`

|  |
| --- |
| Regulatory Impact Statement |
| Child Wellbeing and Safety (Information Sharing) Amendment Regulations 2020 |

|  |
| --- |
| To receive this publication in an accessible format phone 1800 549 646, using the National Relay Service 13 36 77 if required, or email Child Information Sharing Enquiry Line (childinfosharing@edumail.vic.gov.au)Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Australia, November 2019.In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.**ISBN** 978-0-7594-0854-8 **(pdf/online/MS word)** Available at <http://www.betterregulation.vic.gov.au/Home>  |
|  |

Contents

[Executive summary 4](#_Toc23510748)

[Objectives of the proposed Amendment Regulations 4](#_Toc23510749)

[Regulatory Options 4](#_Toc23510750)

[Preferred Option 4](#_Toc23510751)

[Impact of the proposed Amendment Regulations 4](#_Toc23510752)

[Implementation 4](#_Toc23510753)

[Consultation 4](#_Toc23510754)

[Review 4](#_Toc23510755)

[1. Background 4](#_Toc23510756)

[The need for reform 4](#_Toc23510757)

[Policy context 4](#_Toc23510758)

[Interface between the CIS and FVIS schemes 4](#_Toc23510759)

[CIS confidentiality considerations 4](#_Toc23510760)

[2. Problem analysis 4](#_Toc23510761)

[Lack of access to relevant information for service providers limits service delivery and hinders early intervention, compromising child wellbeing and safety 4](#_Toc23510762)

[The absence of regulation will lead to inconsistent information sharing practices between service providers 4](#_Toc23510763)

[3. Objectives 4](#_Toc23510764)

[Objectives of the CIS Scheme 4](#_Toc23510765)

[Objectives of the proposed Child Wellbeing and Safety (Information Sharing) Amendment Regulations 2020 4](#_Toc23510766)

[4. Options 4](#_Toc23510767)

[Consideration of a non-regulatory option (base case scenario) 4](#_Toc23510768)

[Options for determining prescribed ISEs 4](#_Toc23510769)

[5. Determining the preferred option 4](#_Toc23510770)

[Approach to analysis 4](#_Toc23510771)

[Criteria for analysis 4](#_Toc23510772)

[Options assessment 4](#_Toc23510773)

[6. Preferred Option 4](#_Toc23510774)

[Summary of the preferred option 4](#_Toc23510775)

[How workforce impacts were assessed 4](#_Toc23510776)

[Key assumptions informing the analysis of workforce costs 4](#_Toc23510777)

[Total cost of the proposed Amendment Regulations 4](#_Toc23510778)

[Costs to workforces proposed for prescription 4](#_Toc23510779)

[Qualitative ISE impact assessment 4](#_Toc23510780)

[Direct Costs to Government 4](#_Toc23510781)

[7. Expected benefits of the CIS Scheme 4](#_Toc23510782)

[Reduced over-reliance on acute and statutory services 4](#_Toc23510783)

[Improvements in health and wellbeing outcomes for Victorian children 4](#_Toc23510784)

[The CIS Scheme costs versus benefits 4](#_Toc23510785)

[8. Implementation of the CIS Scheme 4](#_Toc23510786)

[Approach to implementation of the CIS Scheme 4](#_Toc23510787)

[Training and change management 4](#_Toc23510788)

[Alignment with the FVIS Scheme 4](#_Toc23510789)

[A multi-agency approach 4](#_Toc23510790)

[Managing complaints under the CIS Scheme 4](#_Toc23510791)

[9. Review of the CIS Scheme 4](#_Toc23510792)

[Two-year and five year legislative reviews 4](#_Toc23510793)

[10. Consultation 4](#_Toc23510794)

[Objectives of consultation 4](#_Toc23510795)

[Consultation approach 4](#_Toc23510796)

[Consultation participation 4](#_Toc23510797)

[Key inputs form the consultations 4](#_Toc23510798)

[11. References 4](#_Toc23510799)

[12. Appendix A Prescribed Phase One Entities 4](#_Toc23510800)

[13. Appendix B Entities Proposed for Phase Two Prescription 4](#_Toc23510801)

[14. Appendix C Costing Methodology and Assumptions 4](#_Toc23510802)

[Overview 4](#_Toc23510803)

[Costing methodology 4](#_Toc23510804)

[Workforce groupings and summary data 4](#_Toc23510805)

# Executive summary

Keeping children safe from harm and promoting their wellbeing is a priority for the Victorian Government. Over the last decade, many independent inquiries and reviews have recommended reform to Victoria’s child information sharing laws. A recurring theme is that improved information sharing and service collaboration around children and families is key to identifying vulnerability and risk early, to enable early support and prevention of harm to children.

As part of the government’s response to these challenges, and in line with the Victorian Government’s Roadmap for Reform, Education State reforms and broader child safety initiatives, Part 6A of the *Child Wellbeing and Safety Act 2005* (the Act) was proclaimed in September 2018. The Act established the Child Information Sharing (CIS) Scheme, which enables information sharing between prescribed entities to promote the wellbeing and safety of children. The Act also authorised the development of a web-based platform that will display factual information about children’s participation in services (the Child Link Register). The CIS Scheme will:

* improve early identification of risk and support for the child and their family
* shift a risk averse culture in relation to information sharing
* increase collaboration and integration between services involved in supporting children and families
* support children's and their families’ participation in services.

The CIS Scheme is modelled on recommendations made by the Royal Commission into Institutional Responses to Child Sexual Abuse (the McClellan Royal Commission) and is supported by a decade of independent reviews and inquiries.

Under the CIS Scheme prescribed entities, known as information sharing entities (ISEs), are authorised to:

* request confidential information from another ISE for the purpose of promoting the wellbeing or safety of a child or a group of children
* disclose confidential information (either voluntarily or in response to a request) to another ISE for the purpose of promoting the wellbeing or safety of a child or group of children and to assist the recipient to deliver services in relation to the child or group of children.

To ensure that the privacy of individuals is not arbitrarily displaced, the CIS Scheme provides for a range of protections for individuals. For example, it recognises that the disclosure of confidential information will not be appropriate in all cases and, therefore, excludes certain information from the operation of the CIS Scheme. The legislative principles include a requirement that information is shared only to the extent necessary to promote the wellbeing or safety of a child or a group of children, consistent with their best interests.

Alongside the CIS Scheme, the *Family Violence Protection Act 2008* now includes the Family Violence Information Sharing (FVIS) Scheme, which enables information to be shared between prescribed entities to assess and manage family violence risk to children and adults. The FVIS Scheme also authorises the operation of a Central Information Point to facilitate family violence information sharing. The FVIS Scheme, which commenced in February 2018, supports the sharing of information to assess each family member’s risk in the family violence context (that is, for adult and child victim survivors, and to hold perpetrators to account) and provides for coordinated risk management and safety planning.

The *Family Violence Protection Act 2008* also authorises the Family Violence Risk Assessment and Risk Management Framework (MARAM) which requires prescribed organisations to align their policies, procedures, practice guidance and tools with MARAM.

The professionals and service providers permitted to share information under the CIS Scheme are very similar to those permitted to share under the FVIS Scheme. Together, the schemes and MARAM enable service providers to share information to promote children’s wellbeing and safety and better protect all Victorian children.

Implementation of the CIS Scheme is organised in a phased manner. Some professionals and service providers were prescribed to share information from September 2018 (Phase One), whereas a greater number of service providers will be prescribed in the second half of 2020 (Phase Two). This aligns with the planned phased prescription of remaining workforces under the FVIS Scheme.

To maximise efficiencies and minimise workforce confusion and reform fatigue, the Department of Education and Training (DET), Family Safety Victoria (FSV), the Department of Justice and Community Safety (DJCS), the Department of Health and Human Services (DHHS), Victoria Police and Court Services Victoria are working together to align workforce training and change management activities across the two schemes and MARAM.

Considering the regulatory impact of the CIS Scheme is key to responsible government decision making. This Regulatory Impact Statement (RIS) has been prepared to assess impacts on government and the workforces proposed for prescription under Phase Two of the CIS Scheme, and includes consideration of possible regulatory options.

## Objectives of the proposed Amendment Regulations

The proposed Amendment Regulations will enable implementation of Phase Two of the CIS Scheme by prescribing ISEs that will be authorised to voluntarily share relevant information with one another for the purposes of promoting child wellbeing and safety (and will be obliged to share that information in response to requests from other ISEs).

The CIS Scheme authorises ISEs to request, collect, use and disclose information to promote child wellbeing and safety. ISEs are obliged to share that information when lawfully requested to do so by another ISE unless the information falls under the exclusion category – Including information that, if shared, would prejudice an ongoing investigation of a breach of the law or a coronial inquest, or would endanger a person’s life or physical safety.

## Regulatory Options

Three options were considered for the proposed Amendment Regulations for Phase Two prescription of ISEs under the CIS Scheme:

* **Option 1**. Targeted prescription of universal health services.
* **Option 2**. Targeted prescription of universal health and education services and other key child service providers.
* **Option 3**. Services prescribed in Option 2 with the addition of other universal health and education services and child service providers.

## Preferred Option

In considering the full range of analytical techniques available for determining the preferred option in this RIS, Multi-Criteria Analysis (MCA) is determined to be the most appropriate. This is due to the difficulty involved in quantifying the expected effects of information shared under the CIS Scheme and associated improvements in child wellbeing or safety. This is compounded by the fact that the CIS Scheme is part of a larger reform program, which aims to grow and improve service delivery, and early intervention and preventative action for children.

MCA is typically applied as an analytical technique in cases where full cost-benefit analysis is infeasible due to difficulties in quantifying benefits. MCA allows options to be compared through both quantitative and qualitative analysis and enables a wider range of criteria, such as social considerations, to be included in the analysis. It involves determining a set of criteria considered to be most relevant to weighing up options and then scoring each option with reference to the selected criteria, where a positive score indicates an option is better than the base case and a negative score indicates an option is worse that the base case. The criteria are also weighted according to their relative importance in the overall decision.

The table below shows the results of the MCA analysis, determining the preferred option for Phase Two prescription of ISEs under the CIS Scheme. Based on the result of the MCA, it was determined that the ISEs listed according to **Option 2, ‘Targeted prescription of universal health and education services and other key child service providers’**, should be prescribed in Phase Two of the CIS Scheme. The preferred option prescribes universal health and education related services as well as services that support vulnerable children and families, ensuring prescription of services that interact with the vast majority of Victorian children and particularly with those who are in greatest need of support. The ISEs prescribed under the preferred option have the capacity to provide timely access to information deemed relevant to the wellbeing or safety of a child, and to facilitate reform delivery within current timelines, with appropriate support from government.

**Table ES.1 MCA results for the prescribed entities options**

|  | Effectiveness(50%) | Risk of infeasibility(25%) | Implementation costs to ISEs(25%) | Weighted score total |
| --- | --- | --- | --- | --- |
|  | **Score** | **Score** | **Score** | **Score** |
| Base case | 0 | 0 | 0 | 0 |
| Option 1 | 4 | -6 | -2 | 0 |
| Option 2 | 8 | -2 | -5 | 2.25 |
| Option 3 | 9 | -9 | -7 | 0.5 |

## Impact of the proposed Amendment Regulations

When factoring in the total costs to prescribed ISEs (both government and non-government organisations) and the direct costs to government, the total cost of Phase Two implementation of the CIS Scheme is estimated at $216 million over 10 years in Net Present Value (NPV) terms.[[1]](#footnote-2) This includes $65.7 million in the first year, in direct costs to government[[2]](#footnote-3), upfront costs to ISEs and first year ongoing costs to ISEs.[[3]](#footnote-4) Across the following nine years, the total cost is $150.3 million. This includes ongoing costs to ISEs and direct costs to government.

A breakdown of these costs to government and to ISEs is outlined below.

### Direct costs to government

The 2018-2022 State Budget allocated $42.9 million over four years, and ongoing funding of $5.2 million per year, to the implementation of the CIS Scheme. This funding was distributed to DET, DHHS, DJCS, FSV, Victoria Police and Court Services Victoria as the agencies and departments responsible for Phase One and Phase Two implementation of the scheme.

The direct costs to government of implementing Phase Two the CIS Scheme, as presented below, represent direct government costs from the 2019-20 financial year (FY) onwards. Although some funding will be allocated to training and support of Phase One workforces in the period, the larger part of costs incurred from 2019-20 FY onwards will be related to Phase Two implementation of the scheme. The costs presented below include funding allocated to DET, DHHS and DJCS as the departments that represent workforces proposed for prescription in Phase Two of the CIS Scheme.[[4]](#footnote-5) In all, the Victorian Government has allocated $21.8 million over three years, from FY 2019-20 and ongoing funding of $2.8 million per annum, to support Phase Two implementation of the CIS Scheme.

**Table ES.2 Overall costs to government**

|  | 2019/20 | 2020/21 | 2021/22 | Ongoing |
| --- | --- | --- | --- | --- |
| WoVG implementation | $1.89M | $1.26M | $1.29M | $0.23M |
| Sector support | $2.42M | $2.35M | $0.56M | $0.00M |
| Workforce training | $7.40M | $2.05M | $2.54M | $2.58M |
| **Total** | **$11.71M** | **$5.66M** | **$4.39M** | **$2.81M** |

### Costs to workforces proposed for prescription

The main upfront costs to ISEs are expected to be associated with:

* training of staff
* updating policies and procedures.

The main ongoing costs to ISEs are expected to be associated with:

* training of new staff, who are not involved in the initial workforce training
* time taken to respond to requests for information
* time spent requesting information
* time spent record keeping.

As shown in the tables below, the total estimated cost impact on Phase Two workforces over a 10-year period is expected to be approximately $181.6 million in NPV terms, of which $80.5 million is attributable to non-government organisations and $101.1 million is attributable to government organisations.[[5]](#footnote-6) Approximately $28 million of the total costs represent upfront costs and $154 million represent ongoing costs to ISEs.

Upfront costs are estimated at $3,738 on average per organisation, and ongoing costs are estimated at $2,177 on average per organisation per year. This represents a total of $24,277 (NPV) per organisation over 10 years, when including initial and ongoing costs.

**Table ES.3 Total workforce costs, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
| Cost Category | Government  | Non-government | Total |
| Upfront costs | ‘000 | ‘000 | ‘000 |
| Update policies | $4,677 | $13,499 | $18,176 |
| Upfront training | $2,207 | $7,577 | $9,784 |
| Ongoing costs  | ‘000 | ‘000 | ‘000 |
| Ongoing training | $2,256 | $7,748 | $10,004 |
| Requests to share information | $35,973 | $16,332 | $52,306 |
| Responses to requests | $26,367 | $16,162 | $42,529 |
| Record keeping  | $29,652 | $19,143 | $48,796 |
| Total Costs | $101,133 | $80,462 | $181,595 |
| *Source: ACIL Allen Consulting 2019* |

**Table ES.4 Average per organisation cost, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
| Cost Category | Government  | Non-government | Total |
| Upfront costs (2020) | $ | $ | $ |
| Update policies | $2,772 | $2,330 | $2,430 |
| Upfront training | $1,308 | $1,308 | $1,308 |
| Ongoing annual costs (from 2022) | $ | $ | $ |
| Ongoing training | $169 | $169 | $169 |
| Request | $2,206 | $302 | $731 |
| Respond | $1,622 | $289 | $590 |
| Record keeping  | $1,851 | $348 | $687 |
| Total ongoing annual costs (from 2022) | $5,863 | $1,104 | $2,177 |
| Avg. total 10 year cost per organisation | $59,948 | $13,890 | $24,277 |
| *Source: ACIL Allen Consulting 2019* |

### Cost impacts by workforce category

ISEs proposed for prescription under Phase Two of the CIS Scheme represent a broad range of services and workforces. In order to model the impact across workforces, this RIS groups workforces together where they are similar in their service offering and cost impacts per workforce member.

The resulting six workforce categories are listed below:

1. Schools (including student disengagement and wellbeing services)
2. Early childhood education and care (ECEC) provider
3. Outside school hours care (OSHC) provider
4. Health and support services
5. Hospitals
6. Government statutory bodies and organisations/services

**Table ES.5 Average annual upfront and ongoing costs per organisation by workforce group (2022)**

|  |  |  |  |
| --- | --- | --- | --- |
| Workforce group | Upfront Costs | Ongoing Costs in 2022 |  |
| Update Policies | Upfront training | Ongoing training | Requests | Respond | RecordKeeping | Annual ongoing costs (excl. upfront) |
|  | $ | $ | $ | $ | $ | $ | $ |
| Grp 1: Schools | $2,507 | $1,308 | $169 | $637 | $610 | $376 | $1,792 |
| Grp 2: ECEC provider | $1,728 | $1,308 | $169 | $286 | $187 | $472 | $1,114 |
| Grp 3: OSHC provider | $1,265 | $1,308 | $169 | $140 | $56 | $138 | $503 |
| Grp 4: Health and support services | $3,292 | $1,308 | $169 | $155 | $333 | $174 | $831 |
| Grp 5: Hospitals | $8,667 | $1,308 | $169 | $33,130 | $21,055 | $29,692 | $84,047 |
| Grp 6: Govt. statutory bodies and organisation/service | $1,027 | $1,308 | $169 | $18 | $160 | $67 | $415 |
| Avg. all organisations | $2430 | $1,308 | $169 | $731 | $590 | $687 | $2,177 |
| *Source: ACIL Allen Consulting 2019* |

The breakdown of costs per workforce category revealed variations in cost impacts, including:

* Variation according to size of organisation, with hospitals ranking highest both in terms of absolute size and cost per organisation, at $84,000 annually (excluding upfront costs). The cost to a hospital is significantly higher than that of any other organisation and is largely a reflection of the very significant size of the average hospital workforce, at around 1,000 full-time equivalent (FTE). OSHC, health and support services and government statutory bodies rank lowest in terms of cost per organisation, at under $1,000 annually (excluding upfront costs).
* Variation according to expected information sharing activity, with schools, ECEC services, hospitals, and health and support services recording a higher cost level per FTE staff member than OSHC services and government statutory bodies and services.

Please refer to Chapter 6 for a detailed presentation of the cost impacts on workforce groupings, and the variation of costs illustrated through sensitivity analysis.

## Implementation

In line with the recommendations of the McClellan Royal Commission, implementation of the CIS Scheme will occur in a phased manner:

* Phase One of the CIS Scheme commenced in September 2018, prescribing ISEs primarily within secondary and tertiary services.
* Phase Two, commencing in the second half of 2020, prescribing ISEs in primary and key universal services across the education, health and justice portfolios, according to the preferred option identified in this RIS.

## Consultation

Impacts of the proposed Amendment Regulations have been estimated through consultations with representatives from entities likely to be impacted by the regulations. While the stakeholders consulted included approximately 120 workforce representatives from 60 different government and non-government organisations across a range of sectors, it should be noted that only a small sample of the organisations likely to be affected by the CIS Scheme could be consulted. As such, the impact estimates reported in this RIS should be considered an approximate indication, rather than anything more definitive. Impacted stakeholders are encouraged to provide feedback on the perceived accuracy of the estimated impacts as part of the public consultation process for this RIS.

The consultations indicated significant variation across organisations in the level of expected impact of their prescription under Phase Two of the CIS Scheme. This in part reflects the uncertainty that organisations invariably face when contemplating the impact of regulations they have not previously encountered. It also reflects the fundamental factors that will drive variation in the regulations’ impacts across ISEs, including the size of the organisation, their resourcing capacity, the nature of their work involving information sharing, and their existing systems and processes.

The release of this RIS marks the beginning of the consultation through which interested members of the public can provide input into the development of the Amendment Regulations. For a minimum of 28 days, DET will invite public comments or submissions to consider before it finalises the Amendment Regulations. Information on how to lodge submissions can be found at the Engage Victoria Consultations web page at:
[engage.vic.gov.au/consultations](https://engage.vic.gov.au/consultations).

Submissions on this RIS are to be received via the Engage Victoria website by 5pm Friday 6th December 2019.

## Review

The Act requires review of the operation of the CIS Scheme within two and five years of commencement of the scheme, and the tabling of a review report in both houses of Parliament within six months of the end of the two-year and five-year review periods. The Act further states that the reviews must be independent and must consider any adverse impacts of the legislation. The reviews may also include recommendations on any matter addressed in the review.

DET is responsible for the review processes, and both the two-year and five-year reviews are to be performed by independent suppliers with expertise in review of government reforms and programs.

# Background

## The need for reform

Since 2011, numerous government reviews and inquiries from the Commission for Children and Young People (CCYP), the Victorian Coroner and the Victorian Auditor-General identified that a lack of information sharing has contributed to negative outcomes for the wellbeing and safety of Victorian children. Recurring themes relating to child information sharing in these reviews include that:

* Victoria’s multiple legislative frameworks for information sharing create complexity and contribute to a culture that is risk-averse to sharing information, which has not adequately supported child safety and wellbeing outcomes.
* the capacity for professionals to form a holistic picture of a child’s circumstances is compromised when information is not shared across services, inhibiting the timely delivery of early intervention and prevention programs to children at risk and contributing to an over-reliance on secondary and tertiary services.
* there are difficulties in determining whether children are accessing and participating in universal or targeted services, and improved access to this information might assist to identify and protect vulnerable children.
* there are restrictions on data-linkage between government-funded programs, including the impact of children’s interactions with universal and targeted services, which limits the ability for government to design responsive policy and programs, perform evaluations and plan in accordance with patterns of service engagement.

The **Royal Commission into Institutional Responses to Child Sexual Abuse** (the McClellan Royal Commission)[[6]](#footnote-7) delivered its recommendations on 15 December 2017 and made a number of recommendations related to improving information sharing and record keeping practices, including for the establishment of a national information exchange scheme between a range of prescribed entities that have responsibilities related to children’s safety and wellbeing. In recommending improvements to information sharing, the McClellan Royal Commission identified New South Wales’ Chapter 16A model in the *Children and Young Persons (Care and Protection) Act 1998* as providing the most promising model for a national information exchange scheme for children’s safety and wellbeing. The McClellan Royal Commission identified a number of key elements to enable an effective national information sharing scheme, including:

* enable direct exchange of relevant information between a range of prescribed entities, including service providers, government and non-government agencies, law enforcement agencies, and regulatory and oversight bodies, which have responsibilities related to children’s safety and wellbeing.
* permitting prescribed entities to request, provide and voluntarily share information related to the wellbeing and safety of children with other prescribed entities.
* explicitly prioritising children’s safety and wellbeing over laws which might otherwise prohibit disclosure of that relevant information.
* providing safeguards and other measures for oversight and accountability to prevent unauthorised sharing and improper use of information.

The importance of improved information sharing to assess and manage risk to children in a family violence context was specifically highlighted in two key Victorian reviews, the **Royal Commission into Family Violence** (Family Violence Royal Commission) and the CCYP (2016) report **Neither seen nor heard: Inquiry into issues of family violence in child deaths*.***

The Family Violence Royal Commission in its final report, delivered in March 2016, found that:” … the Child Protection system has unfairly burdened vulnerable and unsupported women with the responsibility – as a ‘protective parent’ – to manage and mitigate risks to children, at the expense of focusing on the harmful actions of the abusive parent or caregiver”. Hence, there was a need to “shift from seeing the needs of children affected by family violence as merely an extension of those of their caregiver”. It also confirmed that information sharing plays an imperative role in enabling government and supporting agencies to effectively and appropriately respond to the needs of children and families. Information sharing was identified as a necessary precursor to interventions to promote child safety and save lives.

The CCYP (2016) released the report ***Neither seen nor heard: Inquiry into issues of family violence in child deaths*** that examined a representative sample of the CCYP’s child death inquiries, to offer a more complete picture of the intersection of family violence and the Child Protection system. A key finding of the inquiry was that there was a lack of coordination between services, and that services did not share information to adequately form an overall view about the problems the women and their children experienced.

## Policy context

### Roadmap for Reform

The Victorian Government’s ***Roadmap for Reform*** (the Roadmap), released in April 2016, sets out once-in-a-generation changes designed to improve the lives of vulnerable children, young people and families in Victoria. Consistent with the Family Violence Royal Commission, the Roadmap provides an initial outline of how a transformed service system will operate to better support Victoria’s most vulnerable individuals, families and communities.

The Roadmap agenda is underpinned by the need to better respond to pressures on out-of-home care and Child Protection services, and to deliver better outcomes for vulnerable children and families. Child Protection reports grew at an annual average rate of more than 10 per cent in the years leading up to 2015-16 when it reached 107,000 reports, with a significant increase in the number of children subject to multiple (five or more) reports (from 75 in 2006-07, to 911 in 2014-15). Between 2015-16 and 2017-18, the number of Child Protection reports increased at an annual average rate of 4 per cent[[7]](#footnote-8), indicating a continuation of the trend increase in overall reports, albeit a weaker one. Many of the reports to Child Protection involve family violence, parental mental health and parental substance misuse.

The Roadmap outlines a vision of a transformed service system, along with a suite of immediate actions that will build confidence, stability and capability within families by:

* building on the recommendations of the Family Violence Royal Commission to develop shared responsibility and bring together the full range of services and supports that victims and other vulnerable families need.
* prioritising earlier intervention and preventative support, rather than responding to issues once they have become critical.

The CIS Scheme is a key enabler in delivering the objectives of the Roadmap to refocus the service system towards prevention and early intervention, and support proactive and integrated service responses in partnership with the family.

### The Education State

The Education State reforms, launched in 2015, aim at developing the Victorian education system to produce excellence in outcomes and to reduce the impact of disadvantage. The reforms establish targets for Victorian schools that include improvement in outcomes for all students, regardless of their start in life.

The **Education State Early Childhood Reform Plan** outlines the Victorian Government’s vision for early childhood, and the reforms that will be undertaken to create a higher quality, more equitable and inclusive early childhood system. Acknowledging the importance of the early years in a child’s development and the negative impacts of disadvantage, the **Early Childhood Reform Plan**directs support to the children and families who need it most through initiatives including strengthening of kindergarten services, expansion of the Supported Playgroups Program and increased support to children with a disability and Koorie families and children.

In line with the objectives of the Education State reforms, the CIS Scheme facilitates improved coordination of service delivery, including transition between services, and supports increased participation in services among vulnerable Victorian children and their families. As such, and acknowledging the direct link between the health and wellbeing of a child and their ‘school readiness’ and ability to learn, the CIS Scheme is an enabler of the Education State target of breaking the link between disadvantage and the learning outcomes of Victorian children.

### The Child Information Sharing Reform

In response to the reviews, inquiries and Royal Commission recommendations discussed above, and in alignment with the Roadmap for Reform, the Education State reforms and broader child safety initiatives, the Victorian Parliament proclaimed parts 6A and 7A of the Act, establishing the CIS Scheme and the Child Link Register, collectively referred to as the Child Information Sharing (CIS) Reform.

* **Part 6A–Information Sharing**. Part 6A, proclaimed September 2018, mandates the creation of the CIS Scheme to enable prescribed entities to share confidential information in a timely and effective manner in order to promote the wellbeing and safety of children.[[8]](#footnote-9)
* **Part 7A–Child Link Register**. Part 7A, proclaimed February 2019:
	+ mandates the establishment of the Child Link Register to improve child wellbeing and safety outcomes for, and to monitor and support the participation in government-funded programs and services by, children born in or resident of Victoria, and;
	+ authorises the implementation of an information technology (IT) system, referred to as Child Link, to enable the establishment and ongoing provision of the Child Link Register.

The RIS for the Child Wellbeing and Safety (Information Sharing) Regulations 2018 considered options for prescription of services and for record keeping requirements for Phase One implementation of the CIS Scheme. These matters were settled in the 2018 Regulations, and following proclamation of Part 6A of the Act, Phase One of the CIS Scheme commenced on 27 September 2018 prescribing over 28,000 workers representing more than 700 entities, primarily within the secondary and tertiary sectors.

The CIS Scheme is being rolled out to workforces in a phased approach. It is expected that Phase Two of the CIS Scheme will be rolled out in the second half of 2020, and that this phase will bring in key universal services across the education, health and justice portfolios. These services interact with the vast majority of children and families in Victoria, and as such they play a crucial role in early intervention and prevention. This RIS will consider which services to include in Phase Two of the CIS Scheme.

The phased implementation of the scheme is led by DET as part of a Whole of Victorian Government (WoVG) function, and is undertaken in conjunction with partner agencies and departments: FSV, DHHS, DJCS, Court Services Victoria and Victoria Police. Funding to implement the scheme for Phase One and Phase Two workforces was allocated to the responsible agencies and departments over the 2018-22 State Budget. These pre-determined government costs are presented in further detail in Chapter 6.

The development and implementation of the Child Link Register is centrally managed and led by DET. The Child Link Register is expected to commence by the end of 2021 and is a key enabler to ensure the success of the CIS Scheme.

**Child Link Register**

The Child Link Register will be a web-based platform that will display factual information about a child to a prescribed group of authorised professionals who have responsibility for supporting child wellbeing and safety.

The Child Link Register is an enabler for better information sharing and service collaboration between key professionals who work with children. Child Link will provide visibility of the service participation history and vulnerability of a child in their care which will assist them to make informed decisions about the wellbeing or safety related support needs of the child. Access to the Child Link Register is restricted by role and purpose to ensure that only appropriately skilled and trained key professionals within a service will have access to the register.

The thin layer of information displayed on the Child Link Register is limited by legislation and may include the following attributes:

* basic information about a child­­­­­ – including name, birth date and sex (no phone numbers or addresses)
* key family relationships – including carer and sibling information
* whether the child is Aboriginal and/or Torres Strait Islander
* participation in the National Disability Insurance Scheme
* enrolment and participation in certain government childhood services and programs – including Maternal and Child Health services, supported playgroups, funded kindergarten programs and schools
* current or previous Child Protection orders made in relation to the child or a sibling, the date of the order and out of home status
* contact details for services with which the child has been or is engaged
* if a child dies before the age of 18, the date and cause of death.

Key professionals who are authorised as Child Link Register users will only be able to see Child Link Register profiles once a child is enrolled in their service. The Child Link Register is not a tool for key professionals to transfer information to each other. It will, however, contain contact details for the services that the child has been or is currently engaged with, for the purpose of guiding information sharing. The Child Link Register is not a case management system, and it will not record or contain any case notes, professional opinions or health records.

The CIS Reform complements other child safety reforms, including the FVIS Scheme and MARAM. The FVIS Scheme enables information to be shared between prescribed entities to assess and manage family violence risk to children and adults. It supports the sharing of information to assess each family member’s risk of family violence (that is, for adult and child victim survivors, and to hold perpetrators to account) and provide for coordinated risk management and safety planning.[[9]](#footnote-10) The FVIS Scheme also authorises the operation of a Central Information Point to facilitate family violence information sharing. MARAM requires prescribed organisations to align their policies, procedures, practice guidance and tools with the Framework.

## Interface between the CIS and FVIS schemes

Together, the CIS and FVIS Schemes authorise information sharing between entities prescribed under each scheme to facilitate the early identification, assessment and management of children’s wellbeing or safety in a wide range of contexts, enabling services to respond to the multiple, complex needs of families and children.

Both schemes are being implemented in alignment for significantly overlapping workforces and organisations. The situations in which both schemes are applied are also likely to overlap for many children and families.

The design and aligned implementation of the two schemes will support an integrated experience from a client perspective. Key similarities between the schemes include:

* both schemes recognise that a child’s right to safety takes precedence over any individual’s privacy; and neither scheme requires consent to share relevant information to keep a child safe.
* guidelines for both schemes provide practical guidance on the assessment and management (including information sharing) of all family members believed to be at risk of family violence, supporting holistic and coordinated risk management.
* the categories of excluded information are consistent across both schemes.
* the offence provisions are interoperable across both schemes, although the CIS Scheme has an additional offence for impersonating an ISE.

The two schemes will therefore be used in an integrated way wherever children are or may be experiencing family violence, as outlined in the figure below.

**Figure 1.1: Intersection between the CIS and FVIS Schemes**



## CIS confidentiality considerations

Under the CIS Scheme, prescribed information sharing entities (ISEs) are authorised to:[[10]](#footnote-11)

* request confidential information from another ISE for the purpose of promoting the wellbeing or safety of a child or a group of children.
* disclose confidential information (either voluntarily or in response to a request) to another ISE for the purpose of promoting the wellbeing or safety of a child or group of children and to assist the recipient to deliver services or to undertake certain activities in relation to a child or group of children.

To ensure that the privacy of individuals is not arbitrarily displaced, the CIS Scheme provides for a range of protections for individuals. For example, the scheme recognises that the disclosure of confidential information will not be appropriate in all cases and, therefore, excludes certain information from the operation of the scheme. The legislative principles include a requirement that information should be shared only to the extent necessary to promote the wellbeing or safety of a child or a group of children, consistent with their best interests. In addition, ISEs should seek and take into account the views of the child and the relevant family members wherever appropriate, safe and reasonable to do so.

ISEs are required to consider and meet a threshold test before sharing information with another ISE. The threshold test permits information to be shared where:

* the purpose of disclosing the information is to promote the wellbeing or safety of a child or group of children
* the disclosure may assist the recipient to carry out one or more specified activities, as follows:
	+ to make a decision, assessment or plan relating to a child or group of children
	+ initiate or conduct an investigation relating to a child or group of children
	+ provide a service relating to a child or group of children
	+ to manage any risk to a child or group of children
* the information is not ‘excluded information’, which is information that if shared could reasonably be expected to:
	+ endanger a person’s life or result in physical injury
	+ prejudice an investigation of a breach of the law; the enforcement or proper administration of the law; a coronial inquest or inquiry; or a person’s right to a fair trial
	+ contravene legal professional privilege
	+ disclose or enable a person to ascertain a confidential source of information in relation to the enforcement or administration of the law
	+ contravene a court order or provision of an Act that prohibits or restricts the publication or other disclosure of information for or in connection with a court proceeding; or requires or authorises a court or tribunal to close proceedings to the public
	+ be contrary to the public interest.

The Act also contains a list of legislative principles intended to guide ISEs on appropriate practice in relation to sharing of confidential information under the CIS Scheme. Practice guidance resources and binding Ministerial Guidelines for information sharing have been developed to inform ISEs of how these legislative principles are to be upheld in practice. [[11]](#footnote-12)

# Problem analysis

## Lack of access to relevant information for service providers limits service delivery and hinders early intervention, compromising child wellbeing and safety

**When service providers make decisions, or avoid making decisions, on the basis of insufficient information about a child and the child’s circumstances, the child may receive service support that fails to target their needs appropriately, so that the wellbeing or safety of that child is negatively impacted. If relevant information were available, better decisions could be made in relation to service delivery involving the child and their family in support of their wellbeing or safety.**

### Consequences arising from a lack of access to information

Whenever a service provider makes a decision in relation to a child’s wellbeing or safety without access to relevant information about that child, there is a risk of sub-optimal service delivery. The consequences of this may range from missed opportunities to promote a child’s learning outcomes and social wellbeing by ensuring appropriate transitioning between education providers, for example, to a failure to address serious risk to a child’s safety. Critically, harm accumulates incrementally, and serious harm often follows early indicators. An inability to form a more complete picture of a child’s circumstances early therefore hinders the possibility of early intervention and support, representing a missed opportunity to prevent or manage issues or risks before serious harm occurs.

Beyond this, if services cannot share information about a mutual client, they will not be in a position to collaborate and coordinate their services effectively. Consequently, service providers may deliver competing or duplicative services or no service at all. This may represent a risk to the child and their family in terms of slipping between gaps in service delivery.

Numerous reviews have identified these issues. Notably, the Commission for Children and Young People (CCYP) have, for years, revealed consistent problems with siloed information that contributed to the circumstances in which a child died or suffered. In their 2016-17 annual report CCYP reported that inadequate information sharing was a contributing factor in 21 out of 34 child death inquires, and in 2017-18 the CCYP child death inquiries highlighted a critical need for improvement in information sharing and collaboration between Child Protection, medical services and schools focused on promoting the wellbeing and safety of children and young people.[[12]](#footnote-13) Specific inquiries have also highlighted these issues, including the Coroners Court Finding With Inquest into the Death of AA (Baby D) (2016)[[13]](#footnote-14) and CCYP Inquiry into Child O[[14]](#footnote-15).

**Case study: Baby D**

An inquest by the Coroners Court of Victoria into the Death of Baby D in 2015 found that professionals involved in the case of Baby D lacked critical information upon which to make appropriate decisions regarding her health and safety. No single practitioner had a full picture of her circumstances due to the lack of adequate information sharing.

The Inquest noted that in the eight-week period leading up to her death, a number of health professionals were engaged with Baby D’s family, however, as noted by Justice Gray at paragraphs 342-344:

*“…in approaching this task, they did not have the benefit of each other's observations and examinations, except to the extent that information was relayed via the parents. Each practitioner would almost certainly have benefited from information from the others about the bruising, mental health screens, diagnoses, treatment plans. As a result, at inquest there were many hypothetical questions about how assessments and responses may have been different with a more complete picture.”*

While acknowledging that information sharing is a dynamic and complex policy area, the Coroner noted that the circumstances surrounding the death of Baby D crystallises lack of information sharing as an issue that warrants a sector wide response.

Service providers that work with children and families report being deterred from sharing information for several reasons, including confusion about when and what information can lawfully be shared. Victoria’s legislative framework for information sharing is complex. Relevant acts include the *Children Youth and Families Act 2005*, the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001*. There is also additional legislation that relates to child information sharing such as Commonwealth privacy law (for private and Commonwealth funded non-government organisations) and various secrecy and confidentiality provisions under subject-specific legislation.

In response to this complex legislative environment, organisations have not always been confident in their understanding of the legal requirements for information sharing, and risk averse attitudes towards information sharing have developed within the organisation. This has resulted in information not being shared, even when sharing may have been legally permitted and appropriate. In a situation where service providers do not have access to information relevant to a child’s wellbeing or safety, there will be missed opportunities for early intervention or prevention, such as in the tragic case of Child O.

**Case study: Child O**

Child O was born in 1998. Having separated when he was young, his parents’ relationship remained acrimonious. O lived primarily with his mother and younger sibling, but maintained contact with his father, stepmother and paternal sibling, as arranged through the Family Court. In adolescence, following times of conflict with his mother, O lived with his maternal grandparents for short periods.

Child Protection (CP) received three reports about O, all closed at intake. The first, at five years of age, related to allegations of physical and emotional harm by his father’s new partner. It was noted that O was an ‘anxious child and fearful of doing anything wrong’. A further two CP reports related to conflict between O and his mother when he was 16. Both were assessed as wellbeing reports. He was described as suffering from an anxiety disorder, alcohol abuse, self-harm and suicidal ideation.

O had intensive and extensive involvement with public and private services for mental health and addiction issues. From the age of 15, he made three suicide attempts, was admitted to intensive care and subjected to a compulsory assessment and treatment order, although he valued his education, which was seen as a protective factor.

When he died due to suicide at age 17, O had decided to defer year 12 to concentrate on his health and addiction issues.

The Commissioner for Children and Young People’s inquiry findings included that:

O’s early mental health issues demonstrated the need for early intervention and support.

While information was shared between mental health services, there was a lack of information sharing across the service system, in particular with the school, and no one took a lead role to ensure service coordination and integration.

Real-time information to provide a contemporaneous picture of O’s mental and physical health was not available.

### Continued absence of information sharing will reinforce an over-reliance on acute and statutory services

Under current privacy and other laws, it can at times be difficult for organisations to share information lawfully unless it is necessary to prevent a serious threat to a person’s life or safety. Consequently, information is often shared when harm has already occurred or when the risk of harm is considered high. Information is less likely to be shared before the risk of harm becomes acute. Even in cases where information has been shared before the risk of harm becomes acute, it is likely to be shared through the provisions of existing legislation and with services that are not equipped to provide early intervention and support. This adds pressure to Child Protection and Child FIRST systems, and an opportunity to share information earlier with other service providers to prevent issues from escalating is missed. This situation is at odds with the Victorian Government’s priority to assist families before they reach a crisis point[[15]](#footnote-16), which recognises the cost of Child Protection and the failings that arise if there is an over-reliance on the Child Protection system.[[16]](#footnote-17) It is also costlier, as prevention requires less resources than acute and/or statutory intervention.[[17]](#footnote-18) Further, the highest return possible is from investment in children in the early years, and this is highest for children experiencing the greatest socio-economic disadvantage.[[18]](#footnote-19) Importantly, the impacts of not sharing information can be significant well before there is a threat to life, as in the case of David.[[19]](#footnote-20)

**Case study: David**

Sally was the Assistant Principal at a suburban primary school. David enrolled at the school after recently moving into the area. His mother and father met with Sally and outlined David’s serious, chronic health issue. They told Sally this results in frequent absences from school, but that he was very excited to be attending his new school.

David began in Year 6 and made connections with his teachers and other students quickly. His attendance was good but his academic level was extremely low. Sally tried to contact David’s parents to set up a Student Support Group meeting to develop an Individual Education Plan, but was unable to reach them.

David’s mother began to take David home early from school, picking him up during class time. David seemed upset by this and was not happy to leave. David’s mother exhibited erratic behaviour and seemed under the influence of alcohol when she picked him up. David’s attendance began to decline significantly and he started to be absent from school 2-3 days a week. He was seen wandering around the local shopping centre during school times, sometimes with older children and sometimes with his mother.

Having made a series of attempts to connect with the family, Sally contacted Child Protection (CP) to report her concerns about David. CP advised his case did not meet their criteria for intake. However, after a number of calls to CP, CP acknowledged a history of reports about David, and that they had referred him to a Child FIRST service and he had been allocated a case manager by this service. Unfortunately, without a contact person in the very large service they mentioned, the school was unable to find David’s case manager.

The school made a report to the Police to initiate a child safety check, and continued their attempt to connect with his parents, but at last report, David’s absences increased to the point where he had been absent for a whole term.

## The absence of regulation will lead to inconsistent information sharing practices between service providers

**In the absence of the proposed Amendment Regulations, no additional services will be authorised to share information under the CIS Scheme and the operation of the scheme will be limited to its current prescription of services.**

The Act itself does not specify which services can share confidential information to promote child wellbeing or safety. Rather, the Act provides that the services that are permitted to share information under the CIS Scheme must be prescribed by regulation.

Without the proposed Amendment Regulations no additional services will be permitted to share information in accordance with the CIS Scheme, and prescription will be limited to secondary and tertiary services prescribed in Phase One of the scheme. Consequently the Act will not fully overcome the problems described above and cannot realise the objectives of the CIS Scheme described in the following chapter. There are, however, a number of possible approaches to defining the scope of prescribed ISEs, as discuss in Chapter 4, Options.

# Objectives

## Objectives of the CIS Scheme

The CIS Scheme forms part of government’s response to the Family Violence Royal Commission and the McClellan Royal Commission. The scheme supports the Victorian Government’s Roadmap for Reform and Education State agendas to reorientate the focus of service provision away from a focus on crisis response to place a greater emphasis on early intervention and prevention, and to breaking the link between disadvantage and student outcomes.

The CIS Scheme creates a broader and more permissive legislative regime for sharing information to promote child wellbeing and safety across health, education, child, family and community services. The scheme will improve the quality and quantity of information sharing, to ensure that prescribed ISEs working with children and families have access to relevant information to promote the wellbeing or safety of children. Having access to relevant information will help services form a more complete picture of the child and the child’s circumstances, enabling the provision of early support, intervention and prevention to vulnerable children and families. Positive outcomes for children will, to the extent necessary, be prioritised over an individual’s right to privacy.

The Act is intended to support the operation of the CIS Scheme by enabling specified government agencies and service providers to share information that aims to improve child wellbeing or safety by:

* **Improving early risk identification and intervention.** Enabling early intervention to promote wellbeing, prevent or mitigate harm and provide support for families (by permitting professional and respectful sharing of information early).
* **Changing a risk averse culture in relation to information sharing.** Overcoming any risk averse culture of child service entities to encourage and facilitate the timely and easy sharing of information (in part by simplifying legislation).
* **Increasing collaboration and integration between child and family services.** Promoting shared responsibility and collaboration across professionals and organisations that provide services to children and families to reduce the current reliance on reporting to Child Protection authorities to protect children from harm, neglect and abuse.
* **Supporting children’s and their families’ participation in services**. Facilitating the participation of children and their families in services to which they are entitled (including health services, education and family support).

## Objectives of the proposed Child Wellbeing and Safety (Information Sharing) Amendment Regulations 2020

The overarching purpose of the proposed Amendment Regulations is to enable Phase Two of the CIS Scheme by prescribing ISEs that will be authorised to voluntarily share relevant information with one another for the purposes of promoting child wellbeing and safety (and will be obliged to share that information in response to requests from other ISEs).

The CIS Scheme authorises ISEs to request, collect, use and disclose information to promote child wellbeing and safety. ISEs are obliged to share that information when lawfully requested to do so by another ISE unless the information falls under the exclusion category – Including information that, if shared, would prejudice an ongoing investigation of a breach of the law or a coronial inquest, or would endanger a person’s life or physical safety.

The proposed Regulations will support the broader objectives of the Act by prescribing additional ISEs for Phase Two implementation of the CIS Scheme. In this RIS, DET has worked with DHHS and DJCS to consider the appropriate services for Phase Two implementation based on the following objectives:

1. **Relevance** - to prescribe ISEs with timely access to information deemed relevant to the wellbeing or safety of a child. These services often have an established relationship with child and family and hold, produce or collect relevant information within existing professional roles and responsibilities.
2. **Feasibility** - to prescribe ISEs that have established structures for formal risk assessment and management and have the capacity to deliver the reforms within current timelines for Phase Two implementation of the CIS Scheme. Priority is given to services that are delivered, managed, regulated or funded by the Victorian Government. Priority is also given to workforces that can effectively implement reforms and be trained in preparation for Phase Two implementation of the CIS Scheme, and are also scheduled to receive training in the FVIS Scheme and the MARAM.
3. **Resourcing** - to prescribe ISEs accounted for in the 2018-22 State Budget allocation for the implementation of the CIS Scheme. These services will receive necessary government training and support in reform implementation.

# Options

Options for the scope of services to be prescribed in Phase Two of the CIS Scheme were considered for the proposed Amendment Regulations, and are presented in this chapter.

## Consideration of a non-regulatory option (base case scenario)

In the absence of regulations no additional services will be prescribed within the CIS Scheme and prescription will be limited to the secondary and tertiary services already prescribed in Phase One of the scheme. Other services, including key universal services within health and education, will not be allowed or required to share information with ISEs already prescribed under the scheme, and be permitted to share information in accordance with existing privacy laws only.[[20]](#footnote-21)

Consequently, the current state of information sharing will continue. It is reasonable to assume that, to the extent information is currently shared between non-prescribed services, it is performed under variable and ad hoc arrangements throughout Victoria. Any information sharing arrangements that have been formalised through MoUs or similar will continue. Examples of current arrangements include: the Early Childhood Out of Home Care Agreement between DHHS, the Municipal Association of Victoria on behalf of local government authorities and DET, and protocols such as those relating to the sharing of information between kindergartens and schools or Maternal and Child Health (MCH) and schools.

Services will continue to share information under the provisions of existing legislation including the *Privacy and Data Protection Act 2014*, the *Health Records Act 2001* or the *Privacy Act 1988*. This information ‘network’ will continue to operate with Child Protection at the centre, with other services making reports for Child Protection to consider and investigate as appropriate. Information will not flow from Child Protection to service providers that have raised concerns, or between those services prescribed for the CIS Scheme and any non-prescribed services.

A non-regulatory option for Phase Two of the CIS Scheme is not considered viable. The prescription of entities underpins the establishment of the CIS Scheme, and without regulations no additional entities would be authorised to share information to promote children’s wellbeing or safety under the scheme. If prescription for the CIS Scheme were limited to the services prescribed in Phase One of the scheme only, it would exclude key universal services across the education, health and justice portfolios that interact with the vast majority of children and families in Victoria, and as such play a critical role in early intervention and prevention. This would jeopardise the objectives of the CIS Scheme and the scheme would largely fail to address the key problems related to child wellbeing and safety, as identified and discussed in this RIS.

In addition, a non-regulatory option would fail to meet expectations for prescription of services within the CIS Scheme. This could arguably lead to confusion in relation to the obligations of services to share information under the CIS Scheme versus existing privacy laws. This may in turn result in inconsistent application of existing legislation, posing additional risk to children, and the loss of opportunity to share information for child wellbeing purposes.

## Options for determining prescribed ISEs

ISEs prescribed under the CIS Scheme are authorised to:

* request confidential information from another ISE for the purpose of promoting the wellbeing or safety of a child or a group of children.
* disclose confidential information (either voluntarily or in response to a request) to another ISE for the purpose of promoting the wellbeing or safety of a child or group of children and to assist the recipient to deliver services or to undertake certain activities in relation to a child or group of children.

Three viable options were considered for Phase Two prescription of ISEs under the CIS Scheme:

* **Option 1**. Targeted prescription of universal health services.
* **Option 2**. Targeted prescription of universal health and education services and other key child service providers.
* **Option 3**. Services prescribed in Option 2 with the addition of other universal health and education services and child service providers.

In its final report, the McClellan Royal Commission stated that entities prescribed for the recommended information sharing scheme should include government and non-government agencies responsible for the provision or supervision of services in support of the wellbeing or safety of children. The Royal Commission acknowledged that the scope of prescribed entities should capture a very wide range of institutions of different sizes and with varying governance arrangements and capacity to meet the recommended safeguards.

Further, the Royal Commission recommended a careful and phased approach in rolling out the scheme.

In line with these recommendations, the CIS Scheme assumes a phased approach to implementation. Phase One of the CIS Scheme includes services that assess and respond to children most at risk. This includes community and family services, family violence services, Child Protection, Victoria Police and a number of other health and justice services. A full list of the services prescribed for Phase One of the CIS Scheme is presented in Appendix A.

Once fully implemented, the CIS Scheme will involve a wide range of both government and non-government agencies. Further, the phased implementation of the CIS Scheme is as far as possible aligned with the implementation of the FVIS Scheme.

The options for Phase Two prescription are presented in further detail below.

### Option 1: Targeted prescription of universal health services

This option would include health services that are likely to already be sharing or will be in a position to share effectively with secondary and tertiary services prescribed under Phase One of the scheme, in particular in cases that relate to the safety of a child. This option involves prescribing hospitals and general practitioners (GPs) as workforces that collect and have access to information deemed relevant to child wellbeing or safety. The option would involve an estimated 1,750 organisations employing some 150,000 workers, and would need to consider possible gaps in information sharing created by a more restrictive prescription of services and the resulting decoupling of the implementation of the CIS and FVIS schemes.

### Option 2: Targeted prescription of universal health and education services and other key child service providers

This option would include a number of government and non-government agencies responsible for the provision or supervision of services related to the wellbeing or safety of children. Under this option, the scope of ISEs includes a variety of primary and universal services representing organisations of different sizes and governance arrangements, and would include the very large education and health service sectors. The list of prescribed ISEs for this option would include:

* government and non-government schools
* student support and child wellbeing services
* early childhood education services
* outside school hours care
* hospitals
* state funded aged care services
* general practice
* community health services
* housing services
* forensic disability
* community mental health services
* homelessness services
* Ambulance Victoria
* government statutory bodies and organisations/services.

For a complete presentation of the ISEs proposed for prescription under this option, please refer to Appendix B. This option involves prescribing a significant number of ISEs, estimated at 7,500 organisations employing some 370,000 workers, in Phase Two of the CIS Scheme rollout, most likely resulting in a significant increase in information sharing to support the objectives of the scheme.

This option specifically relates to objective 1 of the proposed Amendment Regulations, by ensuring that information is shared between services with timely access to information relevant to the wellbeing or safety of children. The option relates to objectives 2 and 3 by including entities that are often currently involved in some level of information sharing and hold existing capacity in formal risk assessment and management, and have the capacity to support implementation of the scheme.

### Option 3: Services prescribed in Option 2 with the addition of other universal health and education services and child service providers

This option would include all services under Option 2 as well as other health and education services. The list of additional ISEs prescribed under this option would include:

* disability services
* family day care services
* private aged care services
* private hospitals
* bush nursing hospitals and bush nursing centres
* community pharmacies
* non-emergency patient transport services
* private allied health services
* TAFE and universities
* private psychologists
* residential facilities in boarding schools

This option involves prescribing a significantly higher number of entities in Phase Two of the CIS Scheme rollout, estimated at 10,000 organisations employing some 500,000 workers, most likely resulting in a further increase in information sharing to support the objectives of the scheme. This option would need to consider the proposed services’ level of access to relevant information and their existing level of capacity for reform implementation, taking into account the complexity of training significantly larger and more diverse workforces within a short timeframe. Further, the broader prescription of workforces under this option would mean a decoupling of the implementation of the CIS and FVIS Schemes.

# Determining the preferred option

## Approach to analysis

This RIS considers options for the proposed scope of prescription of ISEs for Phase Two of the CIS Scheme, as outlined in the previous chapter. In considering the full range of analytical techniques available for determining the preferred option in this RIS, Multi-Criteria Analysis (MCA) is determined to be the most appropriate. This is due to the difficulty involved in quantifying the expected effects of information shared under the CIS Scheme and associated improvements in child wellbeing or safety. This is compounded by the fact that the CIS Scheme is part of a larger reform program, which aims to grow and improve service delivery, and early intervention and preventative action for children.

MCA is typically applied as an analytical technique in cases where full cost-benefit analysis is infeasible due to difficulties in quantifying benefits. MCA allows options to be compared through both quantitative and qualitative analysis and enables a wider range of criteria, such as social considerations, to be included in the analysis. It involves determining a set of criteria considered to be most relevant to weighing up options and then scoring each option with reference to the selected criteria, where a positive score indicates an option is better than the base case and a negative score indicates an option is worse that the base case. The criteria are also weighted according to their relative importance in the overall decision.

The MCA criteria, weightings and scale for assessing options in this RIS are outlined below.

## Criteria for analysis

The following criteria are used to assess options for the scope of services prescribed as ISEs for Phase Two of the CIS Scheme:

* **Effectiveness** – How successful is the option in prescribing ISEs that can provide timely access to information deemed relevant to the wellbeing or safety of a child? When applying the effectiveness criterion, consideration is given to how well the option could realise the anticipated benefits associated with the CIS Scheme, including early intervention and reduced risk of harm or interaction with Child Protection and statutory services, and improved health and wellbeing outcomes.
* **Risk of infeasibility** – How well will the option support reform delivery by prescribing ISEs that have established structures for formal risk assessment and management, and have the capacity to deliver the reforms within the current timelines for Phase Two implementation of the CIS Scheme? When applying the risk of infeasibility criterion, consideration is given to the services’ capacity for effective reform implementation and the practical limitations of what can realistically be accomplished within the current timeframe for Phase Two implementation. This timeframe is aligned with reform implementation timeframes of the FVIS Scheme and MARAM, and a misalignment of reform implementation risks undermining the objectives of the proposed Amendment Regulations. Consideration is also given to how well the option aligns with the recommendations of the McClellan Royal Commission.
* **Implementation costs to ISEs** – What is the cost impact of the option on ISEs? When applying this criterion, consideration is given to the following two factors:
	+ Whether the option prescribes workforces that will receive necessary government training and support, as funded over the 2018-22 State Budget, or the option will result in additional costs of prescription on ISEs resulting from inadequate government training and support.[[21]](#footnote-22)
	+ DET assumes the link between the number of ISEs prescribed and the cost impact of information sharing on each ISE. As the breadth of prescription widens, the implementation costs to ISEs will increase.

### Weightings

It is common practice for MCA criteria to have neutral weights of 50 per cent in cost-related and 50 per cent in benefit-related criteria. The criteria for analysis are weighted as follows:

* **Effectiveness** – is a benefits related criterion, with a weighting of 50 per cent
* **Risk of infeasibility** – is a cost related criterion with a weighting of 25 per cent
* **Implementation costs to ISEs** – is a cost related criterion with a weighting of 25 per cent.

### Scale

The criterion rating scale ranges from -10 to +10, with a score of zero representing no change from the base case.

**Table 5.1 MCA scoring matrix**

| Score | Description |
| --- | --- |
| -10 | Much worse than the base case |
| -5 | Somewhat worse than the base case |
| 0 | No change from the base case |
| +5 | Somewhat better than the base case |
| +10 | Much better than the base case |

## Options assessment

Options for the proposed scope of prescription of ISEs for Phase Two of the CIS Scheme are assessed below.

### Effectiveness

Given the complexities of service delivery provided by the workforces within each option, this RIS does not present a quantitative measure of the scale of impacts of each option, as compared to the base case. Rather, the effectiveness score for each option has been determined through qualitative assessment of how well each option will realise the benefits of the assessment criterion, as described above.

**Table 5.2 Effectiveness scores – options for prescribing entities**

|  | Base Case | Option 1 | Option 2 | Option 3 |
| --- | --- | --- | --- | --- |
| Effectiveness | 0 | 4 | 8 | 9 |

**Base case**: Without regulations, no additional services would be prescribed for the CIS Scheme. Beyond the information sharing that can legally occur between already prescribed services within the CIS Scheme, information would continue to be shared in an ad hoc manner and in accordance with existing privacy laws only. By not prescribing additional ISEs, the base case scenario will not facilitate an increase in information sharing to support child wellbeing or safety, and will not realise the anticipated benefits of the CIS Scheme.

**Option 1**: The ISEs prescribed under this option have core responsibilities for providing universal health services. Hospitals and GPs, provide services to the majority of Victorian children and their families and collect information deemed relevant to child wellbeing or safety. They are in a position to effectively share relevant health related information with one another as well as with secondary and tertiary services prescribed under Phase One of the scheme, including ISEs involved in promoting better health and socio-economic outcomes for the highest risk children, such as Child Protection, specialist family violence services, Youth Justice and Victoria Police.

Compared to the base case, this option will prescribe services that are in contact with a much higher proportion of all Victorian children, and typically at a much earlier stage in their lives. Prescription of ISEs according to this option will lead to an increased opportunity for information sharing to support early intervention and prevention when compared to the base case, possibly reducing reliance on Child Protection and statutory services.

Based on input from the workforce consultations for this RIS, and given the nature of the services provided by already prescribed ISEs, it is reasonable to expect that much of the information sharing under this option will be focused on issues of child safety, including child safety in a family violence context. It has not, however, been possible to quantify the likely scale of the effects.

**On this basis, this option is scored at +4 for effectiveness relative to the base case.**

**Option 2**: Under this option, a wider range of government and non-government services responsible for the provision of services related to the wellbeing and safety of children are prescribed. The universal health and education related services prescribed under this option interact with the vast majority of children and families in Victoria on a very regular basis, and from the earliest stages of life, and can therefore play a crucial role in early intervention and prevention. In addition, some of the services prescribed under this option, including homelessness services, refugee and migrant services, community housing services and supported playgroups, directly support children and families with complex needs, and their prescription complements the prescription of secondary and tertiary services in Phase One of the scheme. By enabling earlier intervention and prevention, child information sharing can improve health and wellbeing outcomes and reduce the need for acute and statutory services involving the Child Protection system, placement in out of home care, as well as contact with youth justice.

Given the broader prescription of services under this option, it is expected that the amount of information sharing will increase significantly compared to the base case. This is anticipated to lead to a more comprehensive understanding of each child’s circumstances, needs, risks, and the supports required. Increasing information clarity for a greater number of professionals and organisations from the outset, such as health practitioners, early childhood education providers and schools would enable timelier identification of concerns and the potential for earlier provision of supportive services to children and families and, if necessary, referral to targeted and tertiary services. More tailored service provision and collaboration between supportive services around children and families can have positive impacts on children’s social and emotional development, recognising that childhood trauma is a known risk factor for mental illness, drug and alcohol abuse, and being a perpetrator of family violence later in life. Furthermore, meeting critical windows of child brain development is crucial for child wellbeing.[[22]](#footnote-23)

Option 2 will ensure a more effective framework for sharing information relevant to the wellbeing or safety of a child. **On this basis, the option is scored at +8 for effectiveness relative to the base case.**

**Option 3**: This option prescribes an even broader scope of ISEs to the CIS Scheme, including those prescribed under Option 1 and Option 2. Option 3 ensures inclusion of all health and education services that may involve children, or hold information related to children, including disability services, family day care, private aged care and in-home care, private hospitals and private allied health services, TAFE and universities. This would result in a further increase in information sharing which would arguably enable services to identify and respond to issues within a mainstream context, potentially maximising opportunities for early intervention.

**On this basis, this option is also scored at +9 for effectiveness relative to the base case.**

### Risk of infeasibility

The risk of infeasibility score for each option has been determined through qualitative assessment of how well each option will avoid the risks of infeasibility.

**Table 5.3 Risk scores – options for prescribing entities**

|  | Base Case | Option 1 | Option 2 | Option 3 |
| --- | --- | --- | --- | --- |
| Risk of infeasibility | 0 | -6 | -2 | -9 |

**Base case**: As no ISEs would be prescribed in regulation the risk of infeasibility of reform implementation will not change from the current situation.

**Option 1**: This option prescribes a limited scope of ISEs that have existing capacity and capability in formal risk assessment and management. The ISEs will have the capacity to deliver the reforms within the timeframes of Phase Two implementation, further reducing the risk of infeasibility of this option.

However, the limited scope of this option is in misalignment with proposed prescription for the FVIS Scheme and MARAM, which is expected to be much broader in scope and include universal health and education related services. Together, the CIS and FVIS schemes authorise information sharing to enable early identification, assessment and management of children’s wellbeing or safety in a wide range of contexts. This enables services to respond to the multiple, complex needs of families and children. By breaking the alignment of implementation between the two schemes, this option will create complexities and confusion in reform implementation and will undermine ISEs’ ability to respond to the multiple and complex needs of children and their families, and reduces opportunities for information sharing to support the wellbeing of children.

Further, this option does not meet the recommendations of the McClellan Royal Commission that the scope of prescribed entities should capture a very wide range of institutions.

**On this basis, Option 1 option is scored at -6 for risk of infeasibility relative to the base case.**

**Option 2**: This option prescribes universal services that largely have the capacity to deliver the reforms within their current business and according to current timelines for Phase Two implementation of the CIS Scheme. These workforces, including schools, hospitals and other government delivered or supported health services, and the early childhood education sector, have existing capacity within formal risk assessment and management, and already perform information sharing such as Mandatory Reporting.

The option reduces the risk of infeasibility by prescribing workforces that are largely either Victorian Government managed, funded or delivered, or regulated by a Victorian Government authority or business area.

This option ensures optimal alignment with the FVIS Scheme and MARAM implementation timelines. It is also in line with the recommendations of the McClellan Royal Commission to prescribe entities that capture a wide range of institutions whilst considering the possible inclusion of entities over time to reduce the risk of administrative overload.

**On this basis, this option is scored at -2 for risk of infeasibility relative to the base case.**

**Option 3**: By prescribing a large number of organisations, this option puts significant pressure on the organisations and government in implementing Phase Two of the CIS Scheme within the required timeframes, due to the extensive scale of implementation.

The ISEs that would be prescribed under this option have varying degrees of capacity in formal risk assessment and risk management, and the Victorian Government has only limited levers to ensure appropriate reform delivery in a number of the private or Commonwealth Government supported workforces, including private hospitals, private allied health services and universities.

The wide scope of prescription under this option does not align with proposed prescription for the FVIS Scheme and MARAM. By its wide prescription of child health and education services it arguably also goes against the recommendation of the McClellan Royal Commission to consider the inclusion of groups of entities over time to reduce the risk of administrative overload.

**On this basis, this option is scored at -9 for risk of infeasibility relative to the base case.**

### Implementation costs to ISEs

The implementation costs to ISEs score for each option has been determined through a combination of quantitative and qualitative assessment. The implementation cost to each ISE is expected to increase as the breadth of prescription increases. The implementation cost would fall more significantly on the ISEs directly to the extent an option includes ISEs that have not been accounted for in the 2018-22 State Budget and may therefore not receive necessary government training and support.

**Table 5.4 Implementation costs – options for prescribing entities**

|  | Base Case | Option 1 | Option 2 | Option 3 |
| --- | --- | --- | --- | --- |
| Implementation costs to ISEs | 0 | -2 | -5 | -7 |

**Base case**: As no new ISEs would be prescribed in regulation there will be no implementation costs to new ISEs. The level of information sharing activity under the CIS Scheme would remain unchanged, as would the implementation costs to already prescribed ISEs.

**Option 1**: This option prescribes workforces that have been accounted for in the 2018-22 State Budget and will receive necessary government training and support. The limited scope of prescription of this option, involving public hospitals and general practitioners and a total workforce of 150,000 across some 1,750 organisations would likely result in an increase in information sharing activity between the ISEs prescribed under the CIS Scheme. This increase in information sharing activity would in turn generate an implementation cost to ISEs.

Based on the cost estimates for the preferred option as presented in chapter 6 of this RIS , and assuming a linear link between the workforce numbers and total implementation costs of each option, the implementation cost for workforces under this option can be estimated at approximately $73 million over 10 years (NPV).

**On this basis, this option is scored at -2 for implementation costs to ISEs relative to the base case.**

**Option 2**: This option prescribes workforces that have been accounted for in the 2018-22 State Budget and will receive necessary government training and support. The scope of prescription of this option is broad, involving an estimated workforce of 370,000 across 7,500 organisations.

Given the much broader scope of prescription, it is likely that this option will lead to a stronger increase in information sharing and subsequently to even higher costs to ISEs.

Based on the cost estimates for the preferred option as presented in chapter 6 of this RIS, the implementation cost for workforces under this option can be estimated at approximately $182 million over 10 years (NPV).

**On this basis, this option is scored at -5 for implementation costs to ISEs relative to the base case.**

**Option 3**: This option includes prescription of workforces that were not accounted for in the 2018-22 State Budget. This is likely to negatively impact these workforces’ access to training and targeted government support, which may include provision of templates for procedures, guidance materials including operational checklists and forms, and workforce specific operating models. This will likely result in a lower level of reform sector readiness and additional costs to these organisations as they implement the CIS Scheme.

By prescribing a very broad range of workforces, estimated at 500,000 workers across 10,000 organisations, this option further increases the cost of participation to all prescribed ISEs and has the highest cost impact on ISEs of all three options.

Based on the cost estimates for the preferred option as presented in chapter 6 of this RIS, and assuming a linear link between the workforce numbers and total implementation costs of each option, the implementation cost for workforces under this option can be estimated at approximately $245 million over 10 years (NPV). It has not, however, been possible to quantify the likely scale of the additional costs to this option resulting from inclusion of ISEs that have not been accounted for in the 2018-22 State Budget and may therefore not receive necessary government training and support.

**On this basis, this option is scored at -7 for implementation costs to ISEs relative to the base case.**

**Table 5.5 Summary of options analysis**

|  | Effectiveness(50%) | Risk of infeasibility(25%) | Implementation costs to ISEs(25%) | Weighted score total |
| --- | --- | --- | --- | --- |
|  | **Score** | **Score** | **Score** | **Score** |
| Base case | 0 | 0 | 0 | 0 |
| Option 1 | 4 | -6 | -2 | 0 |
| Option 2 | 8 | -2 | -5 | 2.25 |
| Option 3 | 9 | -9 | -7 | 0.5 |

# Preferred Option

## Summary of the preferred option

Based on the outcome of the multi-criteria options analysis presented in the previous chapter, the preferred option for the scope of the proposed Amendment Regulations is:

* **Option 2**. Targeted prescription of universal health and education services and other key child service providers

In line with the recommendations of the McClellan Royal Commission, the CIS Scheme assumes a phased approach to implementation which, upon Phase Two implementation, will involve a wide range of both government and non-government organisations. Further, the phased implementation of the CIS Scheme is as far as possible aligned with the implementation of the FVIS Scheme and MARAM.

The preferred option prescribes universal health and education related services as well as services that support vulnerable children and families, ensuring prescription of services that interact with the vast majority of Victorian children and particularly with those who are in greatest need of support. The ISEs prescribed under the preferred option have the capacity to provide timely access to information deemed relevant to the wellbeing or safety of a child, and to facilitate reform delivery, with appropriate support from government.

## How workforce impacts were assessed

Impacts were estimated through consultations with approximately 120 workforce representatives from 60 unique organisations likely to be impacted by the proposed Amendment Regulations. The consultations included 53 unique interviews with workforce representatives to collect data for the impact analysis of this RIS. Please refer to Chapter 10 for a more detailed description of the consultation process. While the stakeholders consulted included both government and non-government organisations across a range of services, it should be noted that only a small sample of organisations likely to be prescribed in Phase Two of the CIS Scheme could be consulted. As such, the impact estimates reported in this RIS should be considered approximate indication impact estimates, rather than anything more definitive.

The consultations indicated significant variation across organisations in the level of expected impact of their prescription under Phase Two of the CIS Scheme. This in part reflects the uncertainty that organisations invariably face when contemplating the impact of regulations they have not previously encountered. It also reflects the fundamental factors that will drive variation in the regulations’ impacts across ISEs, including the size of the organisation, their resourcing capacity, the nature of their work involving information sharing, and their existing systems and processes.

Reflecting the wide range of circumstances this list of organisational attributes can produce, the range of impacts expected to result from the regulations is also wide. The points below provide examples of the expected variation in practices for information sharing across entities:

* The volume of information sharing occurrences that are expected by organisations ranged from a few to several thousand per year, depending on the services provided by organisations, their reliance on and opportunity for receiving input from/providing input to other services, and their relative size.
* The process and time taken to make a request or respond to a request for information ranged from a phone call or email taking a few minutes, to highly formalised and structured processes for information release.

In addition, consultations revealed significant expected variation in the complexity of information sharing requests, and organisations indicated this would result in a corresponding variation in time impact when responding to a request for information. Scenarios described by organisations varied from retrieving data relatively quickly from an electronic system to conducting significant and time-consuming investigative work to obtain information.

### Types of workforce costs

#### Upfront costs to ISEs

It is anticipated that ISEs will be able to implement the CIS Scheme within their current levels of capacity. However, there will be upfront costs incurred within the first year that are associated with training staff and updating policies and procedures:

* While the financial cost of training targeted staff will be covered by the government, there will be resourcing implications for organisations as staff are attending training and therefore diverted from their core work.
* ISEs will need to update existing policies and procedures related to information sharing practices, in order to meet their obligations under the CIS Scheme. The level of impact depends on factors such as the size and structure of the organisation and the extent to which development of policies and procedures is coordinated within the organisation or by a governance body.

#### Ongoing costs to ISEs

Ongoing costs to ISEs largely depend on their organisational attributes and the volume as well as nature of requests made or received. Identified ongoing yearly cost impacts include:

* training for new staff, who are not involved in the initial workforce training, assuming a 20 per cent turnover rate.
* time taken to respond to requests for information (or proactively sharing information), including receiving the request, identifying the ISE and retrieving the information requested, and providing the information to the requesting ISE in line with the organisation’s internal approval processes.
* time spent requesting information under the CIS Scheme, including identifying the relevant ISE to contact and information required, and contacting the ISE to make the request for information.
* time spent record keeping.

## Key assumptions informing the analysis of workforce costs

DET engaged ACIL Allen Consulting to estimate the cost impact of the proposed Amendment Regulations on Phase Two workforces. The cost impact analysis was informed by data gathered through structured workforce interviews led by representatives of DET and FSV, and involving 53 workforce representatives from as many organisations. The key assumptions underpinning the impact analysis are presented below. These assumptions were derived by DET and largely drawn from the above mentioned workforce consultations. Please refer to Appendix C for further detail on costing assumptions and the costing methodology.

### Assumed wage rates

In the structured interviews, respondents were asked to specify what category of worker typically undertook each task, where the response options comprised: professional, skilled worker, and any worker. The labour costs for these categories were estimated using Australian Bureau of Statistics (ABS) data on wage rates.

Specifically, the assumed labour costs were calculated using the average wage reported by the ABS, adjusted for overheads and on costs at a rate of 75 per cent (as per the Victorian Regulatory Change Measurement manual). In May 2018, the ABS reported that professionals had average hourly earnings of $54 per hour. The average wage across all occupation levels was estimated at $45 per hour, which was applied to the ‘any worker’ category. A skilled worker has been assumed to have a wage 10 per cent lower than that of a professional.

These estimated labour costs are summarised in the table below:

####  Table 6.1 Assumed labour costs

|  Labour |  Assumed cost |
| --- | --- |
|  Professional |  $96.39 |
|  Skilled worker |  $86.75 |
|  Any worker |  $80.33 |
|  Note: wages were adjusted for a 2 per cent wage growth since 2018. Source: www.abs.gov.au/ausstats/abs@.nsf/latestProducts/6306.0Media%20Release1May%202018 |
|  |

### Training requirements

Training costs were estimated using assumed upfront and ongoing training requirements per organisation. The assumed training requirements of organisations is provided in the table below and includes an upfront requirement of 2.5 workers spread across four different types of training (leader/sharers and face-to-face/online), and an ongoing annual training requirement of 0.5 workers undertaking online training (which represents a 20 per cent workforce turnover rate). Note that all affected organisations are expected to undergo these training requirements regardless of size.

**Table 6.2 Per organisation upfront and ongoing training requirements**

| Workforce type  |  Mode of  training | Hours of training | Upfront training participation |  Ongoing training  participation |
| --- | --- | --- | --- | --- |
|  |  | **Hours** | **Persons trained** | **Persons trained** |
|  Leaders  (professional) |  Face to  face | 4 | 0.85 | 0 |
|  Leaders  (professional) |  Online | 3 | 0.15 | 0.2 |
|  Sharers  (Skilled worker) |  Face to  face | 8 | 1.2 | 0 |
|  Sharers  (Skilled worker) |  Online | 4 | 0.3 | 0.3 |
| **Total** |  |  | **2.5** | **0.5** |
| Source: DET estimates |
|  |  |

### Impact of the Child Link Register

The Child Link Register is expected to commence by the start of 2022 and will hold information that could be the subject of an information sharing request. This means that from 2022 some information sharing requests (and as a result the response to these requests) will not be required as the information was accessed through the Child Link Register. Consultations with Phase Two workforces undertaken by DET demonstrated that the majority of information that will be shared between ISEs under the CIS Scheme aligns with information that will be made available in Chid Link, and DET estimates that from 2022, the introduction of the Child Link Register will result in the following:

* the number of information requests and responses will reduce by 25 per cent. Given that DET believes the majority of information which will be requested under the CIS Scheme aligns with information that will be made available in the Child Link Register, DET estimates that the reduction in information requests will be 25 per cent.
* the 25 per cent fewer information requests are assumed to still require 10 minutes of staff time. This accounts for time taken to determine what information is needed, then access and retrieve the information in the Child Link Register and finally consider whether a direct request to another ISE for information is required. It should be noted that the act of looking up information in the Child Link Register in and of itself is expected to take minimal time.
* the time taken to perform the remaining 75 per cent of information requests is assumed to reduce by 10 per cent because some information may be found in the Child Link Register, which in turn refines and potentially reduces the information request. The time to respond to requests for information and record keeping is assumed to stay the same.

### Impact of the online ISE directory

An online, searchable directory that specifies all ISEs and their contact details will be operational in 2020. DET held consultations with both Phase One and proposed Phase Two workforces, which revealed that a key component of the process of requesting information is related to identifying the relevant ISE to which a request for information should be directed. Consultations also revealed that a key component of responding to a request for information is related to confirming that the entity requesting information is a prescribed ISE. DET was informed during consultations that these work processes could account for a significant part of the time taken to make a request, or respond to a request, for information. The online ISE directory is expected to streamline and shorten both these work processes. On this basis, DET estimates that the online ISE directory which will be operational in 2020 (date to be confirmed), will reduce the time taken to request information and the time taken to respond to a request for information by 10 per cent from the start of 2021 onwards.

## Total cost of the proposed Amendment Regulations

The proposed Amendment Regulations will result in impacts to government and to the prescribed ISEs in transitioning to the CIS Scheme, and associated ongoing impacts. When factoring in the total costs to prescribed ISEs (both government and non-government organisations) and the direct costs to government, the total cost of Phase Two implementation of the CIS Scheme over 10 years is estimated at $216 million (NPV).

This includes $65.7 million in the first year, in direct costs to government[[23]](#footnote-24), upfront costs to ISEs and first-year ongoing costs to ISEs.[[24]](#footnote-25) Across the following nine years, the total cost is $150.3 million. This includes ongoing costs to ISEs and direct costs to government.

These cost impacts are presented in further detail below.

## Costs to workforces proposed for prescription

### Total costs to Phase Two workforces

The total estimated cost impact of the proposed Amendment Regulations on Phase Two workforces over a 10-year period is expected to be approximately $181.6 million in NPV terms, of which $101.1 million is attributable to government organisations and $80.5 million in attributable to non-government organisations.

The total cost comprises $18.2 million to update policies, $19.8 million in upfront and ongoing training, $94.8 million for requests to share information and for responses to information sharing requests, and $48.8 million for record keeping costs associated with requests and responses (see table below). Of these costs, it is estimated that over a 10-year period, $28 million will be incurred as upfront costs and $154 million as ongoing costs. From 2022, following the introduction of two new initiatives, the online ISE directory and the Child Link Register, annual ongoing costs are estimated at $16.3 million.

**Table 6.3 Total workforce costs, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
| Cost Category | Government  | Non-government | Total |
| Upfront costs | ‘000 | ‘000 | ‘000 |
| Update policies | $4,677 | $13,499 | $18,176 |
| Upfront training | $2,207 | $7,577 | $9,784 |
| Ongoing cost | ‘000 | ‘000 | ‘000 |
| Ongoing training | $2,256 | $7,748 | $10,004 |
| Requests to share information | $35,973 | $16,332 | $52,306 |
| Responses to requests | $26,367 | $16,162 | $42,529 |
| Record keeping  | $29,652 | $19,143 | $48,796 |
| Total costs | $101,133 | $80,462 | $181,595 |
| *Source: ACIL Allen Consulting 2019* |

### Average costs per organisation

The per organisation estimated cost impact of the proposed Amendment Regulations on Phase Two workforces over a 10-year period is expected to be $24,277 (see table below). The 10-year cost impact per organisation differs between government organisations ($59,948) and non-government organisation ($13,687), largely a reflection of differences in the average size of organisations within each sector, as defined in this RIS.

In 2020, the upfront costs to the workforce include updates to their policies totalling $2,430 on average per organisation and upfront training costs of $1,308 per organisation. By 2022, the estimated ongoing annual costs per organisation in 2019 dollars will include ongoing training, requests, responses to requests and record keeping totalling $2,177 per annum per organisation.

**Table 6.4 Average per organisation cost, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
| Cost Category | Government  | Non-government | Total |
| Upfront costs (2020) | $ | $ | $ |
| Update policies | $2,772 | $2,330 | $2,430 |
| Upfront training | $1,308 | $1,308 | $1,308 |
| Ongoing annual costs (from 2022) | $ | $ | $ |
| Ongoing training | $169 | $169 | $169 |
| Request | $2,206 | $302 | $731 |
| Respond | $1,622 | $289 | $590 |
| Record keeping  | $1,851 | $348 | $687 |
| Total ongoing annual costs (from 2022) | $5,863 | $1,104 | $2,177 |
| Avg. total 10 year cost per organisation | $59,948 | $13,890 | $24,277 |
| *Source: ACIL Allen Consulting 2019* |

### Cost impacts by workforce category

ISEs proposed for prescription under Phase Two of the CIS Scheme represent a broad range of services and workforces, ranging from kindergartens, schools, public hospitals, community health services, GPs, Ambulance Victoria, state funded aged care, community housing, to various government organisations such as the Victorian Registration and Qualifications Authority and the Dispute Settlement Centre of Victoria.

To model the impact on these ISEs it is necessary to group the workforces together where they are similar in their service offering and cost impacts per workforce member (i.e. the impact per workforce member is expected to be similar). The resulting six workforce categories are listed below:

1. schools (including student disengagement and wellbeing services)
2. early childhood education and care (ECEC) providers
3. outside school hours care (OSHC) providers
4. health and support services
5. hospitals
6. government statutory bodies and organisations/services.

### Total costs to Phase Two workforce groupings

The below table illustrates the variance in cost impact across the six workforce groupings. The total impact remains at $181.6 million, with the expected relative cost impact highest for the workforce groupings representing hospitals, schools, ECEC providers, and health and support services. The cost impact is expected to be relatively lower for the workforce groupings of OSHC providers and government statutory bodies and organisations/services.

**Table 6.5 Costs by workforce group and key cost category, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Upfront Costs | Total Costs |  |
| Workforce grouping | Update Policies | Upfront training | Ongoing training | Requests | Respond | Recordingkeeping | Total |
|  | ‘000 | ‘000 | ‘000 | ‘000 | ‘000 | ‘000 | ‘000 |
| Grp 1: Schools | $5,655 | $2,951 | $3,017 | $13,853 | $13,268 | $8,050 | $46,795 |
| Grp 2: ECEC provider | $4,822 | $3,651 | $3,733 | $7,227 | $5,025 | $12,509 | $36,966 |
| Grp 3: OSHC provider | $401 | $415 | $424 | $409 | $172 | $415 | $2,235 |
| Grp 4: Health and support services | $6,482 | $2,575 | $2,634 | $2,913 | $6,316 | $3,254 | $24,174 |
| Grp 5: Hospitals | $754 | $114 | $116 | $27,894 | $17,665 | $24,531 | $71,064 |
| Grp 6: Govt. statutory bodies and organisation/service | $62 | $78 | $80 | $11 | $93 | $38 | $362 |
| Total | $18,176 | $9,784 | $10,004 | $52,306 | $42,529 | $48,796 | $181,595 |
| *Source: ACIL Allen Consulting 2019* |

### Average costs per organisation, by workforce grouping

The tables below present the expected cost impact per organisation by workforce grouping, over one year and 10 years, respectively.

#### Variation according to size of organisation

The breakdown of costs per workforce category reveals variation in cost impact according to the size of organisations, with hospitals ranking highest in terms of absolute size and cost. The cost to a hospital, at $84,000 annually (excluding upfront costs), is significantly higher than that of any other organisation and is largely a reflection of the very significant size of the average hospital workforce, at around 1,000 FTE. OSHC, health and support services and government statutory bodies rank lowest in terms of cost per organisation, at under $1,000 annually (excluding upfront costs).

#### Variation according to expected impact on information sharing activity

Schools, ECEC providers, hospitals, and health and support services record a higher cost level adjusted for organisational size (by FTE) than OSHC providers and government statutory bodies and services. These findings align with feedback received through consultations, where the former group of workforces indicated greater expected workforce impacts of prescription under the CIS Scheme.

**Table 6.6 Average annual upfront and ongoing costs per organisation by workforce group (2022)**

|  |  |  |  |
| --- | --- | --- | --- |
| Workforce group | Upfront Costs | Ongoing Costs in 2022 |  |
| Update Policies | Upfront training | Ongoing training | Requests | Respond | RecordKeeping | Annual ongoing costs (excl. upfront) |
|  | $ | $ | $ | $ | $ | $ | $ |
| Grp 1: Schools | $2,507 | $1,308 | $169 | $637 | $610 | $376 | $1,792 |
| Grp 2: ECEC provider | $1,728 | $1,308 | $169 | $286 | $187 | $472 | $1,114 |
| Grp 3: OSHC provider | $1,265 | $1,308 | $169 | $140 | $56 | $138 | $503 |
| Grp 4: Health and support services | $3,292 | $1,308 | $169 | $155 | $333 | $174 | $831 |
| Grp 5: Hospitals | $8,667 | $1,308 | $169 | $33,130 | $21,055 | $29,692 | $84,047 |
| Grp 6: Govt. statutory bodies and organisation/service | $1,027 | $1,308 | $169 | $18 | $160 | $67 | $415 |
| Avg. all organisations | $2,430 | $1,308 | $169 | $731 | $590 | $687 | $2,177 |
| *Source: ACIL Allen Consulting 2019* |

**Table 6.7 Average per organisation cost, by workforce group, 10 year totals**

|  |  |  |  |
| --- | --- | --- | --- |
| Workforce group | Upfront Costs | Ongoing Costs |  |
| Update Policies | Upfront training | Ongoing training | Requests | Respond | RecordKeeping | Total |
|  | $ | $ | $ | $ | $ | $ | $ |
| Grp 1: Schools | $2,507 | $1,308 | $1,337 | $6,140 | $5,881 | $3,568 | $20,742 |
| Grp 2: ECEC provider | $1,728 | $1,308 | $1,337 | $2,589 | $1,800 | $4,482 | $13,245 |
| Grp 3: OSHC provider | $1,265 | $1,308 | $1,337 | $1,291 | $543 | $1,307 | $7,050 |
| Grp 4: Health and support services | $3,292 | $1,308 | $1,337 | $1,479 | $3,208 | $1,653 | $12,277 |
| Grp 5: Hospitals | $8,667 | $1,308 | $1,337 | $320,619 | $202,932 | $281,962 | $816,825 |
| Grp 6: Govt. statutory bodies and organisation/service | $1,027 | $1,308 | $1,337 | $177 | $1,545 | $635 | $6,029 |
| Avg. all organisations | $2,430 | $1,308 | $1,337 | $6,993 | $5,686 | $6,524 | $24,277 |
| *Source: ACIL Allen Consulting 2019* |

### Sensitivity analysis

Due to the variation in cost estimates provided, both within and across workforce groupings, sensitivity analysis was conducted, varying the following key assumptions:

* **Sensitivity** **1: no ISE directory or Child Link Register –** the online ISE directory and the Child Link Register are not implemented and as such there is no associated reduction in the estimated cost impact.
* **Sensitivity 2: higher record keeping time** – record keeping time is longer than the 12 minutes estimated and assumed to be 24 minutes.
* **Sensitivity 3: higher discount rate –** adiscount rate of 7 per cent is applied.[[25]](#footnote-26)

The sensitivity analysis presented below demonstrates the cost impact of key assumptions made in this RIS. It also serves as a proxy for presenting the significant range of impacts within workforce groupings and workforces, due to differences in organisation size and other factors, as highlighted in the workforce consultations.

**Table 6.8 Sensitivity Analysis – total workforce costs, 10-year totals**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Base case total 10 year cost | Sensitivity 1: No ISE Directory or Childlink | Sensitivity 2: Higher record keeping time | Sensitivity 3: higher discount rate |
|  | ‘000 | ‘000 | ‘000 | ‘000 |
| Grp 1: Schools | $46,795 | $58,609 | $54,845 | $42,692 |
| Grp 2: ECEC provider | $36,966 | $42,776 | $49,475 | $33,818 |
| Grp 3: OSHC provider | $2,235 | $2,478 | $2,649 | $2,074 |
| Grp 4: Health and support services | $24,174 | $28,205 | $27,428 | $22,515 |
| Grp 5: Hospitals | $71,064 | $93,974 | $95,594 | $63,636 |
| Grp 6: Govt. statutory bodies and organisation/service | $362 | $409 | $400 | $337 |
| Total | $181,595 | $226,449 | $230,391 | $165,072 |
| *Source: ACIL Allen Consulting 2019* |

## Qualitative ISE impact assessment

**Table 6.9** **The below table reflects expected key impacts on ISEs, gathered through the consultation process for this RIS**

| **Entity**  | **Impacts - requests**  | **Impacts - systems and processes** |
| --- | --- | --- |
| **Education*** Government schools
* Kindergartens
* Long day care
* Non-government schools and relevant system bodies
* Outside school hours care
* Student disengagement and child wellbeing services/ programs funded/delivered by DET
* Victorian Curriculum and Assessment Authority (VCAA)
* Victorian Institute of Teaching (VIT)
* Victorian Registration and Qualifications Authority (VRQA)
* Quality and Regulation Division (QARD) of DET
 | Due to the wide range of wellbeing and safety issues that present in their environment, education entities stated that under CIS requests would be made to most other prescribed entities. Other education providers represent a key source of information, mainly to ensure a child/student can transition to a new educational environment with a continuum of care.Other ISEs that hold information of particular relevance include acute health entities (hospitals and GPs), Victoria Police and child protection. Education entities stated that there was great potential for improvement in wellbeing services delivery to children/students once information can be shared by acute services and Child Protection. | Education entities reported that their existing record keeping systems will require updating, and a majority of ISEs indicated that these changes would be of modest scope.Some larger organisations, including service providers that operate at a number of locations across the State expect processes for updating systems and processes to be centralised. Other organisations that typically operate in one location, such as schools, expect to manage these tasks locally within the organisation. |
| **Health** * Ambulance Victoria
* Community health services
* Housing services
* Mental health services
* Forensic disability
* General Practice
* Homelessness services
* Public hospitals
* Multiple complex needs
* State funded aged care services
* Early parenting centres
* Migrant and refugee services
* Supported Playgroups
 | Health entities expect the number of incoming requests for information to increase significantly as education entities will be able to request information from health entities. Information sharing across health entities is also expected to increase, often in relation to children at higher risk.The greatest impact is expected to be on hospitals. While hospitals and other health entities have good record keeping policies and procedures, the increase in volume of requests will represent an administrative burden to these workforces due to the large number of “clients” that use the services. | Record keeping is predominantly incorporated into case/patient notes. The additional content requirements may require system upgrades in order to systematically record the necessary information.Certain entities, such as Ambulance Victoria, will need a greater review of their record keeping systems to ensure information sharing requests can be responded to.A number of the organisations, such as hospitals and community health organisations are an amalgamation of a number of services. These services may have different operating models and different record keeping systems, therefore requiring updates to a number of different systems.Some hospitals are in the process of standardising record keeping systems within the institution hospital precinct. Such projects have the potential to simplify information sharing and record keeping in the sector over time. |
| **Justice*** Dispute Settlement Centre of Victoria (DSCV)
 | DSCV expects prescription under the CIS Scheme to lead to a moderate increase in information sharing activity. | DSCV has good record keeping policies and procedures in place, and these must be adapted to information sharing under the CIS Scheme (currently, most of their records are not shared due to privacy considerations).  |
|  |  |  |

## Direct Costs to Government

The 2018-2022 State Budget allocated $42.9 million over four years, and ongoing funding of $5.2 million per year, to the implementation of the CIS Scheme. This funding was distributed to DET, DHHS, DJCS, FSV, Victoria Police and Court Services Victoria as the agencies and departments responsible for Phase One and Phase Two implementation of the scheme.

The direct costs to government of implementing Phase Two of the CIS Scheme, as presented below, represent direct government costs from the 2019-20 financial year (FY) onwards. Although some funding will be allocated to training and support of Phase One workforces in the period, the larger part of costs incurred from 2019-20 FY onwards will be related to Phase Two implementation of the scheme.

The costs presented below include funding allocated to DET, DHHS and DJCS as the departments that represent workforces proposed for prescription in Phase Two of the CIS Scheme. In all, the Victorian Government has allocated $21.8 million over three years, from FY 2019-20 and ongoing funding of $2.8 million per annum, to support Phase Two implementation of the CIS scheme.

### Whole of government implementation

In order to ensure effective implementation of the CIS Scheme, funding has been allocated to support a whole of Victorian Government unit that provides overarching policy and governance support, leads development of guidelines and regulations, manages communications across sectors and to the public, manages ongoing stakeholder consultation and key enabling projects. This unit also ensures the independent two and five-year reviews of the CIS Scheme are undertaken to the highest standard.

**Table 6.10 Direct costs to government - Whole of government implementation**

|  | 2019/20 | 2020/21 | 2021/22 | Ongoing |
| --- | --- | --- | --- | --- |
| WoVG costs | $1.89M | $1.26M | $1.29M | $0.23M |

### Sector support

In addition to the above mentioned whole of government implementation activities, government departments need to review and amend contracts with ISEs within the CIS Scheme where appropriate, provide input to guidelines and regulations, tailor training resources and communications materials, and engage in capacity building programs. Change management resources are needed within DET, DHHS, and DJCS to provide support, training and advice to frontline staff and oversee the delivery of internal workforce training.

It should be noted that there will also be a potential impact on independent government authorities, such as the Office of the Health Complaints Commissioner and the Office of the Victorian Information Commissioner, although these impacts are not quantified in this RIS.

**Table 6.11 Costs to government – Sector support**

|  | 2019/20 | 2020/21 | 2021/22 | Ongoing |
| --- | --- | --- | --- | --- |
| Sector support | $2.42M | $2.35M | $0.56M | $0.00M |

### Training

Each government agency will be responsible for implementing workforce training programs, and in some cases for establishing units that will support industry in facilitating information sharing. For example, DHHS has set up a new ongoing dedicated service unit, called the DHHS Child Wellbeing Information Exchange Unit, to coordinate information sharing for its directly employed workforces.

Training will be delivered in both face-to-face and online modes, with face-to-face training made available to information sharers and leaders within an organisation. It is important to note that online training will be made available to all workers.

The resources required to perform these functions vary dependent on the size and composition of the relevant workforces, as well as agency specific approaches such as the establishment of information exchange functions.

**Table 6.12 Costs to government – Workforce training**

|  | 2019/20 | 2020/21 | 2021/22 | Ongoing |
| --- | --- | --- | --- | --- |
| Workforce training | $7.40M | $2.05M | $2.54M | $2.58M |

# Expected benefits of the CIS Scheme

This RIS does not aim to estimate the monetary value of the totality of benefits to child wellbeing and safety expected to follow from Phase Two implementation of the CIS Scheme. This is in part due to the general nature of the concepts of ‘wellbeing’ and ‘safety’ and the complexities of assigning value to human life or improved health and wellbeing outcomes. Acknowledging that the CIS Scheme forms part of a greater reform agenda, as outlined in Chapter 1, it is also difficult to isolate the effects of the CIS Scheme from general societal developments as well as other reform efforts. Finally, the actual effects of increases in information sharing under the CIS Scheme will only become measurable in years to come through formal review processes and associated research.

In line with the Problem Analysis presented in Chapter 2, the expected benefits of the CIS Scheme are:

* information sharing will improve early intervention and prevention, thereby reducing the current heavy reliance on acute and statutory services
* information sharing will lead to improvements in health and wellbeing outcomes for Victorian children.

These expected benefits are discussed in further detail below.

## Reduced over-reliance on acute and statutory services

Under current laws, organisations may find it difficult or impossible to share information lawfully unless it is necessary to prevent a serious threat to a person’s life or safety. For this reason, information is often shared when harm has already occurred or when the risk of harm is considered serious. Information is less likely to be shared before the risk of harm becomes acute. Even in cases where information is shared before the risk of harm becomes acute, it is likely to be shared through the provisions of existing legislation and with services that are not equipped to provide early intervention and support. This adds pressure to Child Protection and Child FIRST systems.

According to the DHHS Child Protection and Family Services Additional Service Delivery Data report 2017-18[[26]](#footnote-27), there were 115,641 Child Protection reports in that year. After triage of the reports, 33,763 were investigated and of these 18,621 were substantiated. This data does not necessarily show excessive reporting to Child Protection given the current legislative parameters for information sharing, but it does suggest that a large proportion of mandatory reporting to Child Protection is not substantiated. With improved information sharing under the CIS Scheme it may be possible for mandatory reporting to be better informed and for some of the information currently reported to Child Protection to be more appropriately shared with other service providers, creating opportunities for early intervention and tailoring of service delivery to the needs of children and their families.

Stakeholder consultations for this RIS have confirmed that some stakeholders report to Child Protection in cases when they feel they have nowhere else to share information. Although the stakeholders acknowledged that information provided to Child Protection did not always meet the requirements for reporting, the stakeholders felt it was a better course of action than not sharing the information at all.

The majority of stakeholders also advised that they would use the opportunity to share information under the CIS Scheme as a preventative measure, including in cases that they would otherwise have reported directly to Child Protection, noting that reporting to Child Protection may still be necessary in these cases. It is likely that, over time, such preventative action will lead to a reduction in pressure on Child Protection and Child FIRST systems.

Beyond the likely reduction in workload, these attitudes demonstrate a commitment to early intervention amongst workforces proposed for prescription of Phase Two of the CIS Scheme, a commitment which can be expected to have positive consequences for child wellbeing and safety over time.

## Improvements in health and wellbeing outcomes for Victorian children

Information sharing under the CIS Scheme will have the potential to improve service delivery and the health and wellbeing outcomes of all Victorian children, not least because Phase Two of the CIS Scheme will prescribe large universal services that interact with and support nearly all Victorian children and their families. Improvements to health and wellbeing outcomes may range from improved access to academic support or improved transitioning between education or health services, to avoidance of significant risk to the health of a child.

In order to demonstrate any potential positive cost impacts of the implementation of the CIS Scheme, this RIS has relied on data illustrating the cost impacts related to high risk cases where children are already receiving support from secondary and tertiary services. This approach cannot demonstrate the full potential positive impact of the CIS Scheme, but it illustrates that even a limited impact on the number and seriousness of high risk cases will represent significant value from a humanitarian as well as economic perspective.

### The costs of child abuse and neglect

The direct costs associated with the provision of Child Protection services, out-of-home care (OOHC) and related family support services can be determined and are stated in the Productivity Commission’s Report on Government Services.[[27]](#footnote-28) The longer-term and indirect costs of child abuse and neglect are far more difficult to determine, but we know that child abuse and neglect can increase the need for specialist services when those children become adults.[[28]](#footnote-29) These service needs may include and relate to:

* homelessness and housing related problems
* alcohol and other drug issues
* mental illness
* criminality
* poor physical health

In support of these findings, a recent Victorian Government inquiry into youth justice centres found an over-representation in youth justice systems of children and young people who had suffered child abuse and neglect.[[29]](#footnote-30) The report found that of the children and young people sentenced or on remand in 2015/16, 45 per cent had been subject to a previous child protection order, and 19 per cent were subject to a current protection order.

In 2016/2017 Victoria accounted for approximately 20 per cent of the national expenditure on Child Protection, OOHC, intensive family support and family support services.[[30]](#footnote-31) In 2008, it was calculated that the annual cost to society of child abuse in Australia was $4 billion, while the value of the related burden of disease was a further $6.7 billion.[[31]](#footnote-32) Assuming that the relevant cost for Victoria remains at 20 per cent of the national expenditure, the costs for Victoria related to child abuse and associated disease would be $2.64 billion in 2018.[[32]](#footnote-33)

The cost of unresolved childhood trauma, such as child sexual, emotional and physical abuse, was estimated at $6.8 billion per year in 2015.[[33]](#footnote-34) If a broader definition of childhood trauma is applied, the costs increase to a minimum of $9.1 billion per year in 2015. Assuming that Victoria accounts for 20 per cent of the national cost, the total cost to Victoria in 2018 would be $1.94 billion.[[34]](#footnote-35)

## The CIS Scheme costs versus benefits

The statistical data presented above provides some level of insight into the tremendous human cost, and significant negative economic impact, of child abuse and neglect. If one conservatively assumes that the CIS Scheme will over time reduce the above impact by 10 per cent this alone would represent an annual cost saving that far exceeds the 10-year implementation costs as detailed in this RIS. Again, it is noted that this RIS does not aim to estimate the monetary value of the sum of benefits to child wellbeing and safety expected to follow from the implementation of the CIS Scheme, and these benefits are expected to positively impact the health and wellbeing of children and their families across a very broad range of circumstances.

DET therefore anticipates that the benefits of the CIS Scheme will far outweigh the associated costs. The CIS Scheme will increase the flow and quality of information to support child wellbeing and safety, allowing for early and preventative intervention and improved coordination of services. As demonstrated above, even assuming a very small impact of the CIS Scheme on child wellbeing and safety will hold significant benefits in relation to health and wellbeing outcomes for Victorian children, as well as in reduced costs to government and to society in general.

# Implementation of the CIS Scheme

## Approach to implementation of the CIS Scheme

In order to ensure workforce readiness and sector capacity though appropriate training and support, the CIS Scheme is rolled out to workforces in a phased approach according to the following timelines:

* Phase One commenced in September 2018, prescribing ISEs primarily within secondary and tertiary services. The entities’ relatively small workforces (with the exception of Victoria Police) and existing capability in formal risk assessment and management as well as complementary service functions allow for effective scheme implementation. Training delivery for Phase One workforces commenced in the second half of 2018, and continues in 2019.
* Phase Two, commencing in the second half of 2020, prescribing ISEs in primary and key universal services across the education, health and justice portfolios, according to the preferred option identified in this RIS. Training for Phase Two workforces is proposed to commence in the first half of 2020.

This phased approach is in line with the recommendations of the McClellan Royal Commission, and allows for a careful approach to reform implementation including government support and training, significantly reducing the risk of administrative overload, the application of poor risk assessment processes, and inappropriate sharing of information.

## Training and change management

Support offered to ISEs as part of scheme implementation include:

* integrated communication and key messaging on the rollout of the CIS and FVIS schemes and MARAM
* a cross-sector change management strategy, and tailored, workforce-specific implementation approaches
* training across the schemes and MARAM, including face-to-face training delivery and e-learning modules
* help desk service
* practice guidance
* factsheets, checklists and other materials to support the implementation of reforms, including materials tailored for specific workforces
* policy templates and further guidance materials to support organisations to identify and update relevant policies and procedures.

## Alignment with the FVIS Scheme

During consultations on the CIS and FVIS schemes, stakeholders have highlighted that aligned implementation of the schemes presents the following key advantages:

* it mitigates the risk of confusion about workforce obligations and overlap of schemes
* it reduces change fatigue
* it allows for efficiencies and cost savings by aligning workforce implementation activities, communications, and change management and training activities.

The ISEs proposed for inclusion in Phase Two of the CIS Scheme are the same as those proposed for Phase Two of the FVIS Scheme, discussed in the Regulatory Impact Statement for the proposed Family Violence Protection (Information Sharing and Risk Management) Amendment Regulations 2020. Further alignment of the implementation of the schemes will continue to be a high priority throughout the refinement of implementation planning.

## A multi-agency approach

Implementation of the CIS Scheme has implications for a multitude of sectors across Victoria. It is therefore fundamental to successful implementation that all relevant agencies and sectors are engaged in reform implementation.

The phased implementation of the CIS Scheme is led by DET as part of a Whole of Victorian Government (WoVG) function, and is undertaken in conjunction with partner agencies and departments: FSV, DHHS, DJCS, Court Services Victoria and Victoria Police.

Implementation of the CIS and FVIS schemes and MARAM has oversight and input from the Information Sharing and MARAM Framework (ISMARAM) Steering Committee representing DET, DHHS, DJCS, Victoria Police, Department of Premier and Cabinet, Court Services Victoria and FSV. A multi-agency approach to implementation is crucial to ensure that all affected entities are represented and that there is sufficient ability and insight to engage sectors and tailor implementation to meet the needs of all workforces.

**Table 8.1 CIS, FVIS and MARAM governance arrangements**

|  |  |  |
| --- | --- | --- |
|  | **CIS** | **FVIS and MARAM** |
| Secretary Level | Children’s Services Coordination Board (CSCB) | Victorian Secretaries Board sub-committee on Family Violence  |
| Senior Executive Level  | ISMARAM Steering Committee |
| Executive Level | ISMARAM Interdepartmental Committee (IDC) |
| Officer Level  | ISMARAM Working Group |

## Managing complaints under the CIS Scheme

Complaints in relation to the collection, use or disclosure of personal information by ISEs may be made to the Office of the Victorian Information Commissioner. Complaints in relation to the collection, use or disclosure of health information by ISEs (whether in the government or non-government sector) may be made to the Health Complaints Commissioner. If the *Privacy Act 1988* applies, a complaint may be made to the Office of the Australian Information Commissioner.

ISEs should have procedures in place for dealing with complaints made in relation to the CIS Scheme, and should make these available.

# Review of the CIS Scheme

The Act requires review of the operation of the CIS Scheme within two and five years of commencement of the scheme, and the tabling of a review report in both houses of Parliament within six months of the end of the two-year and five-year review periods. The Act further states that the reviews must be independent and must consider any adverse impacts of the legislation. The reviews may also include recommendations on any matter addressed in the review.

DET is responsible for the review processes. To meet the legislative requirements as well as inform implementation of the scheme, the following approach to review is proposed.

## Two-year and five year legislative reviews

Both the two-year and the five-year reviews are to be performed by independent suppliers with expertise in review of government reforms and programs.

The effectiveness of these proposed regulations is to be considered as part of the CIS Scheme reviews. The overarching review questions include:

* identify key enablers and barriers to operation of the CIS Scheme
* determine to what extent the CIS Scheme is achieving its objectives[[35]](#footnote-36)
* consider and identify any adverse impacts of the CIS Scheme
* assess success of prescription of ISEs
* assess impacts on diverse and disadvantaged communities
* potentially include recommendations on any matter addressed
* contribute to inform the roll-out of the CIS Scheme to Phase Two in 2020 (two-year review only).

The two-year and five-year review development follows the timeline below, noting that the timing of data gathering to support the five year review has yet to be determined:

**Table 9.1 Timeline for review of the CIS Scheme**

| Activity  | Date |
| --- | --- |
| Two year review project plan | Q4 2018 |
| Two year review framework | Q1 2019 |
| Two year review baseline data gathering | Q2/Q3 2019 |
| Two year review baseline report | Q4 2019 |
| Two year review, data gathering for review | Q1/Q2 2020 |
| Two year review final report | Q3 2020 |
| Two year review report tabled in Parliament | Q1 2021 |
| Five year review report due  | Q3 2023 |
| Five year review report tabled in Parliament | Q1 2024 |

### Independent review methodology

Independent reviewer ACIL Allen Consulting, in partnership with Wallis Consulting, have been engaged to perform the two-year review and has developed a review methodology that gathers input from of a wide range of stakeholders through various consultations, including:

* workforce surveys
* in-depth interviews with workforce representatives
* interviews with peak organisations
* interviews with young persons affected by the CIS Scheme
* roundtable discussions
* case studies.

By measuring short-term outcomes, such as workforce attitudes towards information sharing to support the wellbeing or safety of children, awareness of and implementation of the CIS Scheme, and ISE information sharing activity and collaboration in/coordination of service delivery, the reviewers will assess the effectiveness of regulations and assess to what extent the CIS Scheme is achieving its objectives.

The two-year review report, for the period September 2018 – September 2020, will be presented in Parliament by March 2021. Due to the phased implementation of the scheme, this review will only involve Phase One workforces.

The five-year review will be a comprehensive review involving all workforces prescribed in Phase One and Phase Two of the CIS Scheme, and the review report for the review period September 2018 – September 2023 will be presented in Parliament by March 2024. The research methodology and review framework will be determined in consultation with the (yet to be appointed) independent reviewer, but like the two-year review will rely on both quantitative and qualitative data gathering techniques and will assess the effectiveness of regulations and assess to what extent the CIS Scheme is achieving its objectives.

# Consultation

Extensive and targeted stakeholder consultations were conducted with the aim to involve all workforces proposed for Phase Two prescription under the CIS Scheme. Whilst consultation occurred with a range of both government and non-government organisations, including regional and metro locations, with workforces varying in size from thousands of employees to less than 30, it is acknowledged that only a small proportion of organisations that will be prescribed under Phase Two of the CIS Scheme could be engaged with through the consultation process.

## Objectives of consultation

The four objectives of the consultations were to:

* introduce the CIS Scheme to stakeholders
* discuss and identify the impact of the proposed Amendment Regulations on sectors and organisations proposed for prescription
* understand relevant organisational or sector-specific circumstances and contexts
* collect data to support the quantification of impacts.

## Consultation approach

The approach to consultation aimed at realising the objectives above by allowing for preliminary engagement and information gathering at sector forums involving a range of workforces, followed by in-depth interview with representatives of each unique organisation.

* Sector forum – a forum with stakeholders from organisations representing services proposed for prescription, to discuss the relevant impacts and risks across the sectors, and how they will vary depending on the sectors or organisations.
* Targeted interviews - structured interviews with representatives of individual organisations to provide further insight into the anticipated impact of the proposed Amendment Regulations on organisations and sectors, including estimated resourcing implications.

## Consultation participation

Approximately 120 workforce representatives from 60 unique organisations participated in six workforce forums (five face-to-face and one online), and 53 workforce interviews were subsequently conducted, either face-to-face or by teleconference.

## Key inputs form the consultations

Throughout the consultations, workforce representatives communicated that there would be a great variety of impacts across organisations resulting from their prescription under the CIS Scheme. Organisations also flagged clear differences in the level of preparedness for the reform and in training needs prior to Phase Two implementation. This variation of estimated impacts and support and training needs in part reflects the uncertainty that organisations invariably face when contemplating the impact of new regulations. It also reflects the fundamental factors that will drive variation in the regulations’ impacts across ISEs, including the size of the organisation, their resourcing capacity, the nature of their work involving information sharing, and their existing systems and processes.

A clear majority of workforce representatives who participated in the consultations expressed support for the reforms and of being prescribed under the CIS Scheme. It should also be noted that many participants flagged the need for comprehensive training provision by the Victorian Government to facilitate the implementation of Phase Two of the CIS Scheme. Another common theme was the need to provide clear communication and practice guidance as well as workforce specific case studies and templates that will support scheme implementation.

Feedback gathered throughout the RIS consultations informs reform delivery of the CIS Scheme. As outlined in this RIS, the preferred option for prescription of Phase Two ISEs and the government support presented in Chapter 6, Preferred Option, to a great extent reflects the feedback received through the RIS consultation.

Stakeholders that participated in the targeted RIS consultation process are listed below:

**Table 10.1 List of stakeholders consulted**

|  |
| --- |
| **RIS Stakeholder Participation** |
| **Schools**Lyndhurst Primary School (DET)Cranbourne East Secondary College (DET)Elwood College (DET)Bialik College (Independent)David Scott School (Independent)Sophia Mundi Steiner School (Independent)Chairo Christian School (Independent)Korowa Anglican Girls’ School (Independent)Mentone Grammar School (Independent)Holy Rosary Primary School (Catholic) Sandhurst Dioceses (Catholic)Avila College (Catholic)Our Lady Star of the Sea Primary School (Cowes) (Catholic) St Laurence O’Toole Primary School (Catholic) | **Early childhood education and care**Glen Eira Kindergarten AssociationKekeco ChildcareBestchance Child Family CareAuburn South PreschoolGowrie VictoriaGoodstart Early LearningNorth East Regional Preschool AssociationCity of FrankstonCity of KnoxShire of Yarra Ranges |
| **Outside school hours care** | **Ambulance** |
| Junior Adventure GroupCamp Australia  | Ambulance Victoria |
| **Hospitals** | **Health and support services** |
| The Royal Women’s HospitalTweddle Child and Family HealthMercy HospitalAlfred HospitalRoyal Victorian Eye and Ear HospitalPeter Mac Cancer CentreThe Royal Melbourne HospitalSt Vincent’s HospitalAustin HospitalThe Royal Children’s Hospital | Queen Elizabeth CentreAccess Health and CommunityLink Health Carrington HealthPeninsula HealthNorthern HealthBendigo HealthMental Health VictoriaMind AustraliaThe Royal Australian College of General PractitionersGeneral practitionersJesuit Social ServicesMonash Health  |
| **Student disengagement and health services** | **Other government departments and services** |
| DET NavigatorDET School NursesChaplaincy Program | DET North Eastern Regional ServicesDET South Eastern Regional ServicesDET South Western Regional ServicesVictorian Curriculum and Assessment AuthorityForensic Disability Multiple and Complex Needs initiative Refugee Minor |

# References

Australian Government (2019) [Report on Government Services](https://www.pc.gov.au/research/ongoing/report-on-government-services)

Australian Institute of Criminology (2007) [*Cost effectiveness of early intervention September 2019*](https://aic.gov.au/publications/crm/crm054)

Australian Institute of Health and Welfare (2019) [*Child Protection Australia 2017-18*](https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2017-18/contents/children-receiving-child-protection-services/new-and-repeat-clients)

Child Family Community Australia (CFCA) (2014) [*Effects of child abuse and neglect for children and adolescents*.](https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents) Melbourne: Australian Institute of Family Studies

[*Children Legislation Amendment (Information Sharing) Act 2017*](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/FF358D4126D026A9CA25826B000AAA7C/%24FILE/18-011aa%20authorised.pdf)

Children Legislation Amendment (Information Sharing) Bill 2017 [*Explanatory Memorandum*](http://www.legislation.vic.gov.au/domino/web_notes/LDMS/PubPDocs_Arch.nsf/5da7442d8f61e92bca256de50013d008/CA257CCA00177A46CA2581F400036887/%24FILE/581377exi1z.pdf)

Commission for Children and Young People (2016) [*Neither seen nor heard: Inquiry into issues of family violence in child deaths*](https://ccyp.vic.gov.au/assets/Publications-inquiries/Neither-seen-nor-heard-Inquiry-into-issues-of-family-violence-in-child-deaths.pdf)

Commission for Children and Young People (2018) [*Commission for Young Children and Young People annual Report 2017-18*](https://ccyp.vic.gov.au/assets/corporate-documents/CCYP-AR-2018-P6-FINAL-web.pdf)

Commission for Children and Young People Inquiry into the Death of Child O

Commonwealth of Australia (2017) [*Royal Commission into Institutional Responses to Child Sexual Abuse*](https://www.childabuseroyalcommission.gov.au/final-report)

Coroners Court of Victoria (2015) [Inquest into the Death of Baby D](https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/aa_babyd_147412_redacted1_redacted.pdf)

Cummins, P, Scott, D and Scales, B (2012) [*Report of the Protecting Victoria’s Vulnerable Children Inquiry*](http://childprotectioninquiry.vic.gov.au/images/stories/inquiry/volume1/cpi%207649%20web-pdf%20volume%201%20protecting%20victoria_s%20vulnerable%20children_%20inquiry_bm.2.pdf)

Department of Health and Human Services (2016) [*Roadmap for Reform: strong families; safe children*](https://www.dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children)

Department of Health and Human Services (2018) [*Child Protection and family services additional service delivery data 2017-18*](https://www.dhhs.vic.gov.au/child-protection-and-family-services-additional-service-delivery-data-2017-18)

Department of Health and Human Services (2018) [Annual Report 2017-2018](https://www.dhhs.vic.gov.au/sites/default/files/documents/201812/DHHS-annual-report-2017-18.pdf)

Department of Treasury and Finance (DTF*)* [*Technical Guidelines on Economic Evaluation*](http://www.dtf.vic.gov.au/Publications/Investment-planning-and-evaluation-publications/Lifecycle-guidance/Technical-guides) (2014)

Family Safety Victoria (2017) [*Regulatory Impact Statement: Family Violence Protection (Information Sharing) Regulations 2017*](http://www.betterregulation.vic.gov.au/files/4620a1f5-7264-4930-a6ae-a88f00be3ef9/Family-Violence-Information-Sharing-RIS-PDF.pdf)

Heckman, J (2011) [*The Economics of Inequality: The value of early childhood education*:](https://eric.ed.gov/?id=EJ920516) American Educator: Spring 2011

Kezelman, C., Hossack, N., Stavropoulos, P., & Burley, P. (2015) [*The cost of unresolved childhood trauma and abuse in adults in Australia*.](https://www.blueknot.org.au/Portals/2/Economic%20Report/The%20cost%20of%20unresolved%20trauma_budget%20report%20fnl.pdf) Sydney: Adults Surviving Child Abuse and Pegasus Economics

Steering Committee for the Review of Government Service Provision. (2018). [*Report on government services 2016*](https://www.pc.gov.au/research/ongoing/report-on-government-services/2018/community-services/child-protection/rogs-2018-partf-chapter16.pdf). Canberra: Productivity Commission

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). [*The cost of child abuse in Australia*.](https://earlytraumagrief.anu.edu.au/files/Access%20Economic%20Report_Exec%20Summary_FINAL.pdf) Melbourne: Australian Childhood Foundation and Child Abuse Prevention Research Australia

Victorian Government (2016) [*Royal Commission into Family Violence (Victoria)*](http://www.rcfv.com.au/Report-Recommendations)

Victorian Government (2018) [*Child Information Sharing Ministerial Guidelines*](https://www.vic.gov.au/sites/default/files/2019-01/Child%20Information%20Sharing%20Scheme%20Ministerial%20Guidlines%20-%20Guidance%20for%20information%20sharing%20entities.pdf)

Victorian Government (2018) [*Inquiry into youth justice centres in Victoria: Final Report*](https://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Youth_Justice_System/Reports/LSIC_Inquiry_into_Youth_Justice_Centres_report_WEB.pdf)*.* Melbourne: Victorian Government Printer

Victorian Parliament (2001) [*Health Records Act 2001 No.2 of 2001*](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt6.nsf/DDE300B846EED9C7CA257616000A3571/77FAA53ECDC0DA44CA2579030015D701/%24FILE/01-2aa023%20authorised.pdf)

Victorian Parliament (2014) [*Privacy and Data Protection Action 2014 No.60 of 2014*](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/05CC92B3F8CB6A6BCA257D4700209220/%24FILE/14-060aa%20authorised.pdf)

Victorian Parliament (2005) [*Children, Youth and Families Act 2005, Act No. 96/2005*](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/15A4CD9FB84C7196CA2570D00022769A/%24FILE/05-096a.pdf)

# Appendix A Prescribed Phase One Entities

|  |  |
| --- | --- |
| **Prescribed workforce** | **Described as:** |
| Maternal & Child Health (MCH) | * a council to the extent that it provides MCH programs
* a person or body engaged by a council to provide MCH programs for a MCH service on behalf of the council, to the extent that the person or body performs functions relating to the provision of MCH programs
* a person or body that is engaged or funded under a State contract to provide MCH services, to the extent that the person or body performs functions relating to the provision of MCH services
* DHHS to the extent that it provides MCH advice through a state-wide telephone service
 |
| Child FIRST | * a community-based child and family service within the meaning of the *Children, Youth and Families Act 2005, to the extent that it performs the functions of a community- based child and family service*
 |
| Integrated Family Services | * a community-based child and family service within the meaning of the *Children, Youth and Families Act 2005, to the extent that it performs the functions of a community- based child and family service*
 |
| Child Protection | * the Secretary to the DHHS, to the extent that the Secretary performs functions under the *Children, Youth and Families Act 2005*
 |
| Out of Home Care | * the Secretary to DHHS, to the extent that the Secretary performs functions under the *Children, Youth and Families Act 2005*
* a registered out of home care service within the meaning of the *Children, Youth and Families Act 2005*, to the extent that it performs the functions of a registered out of home care service
 |
| Support and Safety Hubs | * a body that is declared to be an authorised Hub entity under section 144SC of the *Family Violence Protection Act 2008*, to the extent that the body provides services in relation to a body known as Support and Safety Hub established by Family Safety Victoria
 |
| Risk Assessment and Management Panels | * a person or body that participates in a Risk Assessment and Management Panel meeting, to the extent that the person or body performs functions that relate to the person or body’s participation in a Risk Assessment and Management Panel meeting, including preparation for and attendance at a meeting and associated follow-up action or activities
 |
| Specialist Family Violence services | * a person or body that provides specialist family violence services and is engaged or funded under a State contract to provide family violence information sharing functions, to the extent that the person or body performs functions relating to the provision of those services
 |
| Alcohol and Other Drug services | * a person or body that is engaged or funded under a State contract to provide alcohol and other drugs services, to the extent that the person or body performs functions relating to the provision of alcohol and other drugs services
 |
| Mental Health services | * a designated mental health service within the meaning of the *Mental Health Act 2014*, to the extent that it performs functions relating to the provision of mental health services
 |
| Sexual Assault Services | * a person or body that is engaged or funded under a State contract to provide services to victim survivors of sexual assault, to the extent that the person or body performs functions relating to the provision of services to victim survivors of sexual assault
* a person or body that is engaged or funded under a State contract to provide sexually abusive behaviour treatment services, to the extent that the person or body performs functions relating to the provision of sexually abusive behaviour treatment services
 |
| Homelessness services | * a person or body that is engaged or funded under a State contract to provide homelessness accommodation or homelessness support services, to the extent that the person or body performs functions relating to the provision of access point, outreach or accommodation services
 |
| Housing (DHHS only) | * the Director of Housing within the meaning of the *Housing Act 1983*
* the Secretary to DHHS, to the extent that the Department performs functions under the *Housing Act 1983*
* the Secretary to DHHS, to the extent that Department assists with the performance of the Director of Housing’s functions under the *Housing Act 1983*
 |
| Youth Justice | * the Secretary to the DJCS, to the extent that the Department performs functions under the *Children, Youth and Families Act 2005*
* a person or body that is engaged or funded under a State contract to provide youth justice community support services or programs, to the extent that the person or body provides the youth justice community support services or programs
 |
| Youth Parole Board | * the Secretary to the DJCS, to the extent that the Department supports the performance of the functions under Chapter 5 of the *Children, Youth and Families Act 2005*of the Youth Parole Board within the meaning of that Act
 |
| Justice Health | * the Secretary to the DJCS, to the extent that the Department manages or delivers justice health, rehabilitation or reintegration services or programs for children
* a person or body that is engaged or funded under a State contract by the DJCS to provide or deliver health, rehabilitation or reintegration services or programs for children, to the extent that they provide or deliver those services or programs directly to children
 |
| Multi-Agency Panels to Prevent Youth Offending | * a person or body that participates in a Multi-Agency Panel to Prevent Youth Offending meeting, to the extent of that participation, including preparation for and attendance at the meeting and associated follow-up actions or activities
 |
| Victoria Police | * Victoria Police within the meaning of the *Victoria Police Act 2013*
 |
| Victims of Crime Helpline and Victims Assistance Programs | * the Secretary to the DJCS, to the extent that the Department provides victims of crime support through a state-wide telephone service
* a person or body that is engaged or funded under a State contract to provide case management services to victims of crime, to the extent that the person or body performs functions relating to the delivery of case management services to victims of crime
 |
| Registry of Births, Deaths and Marriages | * the Secretary to the DJCS, to the extent that the Department supports the performance of the functions of the Registrar within the meaning of the *Births, Deaths and Marriages Registration Act 1996* and the *Relationships Act 2008*
 |
| Disability Services Commissioner | * the Disability Services Commissioner within the meaning of the *Disability Act 2006*
 |
| Commission for Children and Young People | * the Commission for Children and Young People established by section 6 of the *Commission for Children and Young People**Act 2012*
 |

Total number of entities: 711 (approximate)

Total workforce for prescribed entities: 28,000 (approximate)

# Appendix B Entities Proposed for Phase Two Prescription

|  |  |
| --- | --- |
| **Prescribed workforce** | **Described as:** |
| Government and non-government schools | * registered schools within the meaning of section 1.1.3(1) of the *Education and Training Reform Act 2006*
 |
| Relevant non-government school system bodies | * a person or body that provides support and services to Catholic schools for the Archdiocese of Melbourne, Diocese of Sale, Diocese Ballarat, and Diocese of Sandhurst, to the extent that the person or body performs functions relating to: (a) student wellbeing support, or (b) professional ethics and conduct support, or (c) learning diversity support
 |
| Kindergartens | * an education and care service within the meaning of clause 5(1) of the Schedule to the *Education and Care Services National Law Act 2010*, to the extent that the service is registered to provide kindergarten
 |
| Long day care services | * an education and care service within the meaning of clause 5(1) of the Schedule to the *Education and Care Services National Law Act 2010*, to the extent that the service is registered to provide long day care
 |
| Outside school hours care services | * an education and care service within the meaning of clause 5(1) of the Schedule to the *Education and Care Services National Law Act 2010*, registered to provide outside school hours care, to the extent that the service provides before school care and after school care
 |
| Student disengagement and wellbeing services/programs funded by the Department of Education and Training | * **Enhancing Mental Health Support in Schools Program –** a person or body that is engaged or funded under a State contract to provide mental health support services, to the extent that the person or body performs functions relating to the provision of mental health support services in government schools
* **Lookout Program –** a person or body that is engaged or funded under a State contract to manage or deliver programs which support educational outcomes for children and young people in out of home care, to the extent that the person or body performs functions relating to the provision of programs to support educational outcomes for children and young people in out of home care
* **Primary School Nursing Program –** a person or body that is engaged or funded under a State contract to manage or deliver primary school nursing programs and services, to the extent that the person or body performs functions relating to the provision of primary school nursing programs and services in registered schools
* **Project REAL and Navigator Program –** a person or body that is engaged or funded under a State contract to provide re-engagement services to children and young people at risk of disengaging with education, to the extent that the person or body performs functions relating to the provision of those services
* **Royal Children’s Hospital Education Institute –** a person or body that is engaged or funded under a State contract to provide education support to children and young people experiencing chronic health conditions, to the extent that the person or body performs functions relating to the provision of those services at the Royal Children’s Hospital
* **School-focussed youth services and the Geelong Project –** a person or body that is engaged or funded under a State contract to provide early intervention services to children and young people at risk of disengaging with education, to the extent that the person or body performs functions relating to the provision of those services
* **Secondary School Nursing Program –** a person or body that is engaged or funded under a State contract to manage or deliver secondary school nursing programs and services, to the extent that the person or body performs functions relating to the provision of secondary school nursing programs and services in government schools
* **State Chaplaincy Program –** a person or body that is engaged or funded under a State contract to provide chaplaincy services, to the extent that the person or body performs functions relating to the provision of chaplaincy services in government schools
* **Student Support Services –** a person or body that is engaged or funded under a State contract to manage or deliver student support services to assist children and young people with learning, mental health and developmental barriers, to the extent that the person or body performs functions relating to the provision of services to assist children and young people with learning, mental health and developmental barriers
 |
| Child and wellbeing services/programs delivered by the Department of Education and Training | * **Early Years Managers –** the Secretary to the Department of Education and Training, to the extent that that Department operates or manages services for kindergartens based in local government or community organisations, to the extent that the services have direct engagement with children or hold relevant information about children
* **Education Justice Initiative –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers programs which support the educational outcomes of children and young people involved in the criminal justice system
* **Koorie Engagement Support Officers –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers programs and services to support cultural engagement and improved outcomes for children and young people who are Aboriginal or Torres Strait Islander, or both
* **Lookout –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers programs which support educational outcomes for children and young people in out of home care
* **National School Chaplaincy Program –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers chaplaincy programs to support the emotional wellbeing of students
* **Quality Assessment and Regulation Division –** the Secretary to the Department of Education and Training, to the extent that that Department manages the approval and regulation of education and care services that operate under the *Education and Care Services National Law Act 2010*, or manages the licensing and regulation of children’s services under the *Children’s Services Act 1996*
* **Security and Emergency Management Division –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers emergency and critical incident management, security, and incident management programs and services
* **State-wide Vision Resource Centre –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers programs and services to assist children and young people with vision impairment
* **Student Support Services –** the Secretary to the Department of Education and Training, to the extent that that Department manages or delivers student support services to assist children and young people with learning, mental health and developmental barriers
 |
| Victorian Curriculum and Assessment Authority | * the Victorian Institute of Teaching continued in operation by Part 2.6 of the *Education and Training Reform Act 2006*
 |
| Victorian Institute of Teaching | * the Victorian Curriculum and Assessment Authority continued in operation by Part 2.5 of the *Education and Training Reform Act 2006*
 |
| Victorian Registration and Qualifications Authority | * the Victorian Registration and Qualifications Authority established under Chapter 4 of the *Education and Training Reform Act 2006*
 |
| Community mental health services | * a person or body that is a mental health service provider within the meaning of the *Mental Health Act 2014* that is engaged or funded under a State contract to provide mental health services, to the extent that it performs functions relating to the provision of mental health services
 |
| Homelessness services | * a person or body that is engaged or funded under a State contract to provide homelessness accommodation or homelessness support services, to the extent that the person or body performs functions relating to the provision of homelessness accommodation or homelessness support services
 |
| Housing | * a registered agency within the meaning of the *Housing Act 1983*
* a person or body that is engaged or funded under a State contract to provide case management support for at risk social housing tenants to assist to establish or sustain tenancy
 |
| Forensic disability | * a person or body that is engaged or funded under a State contract to provide specialist forensic disability accommodation services, to the extent that the person or body performs functions relating to the provision of specialist forensic disability accommodation services
* the Secretary of DHHS performs functions under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, *Sentencing Act 1991* and *Disability Act 2006*
 |
| Multiple and Complex Needs Initiative (MACNI) | * The Secretary of DHHS performs functions under the *Human Services (Complex Needs) Act 2009*
 |
| Health | * Ambulance Victoria created under section 23(1)(a) of the *Ambulance Services Act 1986* and any successor ambulance service
* a registered funded agency within the meaning of the *Health Services Act 1988*
* a multi-purpose service within the meaning of the *Health Services Act 1988*
* a registered community health centre within the meaning of the *Health Services Act 1988*
* a registered medical practitioner who practises in the medical profession as a general practitioner in Victoria
* a general practice nurse who is employed by, or whose services are otherwise retained by, a general practice in Victoria
 |
| Aged care | * a person or body operating a Commonwealth approved residential aged care home that provides State funded public sector residential aged care services, including State funded residential aged care homes but not including supported residential services within the meaning of the *Health Services Act 1988*
 |
| Migrant and refugee services | * a person or body that provides settlement or targeted casework services specifically for migrants, refugees or asylum seekers, to the extent that the person or body provides settlement or casework services for migrants, refugees or asylum seekers
* the Secretary to DHHS to the extent that the Secretary performs functions conferred under regulation 15(3) of the Immigration (Guardianship of Children) Regulations 2018 (Commonwealth) in relation to a function delegated to the Secretary under section 5 of the *Immigration (Guardianship of Children) Act 1946 (Commonwealth)*
 |
| Supported playgroups | * a person or body that is engaged or funded by DHHS under a State contract to provide supported playgroups, to the extent that the person or body performs functions relating to supported playgroups
 |
| Dispute Settlement Centre of Victoria | * a dispute settlement centre declared under section 21K of the *Evidence (Miscellaneous Provisions) Act 1958*
* the Secretary to the Department of Justice and Community Safety to the extent that persons within that Department are declared to be mediators under section 21K of the *Evidence (Miscellaneous Provisions) Act 1958*
 |

Total number of ISEs: 7,500 (approximately)

Total workforce number for ISEs: 370,000 (approximately)

**Note**:

Legislative amendments are presently underway to prescribe the Children’s Court and Magistrates’ Court as ISEs in the CIS Scheme. It is anticipated that the Courts will be included in the CIS Scheme through a tailored commencement date in 2020, pending legislative resolution.

# Appendix C Costing Methodology and Assumptions

DET engaged ACIL Allen Consulting to estimate the cost impact of the proposed Amendment Regulations, prescribing workforces for Phase Two implementation of the CIS Scheme. This appendix presents the methodology of cost analysis, and the assumptions applied to estimate the cost impact of the preferred option, noting that some of the key assumptions are presented in Chapter 6 of this RIS.

## Overview

The costs outlined in this RIS were estimated by interviewing a selected group of 53 Phase Two workforce representatives to understand the likely cost to comply with the scheme. These estimated costs were then applied to the total estimated Phase Two workforces, to estimate a total cost of the Scheme. The key costs of CIS Scheme implementation include updating policies, training, undertaking additional information requests, responding to additional information requests, and additional record keeping. The ‘cost’ represents the value of the time required by these workforces to undertake these tasks.

The scope of the costs included in the analysis is limited to the increase in information sharing which will be newly permitted, or required, following the roll-out of the proposed Amendment Regulations, enabling Phase Two implementation of the CIS Scheme. The cost estimation does not include any flow-on effects of the new scheme on the amount of information sharing under existing regulation (as these may occur due to promotion, training and greater education about information sharing). That is, the cost estimation does not include the cost associated with an increase in the practice of information sharing within the scope of existing laws and regulations that may be prompted by the implementation of the CIS Scheme to Phase Two workforces.

Key data used in the analysis was provided by DET, on behalf of other departments as required, and includes:

* *workforce data* – including estimated FTE, and associated number of organisations
* *workforce cost interview data* – including estimated cost impacts of the CIS Scheme on Phase Two workforces.

## Costing methodology

As outlined above, the total annual cost of the Scheme was estimated by interviewing a group of Phase Two workforces to understand the likely cost of complying with the Scheme. These costs were then applied to the total estimated workforce size to estimate the total annual cost.

The total cost of the Scheme over a 10-year period was calculated using the estimated annual cost of the Scheme, and then discounted to estimate the present value (PV) of the cost of the Scheme.

The Phase Two workforces are relatively diverse and range from schools to government organisations. As such, the cost estimation was undertaken across various sub-groups of the Phase Two workforces. Specifically, the detailed methodology comprises the following key steps:

* *Workforce sub-grouping –* The Phase Two workforces are grouped into sub-groups based on their service offering and level of information sharing, that is, the Phase Two workforces are grouped into sub-groups with similar estimated cost impacts.
* *Unit cost estimation by group* – Estimate of key cost metrics for each workforce sub-group, including cost of updating policies per organisation, cost of undertaking additional information requests per FTE, cost of responding to additional information requests per FTE, and cost of additional record keeping per FTE.
* *Total workforce cost estimation* – Estimate the per annum cost across the full workforce by multiplying out the per worker or organisation costs by the full workforce size.

The table below summarises the cost analysis framework used, showing the costs considered and key assumptions.

### Table 14.1 Cost analysis framework

|  | Estimation method |
| --- | --- |
|  **Upfront costs** |  |
| Update policies | cost of updating policies (average per organisation),multiplied by the total number of organisations |
| Training costs \* | assumed training delivery per organisation provided by DET,multiplied by the total number of organisations |
|  **Ongoing costs** |  |
| Making requests | cost of making requests (average per FTE),multiplied by the total FTE workforce |
| Record keeping requests \*\* | cost of record keeping for requests (average per FTE), multiplied by the total FTE workforce |
| Responding to requests | cost of responding to requests (average per FTE), multiplied by the total FTE workforce |
| Record keeping for responding to requests\*\* | cost of record keeping for responding (average per FTE), multiplied by the total FTE workforce |
|  **Key assumptions** |
| *Discount rate[[36]](#footnote-37)*: 4 per cent[[37]](#footnote-38)  |
| *Time period:* 2020 to 2029 |
| \* training requirements and costs were estimated using assumptions provided by DET as outlined in Chapter 6.\*\* the time taken to keep records was estimated using assumptions provided by DET as outlined under Key Assumptions, below.Source: ACIL Allen Consulting 2019 |

### Unit cost estimation by group

This step estimates the average cost of each cost item per FTE worker (or per organisation for the upfront costs). A cost ‘item’ represents a cost per FTE worker (or organisation) of record keeping per annum, or cost per workforce member (or organisation) of making or responding to requests. Note that this is an average cost calculated per workforce member, and not a cost calculated per workforce member who is expected to directly perform information sharing activities.[[38]](#footnote-39)

Generally, the process applied for each cost category is as follows:

* from the structured interviews the following data is collected:
	+ average hourly cost (wage)
	+ number of ‘activities’ per annum (e.g. data requests, record keeping, provision of information etc)
	+ average number of hours required per ‘activity’
	+ total organisation FTE workforce.
* the data are then used to calculate the average annual cost per FTE workforce member (or organisation) for that group. This is achieved by multiplying the ‘average wage’ by ‘the number of activities per annum’ by the ‘average hours required per item’ divided through by the total organisational workforce. This outputs the average cost per FTE workforce member (or organisation) of each of the cost items.
* the outputs are then averaged across multiple interview responses for a given category, to provide an average cost per workforce member of the Phase Two workforce sub-group.

### Total workforce cost estimation

Having first established unit cost per FTE for each group and cost category, aggregate workforce statistics can be applied to calculate the total cost to the total Phase Two workforce. For example, the costs per workforce member[[39]](#footnote-40) may then be multiplied out using aggregate workforce statistics (total workforce count) of the broader grouping. For example:

*If we assume that it costs an average of $10 per FTE per annum in schools to keep records, and there are 10,000 FTE in the total school workforce, then the total annual cost of record keeping for schools would be estimated at $100,000 ($10 x 10,000 workers).*

### Costing assumptions

Other notes and clarifications on the methodology include:

* The split of information sharing between FVIS and CIS schemes was estimated through the interviews, which sought to isolate information sharing attributable to the CIS Scheme only.
* The interviews collected estimates of the time impact on workforces of updating policies and procedures for the FVIS and CIS schemes combined, given the aligned implementation of the schemes and the largely overlapping regulatory requirements. For each response, 50 per cent of the reported impact was attributed to each scheme (CIS and FVIS). The calculations of monetary value of these impacts may differ somewhat between the RIS for the CIS Scheme and RIS for the FVIS Scheme due to variations in methodology and approach to analysis of available data.
* The cost estimate of updating policies and procedures assumed that Departments will provide templates for workforces where this is seen as useful, i.e. interview respondents were asked how much time will be required to update policies and procedures given they will be provided templates to guide them, if needed.
* In the consultations undertaken by DET with Phase Two workforces, a great deal of confusion existed around the record keeping requirements under the proposed Amendment Regulations and how long it may take to perform the task of record keeping. Specifically, many respondents provided feedback with the explicit assumption that their procedures and policies would not support this work (currently they may not, but the cost of developing such procedures is separately recorded in this RIS). DET therefore consulted with Phase One workforces to identify that record keeping under the CIS Scheme takes 10 minutes on average. It was determined to add 20 per cent to the average record keeping time, to avoid any underestimation of the labour impact of the requirement. As such, the analysis assumes record keeping is 12 minutes per request or response.
* The 10-year cost of the scheme was estimated using two additional assumptions:
	+ the amount of information sharing was assumed to increase annually in line with population growth forecasts, where a population growth rate of 1.7 per cent was applied.[[40]](#footnote-41)
	+ real wages (wage growth adjusted for inflation) were assumed to increase at an annual rate of 0.5 per cent.[[41]](#footnote-42)

## Workforce groupings and summary data

The broader impacted workforce group (proposed Phase Two workforces) includes 40-45 categories of ISEs. The organisations involved range from kindergartens, schools, public hospitals, community health services, GPs, Ambulance Victoria, state funded aged care, community housing, to various government organisations such as the Dispute Settlement Centre of Victoria and the Victorian Registration and Qualifications authority.

To model the impact on these workforces it is necessary to group the organisations together where they are similar in their service offering and cost impacts per workforce member (i.e. the impact per workforce is expected to be similar).

Administrative data provided below (number of organisations and FTE) are based on current (2018-2019) information available. No assumptions have been made in relation to possible future changes to the administrative data, e.g. workforce growth. The grouping of Phase Two workforces and workforce data by group is provided in the table below:

**Table 14.2 Phase Two workforce groupings and key metrics (2018-19)**

|  Workforce Grouping | Organisations | FTEs |  |
| --- | --- | --- | --- |
|  **Group 1: Schools** |  |
| Government |  |  |  |
| Independent |  |  |  |
| Catholic |  |  |  |
| Relevant non-government school system bodies[[42]](#footnote-43) |  |  |  |
| Student disengagement and child wellbeing services/ programs funded/delivered by DET[[43]](#footnote-44) |  |  |  |
| ***Total Group 1:*** | ***2,256*** | ***85,018*** |  |
| **Group 2: Early Childhood Education and Care provider** |
| Kindergartens  |  |  |  |
| Long Day Care |  |  |  |
| Supported Playgroups  |  |  |  |
| ***Total Group 2:*** | ***2,791*** | ***35,902*** |  |
| **Group 3: Outside School Hours care** |  |
| Outside School Hours Care |  |  |  |
| ***Total Group 3:*** | ***317*** | ***6,311*** |  |
| **Group 4: Health and support services** |
| Community health services |  |  |  |
| Housing services |  |  |  |
| Community mental health services |  |  |  |
| Ambulance Victoria |  |  |  |
| Homelessness services |  |  |  |
| General Practitioners (general practices) |  |  |  |
| General Practice nurses[[44]](#footnote-45) |  |  |  |
| ***Total Group 4:*** |  ***1,969***  |  ***16,190***  |  |
| **Group 5: Hospitals** |  |
| Public Hospitals |  |  |  |
| State funded aged care services[[45]](#footnote-46) |  |  |
| Early parenting centres[[46]](#footnote-47) |  |  |
| ***Total Group 5:*** | ***87*** | ***91,665*** |  |
| **Group 6: Government statutory bodies and organisations/services** |
| Victorian Curriculum and Assessment Authority (VCAA) |  |  |  |
| Victorian Institute of Teaching (VIT) |  |  |  |
| Victorian Registration and Qualifications Authority (VRQA) |  |  |  |
| Migrant and refugee services |  |  |  |
| Multiple and Complex Needs Initiative (MACNI) |  |  |  |
| Quality and Regulation Division (QARD) of DET |  |  |  |
| Dispute Settlement Centre of Victoria |  |  |  |
| Forensic disability |  |  |  |
| ***Total Group 6:*** |  ***60*** |  ***830***  |  |
| ***Total Phase Two workforces*** |  **7,480**  |  **235,915**  |  |
| Source: DHHS and DET provided Data 2018-19 |
|  |

1. Net present value is a measure of costs of future investments in ‘today’s money’. $110 due in 12 months can have a net present value of $100, for example. [↑](#footnote-ref-2)
2. The total year one direct cost to government is calculated at $17.4 million. This figure matches the budget allocations for CIS Scheme implementation for financial years 2019-20 and 2020-21, and accounts for upfront costs and costs in the first year of scheme operation. The direct cost to government over ten years is $34.4 million (NPV). [↑](#footnote-ref-3)
3. Total estimated year one cost impact of the CIS Scheme Regulations on Phase Two workforces (government and non-government) is approximately $48.3 million. This comprises $18.2 million to update policies, $9.8 million in upfront training, $13.8 million for requests to share information and for responses to information sharing requests, and $6.6 million for record keeping costs. [↑](#footnote-ref-4)
4. This RIS does not perfectly separate the direct cost impact on government of Phase One and Phase Two implementation. It should be noted that DJCS represents one workforce proposed for Phase Two prescription under the CIS Scheme, namely the Dispute Settlement Centre of Victoria. A greater number of workforces represented by DJCS were prescribed for Phase One of the scheme. By including all funding allocated to DJCS over the State budget from FY 2019-20 onwards for implementation of the CIS Scheme, this RIS arguably somewhat overstates the direct cost impact on government related to Phase Two implementation of the scheme. This RIS does not make assumptions around any possible future State Budget allocations to support implementation of the CIS Scheme. [↑](#footnote-ref-5)
5. For the purposes of this RIS, government organisations are those organisations owned, operated or managed by Victorian Government departments, agencies, statutory bodies or state owned enterprises. This excludes local government. [↑](#footnote-ref-6)
6. Commonwealth of Australia (2017) *Royal Commission into Institutional Responses to Child Sexual Abuse.* [↑](#footnote-ref-7)
7. Department of Health and Human Services Annual Report (2018). Page 52. [↑](#footnote-ref-8)
8. Children are defined as persons who are under the age of 18 years and an unborn child that is the subject of a report made under section 29 of the *Children, Youth and Families Act 2005* or a referral under section 32 of that Act. [↑](#footnote-ref-9)
9. The terms ‘victim survivor’ and ‘perpetrator’ are specifically defined in FVIS and MARAM Ministerial Guidelines. [↑](#footnote-ref-10)
10. Children Legislation Amendment (Information Sharing) Bill 2017 Explanatory Memorandum. [↑](#footnote-ref-11)
11. Victorian Government (2018) *Child Information Sharing Ministerial Guidelines.* [↑](#footnote-ref-12)
12. Commission for Children and Young People (2018) *Commission for Young Children and Young People Annual Report 2017-18.* [↑](#footnote-ref-13)
13. Coroners Court of Victoria (2015) Inquest in the Death of Baby D. [↑](#footnote-ref-14)
14. Commission for Children and Young People Inquiry into the Death of Child O. [↑](#footnote-ref-15)
15. Department of Health and Human Services (2016) *Roadmap for Reform: strong families; safe children* page 7. [↑](#footnote-ref-16)
16. Cummins, P, Scott, D and Scales, B (2012) *Report of the Protecting Victoria’s Vulnerable Children Inquiry.* [↑](#footnote-ref-17)
17. Australian Institute of Criminology (2007) *Cost effectiveness of early intervention September 2019.*  [↑](#footnote-ref-18)
18. Heckman, J (2011). *The Economics of Inequality: The value of early childhood education*: American Educator: Spring 2011, p 32. [↑](#footnote-ref-19)
19. The case of ‘David’ (not his real name), was relayed to DET staff members during CIS Scheme workforce consultations not specifically related to this RIS. [↑](#footnote-ref-20)
20. That is, use or disclosure for the reason it was collected, for a reasonably related purpose, to protect safety, or for law enforcement purposes. [↑](#footnote-ref-21)
21. Government funding for CIS Scheme implementation, including for workforce training for Phase One and Phase Two workforces, is pre-determined and was allocated to the responsible agencies and departments over the 2018-22 State Budget. [↑](#footnote-ref-22)
22. Department of Health and Human Services. (2016). Roadmap to Reform: strong families, safe children page 13. [↑](#footnote-ref-23)
23. The total year one direct cost to government is calculated at $17.4 million. This figure matches the budget allocations for CIS Scheme implementation in financial years 2019-20 and 2020-21, and accounts for upfront costs and costs in the first year of scheme operation. [↑](#footnote-ref-24)
24. The total estimated year one cost impact of the CIS Scheme Regulations on Phase Two workforces (government and non-government) is expected to be approximately $48.3 million. This total year one cost comprises $18.2 million to update policies, $9.8 million in upfront training, $13.8 million for requests to share information and for responses to information sharing requests, and $6.6 million for record keeping costs associated with requests and responses. [↑](#footnote-ref-25)
25. The discount rate is applied to convert annual future costs to a total present value of costs. [↑](#footnote-ref-26)
26. Department of Health and Human Services (2018) *Child Protection and family services additional service delivery data 2017-18*. [↑](#footnote-ref-27)
27. Australian government Productivity Commission (2019). *Report on Government Services*. [↑](#footnote-ref-28)
28. Child Family Community Australia (2014). *Effects of child abuse and neglect for children and adolescents*. Melbourne: Australian Institute of Family Studies. [↑](#footnote-ref-29)
29. Victorian Government. (2018). *Inquiry into youth justice centres in Victoria: Final Report.* Melbourne: Victorian Government Printer. Page 27. [↑](#footnote-ref-30)
30. Steering Committee for the Review of Government Service Provision (SCRGSP). (2018). *Report on government services 2016*. Canberra: Productivity Commission. Table 16A.23. [↑](#footnote-ref-31)
31. Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). *The cost of child abuse in Australia*. Melbourne: Australian Childhood Foundation and Child Abuse Prevention Research Australia. Page ESxii. [↑](#footnote-ref-32)
32. Adjusted for annual inflation at a rate of 2.1 per cent. [↑](#footnote-ref-33)
33. Kezelman, C., Hossack, N., Stavropoulos, P., & Burley, P. (2015). *The cost of unresolved childhood trauma and abuse in adults in Australia*. Sydney: Adults Surviving Child Abuse and Pegasus Economics. Page ES. [↑](#footnote-ref-34)
34. Adjusted for annual inflation at a rate of 2.1 per cent. [↑](#footnote-ref-35)
35. As outlined in Chapter 3 ‘Objectives’ in this RIS. [↑](#footnote-ref-36)
36. The analysis converts annual future costs (until 2029) to a total present value (PV) of costs. The present value is calculated using a discount rate of 4 per cent per annum (which reflects the time value of money). [↑](#footnote-ref-37)
37. A rate of 4 per cent is recommended in the Department of Treasury and Finance Technical Guidelines on Economic Evaluation (2014) for projects relating to core service delivery areas of government, such as public health, justice and education. This also aligns with the discount rate used in the RIS estimating the impact of CIS Scheme Phase One workforce prescription. [↑](#footnote-ref-38)
38. The available data on workforces includes only total workforce numbers, there is no estimate of the number of workers that will undertake information sharing activities. As such an average cost per workforce member is needed to estimate the impact on the workforce as a whole.

 For some ISE groups, workforce or organisation size is a good indicator of the cost impact to the organisation. The calculation of cost per workforce member allows for variance in cost impact as the size of an organisation changes (as the cost to the organisation can be calculated as the product of workforce size and cost per workforce member). [↑](#footnote-ref-39)
39. The cost per workforce member is calculated as total cost of information sharing by organisation divided by total workforce. It is not cost per workforce member who shares information. [↑](#footnote-ref-40)
40. Victoria in Future 2016, <https://www.planning.vic.gov.au/__data/assets/pdf_file/0014/14036/Victoria-in-Future-2016-FINAL-web.pdf> [↑](#footnote-ref-41)
41. Parliament of Australia 2019 <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/WageSlowdown> [↑](#footnote-ref-42)
42. Impact on these services accounted for through impact on the non-government school sectors [↑](#footnote-ref-43)
43. Impact on these services accounted for through impact on the government school sector [↑](#footnote-ref-44)
44. Impact on this workforce accounted for through impact on general practices [↑](#footnote-ref-45)
45. Impact on this service accounted for through impact on public hospitals [↑](#footnote-ref-46)
46. Impact on this service accounted for through impact on public hospitals [↑](#footnote-ref-47)