency Relief, Op Shop

North East Victoria		
UnitingCare Cutting Edge	Shepparton: 03 5822 1778	Youth, Migrant, Horses for Hope

UnitingCare Goulburn North East	Wangaratta, Albury, Benalla: 03 5723 8000	Community Based Aged Care, Independent Living Units, Gamblers Support, Respite
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UnitingCare Wodonga	Wodonga: 02 6024 2108	Emergency Relief, Food Bank, Counselling
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Port Phillip East

Connections UnitingCare	*Croydon, Mount Waverley, Ringwood, Mornington: 03 9271 0800	Early Childhood and Family Services, Youth, No Interest Loan Scheme, Housing
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Creative Ministries Network	South Yarra: 03 9827 8322	Arts & Faith based Activities, Grief Support Program
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Endeavour Hills UnitingCare Neighbourhood Centre	Endeavour Hills: 03 9700 3789	Adult Learning, Children's Services, Friendship Groups
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John Macrae Centre	Toorak: 03 9829 0320	Day Care for Older People
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Prahran Mission - UnitingCare	Prahran: 03 9692 9500	Home Based Outreach, Job Supply, Day Rehabilitation, Community Services, Emergency Relief, Disability, Cafe & Shop
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St Kilda UnitingCare	St Kilda: 03 9525 5478	Drop In Centre, Disability Services
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South Port UnitingCare	South Melbourne: 03 9690 1188	Emergency Relief, Op Shop, Children's Services, Older Person's Services
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Port Phillip West

Narana Aboriginal and Torres Strait Islander Community Care	Grovedale: 03 5241 5700	Aboriginal Cultural Tourism, Education, Retail Outlet
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Orana UnitingCare	Meadow Heights: 03 9307 1355	Children's Services, Out of Home Care, Early Intervention and Prevention, Family Services
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UnitingCare Geelong	South Geelong, Norlane: 03 5222 3293	Emergency Relief, Financial Counselling
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UnitingCare Moreland Hall	Moreland: 03 9386 2876	Drug and Alcohol Support Services
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UnitingCare Sunshine and Broadmeadows	Broadmeadows, Sunshine: 03 9351 3600	Early Years Services, Emergency Relief, Op Shops, Children's Services, Financial Counselling, Migrant Services, Family Services
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UnitingCare Werribee Support and Housing	Werribee: 03 9742 6452	Housing, Emergency Relief, Food Bank, Counselling
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Tasmania

UnitingCare Tasmania	Bellerive, Bridgewater, Gagebrook, Launceston: 03 6244 1144	Emergency Relief, Early Childhood Services, Family Services
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*Connections locations also include: Beaumaris, Blackburn, Cranbourne, Dandenong, Narre Warren, Pakenham and Windsor



Western Victoria

Heatherlie Homes	Warrnambool: 03 5561 5565	Independent Living Units
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UnitingCare Ballarat	Ballarat: 03 5332 1286	Housing, Early Childhood, Lifeline, Drug and Alcohol Support Services, Emergency Relief, Meals
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Wimmera UnitingCare	Horsham, Stawell, Ararat: 03 5382 6789	Disability, Family, Early Childhood, Independent Living Units, Drop In Centre, Housing
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Yarra Yarra

Wesley Mission Victoria	Melbourne: 03 9662 2355	Lifeline, Aged Care, Homelessness, Children, Youth and Family Services, Employment, Disability, Social Enterprise
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Church of All Nations Community Support Agency	Carlton: 03 9347 7077	Community Services, Emergency Relief, Food Programs
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Kildonan UnitingCare	Epping, Coburg, Preston, Collingwood: 03 8401 0100	Community, Family, Youth, Advocacy, No Interest Loan Scheme, Financial Counselling
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UnitingCare Community Options	Glen Waverley, Knox: 03 9239 2500	Community Aged Care, Case Management, Carer Respite, Disability Services
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UnitingCare East Burwood Centre	East Burwood: 03 9803 3400	Emergency Relief, No Interest Loan Scheme
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UnitingCare Harrison	Wantirna South: 03 9887 1055	Housing, Independent Living Units, Emergency Relief, Disability, Youth Drop In
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UnitingCare Hotham Mission	North Melbourne: 03 9326 8245	Asylum Seeker Project
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Financial Counselling



Life skills training for young people at risk



Support for children and adults with disabilities



Support for asylum seekers