

Part 4: Major protective system elements

Chapter 8:
Early intervention

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Key points

- Evidence from overseas shows that early intervention programs – when well designed and resourced – can be an effective method of improving outcomes for vulnerable children and young people, including reducing the risk of child abuse and neglect. Studies have also shown early intervention can be a more cost-effective investment in the long term than later interventions.
- Victoria has a substantial range of early intervention programs with the potential to support vulnerable children, young people and their families. These include early childhood programs, school supports, health services, community-based family services and specialist adult services. However, these programs do not combine to form a comprehensive, coherent and coordinated system of early interventions that address the diverse needs of vulnerable children and their families.
- Supporting vulnerable children and young people should be part of the core business of services in each of these sectors. While there are a number of promising practices, they are varied, not coordinated and not consistently adopted. The Inquiry recommends additional investment to support services to identify and respond to risk factors for child abuse and neglect.
- Existing data systems and practices within services do not allow Victoria to identify all vulnerable children and young people who could benefit from early intervention services.
- Child FIRST and the local Alliances of family services provide a basis for developing an accessible entry point to an integrated network of services to meet the full range of needs of vulnerable children and their families. However, the capacity of Alliances to deliver services that meet local needs is being undermined in several catchments because of a lack of suitable providers and because Alliances are not undertaking effective service planning.
- The Inquiry recommends that consistent governance arrangements be established across catchments to strengthen Alliances' accountability for their performance. Accountability arrangements should be strengthened further by ensuring the Department of Human Services' funding agreements with Alliance lead agencies clearly specify the community service organisation's role and responsibilities, and include appropriate accountability and performance measures.
- There is an opportunity to expand upon the existing Alliances of family services and statutory child protection services to develop broader, more coherent Child and Family Service Networks encompassing specialist adult services, health services and targeted programs linked to universal services. This would support the provision of an integrated package of services that meets the full range of needs of vulnerable children and their families.
- The Inquiry recommends that the legislation governing relevant services should establish the accountabilities and responsibilities of services to act in the best interests of children and young people, and to prioritise service delivery to vulnerable children, young people and their families.
- Specialist adult services and health services should be supported to develop child-and family-sensitive practices that address the needs of vulnerable children and their families.

8.1 Introduction

This chapter is concerned with the role of early intervention in protecting vulnerable children and young people from the risk of abuse and neglect. The Inquiry has been asked to develop recommendations to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services, and ways to strengthen the capability of those organisations involved.

This chapter begins by considering what early intervention is and the evidence of its effectiveness. A snapshot of the range of early intervention services in Victoria is then provided across early years programs, school programs, community-based family services, general health services and specialist adult services. An analysis of the performance of the current service arrangements follows. The chapter concludes with recommendations to strengthen early intervention for vulnerable children in Victoria.

8.1.1 What is early intervention?

Many participants discussed prevention and early intervention in the consultation phase of the Inquiry, with the terms often being used interchangeably. For the purposes of this Report, the Inquiry has adopted the following definition:

Inquiry definition of early intervention

Interventions directed to individuals, families or communities displaying the early signs, symptoms or predispositions that may lead to child abuse or neglect.

This means that early intervention occurs when heightened vulnerability for a child or young person has been identified. Effective early intervention requires both the identification of vulnerable children and young people, and a service response that meets the needs of the child or young person and their family.

Early intervention services are targeted interventions based on the identification of broad risk factors. As described in Chapter 7, from a public health perspective, secondary prevention or early intervention services can be considered to lie between:

- Primary prevention services, often universal in nature, that target whole communities in order to reduce risk factors and strengthen protective factors that contribute to abuse and neglect; and
- Tertiary services that focus on children and families where there is a significant risk of harm, or where abuse has already occurred.

In Australia and other developed countries, government support for vulnerable children has historically focused on tertiary interventions after abuse or neglect has occurred. In recent years, however, governments have been increasingly seeking to intervene early to support vulnerable children and families.

This is most clearly demonstrated in Australia by the Council of Australian Governments' (COAG) *National Framework for Protecting Children 2009-2020*. Through the framework, the Commonwealth, state and territory governments committed to early intervention as one of six 'supporting outcomes' or goals for protecting children:

All children and families receive appropriate support and services to create the conditions for safety and care. When required, early intervention and specialist services are available to meet additional needs of vulnerable families, to ensure children's safety and wellbeing (COAG 2009e, p. 17).

The framework noted that state and territory governments were already 'implementing reforms to their statutory child protection systems – all focused on early intervention' (COAG 2009e, p. 9).

Early intervention does not necessarily involve intervention early in the life of a child. Rather, early intervention services are those that are delivered early in the life of an identified problem or early in the causal pathway. While many of the programs and research focus on young children, the concept of early intervention is also applicable and relevant to older children and young people.

8.1.2 Effectiveness of early intervention

Governments' increasing focus on and investment in early intervention, especially in early childhood, has been prompted by research showing that early interventions are more cost-effective in the long term than later interventions aimed at treating the impact of problems such as abuse and neglect (Stronger Families Learning Exchange 2002). It is argued that it is more cost-effective to tackle problems earlier because it is easier to succeed; if they are tackled later they are likely to escalate and intensify. As a result, intervening later is usually more costly and often cannot achieve the results that early interventions are able to deliver (Allen 2011, p. xiv). Chapter 2 has shown that the estimated lifetime cost of child abuse and neglect that occurred for the first time in 2009-10 is between \$1.6 and \$1.9 billion.

Advances in neuroscience and the behavioural and social sciences have improved our understanding of how healthy development happens in children, how it can be derailed and what societies can do to keep it on track (Shonkoff 2010, p. 1). The architecture of a child's brain begins to develop before birth and continues into early adulthood. There are critical and sensitive periods in brain development during which certain skills or traits are more readily developed (Cunha & Heckman 2007, p. 4). Over time, the developing brain's architecture stabilises, making it harder to modify. This means that interventions in later life are less likely to be effective (Mustard 2005, p. 7).

The environment and experiences that are encountered by a child are critical to healthy brain development, particularly in the early years. Children who grow up in stimulating, nurturing and non-violent environments are more likely to thrive in all aspects of their lives. In contrast, a child who is exposed to recurrent abuse or neglect early in life can experience persistent elevations of stress hormones and altered levels of key brain chemicals that disrupt the architecture and chemistry of their developing brain (Centre on the Developing Child 2007, p. 9). This has consequences for a child's future learning, social and emotional development, and physical and mental health, as well as having significant costs to society (COAG 2009a, p. 8). As shown in Chapter 2, the peak age for child abuse is in the first year of life, during precisely the period when the child's brain is most vulnerable.

Most of the evidence regarding the effectiveness of early intervention services comes from overseas programs focusing on vulnerable children in the early years. This means there is relatively little evidence about what works in an Australian context. Table 1 in Appendix 8 summarises some key early intervention programs that have been extensively evaluated.

A number of countries have implemented various forms of nurse home visiting (NHV) programs. In 1977 the United States (US) Nurse-Family Partnership pioneered an intensive, long-term, high-quality model of home visits by public health nurses to support low-income first-time pregnant women and mothers to foster emotional attunement and non-violent parenting. In efficacy trials the model has been found to reduce child abuse and neglect, criminal behaviour and welfare dependency for up to 15 years after the birth of the child (Olds et al. 1997). The cumulative benefits of the program after 15 years are estimated to be up to five times greater than its cost (Karoly et al. 2005, p. 109).

Reviews of other NHV programs internationally have also found that they can produce benefits for children and parents, such as improved parental attitudes and capacity and better quality parent-child interactions, but the size of these benefits is significantly more modest under standard service conditions. Other main conclusions from these reviews include:

- Implementing NHV programs is difficult. There are low participation rates for families invited to enrol and significant proportions of families leave the programs before completion;
- Results from NHV programs and the retention of participants may be improved if the programs were more flexible in delivering scheduled activities according to parental needs;
- The results of long-term studies of NHV programs vary depending on the program sites, the evaluation methodologies employed, and the demographic characteristics of participating families; and
- Fostering close linkages between NHV and other programs may have a multiplier effect, improving individual effectiveness of linked programs (Sawyer et al. 2010, p. 45).

Programs such as the Perry Pre-School Program and the Abecedarian Project in the US have shown that high-quality early childhood education and family support programs for vulnerable children and their parents also deliver long-term benefits to the child, family and society. Longitudinal studies have demonstrated that these programs have resulted in sustained improvements in behaviour, reduced criminal and antisocial activity, better educational and employment outcomes, reduced intergenerational abuse, and a lower long-term burden on the health system.

The average economic benefits of early education programs for three and four year olds from low-income families has been found to be almost two and a half times the initial investment. These benefits take the form of improved educational attainment, reduced crime and fewer instances of child abuse and neglect (Aos et al. 2004, p. 6). Within this overall figure, there is substantial variation. Some early education programs have been found to yield much higher benefit-to-cost ratios, while the benefits of others are exceeded by their costs.

In Australia, the New South Wales Brighter Futures program has been found to significantly reduce harm reports and the likelihood of children going into out-of-home care. The program provides targeted support to pregnant women and families with children aged eight years or younger who face problems such as family violence, parental drug or alcohol misuse or mental health issues (further details are provided in Table 1 in Appendix 8). Support is provided for up to two years and varies according to the family's need. Services may include home visiting, parenting programs and quality children's services. An evaluation found that the program produced savings for the Department of Community Services in terms of avoided costs in responding to harm reports and providing out-of-home care. Families that remained on the program for longer periods of time had better outcomes – but the majority of families stayed on the program for a shorter time (Hilferty et al. 2010, p. 3).

Overall, the evidence establishes that early intervention programs, when well designed and resourced, can have a positive impact on the lives of vulnerable children and families, in a range of areas including educational outcomes, lower welfare dependency, decreased criminal behaviour and improved parenting skills. The US Nurse-Family Partnership program and the New South Wales Brighter Futures program indicate that early intervention programs targeted at vulnerable families can also reduce the incidence of child abuse and neglect. The long-term economic and social benefits of the most effective programs far exceed their costs.

The evidence on the effectiveness of early intervention is strongest for programs for vulnerable families with young children, in particular for home visiting programs and early childhood education programs. This is consistent with the research on the significance of the early years in the development of a child's brain. There is less evidence of the effectiveness of early interventions to support vulnerable older children and young people. However, there is support among researchers, academics and service providers for early intervention focusing on vulnerable children beyond their early years. A key requirement for successful programs is the engagement of families over extended periods.

Caution needs to be exercised when considering whether the results of overseas programs can be successfully replicated in Victoria. The costs and benefits for any given program are specific to the environment in which they are implemented. The demographics of the target population, labour market conditions and local infrastructure are just three examples of important contextual factors that can significantly change the costs and benefits of programs (Allen 2011, p. 33).

Further, the available evidence base is not deep enough to conclusively demonstrate what amount of investment and what mix of programs is necessary to produce improved outcomes. However, programs such as Brighter Futures in New South Wales indicate that programs with longer duration produce greater benefits, if families can continue to be engaged.

Two recent initiatives will help to build a local evidence base about the effectiveness of early intervention programs in Australia. The Australian Intensive Nurse Home Visiting randomised control trial, to be conducted by the Australian Research Alliance for Children and Youth with the Centre for Child and Community Health, will examine the value of a best practice intensive NHV approach as a means to alleviate the impacts of poverty on children's learning abilities. The Effective Early Educational Experiences (E4Kids) study, conducted by The University of Melbourne and Queensland University of Technology, is a five-year longitudinal study of more than 2,800 children living in Victoria and Queensland, which will examine the contributions made by different early childhood education programs to children's learning and development over time.

8.2 Early intervention in Victoria

A number of early intervention programs focusing on vulnerable children and young people have been introduced in Victoria in recent years. Early intervention programs are delivered across the range of sectors that deliver services to vulnerable children and young people. In most cases, these programs have been developed and implemented independently by government departments and agencies as they have sought to pursue their particular policy goals. For example, The Royal Women's Hospital Women's Alcohol and Drug Service (described in Table 4 of Appendix 8) is specifically aimed at pregnant women who use drugs and alcohol. This service operates in a health context by referral and is not integrated into a broader response.

Many Victorian programs have been informed by the evidence from overseas that early interventions can have a positive impact on the lives of vulnerable children and families, and produce long-term benefits for society. The lack of evidence about what early interventions are effective in Australia presents challenges to governments as they seek to support vulnerable children and families. As discussed above, the success of a program for a certain target population in the US, for example, may not be replicated when it is applied in a different economic and social context in Victoria. The intensity and duration of the intervention must also be defined. This has led to agencies implementing a number of initiatives that are small in scale.

Some programs have been introduced as pilot programs or trials in local areas to gather further evidence about their effectiveness in Victoria. Examples of these programs include Tummies to Toddlers, Family Life's Community Bubs and the Children's Protection Society model of child care (all described in Table 3 of Appendix 8).

Universal services, including early childhood services, schools and the public health system, play a key role in identifying children and young people at risk. Services for vulnerable adults, such as drug and alcohol services, mental health services and disability services, are also well placed to identify vulnerable children and families and to respond to their needs. It is important that these services act in a coordinated way to provide holistic support for the full range of needs of vulnerable children and their families.

The *National Framework for Protecting Australia's Children 2009-2020* included a commitment to convene an expert taskforce to develop a common national, cross-sector approach to identifying and responding early to the needs of vulnerable children and families. The taskforce submitted its report to the Commonwealth in 2010, recommending that further work be undertaken to confirm the efficacy and effectiveness of the common approach.

This section describes the role of universal services and specialist adult services in identifying vulnerable children and families, and summarises the early intervention programs that seek to respond to their needs. Specifically, the section examines:

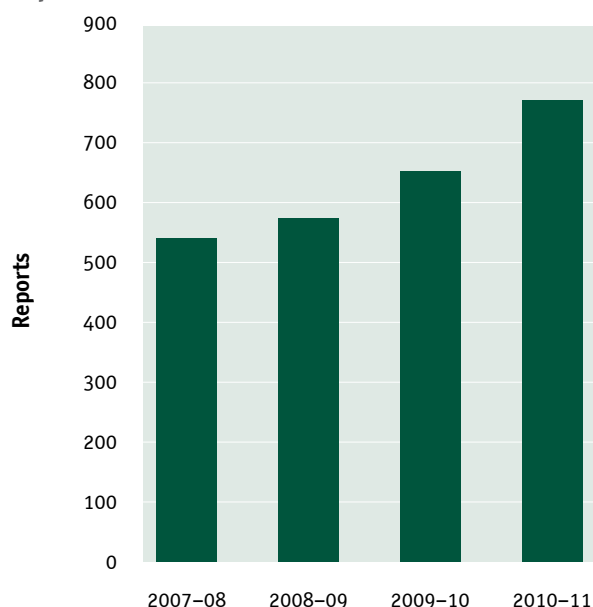
- Pre-birth responses;
- Early childhood services;
- School-based services and programs;
- Youth services;
- Community-based family services including Child FIRST;
- Health services; and
- Specialist adult services.

Section 8.3 then analyses the performance of these services and programs.

Table 8.1 presents a snapshot of Victoria's early intervention programs for vulnerable children and young people and their families. It highlights that responsibility for vulnerable children and young people is shared by the Commonwealth, state and local governments, as well as a range of non-government organisations that deliver services. Within the Victorian Government, responsibility for setting policy, funding and delivering services is shared by the Department of Human Services (DHS), the Department of Education and Early Childhood Development (DEECD) and the Department of Health (DOH).

Table 8.1 also illustrates the range of responses available to address a range of risk factors related to vulnerability as discussed in Chapter 2. The table highlights that the majority of services are focused on limited risk factors, despite the growing acknowledgement that vulnerable children and families are facing increasingly complex and multiple issues. Note that Table 8.1 is representative of the key early intervention programs in Victoria; however, the Inquiry has not attempted to provide an exhaustive list of all Victorian early intervention services for vulnerable children and families.

Figure 8.1 Pre-birth child protection reports, Victoria, 2007–08 to 2010–11



Source: Information provided by DHS

8.2.1 Pre-birth responses

The *Children, Youth and Families Act 2005* (CYF Act) introduced the capacity for a person to make a report to DHS when they have a significant concern before the birth of a child for the wellbeing of a child after the child's birth. These actions are referred to as 'pre-birth reports' and the subsequent service system response are 'pre-birth responses'. The intention of the government when introducing pre-birth reports and pre-birth responses was to provide assistance and support to a pregnant woman to reduce the likelihood that her child, when born, would need to be placed in out-of-home care or be the subject of any protective intervention by the Secretary of DHS. The explanatory memorandum to the Children, Youth and Families Bill 2005 indicated that the principle is one of supportive intervention rather than interference with the rights of any pregnant women.

The number of pre-birth reports received by DHS has increased steadily since the introduction of the legislation (see Figure 8.1). Child and Family Information Referral and Support Teams (Child FIRST) and community-based family service providers have reported that the capacity to refer or report concerns before birth adds significantly to earlier intervention capacity.

This includes the capacity to undertake pre-birth planning meetings, liaise with other services and the extended family to ensure an appropriate support network is in place, make clearer planned decisions and set clear shared expectations with parents about how protective concerns and significant concerns for wellbeing can be overcome to avoid statutory involvement after birth (KPMG 2011b, pp. 106-107).

The Inquiry was unable to uncover any information regarding the outcomes of pre-birth reports. It is not known what support has actually been provided to pregnant women as a result of pre-birth reports, how families have responded to pre-birth reports or how effective pre-birth reports have been in preventing infants coming into out-of-home care. The Inquiry considers this to be an area that requires urgent evaluation – see Recommendation 15 in section 8.4.

8.2.2 Early childhood services

DEECD is responsible for the planning and delivery of early childhood development services in Victoria. These services include universal maternal and child health (MCH) and kindergarten services for all children and enhanced MCH, supported playgroups and Early Start Kindergarten for vulnerable and disadvantaged children and families. In 2010-11 the DEECD budget for early childhood development services was \$405 million (Victorian Auditor-General's Office (VAGO) 2011b, p. ii). Services are provided by local government, community service organisations (CSOs) and private businesses. DHS and DOH are also responsible for other antenatal early intervention programs.

Table 2 in Appendix 8 provides a summary of targeted early childhood services in Victoria. The performance of early childhood services in providing an early intervention response to vulnerable children and young people is examined in section 8.3.1, with the Inquiry concluding that opportunities exist to effectively expand these services to provide better outcomes for vulnerable children and their families.

Table 8.1 Early intervention programs in Victoria, by risk factors addressed

Program	Delivered by	Funded by	Risk factors addressed									
			Child		Parent, family or caregiver						Community	
			Age and gender of the child	Health and disability factors	History of family violence	Situational stress	Alcohol and other substance misuse	Mental health problems	Parental history of abuse	Intellectual disability	Social inclusion and exclusion	Social norms and values
Early childhood services												
Enhanced maternal and child health	Local government	DEECD	✓	✓					✓			✓
Early parenting centres	CSOs	DHS	✓						✓			✓
Early childhood intervention services	DEECD and CSOs	DEECD	✓	✓							✓	
Healthy Mothers, Healthy Babies	Community health agencies	DOH	✓								✓	
Supported playgroups	Local government, CSOs	DEECD							✓		✓	✓
Early Start Kindergarten / Access to early learning	Non-profit and for-profit centres	DEECD	✓	✓							✓	
School supports												
Student support services program	DEECD	DEECD		✓								
Primary welfare officer initiative	DEECD	DEECD		✓								
Student welfare coordinators	DEECD	DEECD		✓								
School focused youth service	DEECD	DEECD		✓							✓	
Youth services												
Finding Solutions	CSOs	DHS	✓	✓								✓
Youth support services	CSOs and a community health agency	City of Melbourne	✓	✓								✓
Reconnect	CSOs	Australian Government	✓	✓								
headspace	CSOs	Australian Government	✓	✓								
Community-based family services												
CHILD FIRST / Community-based family services	CSOs	DHS	✓	✓	✓		✓	✓	✓			✓

Program	Delivered by	Funded by	Risk factors addressed									
			Child		Parent, family or caregiver						Community	
			Age and gender of the child	Health and disability factors	History of family violence	Situational stress	Alcohol and other substance misuse	Mental health problems	Parental history of abuse	Intellectual disability	Social inclusion and exclusion	Social norms and values
Health services												
Child health teams (Community health)	Non-profit agencies	DHS		✓								
Peer Support for Young People	Royal Children’s Hospital	DOH	✓								✓	
Family violence programs	Royal Children’s Hospital	DOH			✓							
Gatehouse Centre	Royal Children’s Hospital	DOH		✓								
Psychiatric mother and baby units	Austin Health, Southern Health, and Mercy Health.	DOH						✓				
Specialist adult services												
Family Drug Help		DOH		✓			✓				✓	
Youth-focused drug and alcohol services	CSOs	DOH	✓	✓								
Kids in Focus (and associated programs)	Odyssey House Victoria	DOH					✓					✓
Specialist child and adolescent mental health services	CSOs	DOH	✓	✓								
Families where a Parent has a Mental Illness (FaPMI)	CSOs	DOH						✓				
Disability services												
Respite	CSOs	DHS		✓						✓		
Flexible support packages	CSOs	DHS		✓						✓		
Individual support packages	CSOs	DHS		✓						✓		

Source: Inquiry analysis (Note: CSOs refers to community service organisations)

Universal services

As described in Chapter 7, Victoria has a strong infrastructure of universal services for infants and children, including the universal MCH service and kindergarten. These provide an accessible and non-stigmatising service for identifying vulnerable children and families who would benefit from early intervention.

The universal MCH service provides 10 'key ages and stages' consultations from birth to 3.5 years, including an initial home visit for all children and their families. MCH nurses assess and monitor the health, growth and development of children, and provide information and advice on breastfeeding, appropriate nutrition, child behaviour, parenting and maternal physical and emotional health and wellbeing. MCH services also run new-parent groups to help parents through the early stages of parenting and to strengthen social supports between parents in a neighbourhood. The vast majority of MCH services are delivered by local government, with DEECD and local government each funding 50 per cent of the cost.

In 2009-10, 99.8 per cent of Victorian newborns received an initial MCH consultation, usually a home visit. This means that Victoria has an exceptional platform for monitoring all children from birth and identifying vulnerable children and families. However, participation in the service is voluntary, and there is a progressive decline in participation as children grow older. The potential of MCH to help address the needs of children and families who would benefit from referral to an early intervention service is not being fully realised. By 18 months, 28 per cent of children do not attend an MCH service for a consultation. By the last consultation at 3.5 years, only 63 per cent of families are still using the service (VAGO 2011b, p. 10).

The decline in participation in MCH heightens the risk that vulnerable children between the ages of 12 months and four years may not be identified until the opportunity for early intervention has passed. As discussed in Chapter 7, the only universal services available to families during these three years are the three MCH visits when the child is aged 18 months, two years and 3.5 years. Children may attend playgroups, long day care or other early childhood education and care services during these years, but participation in these services is far from universal.

Kindergarten is a voluntary and universally available early childhood education program for children in the year before they start school, mostly for children aged four years. The majority of kindergarten programs are run by CSOs in stand-alone centres, with the remainder provided by local councils and private sector operators. DEECD subsidises the cost of four year old kindergarten programs, with remaining costs met by local fundraising and fees paid by families. Families with a concession card, or who have triplets or quadruplets starting at the same time are eligible for a larger fee subsidy that allows the child to attend a standard 10.75 hour per week program for free.

In 2010, 95 per cent of Victorian four year olds participated in a kindergarten program. This strong participation rate makes kindergarten another excellent potential platform for identifying vulnerable children, and for referring them or their families to appropriate services. However, in 2010-11, there were only 62 referrals from kindergartens or preschools to Child FIRST. This represents about 0.1 per cent of children attending four year old kindergarten, and 0.3 per cent of all referrals to Child FIRST. In addition, there were 582 reports made to statutory child protection by child care services and preschool teachers, representing just 1 per cent of all statutory child protection reports.

DEECD is not currently taking full advantage of the strong participation rates in MCH and kindergarten to identify and respond to vulnerable children and families. In 2007 the Auditor-General recommended that the government:

Establish a common statewide database system for early childhood services across the state, including improved monitoring of vulnerable clients to assist in the development of targeted programs in local areas of need (VAGO 2007, p. 5).

This system is yet to be implemented, which means DEECD lacks the capability to systematically identify vulnerable children or track service delivery to individual children. In his 2011 report on early childhood services, the Auditor-General found that DEECD does not sufficiently understand or effectively manage demand for early childhood services:

The department's inability to reliably identify all vulnerable children and families means it does not know the extent to which children are missing out on the benefits of attending targeted services specifically developed and funded to meet their needs (VAGO 2011b, p. vii).

In its submission to the Inquiry, the Municipal Association of Victoria reinforced that there is an opportunity to enhance early intervention in Victoria by resourcing MCH and kindergarten to identify and respond to children and families at risk (Municipal Association of Victoria submission, pp. 4-5).

The Inquiry supports the recommendations made by the Auditor-General in the 2011 report that DEECD develop a better understanding of service demand, particularly for the vulnerable and disadvantaged, by:

- Reviewing its definition of vulnerability to guard against children and families 'slipping through the net';
- Working in partnership with service providers to identify and act to remove barriers to access and participation, especially for the vulnerable and disadvantaged;
- Working in partnership with service providers to identify and act to mitigate the reasons for the fall in attendance at MCH checks after the first visit (VAGO 2011b, p. 36).

The Inquiry notes that DEECD accepted these recommendations and has commenced their implementation. In addition, in Chapter 7 the Inquiry recommends that DEECD provide funding and access to appropriate infrastructure such as kindergartens, MCH services and community playgroups to operate in locations where there are high numbers of vulnerable children and families.

Enhanced maternal and child health

Enhanced MCH is a targeted program delivered by MCH services to families assessed as at risk of poor outcomes, in particular where there is more than one risk factor. Priority is given to families with children aged under 12 months. The service aims to improve the health and wellbeing of children by providing more focused and intensive support than is available through the universal MCH service. A tailored service is provided to each family, which can include parenting advice, home visits, referring the family to specialist services and respite services.

Enhanced MCH services are fully funded by DEECD and delivered by local government. The service is not funded to provide any pre-birth response. In 2009-10, Enhanced MCH services were used by 12,700 families – about 16 per cent of families with a child aged under 12 months. The Auditor-General found that the actual need for Enhanced MCH is likely to exceed the number of available places (VAGO 2011b, p. 12).

The Inquiry examined the utilisation of enhanced MCH services across DHS regions, finding that while a greater number of services are provided in metropolitan regions, the average utilisation rate per family with a child aged under 12 months is higher in non-metropolitan regions. As discussed in Chapter 9, non-metropolitan areas typically have higher rates of statutory child protection reports than metropolitan regions. The Inquiry examined the same data at the local government area (LGA) level, but could not find a strong correlation between the utilisation of enhanced MCH services and statutory child protection reports or vulnerability as measured by the Australian Early Development Index. This indicates DEECD and local governments should endeavour to more closely align the geographical distribution of utilisation of enhanced MCH with the distribution of vulnerability.

Other antenatal and postnatal services

The Healthy Mothers, Healthy Babies program supports disadvantaged or vulnerable pregnant women to access services and improve their health behaviours through the antenatal and perinatal stages (HDG Consulting Group 2011). The program targets women who experience barriers to accessing antenatal care services or who require additional support in pregnancy. The program worker supports the woman throughout her pregnancy, based on what the woman considers her most important priorities. This can include providing health education, promoting healthy behaviours, addressing psychosocial needs, ensuring attendance at antenatal and other relevant services and to generally empower and support the woman. Following birth the worker ensures the mother is linked to MCH and other relevant service providers. DOH funds six community health agencies to deliver the program in eight LGAs in metropolitan Melbourne.

Early parenting centres aim to increase the knowledge, skills and confidence of parents with children from birth to three years who are experiencing acute early parenting difficulties. Services provided include day-stay programs (on or off campus), a residential program, in-home programs and group education or seminars. There are three early parenting centres funded by DHS to deliver services across the state. However, the three centres are all based in metropolitan Melbourne which may limit the availability of service to families living in regional and rural areas.

In recent years the early parenting centres have moved to provide services to more vulnerable infants and their families. This is a welcome shift of focus that will help support those infants and families who will benefit most from an early intervention service. However, due to the limited program budget, more intensive programs, such as residential programs, are now largely confined to statutory child protection clients.

The government has committed \$16 million over four years to establish the Cradle to Kinder program, which will provide pregnant women and vulnerable mothers and their families with intensive antenatal and postnatal assistance and case management. The program commences in pregnancy and continues until the child reaches four years of age. The target group is pregnant women aged under 25 years where a report to statutory child protection has been made regarding their unborn child or where there are a number of indicators of vulnerability. The Inquiry understands that services will be provided at a local catchment level, with Child FIRST being the point of entry to the program. DHS advised the Inquiry that it anticipates that Cradle to Kinder programs will be established in 10 to 14 Child FIRST catchments, with between two and four Aboriginal-specific programs being developed.

Supported playgroups

DEECD's Supported Playgroups and Parent Groups Initiative seeks to engage vulnerable and disadvantaged families with children aged up to four years who may, for a range of reasons, under-utilise or have difficulties accessing universal early childhood services and supports, including community playgroups. The initiative aims to build parents' capacity to support their child's health, development, learning and wellbeing and to increase families' participation and linkages with other early years services. The initiative targets four population groups: Indigenous families; culturally and linguistically diverse families; families affected by disability; and disadvantaged families with complex needs.

Supported playgroups are provided in the 29 municipalities that host Best Start partnerships (see Table 2 in Appendix 8). They are a low cost initiative, with no cost to participating families. Funding is used to support group activities, including employing a qualified worker to facilitate the group. Playgroup Victoria's submission to the Inquiry noted that supported playgroups are a particularly flexible service model, given they can be replicated in any community, including Aboriginal and culturally and linguistically diverse communities, without the need of extensive infrastructure (Playgroup Victoria submission, p. 3).

Targeted preschool programs

Since 2008, Early Start Kindergarten has provided free kindergarten programs for three year old children known to statutory child protection (including those referred directly from statutory child protection to Child FIRST) and three year old Aboriginal and Torres Strait Islander children. The objective is to provide vulnerable three year olds with access to a quality early childhood education and care program that helps with their language and development, social interactions and self-confidence. The program is fully funded by DEECD.

The take up of Early Start Kindergarten by vulnerable children and families has been disappointingly low, particularly among children known to statutory child protection. In 2010, only 463 three year olds accessed the program across Victoria, which represents about 12 per cent of the eligible population. This included 258 Indigenous children and 205 children known to statutory child protection. A DEECD evaluation of the program identified a range of factors for the low take-up including that there were too few kindergartens that could accommodate eligible children; and that the referral and placement arrangements did not work as envisaged (VAGO 2011b, pp. 13-15).

DEECD is exploring new ways to support vulnerable children to access kindergarten. The Access to Early Learning initiative is a new service model that aims to support vulnerable three year old children to participate in early childhood education and care, addressing the barriers to participation in Early Start Kindergarten. Three pilots of the Access to Early Learning model commenced in July 2011. Table 3 in Appendix 8 provides further details about this and other locally based early intervention programs.

The Inquiry understands that DEECD is conducting an evaluation of effective early childhood service provision to vulnerable children, including the Access to Early Learning program. This evaluation will provide valuable information to assist the design of effective early intervention programs in this area.

8.2.3 School-based services and programs

As a universal and compulsory service, schools are uniquely placed to identify vulnerable children and young people, to provide additional support to children in need, and to refer children and their families to other specialist services where appropriate.

Table 2 in Appendix 8 summarises those school-based programs that help identify vulnerable children and provide early intervention supports. The Primary School Nursing Program and the *School Entrant Health Questionnaire* are the main programs that identify vulnerable children, while early intervention supports include the Student Support Services program, the Primary Welfare Office Initiative, student welfare coordinators and the School-Focused Youth Service.

The contribution of school supports to providing an early intervention response to vulnerable children and young people is examined in section 8.3.1. The Inquiry concludes that there is a range of school-based initiatives that support vulnerable students and their families, but there is limited evidence regarding their effectiveness.

Identifying vulnerable children

The Primary School Nursing Program is a free service offered by DEECD to all children attending primary schools in Victoria. Primary school nurses visit schools throughout the year to provide children with the opportunity to have a health assessment, provide information and advice about healthy behaviours and link children and families to community-based health and wellbeing services. The program is designed to identify children with potential health-related learning difficulties and to respond to parent/carer concerns and observations about their child's health and wellbeing.

With the parent's or carer's permission, assessment results may be shared with relevant staff at the school, such as the teacher, principal or student support officers, to provide children with appropriate ongoing support in the school environment.

A *School Entrant Health Questionnaire* is completed by parents or carers during a child's first year of school. The questionnaire records information about the parent or carer's concerns and observations about their child's health and wellbeing. The questionnaire is an important source of information about a child's vulnerability. It records information regarding child and family demographics, the child's general health, dental health, speech and language, service use, behaviour and emotional wellbeing, risk of developmental and behavioural problems and family stress.

In 2010, questionnaires were returned for 57,000 children, representing 87 per cent of children enrolled in Prep.

Primary school nurses review the questionnaires prior to undertaking the child's health assessment. If the nurse has concerns about a child's health after assessing the questionnaire or the child, the nurse will provide the child's parent or carer with information based on the child's needs and may also suggest referring the child to another health professional or agency.

Student Support Services

The Student Support Services program aims to support children and young people in Victorian government schools who are vulnerable, have additional needs or are at risk of disengagement. The program also aims to strengthen the capacity of schools to engage all students in education and improve learning and wellbeing outcomes. Student support services officers are employed by DEECD and include psychologists, guidance officers, speech pathologists, social workers and visiting teachers and other allied health professionals.

The impact of the Student Support Services program has not been evaluated. DEECD conducted an 'extensive' public consultation process regarding the program in 2008 to inform a set of strategies to enhance the program. Strategies included officers working on a school network or sub-regional basis, rather than being allocated to specific schools, in order to provide greater support for students with the greatest need and ensure more effective distribution of services across schools, networks and regions (DEECD 2009b, p. 8).

School satisfaction with student support services has declined markedly in recent years. In 2006-07, 87.9 per cent of schools were satisfied with these services (Victorian Government 2008b, p. 75). By 2010-11, DEECD expected this to have declined to 73.2 per cent. DEECD reported that the lower satisfaction rate is the result of the program undergoing major reform, suggesting that satisfaction with the program may have been affected by principals' perceptions of a reduced role in determining service priorities and allocating resources under the new service model. Service delivery arrangements were being reviewed in 2011, and DEECD predicted satisfaction levels would continue to be down until the revised model was implemented by the end of 2012 (Victorian Government 2011c, p. 181).

Primary Welfare Officer Initiative

The Primary Welfare Officer Initiative aims to enhance the capacity of schools to support students who are at risk of disengagement from school and who are not achieving their educational potential. Primary welfare officers assist schools to promote the resilience of children and their engagement in school. Since 2006, DEECD has employed the equivalent of 256 full-time primary welfare officer positions in 450 Victorian schools identified as having high needs (DEECD 2011a). The government has recently expanded this initiative to provide an additional 150 primary welfare officers over the next three years. In total, 569 schools will receive primary welfare officer funding in 2012. These will be followed by approximately 87 schools in 2013 and 148 schools in 2014.

Evaluations of the Primary Welfare Officer Initiative commissioned by DEECD prior to 2007 concluded that the initiative has increased the capacity of schools to support at-risk students and their families, including by improving links with families and external agencies. The initiative was also found to have had a positive impact on individual students, including by raising self-esteem and reducing incidences of aggressive behaviour (DEECD 2007b, p. 3).

Student welfare coordinators

DEECD provides funds to all government secondary schools to employ student welfare coordinators. The coordinators are responsible for helping students handle issues such as truancy, bullying, drug use and depression. Coordinators work with other welfare professionals and agencies to address student needs. DEECD advised the Inquiry that in most cases student welfare coordinators are likely to be part-time roles, or the funding will be used by schools to provide teacher release to undertake student welfare duties. The total budget for this program is \$12 million per annum, or an average of \$37,500 per school (roughly equivalent to 0.5 effective full-time staff per school). Small schools may receive funding equivalent to around 0.2 EFT (effective full-time). This initiative has not been evaluated in recent years. The Inquiry was unable to uncover any evidence on the degree to which coordinators assist students who are at risk of, or who have experienced, abuse and neglect.

School Focused Youth Service

The School Focused Youth Service is a statewide service that aims to develop a more coordinated and integrated response for young people aged 10 to 18 years, who are at risk of developing behaviours that make them vulnerable to self-harm, disengagement from school, family or community, or who are displaying behaviours that require support and intervention.

The service is an initiative of DEECD, in partnership with the Catholic Education Office and the Association of Independent Schools of Victoria. It adopts a partnership approach to strengthen the capacity of local services, communities and schools to collaborate, develop and better coordinate stronger prevention and early intervention strategies as part of a service continuum for vulnerable children and young people. According to information provided to the Inquiry by DEECD, 45,147 children and young people received a service in 2010-11.

An evaluation of the School Focused Youth Service in 2007 found that the service had positive impacts on young people, including positive changes in behaviours, improved attendance and engagement with school, better peer relationships and communication skills, and more positive attitudes to self, peers, teachers and school. The program was also found to improve knowledge about issues and services in the community and school, and to contribute to the development of partnerships, planning and programs between education and community sectors at the local community level. The evaluation identified a need for further development of quantitative data to highlight program outcomes (DEECD 2007c, p. 5).

8.2.4 Youth services

Young people undergo significant changes as they go through adolescence and increasingly take on adult roles and responsibilities. While many young people manage this transition effectively, others require support. In Victoria a range of early intervention programs and initiatives are in place to support and assist young people who experience difficulties. Such services have the potential to identify and respond to young people subject to abuse or neglect.

Youthcentral is a Victorian Government website for young people aged 12 to 25 years that offers information and advice on a range of issues and access to services.

Finding Solutions is a statewide early intervention program funded by DHS and operated by CSOs, targeting young people of secondary school age and their families who are at immediate risk of being placed in out-of-home care. The program provides mediation and support to young people and their families to assist them in identifying, addressing and resolving issues, behaviours and/or needs that place the relationship 'at risk' of breakdown. The program aims to divert the family and young person from involvement in the statutory child protection and placement system (DHS 2011a).

The Youth Support Service is a statewide service that aims to help young people at risk of entering the youth justice system. The service is funded by DHS and delivered by CSOs. Young people are referred to the Youth Support Service by Victoria Police, youth justice court advisors and agencies providing services to young people. Young people must have had recent contact with Victoria Police but not be a client of Youth Justice or statutory child protection. Participation is voluntary. The service works with the young person to assess their needs and assist them to develop positive life goals and access other support and services as required (DHS 2011a).

Reconnect is a Commonwealth funded community-based early intervention service operated by CSOs that assists young people aged 12 to 18 years who are homeless, or at risk of homelessness, and their families. It assists young people to stabilise their living situation and improve their level of engagement with family, work, education, training and their local community. The Newly Arrived Youth Support Services is incorporated into Reconnect to support young people aged 12 to 21 years who have arrived in Australia in the previous five years, focusing on people entering Australia on humanitarian visas and family visas, and who are homeless or at risk of homelessness.

The National Youth Mental Health Foundation, headspace, operated by Orygen Youth Services helps young people aged 12 to 25 years who are experiencing mental health difficulties and seeking assistance. Headspace provides assistance with: general health; mental health and counselling; education, employment and other services; and alcohol and other drug services. Section 8.2.7 describes a range of other mental health services and drug and alcohol initiatives that are available to vulnerable youth.

These examples, and the youth-focused mental health programs outlined in Table 5 of Appendix 8, highlight that Victoria has a wide range of programs that offer early intervention to vulnerable youth. However, similar to the other service areas discussed in this chapter, these programs have not been recently evaluated, are not necessarily well connected with the broader service system supporting vulnerable children and are not well coordinated with each other and require specialist access arrangements. This lack of coordination and integration leads to less than optimal service delivery for vulnerable youth and their families.

A whole-of-government Youth Partnerships initiative will trial new approaches to bring existing youth service providers together to identify and respond more effectively to disengaged youth. DEECD is responsible for the implementation of this initiative. The initiative aims to better support at-risk young people by improving the coordination and efficiency of services at the local level. The initiative is based in seven locally governed demonstration sites, established across the following LGAs:

- Greater Geelong, Queenscliffe and Surf Coast;
- Yarra Ranges, Maroondah and Knox;
- Frankston and Mornington Peninsula;
- Swan Hill, Gannawarra, Buloke and Mildura;
- Ballarat, Hepburn, Pyrenees, Moorabool, Golden Plains;
- Greater Bendigo, Central Goldfields, Mount Alexander, Campaspe, Macedon Ranges and Loddon; and
- Wyndham and Hobsons Bay.

The Inquiry considers this to be an encouraging initiative to address what is presently an uncoordinated and inefficient service sector. It is to be hoped that any positive changes achieved in the trial sites achieve can be replicated and implemented statewide.

Adolescents are vulnerable to the risk of abuse and neglect. The Inquiry considers that mental health services have a role to play in the identification of and response to young people who have experienced, or are at risk of, child abuse and neglect.

8.2.5 *Community-based family services*

DHS funds the delivery of a range of community-based family services ('family services') to promote the safety, stability and development of vulnerable children, young people and their families, and to build capacity and resilience for children, families and communities (DHS 2011a).

Family services are focused on vulnerable young people and families that:

- Are likely to experience greater challenges because the child or young person's development has been affected by the experience of risk factors and/or cumulative harm; or
- Are at risk of concerns escalating and becoming involved with statutory child protection if problems are not addressed.

The intention is to provide services earlier to protect children and young people and improve family functioning.

Family services include interventions to enhance parenting capacity and skills, parent-child relationships, child development and social connectedness. The interventions provided to a family are determined by an assessment of need. A child and family action plan is developed to determine the goals of intervention for the child and family and details the interventions to be undertaken to address the needs identified (DHS 2011a). Interventions may include counselling, mediation, group work, assertive outreach, parenting skill development, in-home support and referrals to other appropriate services.

DHS engages CSOs to deliver family services on its behalf. As of June 2011, 96 CSOs were funded by DHS to deliver family services, 13 of which are Aboriginal community controlled organisations (ACCOs). Chapter 3 describes the role of CSOs in Victoria's approach to protecting vulnerable children. The process by which DHS registers and monitors CSOs is described in Chapter 21, while the capability of CSOs is examined in Chapter 17.

Child FIRST

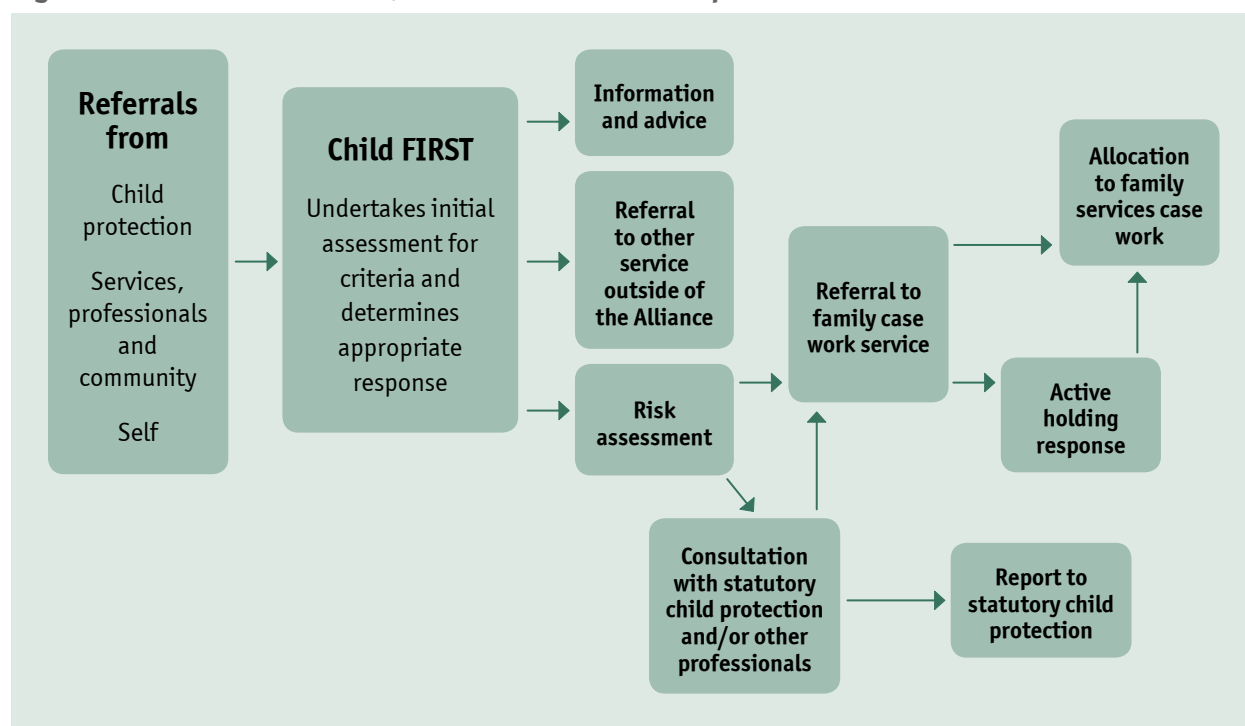
Child FIRST has been established in 24 catchments across Victoria to provide a visible point of entry to local family service providers and other support services for vulnerable families. The first nine Child FIRST sites were established in 2006-07, with all 24 established by 2008-09.

Under section 22 of the CYF Act, the objectives of Child FIRST and family services are to:

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

Given these objectives, a key role of Child FIRST is to assess the needs of a family, determine the priority of a service response and allocate families to the organisation within the catchment that is best placed to provide the response, allowing case work to commence at the earliest possible time (KPMG 2009, p. 27). A CSO providing family services will then provide a range of service interventions with a whole-of-family focus, depending on the available services of the particular agency and the needs of the client. The pathway for families engaging with Child FIRST is reflected in Figure 8.2.

Figure 8.2 Child FIRST intake, referral and allocation process



Source: Information provided by DHS

Note that this is a generic model of Child FIRST. Individual Alliance Child FIRST. Models may have variations on this flowchart

Each of the 24 Child FIRST catchments have developed local Alliances, which are a conglomerate of the local family service providers and statutory child protection services. Each Alliance typically includes three or four local family service providers. ACCOs operate in 18 of the 24 catchments. The six catchments that do not have an ACCO providing family services are all rurally based. The Alliances are responsible for operational management, catchment planning and providing service coordination at the sub-regional level. A specific 'lead' CSO in each Alliance provides the Child FIRST intake and referral functions for the Alliance (KPMG 2009, p. 21). These cooperative arrangements are referred to as integrated family services in the sector. The Inquiry refers to these services as community-based child and family services, consistent with the legislation, as the services cannot yet be said to be 'integrated'.

A core function of local Alliances is to develop a catchment plan to guide future service delivery. Informed by data on the needs of vulnerable children and families in the local area, the catchment plan is intended to:

- Lead to strengthened referral processes and pathways;
- Promote earlier intervention and prevention;
- Improve the focus on enabling culturally competent services for Aboriginal people;
- Focus on quality improvement; and
- Improve training and workforce planning.

Context for family services and Child FIRST

Child FIRST and community-based child and family services had their genesis in the 'every child every chance' reforms, which were introduced in the mid-2000s by the Victorian Government in response to a range of factors including:

- A rapid growth in reports to statutory child protection services;
- The impact on the rise in reports to statutory child protection services caused by the introduction of mandatory reporting in Victoria in 1993;
- Recognition that the existing service system did not provide a graduated continuum of responses to vulnerable children and families;
- Families presenting with increasingly complex and multiple problems; and
- Growing evidence regarding the long-term impact of trauma on children.

As a result of these factors, DHS began piloting Family Support Innovation Projects in 2003. These projects had the aim of:

- Reducing demand for statutory child protection by obtaining assistance earlier from community-based services for a significant proportion of families reported to statutory child protection; and
- Minimising progression of families into statutory child protection services, leading to the reduction in growth in demand for high-cost, out-of-home care services.

Additional projects commenced in subsequent years within targeted LGAs. By 2006 Family Support Innovations Projects had been established in 44 LGAs (Thomas et al. 2007, p. 13).

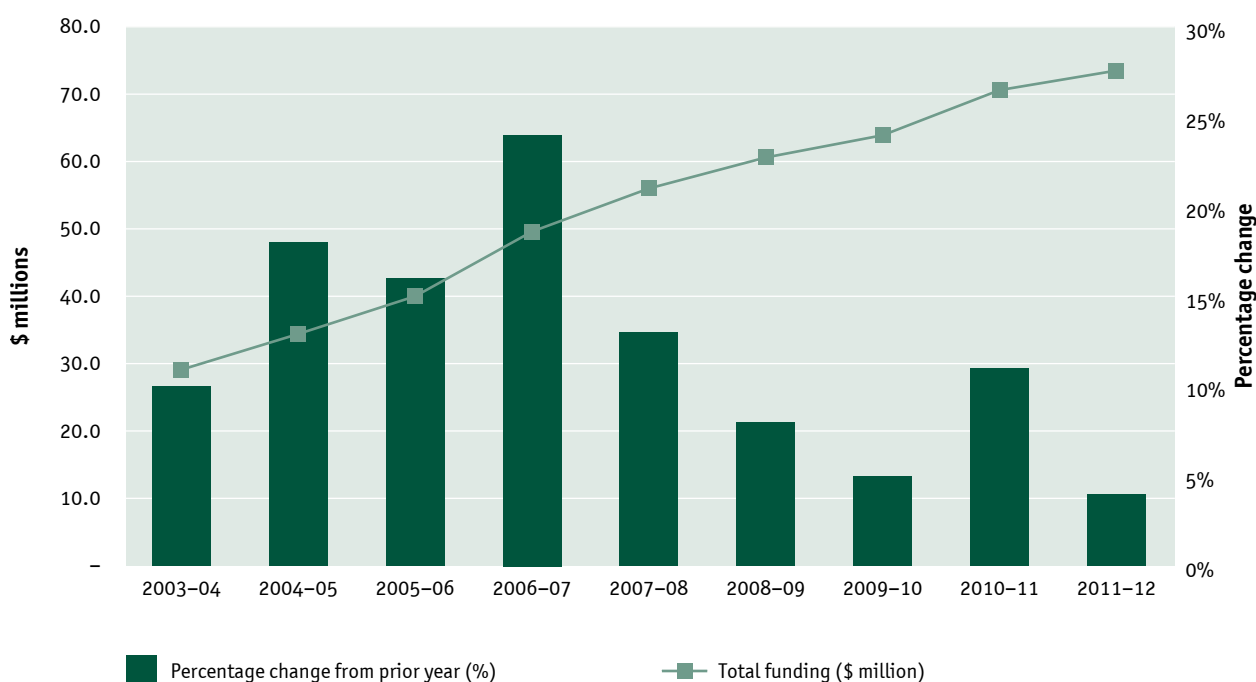
The final evaluation of Family Support Innovation Projects concluded that Victoria's prevention policies and programs, including the Family Support Innovation Projects, were successful in constraining growth in reports and enabling access to early intervention services for families and children (Thomas et al. 2007, p. 7). As a result of this success, DHS proceeded to implement Child FIRST.

The original intention of Child FIRST was to support the further development of a more systematic approach to early intervention within family services, with the legislation emphasising that family support should be targeted at the most vulnerable children and families. The intent was for community-based intake, assessment and referral services to provide a central point within a local community for professionals and other community members to raise significant concerns about the wellbeing of a child or young person. Professionals and members of the public were to have somewhere to go for help, if they had concerns that a family was under stress and would benefit from support. This intervention was to be before problems escalated to the point that the children are placed at risk of significant harm (Parliament of Victoria, Legislative Assembly 2005b, p. 1,371).

With the introduction of Family Support Innovation Projects and then Child FIRST, the Victorian Government substantially increased its investment in family services throughout the 2000s, with notably the most significant proportional increase occurring in 2004-05 and 2006-07. This increase is reflected in Figure 8.3. In 2010 11, 26,461 cases of family services were provided at a cost of \$73.5 million. The number of cases does not equate to the number of families supported because some families may have had multiple episodes of service.

The performance of family services and CHILD First in providing early intervention support for vulnerable children and families is considered in section 8.3.2. Many participants in the Inquiry were of the view that Child FIRST and the establishment of local Alliances of family services has supported improved coordination of family services and better collaboration with statutory child protection. However, because of the lack of comparative information the Inquiry is not able to establish whether this was in fact the case. It is also not yet clear whether Child FIRST has provided a more accessible entry point to family services for vulnerable children, young people and their families. The Inquiry heard that the service system is now prioritising highly vulnerable children and families more than previously, although there are significant demand issues and a lack of evidence regarding the impact of services on client outcomes. There is a need for consistent governance arrangements across catchments to strengthen accountability and better links with other services for vulnerable children and families.

Figure 8.3 DHS funding of Family Services, 2002-03 to 2011-12



Source: Information provided by DHS

8.2.6 Health services

Health service providers come into contact with a large number of children and young people and their families. Accordingly they are well placed to identify vulnerable children and to intervene early to prevent harm and support the wellbeing of both child and family.

DOH is responsible for the planning, policy development, funding and regulation of health service providers and activities that promote and protect Victorians' health. This includes health care services provided through the public hospital system and community health services. The Commonwealth Government has policy and funding responsibility for general practitioners (GPs) and primary health care.

The *Victorian Public Health and Wellbeing Plan 2011-2015* identifies Victoria's public health priorities to 2015. The plan aims to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventative health care across all sectors and all levels of government (DOH 2011b, p. 1). It identifies the need for individuals and health professionals to recognise symptoms and provide access to treatment early in the progression of a disease to improve health outcomes – but does not identify the opportunity to also identify vulnerable children and young people at risk of child abuse or neglect, or other poor outcomes.

The health system has traditionally focused on identifying and treating medical risk. In recent years there has been a move to identify psycho-social risk, as these contribute to medical risks. Reflecting this shift, DOH has established the Vulnerable Children's Program to support health services in the early identification and response to children and young people at risk of child abuse and neglect. It focuses on education and improving communication and collaboration between health, statutory child protection and family services. The level of investment in the program is very low. With less than one full-time equivalent staff member attached to the program and no additional funding available to health services to adopt recommendations or guidelines to improve early intervention services for vulnerable children, the program is inadequately resourced to change behaviour at the service level. The impact of the program has not been evaluated.

The DOH framework for monitoring the performance of health services does not include specific reference to support for vulnerable children, young people and their families, nor does it refer to the role of child- and family-sensitive practice by specialist adult services.

The performance of health services in providing an early intervention response to vulnerable children and young people is examined in section 8.3.1. The Inquiry concludes that Victoria's extensive health system could be better utilised to identify and respond to vulnerable children and their families. In particular, community health services and GPs could be more effectively used.

Public hospitals

Public hospitals are an integral part of improving the health and wellbeing of children and young people. More than 201,000 children and young people (aged up to 24 years) were admitted for public inpatient care across Victoria public hospitals. Further, emergency departments of major public hospitals had an additional, non-admitted, 512,000 presentations of children and young people aged up to 24 years (Australian Institute of Health and Welfare (AIHW) 2011b, pp. 116, 180).

The DOH Vulnerable Children's Program has produced and distributed a best practice framework for public hospitals and acute health care professionals that provides information and guidance on issues relating to children and young people at risk of child abuse and neglect. This framework forms the basis of regular annual reporting by health services on their progress to achieve improved outcomes for vulnerable children.

Hospitals are often the first point of contact for children and young people at suspected risk of harm from child abuse and neglect. This places a special responsibility on hospital staff to identify this risk and reduce it by offering crisis support, ongoing care and referral to specialist intervention services, and by working with other agencies to provide the best combination of services for a particular child and family. Hospital staff made 2,019 reports to statutory child protection and 982 referrals to Child FIRST in 2010-11. This represented 3.6 per cent of all reports to statutory child protection and 5.2 per cent of all referrals to Child FIRST.

The Royal Children's Hospital (RCH) has a special role in responding to the needs of vulnerable children and young people. RCH operates the Centre for Adolescent Health, which includes the Adolescent Forensic Health Service for clients of youth justice and the Young People's Health Service for homeless young people, in addition to clinical services providing general medical services (RCH, Centre for Adolescent Health submission, pp. 3-4).

Other RCH services that provide early intervention support for vulnerable children, young people and their families include:

- A peer support program for young people with significant chronic illness;
- A range of programs for children and their families involved in family violence;
- The Centre for Community Health, which researches the many conditions and common problems faced by children, such as obesity, language and literacy delay, and behavioural concerns; The Family Services Department, which provides family-focused support services including information and support group details for many childhood diseases and chronic illnesses and advice on safety promotion and injury prevention.
- The Social Work Department, which provides social work services via referral to all inpatient wards, medical and surgical units of the hospital, and continues to work with some patients and families after leaving the hospital; and
- The Gatehouse Centre, which offers, among other things, short and longer term counselling for victims of child abuse and their families, assessment and treatment for children and young people with sexually abusive behaviours and problem sexual behaviours, outreach services, and a group work program (RCH 2011; RCH Integrated Mental Health Program, Addressing Family Violence Programs submission, p. 2).

Hospitals also see adult patients whose health status or lifestyle (such as physical or mental health problems or disabilities, and substance misuse) may place their children at risk of harm. In such situations, health care staff have a responsibility to intervene early to ensure the child's safety, as well as to care for and support the parent and family. For example, if a person is being discharged from a specialist treatment facility, it is important to know if they are responsible for the care of children.

There is no evidence to indicate how well health professionals are meeting their responsibilities to identify and respond to vulnerable children and young people. The Inquiry has received anecdotal material from DOH suggesting that the identification and response to risk is highly varied.

One example of good practice in public hospitals is the psychiatric mother and baby units established at the Austin Hospital, Mercy Hospital for Women and Monash Medical Centre. These specialist units provide for the admission of mothers with a mental illness with their babies up to 12 months of age. The mother receives psychiatric assessment as well as treatment, and support to look after her baby and strengthen her relationship with her baby (Post and Antenatal Depression Association 2010). There are similar units in a number of private hospitals.

According to The University of Melbourne and Austin Health, Victoria has more mother and baby units per capita than anywhere else in the world. There is an absence, however, of community programs that act as a stepping stone for those being discharged from units (The University of Melbourne and Austin Health supplementary submission). The government has committed to establishing three new units in rural and regional Victoria. The first of these, to be located at Bendigo Hospital, was funded in the 2011-12 Budget.

Matter for attention 3

The Inquiry draws attention to the fact that an evaluation of the new mother and baby units and the transition of discharged mothers back into the community is needed to inform further investment in this field.

Community health services

Community health services are a network of agencies delivering care from 351 sites spanning every LGA across the state. Services are funded by DOH, the Commonwealth Government and philanthropic sources to deliver an integrated suite of primary health and human services including drug and alcohol, dental, disability, family violence services, home and community care, medical, mental health, and post-acute care. While some of these programs focus on particular client cohorts, services have an overarching strategic intent to prioritise services to more vulnerable population groups, and this is a requirement of their funding agreements with DOH.

Community health services can play a significant role in identifying children, young people and their families who would benefit from early intervention support, and in providing some of those support services. Services aim to promote children's positive development, intervene early to address child health and developmental problems and support parents' active participation in their child's early learning and development (Sabol et al. 2004). In 2009-10, 88 per cent of registered community health clients in Victoria stated they were concession card holders. About 4,900 clients identified as being refugees, and 2,400 clients identified as being from an Aboriginal or Torres Strait Islander background. However, community health services do not collect data on other risk factors presented by clients.

Initiatives and resources within community health that support vulnerable families include:

- 12 child health teams, which provide services to Victorian children from birth to 12 years of age experiencing mild to moderate developmental difficulties and behavioural issues;
- Flexible models of care that allow individual community health services to develop programs that respond to the needs of local vulnerable communities, such as young mothers programs, single dads groups and support for young families;
- A community health counselling policy framework and service standards that include a focus on young people and their families as well as people with mental health issues at risk of other complex issues; and
- A suite of priority tools to enable those most in need to access services and receive help.

At present there is a lack of data about how community health services are performing in supporting vulnerable children and young people and their families. The role of community health services with vulnerable families is not prescribed or monitored. There is no comprehensive data about how many vulnerable families receive support from services.

Matter for attention 4

The Inquiry draws the government's attention to the fact that the development of assessment tools, planning for services and resource allocations in relation to services for vulnerable children, young people and their families, is occurring independently of other government initiatives to support vulnerable families. The early intervention potential of community health services to reduce the vulnerability of children and young people needs further consideration.

General practitioners

GPs are the first point of contact for medical care and referral in Victoria. In 2009-10 there were 1,691 general practices in Victoria and 6,007 general practitioners (GPs) (Carne et al. 2011, p. 11). This broad coverage means that GPs are well placed to identify vulnerable children, young people and families who would benefit from early intervention programs. However, there is no available data to illustrate the support provided by GPs to vulnerable children and families.

Research has been undertaken to study factors that influence the willingness and readiness of GPs to undertake health assessments for children entering out-of-home care. This study found significant barriers for GPs undertaking these assessments. These barriers include: practice system challenges; lack of awareness of the particular health needs of the group of children; lack of relationships with statutory child protection services; difficulties with 'red tape' burdens when interacting with a government body; potential medico-legal risks; and competing workload pressures (Webster & Temple-Smith 2010, p. 299).

Similar challenges may apply to expanding the role of GPs in identifying and supporting children, young people and their families who would benefit from targeted early intervention. Further, GPs are independent, autonomous small business professionals, so their priorities may not easily align with government policy directions and priorities. While these are not necessarily insurmountable barriers to greater use of GPs in this area, they are significant. The Victorian Forensic Paediatric Medical Service's submission (p. 8) to the Inquiry calls for more education of GPs and other health professionals regarding the early identification of the 'at-risk' target group and better involvement of extended families and neighbourhood supports.

8.2.7 Specialist adult services

Victoria offers a broad range of specialist services to support vulnerable adults. Traditionally, the role of professionals working in specialist adult services has been to focus on the needs of the adult client. A range of adult clients may be impacted by child abuse and neglect, including having been victims of abuse and neglect themselves.

Professionals also see adults whose children may be at risk because of the parent's health or social problems. As discussed in Chapter 2, parent, family or caregiver characteristics can influence whether a child is at risk of abuse and neglect. In particular, evidence has confirmed that the presence of poverty, family violence, substance misuse, mental health issues, intergenerational abuse and parent or caregiver disability heighten the risk of abuse and neglect.

This section provides some examples of specialist adult services in Victoria that adopt child and family-sensitive practice or otherwise seek to accommodate the needs of children, focusing on services that are particularly relevant to supporting vulnerable children, young people and their families who are at risk of child abuse and neglect, including alcohol and drugs services, mental health services, disability services and housing. Other relevant services not examined by the Inquiry include problem gambling, financial counselling and correctional services.

The performance of specialist adult services in responding to the needs of vulnerable children and young people is examined in section 8.3.3. The Inquiry concludes that services are not consistently identifying vulnerable children or delivering services that respond to their needs. While promising programs exist, they are varied, not coordinated and are without a simple, visible point of entry.

Alcohol and drug services

Alcohol and drug services aim to prevent and reduce the harm to individuals, families and communities associated with alcohol and other drug misuse. Programs include prevention initiatives aimed at the general community, as well as early interventions, treatment and support for people experiencing substance misuse and their carers and family members. More than 27,000 Victorians enter government-funded alcohol and drug treatment programs each year (VAGO 2011d, p. 1). DOH is responsible for Victoria's alcohol and drug program and funds CSOs, community health services and health services to deliver the programs. Table 4 in Appendix 8 provides a brief description of alcohol and drug resources and treatment services available in Victoria.

Alcohol and drug services can contribute to reducing child abuse and neglect by reducing harm to individuals and families associated with alcohol and drug misuse by both parents and young people. In 2009-10, about one-third of clients of alcohol treatment programs had dependent children (VAGO 2011d, p. 5). The prevalence of alcohol and drug use among parents is described in Chapter 2.

Family Drug Help is a service for people concerned about a friend or relative using alcohol or other drugs. Family Drug Help aims to provide ongoing help to families to reduce the isolation and stigma often associated with a family members misuse and provide non-judgmental, empathic support, as well as accurate information on alcohol and drugs and treatment options.

In addition, a range of services are available specifically to reduce alcohol and drug misuse among young people, including youth outreach and support, residential and home-based withdrawal services, youth residential rehabilitation and youth supported accommodation. The Parent Support Program supports parents and families of drug users and assists them to respond effectively to adolescents and other family members with a drug problem.

While there are supports in place for the adult relatives of a young person with a alcohol and drug problem, to date there has been little recognition of the needs of children whose parents have a problem. One of the few examples is the alcohol and drug residential rehabilitation program provided for parents and their children by Odyssey House. The agency provides a range of services including: home-based support to parents and children with the most intractable problems through the Kids in Focus program; supported accommodation, which caters for parents and children; the Family Eclipse program, a family inclusive intervention for young people aged 16 to 24 years with mental health and drug issues and their families; and the Stonnington Youth Precinct that brings together a number of services including local government to offer wraparound, coordinated services to young people experiencing alcohol and other drug issues.

The Young Parents Program supports young parents or pregnant women aged 12 to 25 years with substance use issues, whose children are likely to become subject to statutory child protection reports. Through intensive case work and support, the program aims to protect the children in the family and enhance participants' parenting capacity by providing family support and drug treatment simultaneously (YSAS submission, p. 6).

Mental health services

Mental health services can help to reduce the risk of child abuse and neglect. A correlation exists between parents who experience mental illness and child abuse and neglect. Estimates of all children in families with parental mental illness are 23.3 per cent (when not constrained by level of mental illness) and 1.3 per cent where the illness is severe (Maybery et al. 2009, p. 24). Services that work to identify and treat children, young people and parents for mental illness can have an impact in reducing the risk of abuse and neglect. Further, services that work with the whole family have the additional benefit of addressing the range of compounding issues that mental illness can impose upon a family.

DOH is responsible for Victoria's specialist public mental health system. Specialist services for children and adolescents, adults and aged persons are delivered by area-based mental health services. Information provided to the Inquiry by DOH indicated that the redesign of specialist mental health care for children and young people and improving outcomes for vulnerable families where a parent has a mental illness are current priorities. Table 5 in Appendix 8 provides a brief description of early intervention mental health services available in Victoria.

Specialist child and adolescent mental health services are provided for children and young people up to the age of 18 years. Early intervention mental health services for children and young people include:

- Integrated therapeutic and educational day programs for young people with behavioural difficulties, emotional problems such as severe depression or anxiety, emerging personality difficulties or a severe mental illness such as early psychosis;
- The Child and Adolescent Area Mental Health Services (CAMHS) and Schools: Early Access program, which aims to reduce the prevalence of conduct disorder in children by delivering sustainable evidence-based interventions in the early years of school and within the school setting. The target population for the initiative is young children displaying challenging or difficult behaviours and/or have conduct disorder in Prep to Grade 3 in mainstream primary schools; and
- The Child and Youth Mental Health Service for children and young people aged under 25 years is being piloted by Alfred Health. The redesigned service model includes a new Youth Early Intervention Team that provides or facilitates a range of services for young people where they are needed through outreach and collaboration with other agencies.

The Families where a Parent has a Mental Illness (FaPMI) strategy is an example of an early intervention initiative to enhance capacity in mental health specialist services, family services and other services to better provide for vulnerable families. The strategy focuses on vulnerable families who are being supported by community-based child and family services and who may have co-occurring drug and alcohol issues as well as parental mental illness. FaPMI coordinators work with mental health services, families and other service providers with the aim of reducing the impact of parental mental illness on all family members through timely, coordinated, preventative and supportive action. Limited brokerage funding is available to support families to engage with other services.

DOH has advised that the budget for the FaPMI initiative in 2010-11 is \$1.3 million. Currently only half of adult mental health services are funding a FaPMI coordinator position. Where FaPMI coordinators exist, services are better linked. Adult mental health clients are more readily identified as parents and family needs are assessed and addressed by clear referral processes.

The FaPMI initiative has not been formally evaluated. However, a progress review by La Trobe University and the Bouverie Centre for DOH suggests that FaPMI coordinators provide an identifiable and accessible point of contact for services outside mental health, consequently promoting collaboration and reducing silos in service delivery systems (Bouverie Centre, La Trobe University 2011, p. 20).

Matter for attention 5

The Families where a Parent has a Mental Illness strategy is a promising initiative that should be extended to operate in all adult mental services. This warrants further consideration by the Department of Health.

Disability services

As discussed in Chapter 2, children with a disability and parents with an intellectual disability are more likely to come into contact with statutory child protection services. This means that, like alcohol and drug services and mental health services, disability services have the potential to identify and provide early interventions to reduce the risk of child abuse and neglect.

DHS funds CSOs to deliver direct support and care to people with an acquired brain injury or an intellectual, physical, sensory or neurological disability in Victoria. DHS also directly provides some care and support services to people with a range of disabilities.

These services include: case management to assist people achieve their goals, become more independent and active in community life; respite services to provide short-term and time-limited breaks on a regular, occasional or emergency basis; flexible support packages to assist children and adults with a disability to maintain family networks, access community activities, enhance independence and reduce the need for more intensive services; individual support packages allocated to a child or adult with a disability to purchase supports to meet their ongoing disability needs; and the Aids and Equipment Program, which assists people with permanent or long-term disabilities to enhance independence in their own home, facilitate their participation in the community and support families and carers.

There are further localised programs in some DHS regions focused on parents with a disability and families with a child with a disability.

A challenge for the successful use of disability services to provide early intervention support for vulnerable children can be the reluctance of parents with a disability to engage with these services. The Victorian Disability Services Commissioner noted that parents with a disability can be fearful of seeking assistance, and understate their need for support (Disability Services Commissioner Victoria submission, p. 4).

Housing

DHS provides public and social housing and support for low-income Victorians, focusing on those most in need. Each year DHS provides housing services to approximately 63,000 public tenant households across Victoria. In June 2011 there were about 17,600 families with children living in public housing (unpublished DHS data). About 16,400 families with children were waiting for public housing in June 2010 (2011 data not yet available).

The provision of public housing can be an early intervention strategy for children and young people at risk of abuse and neglect. A constant theme reiterated through the consultation and submission phase of the Inquiry was the importance of housing in addressing the needs of vulnerable families and the prevalent shortage of available public housing:

By any measure ... the service infrastructure problem in most urgent need of redress for vulnerable children and young people is the lack of affordable housing. The inability of successive governments to provide for this most basic need has been particularly damaging for the children affected (Good Shepherd Youth and Family Service submission, p. 14).

This was also a theme that was specifically highlighted for Aboriginal communities:

There are many families I have seen over the years that are on waiting lists for accommodation. Some request medical certificates justifying to be of a high priority. In my opinion they are all of high priority - safe accommodation is a basic human right. Most families and individuals need to access emergency accommodation at a time of financial and personal crisis. This is a very real time of risk and we should be doing all possible to support them at this time (Victorian Aboriginal Health Service Co-operative submission, p. 6).

The Supported Accommodation Assistance Program is a joint Commonwealth, state and territory government initiative that provides funding for services to help people who are homeless or at risk of homelessness, including women and children experiencing family violence.

Services include crisis accommodation, transitional support, homeless persons support centres and telephone information and referral services. Transitional Housing Management is a related program that offers housing information and referral, crisis and transitional housing and the provision of financial assistance to households in crisis.

Children and young people represented 45 per cent of people in the Supported Accommodation Assistance Program in Victoria in 2009-10. A total of 29,200 children and young people were supported. This included 3,500 direct clients (9 per cent of all clients) and 25,700 children accompanying clients. Overall, 2.3 per cent of Victorian children and young people aged 0 to 17 years were provided accommodation and support by the program (AIHW 2011d, pp. 12-13).

DHS provides a number of homelessness support and assistance programs directed towards vulnerable children and young people. These are summarised in Table 6 of Appendix 8. A number of these programs are funded by the *National Partnership Agreement on Homelessness*, under which the Commonwealth and Victorian governments have contributed \$209.7 million to Victoria over the five years to 2012-13 (Ministerial Council for Federal Financial Relations 2009, p. 11). DHS has advised the Inquiry that it is difficult to collect the data needed to measure progress against the homelessness outcomes identified in the National Partnership.

There is some progress being made by housing services to collaborate with other sector programs, such as family violence and young people leaving care. However, housing availability remains a key issue for vulnerable children and their families.

8.3 Performance of current arrangements

In submissions to and consultations with the Inquiry, stakeholders provided near unanimous support for the use of early intervention to support vulnerable children, young people and families. Stakeholders consistently put to the Inquiry that a greater role for early intervention and prevention is needed to improve the current system response to child abuse and neglect. For example, the joint submission by Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency (VACCA) and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) (p. 42) contended that greater expansion and embedment of early intervention will result in the best gains for vulnerable children and their families, and the whole community, by reducing the need for the government to continue to grow investment in statutory child protection services.

Victoria has a substantial range of early intervention programs that are directed at identifying children, young people and their families who are at risk, and then providing support to these families to reduce the incidence of child abuse and neglect.

While there are many individual programs across sectors, the Inquiry considers that they do not come together to form a comprehensive, coherent and coordinated system of early interventions that addresses the needs of vulnerable children and their families. Within the Victorian Government, DHS, DEECD and DOH each deliver or fund a set of early intervention programs to target groups, consistent with their particular policy goals. There is an absence of holistic service planning and provision that meets the diverse needs of the particular child or young person. Chapter 6 recommends that this be addressed through the development of a Vulnerable Children and Families Strategy.

A more coordinated approach to providing early intervention support for vulnerable children will require better collection and coordination of data about vulnerable children. The information management systems supporting programs and services for vulnerable children are separate and disparate. Data quality is variable and in some cases systems have not kept up with modern business processes or government requirements.

The shortcomings of existing data systems and practices mean agencies may not identify all vulnerable children and young people who could benefit from early intervention services. This means that government is failing to provide all vulnerable children, young people and their families with the support they need to decrease the risk of abuse and neglect. Agencies are often not held accountable for the support they provide, with performance measures tending to focus on outputs rather than child outcomes.

Related to these data issues, Victoria's early intervention efforts are hampered by a lack of evidence on what interventions work. Agencies have largely relied on the evidence of the effectiveness of overseas programs when designing interventions for vulnerable Victorians. As discussed in section 8.1.2, there is a range of factors that could inhibit the successful replication of a program in another economic and social context.

Given the lack of local evidence, it is concerning that many of Victoria's early intervention programs have not been rigorously evaluated. Where local evaluations do exist, the results are generally promising, but the findings are far less conclusive than the extensive, longitudinal evaluations of the international models utilising randomised control groups.

A rigorous evaluation should be an essential feature of any future early intervention initiatives funded by governments.

8.3.1 *Performance of targeted programs linked to universal services*

This section considers the performance of early childhood services, school supports and health services in identifying and responding to the needs of vulnerable children and their families.

Early childhood services

An effective system of early childhood supports for vulnerable children is critical given the importance of the early years to a child's development, and the fact that most reports of abuse and neglect occur in the early years.

Due to its inability to record data on individual children, DEECD does not know how many vulnerable children are missing out on this important service and, potentially, from not being identified as vulnerable until the opportunity for early intervention has passed. As discussed in section 8.2.2, the Inquiry supports the recommendations made in the recent Auditor-General's report on this issue, and recommends DEECD implement them by the end of 2012. The shared funding of MCH between local and state government raises a further potential concern regarding access in lower income municipalities that have less revenue-raising capacity but a relatively larger population of vulnerable families.

To further develop the use of MCH for early intervention, there may be a need to increase the capacity of the enhanced MCH service and strengthen the referral relationship from MCH nurses to other programs focused on supporting vulnerable children. MCH nurses accounted for 4.4 per cent of all referrals to Child FIRST and family services in 2010–11 (unpublished DHS data). It is unclear whether all vulnerable children and their families are being provided with a tailored response to whatever service is most suitable, including referral to Child FIRST or statutory child protection, by all MCH nurses. In order to properly identify all families who would benefit from early intervention supports, there may be a need to develop the ability of MCH nurses to identify and respond to all relevant risk factors. The Inquiry considers that this warrants attention by government.

Families with one or more of a broad range of risk factors are currently eligible to receive an enhanced MCH service. Eligible families include: those with drug and alcohol, mental health or family violence issues; families known to statutory child protection; homeless families; unsupported parents under 24 years of age; low income, socially isolated, single-parent families; families with significant parent/baby bonding and attachment issues; parents with an intellectual disability; children with a physical or intellectual disability; and infants at

increased medical risk due to prematurity, low birth-weight, drug dependency and failure to thrive (DHS 2003a, p. 6). When DEECD reviews its definition of vulnerability, as recommended by the Auditor-General, it will be important that the eligibility criteria for enhanced MCH remain sufficiently broad to include all children and families at risk of poor outcomes. The need for the enhanced MCH provision to be aligned with the concentration of vulnerable children and families is addressed by Recommendation 7 in Chapter 7.

Victoria's existing antenatal and early childhood programs provides a solid base for further investment in early intervention to support the needs of vulnerable children. There is insufficient evidence, however, of the effectiveness of these programs in improving child outcomes. In some cases departments have not put in place the data systems to support the regular monitoring and evaluation of their performance.

The Inquiry considers early parenting centres to be a particularly valuable initiative that should be expanded to reach a broader range of vulnerable families. In particular it would be beneficial if the more intensive residential programs were expanded so they are available to families with multiple risk factors but not yet known to statutory child protection. This would require an improvement in the access of families living in outer Melbourne suburbs, regional and rural areas.

The range of targeted services is potentially difficult for vulnerable families to access and navigate. Programs have been implemented independently over time to address specific objectives rather than as a comprehensive and coherent suite of initiatives to meet the needs of children and their families. Programs are not integrated across sectors, and there is some duplication in their objectives. A number of programs are being delivered on a pilot basis, which means there is not a consistent coverage of services across the state.

Recommendation 11

The Department of Education and Early Childhood Development should implement the recommendations from the Auditor-General's report on early childhood services by the end of 2012.

Recommendation 12

The Government should fund the expansion of early parenting centres to provide services to a greater range of vulnerable families and to improve access to families living in outer Melbourne, regional and rural areas.

School supports

The Primary School Nursing Program and the *School Entrant Health Questionnaire* are important universal programs that can help to identify vulnerable children in the first year of school. Information provided by DEECD to the Inquiry indicates that more could be done to use *School Entrant Health Questionnaire* data to develop school-based programs that meet the needs of vulnerable children. At present there is a range of school supports that support vulnerable students and their families, but there is limited evidence regarding their effectiveness. The Inquiry recommends that DEECD undertake a comprehensive evaluation of these programs.

There are no further universal assessments of a child's health and wellbeing as children grow older. The Inquiry considers that there would be merit in a population health and wellbeing questionnaire of students as they make the transition from childhood to adolescence. In the first instance a pilot questionnaire could be undertaken in disadvantaged government schools. Data could be used to identify vulnerable young people in need of additional support, and to inform the development of school-based programs that meet the needs of vulnerable students.

Recommendation 13

The Department of Education and Early Childhood Development should improve its capacity to respond to the needs of vulnerable children and young people by:

- Undertaking a comprehensive evaluation of whether existing school-based programs are meeting the needs of vulnerable children and young people; and
- Introducing a population health and wellbeing questionnaire of students as they make the transition from childhood to adolescence, and publishing the outcomes in *The state of Victoria's children* report.

Health services

Victoria has an extensive public health system that could be better utilised to identify and respond to vulnerable children, young people and their families. In particular, community health services and GPs have a potentially important role to play. The presence of community health services and GPs in every LGA presents an opportunity for a place-based approach to early intervention. However, as in other sectors, there is insufficient data collected and reported regarding vulnerable children and young people involved with health services.

The recent *Victorian Public Health and Wellbeing Plan 2011-2015* states that:

Currently, many prevention programs and organisations (government and non-government) delivering prevention interventions and services operate in isolation from one another, resulting in duplication of effort, and an inefficient use of available staffing and funding resources (DOH 2011b, p. 32).

There is a need to clarify and monitor the responsibilities of health professionals regarding support for vulnerable children. A focus on vulnerable families and child- and family-sensitive practice should be added to DOH's framework for monitoring the performance of health services.

DOH's Vulnerable Children's Program is a welcome initiative that could support health services to identify and respond to children at risk of child abuse and neglect. However, there needs to be a substantial increase in investment in the program if its goals are to be realised. The program requires sufficient resources to drive change in practice in health services to ensure a stronger focus on identifying the full range of risk factors to children and young people. The Inquiry's recommendations regarding this issue are in section 8.4.

The development of specific early intervention programs within community health services is promising; however the objectives of these programs remain vague. There is a lack of data to assess whether the programs are effective in the targeting and engagement of vulnerable children, young people and families at risk of child abuse and neglect.

Recommendation 14

The Department of Health should amend the framework for monitoring the performance of health services to hold services accountable for support they provide to vulnerable children and families, consistent with their responsibilities under the recommended whole-of-government Vulnerable Children and Families Strategy.

8.3.2 Performance of community-based family services and Child FIRST

Child FIRST and family services were the subject of much comment throughout the Inquiry's consultations. Child FIRST's performance, and perceived success, is largely seen in the context of the family service system prior to its introduction, which was regarded as uncoordinated, difficult to access for families and dramatically under-resourced (Mr Bonnice, St Luke's Anglicare, Bendigo Public Sitting).

DHS engaged KPMG to evaluate the 2007 child and family service system reforms, including the implementation of Child FIRST and family services. The final report of the evaluation of Child FIRST and family services was published by DHS in February 2011.

The Inquiry has reservations about some of the findings reached by KPMG. However, it is not the purpose of the Inquiry to undertake an alternative program evaluation, nor to present a critique of the KPMG evaluation. Instead, this section presents the Inquiry's observations and findings on the performance of Child FIRST and family services, based on the evidence presented in the KPMG report, more recent data made available to the Inquiry, and the views of stakeholders as presented to the Inquiry in submissions and consultations.

In summary, the Inquiry has found that:

- While Child FIRST is broadly considered by agencies to have provided a more accessible entry point to family services compared with previous arrangements, the evidence regarding this is not yet conclusive;
- Many participants in the Inquiry were of the view that Child FIRST and the establishment of local Alliances of family services has supported better integration of family services at the local level than previously, but the Inquiry found that not all Alliances have undertaken effective catchment planning;
- Many participants to the Inquiry were of the view that local Alliances have also contributed to better collaboration and coordination between family services and statutory child protection than previously. However, the Inquiry found that there is a need for better links between family services and specialist adult services, health services, early childhood services and schools;
- Many participants to the Inquiry were of the view that Child FIRST and family services are prioritising highly vulnerable clients to receive services more than previously, but the Inquiry found that there are significant challenges to meet demand for services from families who are at lower risk. In some catchments, there are insufficient family services to meet the needs of vulnerable families;
- There is a lack of evidence on the impact of Child FIRST and family services on outcomes for individual vulnerable children and their families. There is also insufficient evidence to demonstrate that the introduction of Child FIRST has been an effective early intervention by preventing clients from becoming known to statutory child protection; and
- The governance arrangements for Child FIRST Alliances do not provide sufficient accountability for the extent to which the needs of vulnerable children and families in a given Child FIRST catchment are being met. There are also concerns about the sustainability of some Alliances.

Governance arrangements

Section 8.2.5 describes how family services in each of the 24 Child FIRST catchments are governed by local Alliances. Alliances are responsible for operational management, catchment planning and service coordination but have no role in monitoring quality of service provision or achieving client outcomes. Each agency remains autonomous in relation to its accountability for the delivery of services. The Inquiry considers these arrangements to be unsatisfactory because there is an absence of responsibility and accountability at the catchment level for meeting the full range of vulnerable children's and families' needs.

There is a risk that the reliance on local governance arrangements could reduce statewide consistency and public accountability if DHS does not provide Alliances with sufficient guidance and support.

KPMG found there is no consistent approach across Alliances to determining eligibility for family services. The use of different intake and initial assessment tools may reduce the consistency of determining the eligibility and priority level of vulnerable children and families. This would impede the capacity of DHS to ensure vulnerable families have equitable access to family services across the state (KPMG 2011b, p. xii).

The responsibilities of the 'lead' CSO in each Alliance for intake, initial assessment and facilitating an appropriate service response were documented in DHS' request for submissions from CSOs to deliver family services including Child FIRST. These responsibilities are not, however, clearly articulated in the statewide 'shell agreement' for statutory child protection and family services, nor are they specified in DHS' service agreements with lead CSOs. Neither document includes appropriate performance measures for lead CSOs. This is a significant gap in the governance arrangements for Child FIRST and family services, which restricts the ability of DHS to hold lead CSOs to account for meeting their responsibilities.

Of further concern is KPMG's finding that a minority of Alliances are showing early warning signs that they may not be sustainable, such as declining commitment by CSO senior managers to Alliance governance structures. Similarly, capacity constraints are limiting the involvement of some ACCOs in Alliances. KPMG contends that it is likely that more Alliances will face these challenges unless DHS puts in place greater supports for Alliance sustainability (KPMG 2011b, p. xi).

DHS has advised that it is considering a range of options to address these challenges including partnership checks, increased clarity regarding the role of DHS within Alliances, resourcing Alliance project officers and improving ACCO involvement in Alliances.

An accessible entry point

A primary objective of the Child FIRST reforms was to provide a readily accessible point of entry into an integrated network of family services. Prior to the introduction of the 'every child every chance' reforms in the mid-2000s, entry into the family services sector occurred at individual CSO level. As families and professionals did not always know the type of service offered by a particular agency, statutory child protection intake had become the major pathway by which families could gain access to family services and supports (KPMG 2011a, p. 33).

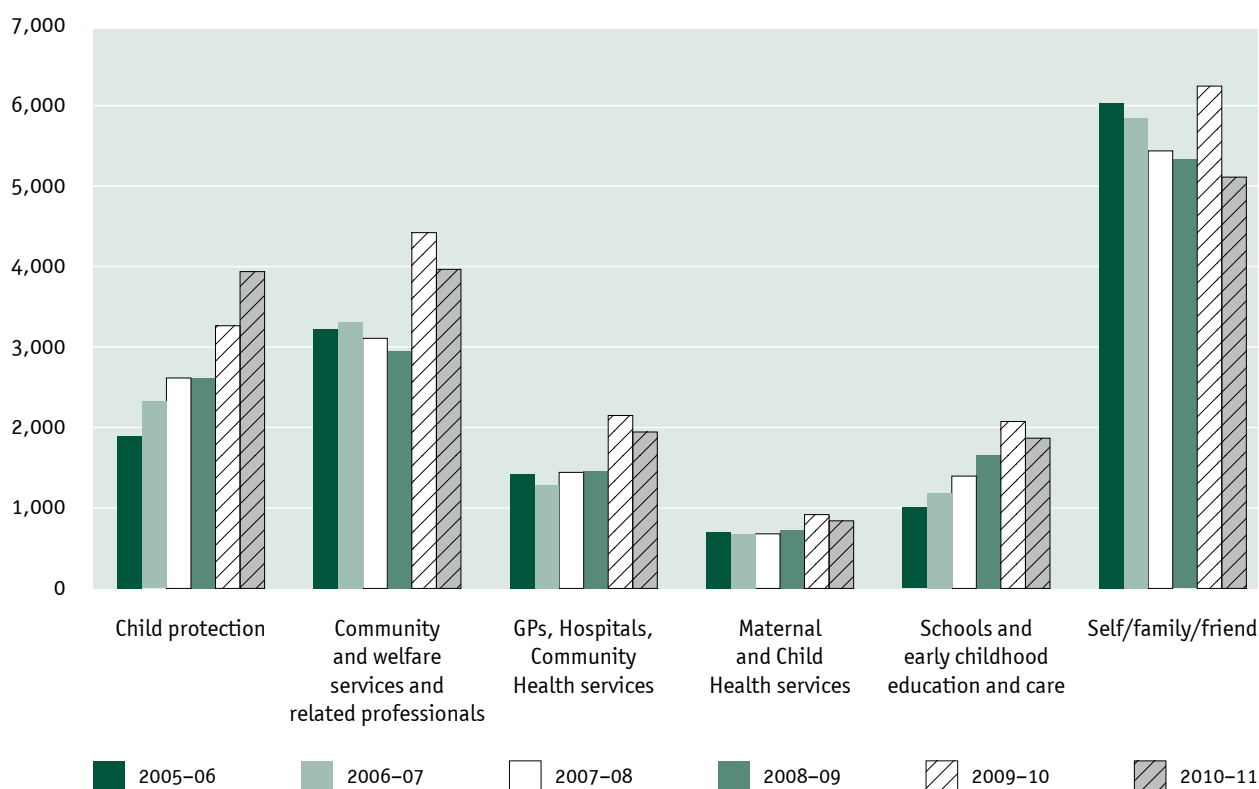
Several CSO providers of family services reported to the Inquiry that the introduction of Child FIRST has increased the visibility of family services:

As a visible point of entry the Child FIRST model has improved pathways to support vulnerable children, young people and families (MacKillop Family Services submission, p. 29).

The changes that have been implemented have greatly improved access for families through the Child FIRST model. Whilst Child FIRST is a challenging model to deliver and maintain it has been one of the most significant and positive service developments to have occurred in recent times (St Luke's Anglicare submission, p. 11).

The North East Child FIRST intake system has opened an important alternative access point to services for very vulnerable families and strengthened community capacity to protect children outside of the tertiary child protection system (North East Metro Child and Family Services Alliance submission, p. 8).

This view is supported to some extent by preliminary trends in referrals to family services and Child FIRST. Figure 8.4 shows that since the introduction of Child FIRST in 2006-07, there has been a steady increase in referrals by child protection practitioners. There was also a consistent growth in referrals from schools and early childhood services to 2009-10. The trend for community and welfare services and related professionals and health services is more ambiguous, with increases in referrals of different proportions. There has also been a decline in self-referrals. This may suggest that family services have increasingly focused on high needs clients. The decline in referrals from all sources except child protection from 2009-10 to 2010-11, however, is of some concern. Given this mixed evidence, the Inquiry is unable to draw a firm conclusion regarding whether Child FIRST has created a more accessible entry point to family services.

Figure 8.4 Referrals to family services and Child FIRST, Victoria, 2005–06 to 2010–11

Source: Information provided by DHS

Service planning and coordination

Many participants to the Inquiry were of the view that Child FIRST has also supported coordination of different family services at the local level. The Joint CSO submission argued that a great strength of Child FIRST is its design and location – it is local, supports integrated responses and is multidisciplinary in its focus (p. 32).

Reinforcing the view of stakeholders, the KPMG evaluation found that the local Alliances have created: shared responsibility for service delivery to vulnerable children and families within local catchments; a mechanism to support consistent intake, prioritisation and allocation based on need and risk; an opportunity to consistently improve the service provision; capacity for joint planning; and a shared approach to demand management across family services (KPMG 2011b, p. 27).

KPMG also found, however, that not all Alliances had undertaken catchment planning, despite this being a core responsibility of Alliances. KPMG reported that some Alliances had not undertaken planning because they did not have sufficient resources, or they had been focused on 'more pressing' issues, such as maintaining relationships between CSOs to ensure the sustainability of the Alliance.

Where Alliances had completed catchment plans, there was considerable variation in the extent to which they included rigorous data analysis and identified the needs of local vulnerable children and families.

Collaboration with other services

In his 2009 investigation, the Victorian Ombudsman noted that the development of the Child FIRST system was a valuable step in encouraging a collaborative approach to protecting children while minimising the need for legal intervention (Victorian Ombudsman 2009, p. 65). Stakeholder submissions and Inquiry consultations have consistently identified the co-location of community-based child protection workers at Child FIRST sites as having had a positive influence on collaboration between family services and statutory child protection (submissions from Anglicare Victoria, p. 18; Bendigo Community Health Services, p. 10; Community and Public Sector Union, p. 11; MacKillop Family Services, p. 30).

In contrast, there remains a lack of coordination between family services and other services that focus on vulnerable children and young people. In some cases, this reflects a lack of basic awareness:

Last year the Office and Child Safety Commissioner engaged with staff working in adult drug and alcohol services at a series of forums and was surprised to hear that not many of those workers had heard of Child FIRST, let alone made a referral to them (Office of the Child Safety Commissioner submission, p. 6).

This suggests that the Children's Services Coordination Board (discussed in Chapter 20) has not been effective in coordinating government actions relating to children at local and regional levels.

The integration of family services with local adult and universal services is arguably a more ambitious objective than the initial aims of the Child FIRST program, however, addressing this issue may be a logical next step:

In hindsight, it would have been advantageous to formally include mental health and alcohol and drug services into the Child FIRST platform during the formulation of the CYF Act 2005. As it stands, responsibility for joint governance arrangements and local service integration including mechanisms for interagency consultation and support currently rests with funded family services. It would appear that responsibility to support family resilience and mitigate vulnerability and risk for children in a broad sense remains aspirational rather than actual. The need to build a platform where adult services are active and willing participants is the next step for a maturing Child FIRST system (Anglicare Victoria submission, p. 14).

Engagement with Aboriginal community controlled organisations

The Inquiry heard from some participants that the introduction of Child FIRST has assisted the integration of local ACCOs into the family services sector. KPMG found that partnerships between mainstream family services and ACCOs have generally improved at both the governance and service delivery levels.

From a governance perspective, ACCOs are now formally engaged as Alliance partners, and there is a stronger emphasis on mutual support. ACCOs gain through improving their understanding of mainstream programs that can be accessed by their clients, and having access to shared training and organisational support. For mainstream organisations, ACCO involvement enables improved cultural understanding, a more culturally competent approach, and the capacity to develop new service-delivery structures to better support Aboriginal children and their families. However, in some Alliances ACCO engagement continues to be limited by factors such as constraints on the capacity of the ACCO, or a limited focus on Aboriginal issues within the Alliance (KPMG 2011b, p. 42).

In some catchments this has impacted on service accessibility for Aboriginal children and families.

In terms of service delivery, mainstream agencies have sought to enhance the skills and cultural competence of their workforce, thereby offering greater choice in service providers to Aboriginal children and families (KPMG 2011b, p. xvii). In some catchments, the CSOs that form the Child FIRST Alliances funded an Aboriginal liaison position. These have played a significant role in providing culturally responsible services in some areas (VACCA submission, p. 41).

These gains have not, however, been realised in all areas of Victoria. KPMG found that within some Alliances, ACCO engagement is limited by ACCO capacity constraints, a limited focus on Aboriginal issues within the Alliance, or a lack of local ACCOs, which is reducing the extent of local knowledge available to Alliances (KPMG 2011b, p. 29). To build on the gains achieved elsewhere, there is a need for some mainstream agencies to focus on their relationships with ACCOs and for examples of good practice to be shared.

Meeting client demand

There is evidence that demand for family services is exceeding the available supply. KPMG found that there are increasing demand pressures within some catchment areas that Child FIRST is unable to effectively meet (KPMG 2011a, p. 88). Several Alliance lead agencies – particularly those in growth corridors – have moved to restrict intake in peak periods, while others have introduced waiting lists, potentially undermining the intention of responding at the early stage of a problem (Office of the Child Safety Commissioner submission). Several stakeholders from within the service system told the Inquiry that the government's investment in Child FIRST has not been sufficient to fully deliver on its objectives. The Inquiry accepts that greater government investment is required to respond to client demand, and considers it unacceptable that lead agencies in some areas have not been able to accept referrals of families in need.

The Inquiry also heard that the legislative requirement to focus on the highly vulnerable has meant that Child FIRST and family services can only deal with urgent matters, and matters involving cumulative harm are not able to be prioritised (Berry Street submission, pp. 15, 26). Consequently, the intended emphasis on cumulative harm that was introduced with the 2005 legislation has not been realised. VACCA stated that its family service is rarely able to support families with relatively 'straightforward challenges' (VACCA submission, p. 36).

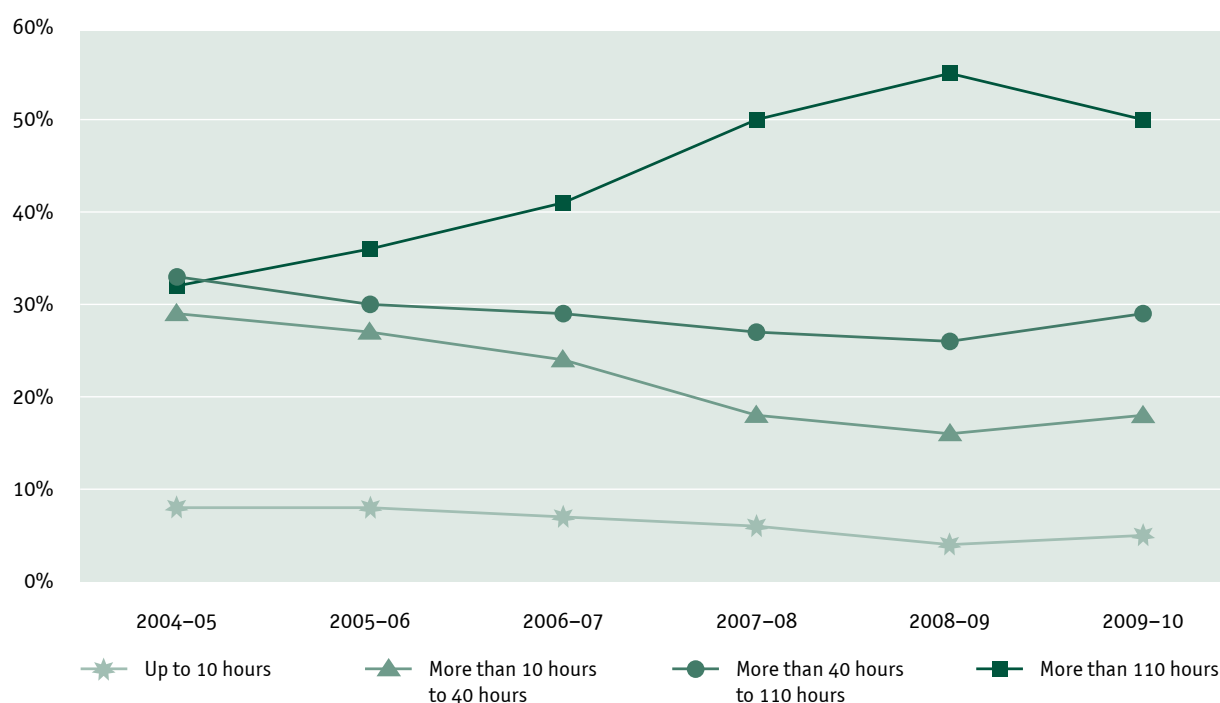
Information provided by DHS and many stakeholders suggests that demand pressures are being contributed to by an increasing number of families presenting to Child FIRST with complex and multiple issues. These issues can include a range of vulnerabilities and problems including: family violence; disability; debt and financial insecurity; parental stress; lack of social support and social isolation; mental health issues; and drug and alcohol problems (Anglicare Victoria submission, p. 12). In 2010, 92 per cent of all referrals to the North East Metro Child FIRST Alliance included one or more complex issues or significant wellbeing concerns (North East Metro Child and Family Services Alliance submission, p. 8).

The existence of increasingly complex cases for Child FIRST and family services is consistent with the data in Figure 8.5, which suggests that family services are working with fewer cases for longer periods of time. Recognising the increasing complexity of cases leads to consideration of whether the skills of the family services workforce are adequate to meet the needs of the presenting vulnerable children, young people and their families.

There is consistent criticism from CSOs that families that are at lower risk but that would benefit from supports are no longer meeting the threshold for access to family services because of the necessity to address the needs of the most vulnerable. This contention was supported by DOH, which suggested that health professionals are not making referrals to Child FIRST because families that had previously been referred had not met the threshold to receive services. It is also consistent with the KPMG finding that as family services increasingly manage more complex cases, their capacity to provide their former preventative intervention services is being reduced (KPMG 2011a, p. 4).

These criticisms need to be considered in the context that it was the intention of government when introducing reforms in the mid-2000s to ensure the needs of the highly vulnerable were prioritised. The combined effect of increased demand for family services, increased complexity of client needs, and the priority given to high-needs clients is that there appears to be a lack of capacity among family services agencies to work with a broader range of children and families.

Figure 8.5 Family services resources expended, by hours expended per case, Victoria, 2004-05 to 2009-10



Source: KPMG 2011b, p. 59

Role clarity

Related to the demand pressure facing family services, submissions and the Inquiry's consultations have highlighted that there is some confusion, misunderstanding or a 'gatekeeping' response regarding the boundaries between Child FIRST, family services and statutory child protection. A number of CSOs expressed the view to the Inquiry that statutory child protection was referring matters to Child FIRST that, in their view, required a statutory response. This issue is addressed further in Chapter 9.

As noted by the Victorian Ombudsman, it is inevitable that Child FIRST will have contact with children who should be referred to statutory child protection through protective intervention reports. In many ways Child FIRST is well placed to identify children at risk and ensure they are brought to the attention of DHS in a timely manner (Victorian Ombudsman 2009, p. 30).

There is a common contention that a high threshold for child protection services has resulted in higher risk cases being referred to Child FIRST from statutory child protection. Yet, there is little evidence available to the Inquiry to indicate the degree to which matters being referred by statutory child protection to Child FIRST are cases involving unacceptably high risk. It does seem that at times family services and statutory child protection may disagree as to the appropriate service response to some clients. The Inquiry considers that there is scope for the decision making regarding these clients to be more collaborative.

Early intervention

One of the key goals of Child FIRST and family services was to intervene earlier to assist vulnerable children and families, thereby avoiding the need for a statutory child protection response. Some stakeholders suggest that this goal has been achieved (Joint CSO submission, p. 31). The KPMG evaluation also supported this view, on the basis that statutory child protection reports, investigations and protective orders grew at a slower rate in Victoria compared with other jurisdictions between 2005-06 and 2008-09 (KPMG 2011a, pp. 127-128).

However, the Inquiry considers there is insufficient evidence to demonstrate that the introduction of Child FIRST has prevented some clients from being subject to a statutory child protection response. In particular, there is no evidence of a causal link between Child FIRST and any decrease in reports to statutory child protection. There are a number of other reforms and external factors that could have contributed to the change in the fall in reports. The Inquiry also notes that there was a substantial increase in reports to statutory child protection in Victoria in 2009-10 and 2010-11.

Client outcomes

There is a lack of evidence on the impact of Child FIRST and family services on outcomes for individual vulnerable children and their families. Further, there is little comment on this in submissions.

The Inquiry has been advised that work is underway within DHS to address this evidence gap. The Child and Family Services Outcomes Survey is a collaborative project to enable outcomes for a representative statewide sample of children receiving statutory child protection services, out-of-home care and family services to be measured and tracked over time. The first stage of the project surveys parents and carers about their children and focuses on their children's safety, stability and development including health, education, relationships and connections with family, community and culture. It will also include a range of questions about service experiences. It is intended that the survey will be conducted every two years. The second stage of the project, which will involve surveying children and young people, is due to commence in 2012.

While the initial findings from this work should be interpreted with caution, the preliminary report on the first survey includes a number of encouraging findings regarding family services, with parents and carers reporting they generally felt more confident in their parenting, were better able to relate to their children and manage their behaviour, as well as relate to others and manage their finances. About 75 per cent of parents believed that the child's health and wellbeing had improved since the provision of family services, and 90.4 per cent felt these improvements were as a result of the family service involvement. It is not possible to identify clearly whether family services had helped to prevent child abuse and neglect (Lonne et al. 2011).

The submission received from the North East Metro Child and Family Service Alliance (p. 9) provides some data regarding outcomes for children who have been engaged in Child FIRST and family services. The Alliance examined the outcomes for 382 families allocated to receive family services from Alliance agencies between July 2009 and June 2010, with follow-up occurring six months after allocation. The audit found that this Alliance of family services was generally effective at engaging complex, vulnerable families in services, with 67 per cent engaged, 13 per cent not engaged, and 20 per cent indeterminate.

It was further noted that the lowest engagement rate was with families referred from statutory child protection, with 58 per cent of referrals closed at Child FIRST. The study found that most referrals were closed because the families did not engage with services or ceased contact with services. This may suggest that Child FIRST is not as effective as an early intervention program if it is being provided to families that are not voluntarily engaged in working on problems within the family, and require an alternative tertiary response. While its conclusions cannot be generalised, this study demonstrates the benefits of analysing service data, and provides an example of how an audit or evaluation could be built into programs.

8.3.3 *Performance of specialist adult and youth services*

Victoria has a wide range of specialist adult and youth services including mental health services, drug and alcohol services, housing services and disability services. Many programs offered by specialist adult services to parents and caregivers are relevant to the risk factors for child abuse and neglect. Specialist adult services are therefore a critical platform for identifying vulnerable children and young people. In many instances, an adult service is also best placed to provide an early intervention service response to meet the needs of vulnerable children.

Family-sensitive practice

Family-sensitive policy and practice involves being aware of the impact of abuse upon families, addressing the needs of families and seeing the family – rather than an individual adult or child – as the unit of intervention (Battams et al. 2010).

Service providers owe a different duty of care to children. In order to respond effectively to the needs of children and young people, specialist adult services need to develop family-sensitive practices that incorporate risk assessment of child abuse and neglect, and the practical application of the service's responsibility to children.

The Inquiry received a number of submissions addressing family-sensitive practice. The Child Safety Commissioner suggested that developing a family focus in adult support services would enable better support to be provided to vulnerable children and families (Office of the Child Safety Commissioner submission, p. 6). The Family Alcohol and Drug Network noted that growing evidence indicates interventions that include family members are likely to achieve greater success than individually focused drug treatment programs (Family Alcohol and Drug Network submission, p. 2).

The College of Psychiatrists highlighted the potential benefit of strengthening priority access to mental health services for adults who are parents to vulnerable children. The college noted that under a narrow, adult-focused approach, some parents with a mental illness may not be able to access treatment due to the less severe nature of their illness. Under a broader, family-sensitive approach, some of those parents may receive treatment due to the impact of their illness on their parental functioning and as a consequence on the risk to the children (The Royal Australian and New Zealand College of Psychiatrists - Victorian Branch Faculty of Child and Adolescent Psychiatry and The Royal Australian and New Zealand College of Psychiatrists - Victorian Branch submission, p. 2).

The notion of supporting the needs of vulnerable children by prioritising the access to specialist adult services by parents and carers was canvassed in the recent New Zealand Green Paper for vulnerable children. The Green Paper suggested such a policy could apply to services where there are limited resources and adults may be on waiting lists, such as housing and alcohol and drug rehabilitation services. Some services use assessment tools that are too narrow to take the needs of vulnerable dependent children into account when determining their parents' or carers' priority for services (New Zealand Government 2011, p. 21).

In the United Kingdom a recent interim evaluation has considered the early stages of implementation of the *Think child, think parent, think family* guide being piloted by some service providers across adult mental health and children services to improve their response to parents with mental health problems and their families (Social Care Institute for Excellence 2011). While some preliminary promising practice is emerging, the evaluation highlights the significant challenges to this approach, particularly with competing pressures for service providers, the need for senior managers' commitment, information sharing challenges and the need for additional funding and resources to implement.

It is unclear to the Inquiry how extensive the adoption of family-sensitive practice and policy is in Victoria's specialist adult services. It is apparent, however, that services are not consistently identifying vulnerable children or delivering services that respond to their needs. While promising programs exist, they are varied, not coordinated, and without a simple, visible point of entry.

This gap is in part due to some confusion about who is responsible for the needs of vulnerable children and young people. Victoria lacks a clear expectation that specialist adult services must be responsive to the needs of their clients as parents and to the needs of their clients' children, even though their primary responsibility is to recognise the adult's personal needs and circumstances (Humphreys & Campbell (c) submission, p. 5).

Without an understanding of the extent of family-sensitive practice it is difficult, if not impossible, to determine how effective such a policy and practice would be in improving the role of specialist adult services in supporting early intervention to vulnerable children, young people and their families. An audit of all Victorian specialist adult services would assist in determining this matter.

The Inquiry is mindful that a broad adoption of family-sensitive practice by Victorian specialist adult services will have significant resource implications beyond increased service capacity. As noted by the Victorian Alcohol and Drug Association (VAADA), organisations will need to be redesigned to cater for a greater mix of clients, including children, which will require significant modifications to infrastructure. It will also necessitate the introduction of new training programs on models of service delivery and screening tools (VAADA submission, p. 7).

Service integration

Section 8.3.2 described the need for better links between family services and specialist adult services. The Inquiry also heard through submissions and consultations that an effective response to the multiple and complex problems for parents of vulnerable children and young people also required the integration of different specialist adult services. Odyssey House commented that the association between substance-dependence and family violence is of serious concern, not only between parents or adult partners, but also from parents to children and from adolescents and young adults towards parents. However, family violence is rarely identified or addressed within alcohol and drug services. The overlap in characteristics of families involved with child abuse and neglect, alcohol and other drug use, family violence and mental health suggests an urgent need to align the disparate services that address these parental factors with family services and the system for protecting vulnerable children more broadly. A shared framework, or universal screening tool, should be considered for all services working with vulnerable children and families (Odyssey House Victoria submission, p. 15).

Similarly, while a range of youth programs are available, they are not necessarily well connected with the broader service system supporting vulnerable young people, are not well coordinated with each other and may be difficult to access.

8.4 Conclusion

There is a great opportunity for the Victorian Government to provide earlier, more effective targeted supports for Victoria's vulnerable children and young people. The overseas evidence shows that early intervention programs, when well designed and resourced, can be an effective approach to improving a range of outcomes for vulnerable children and young people, including reducing the risk of child abuse and neglect. The long-term economic and social benefits of the most effective overseas programs far exceed their costs.

Victoria already has a substantial range of early intervention programs targeting vulnerable children and young people, but they do not come together to form a comprehensive, coherent and coordinated system of early interventions that addresses the needs of vulnerable children and their families. While service integration is improving, in the main, DHS, DEECD and DOH deliver or fund a set of early intervention programs to specific groups, consistent with their particular policy goals. There is an absence of holistic service planning and provision that meets the diverse needs of the particular child or young person and their family. This is an example of where the Children's Services Coordination Board, discussed in Chapter 20, has failed to drive coordination of government actions relating to children at local and regional levels.

In Chapter 6, the Inquiry recommends the development of a whole-of-government Vulnerable Children and Families Strategy to synchronise government efforts. The strategy would identify whole-of-government policy objectives, specific roles and responsibilities for individual departments, and a set of performance measures and indicators to monitor progress. As set out in Chapter 21, the Inquiry recommends that a new Commission for Children and Young People be established to oversee departments' performance in meeting their responsibilities under the framework.

An effective system of early intervention must both identify vulnerable children and families and deliver services that meet their needs. This requires all relevant services across sectors to put the consideration of the best interests of children at the heart of their practice. Universal services and specialist adult services have an essential role to play in the early identification of children and young people who are at risk and providing support based on a holistic assessment of the family's needs. Targeted services need to be coordinated at the local level to support an integrated, multidisciplinary response to individual families.

In Chapter 14 the Inquiry considers the role that amendments to legislation may provide to clarify the responsibilities of adult service providers to the children of their clients.

Enhancing early identification

The Inquiry recognises the potential benefit of utilising the CYF Act provisions regarding pre-birth reports to identify vulnerable children early and to avoid a tertiary response for these children. The Inquiry is also concerned, however, that there could be unintended consequences from subjecting a pregnant woman to the stress of a child protection pre-birth report, particularly if it is not followed by a comprehensive service response. The Inquiry therefore considers this to be an area that requires urgent evaluation.

Existing data systems and practices within services do not allow Victoria to identify all vulnerable children and young people who could benefit from early intervention services. There is a need for investment in modern client information systems that collect data about Victoria's children and their service utilisation. Improved data collection will support government agencies and services to better understand children's needs, improve the targeting of programs for vulnerable children, help maintain contact with hard-to-reach families, improve pathways between universal and targeted services, and support better program evaluation. As discussed in Chapter 20, it is important that appropriate protocols are established for the sharing of information without breaching clients' privacy.

Identifying vulnerable children and young people should be part of the core business of all universal early childhood services, schools, health services and specialist adult services. This chapter has identified promising practices in each of these sectors, but they are varied, not coordinated and not consistently adopted. The Inquiry recommends additional investment in these services supporting them to identify and respond to risk factors for child abuse and neglect and, where appropriate, to refer vulnerable families to other support services. Specialist adult services and health services should be supported to develop family-sensitive practices that address the needs of the whole family. A substantial increase in investment in DOH's Vulnerable Children's Program is required.

Through these steps, Victoria can make best use of its available resources to properly identify the families that would benefit from the support of early intervention.

Recommendation 15

The Government should enhance its capacity to identify and respond to vulnerable children and young people by:

- Evaluating the outcomes of pre-birth reports to statutory child protection and pre-birth responses to support pregnant women;
- Providing funding to support universal early childhood services, schools, health services (including General Practitioners) and specialist adult services to identify and respond to the full range of risk factors for child abuse and neglect. This should include increased investment in the Department of Health's Vulnerable Children's Program; and
- Providing funding to support specialist adult services to develop family-sensitive practices, commencing with an audit of practices by specialist adult services that identify and respond to the needs of any children of parents being treated, prioritising drug and alcohol services.

An integrated, comprehensive service response

The Inquiry has recommended that an area-based approach should be taken to address vulnerability and protect Victoria's vulnerable children and young people (see Recommendation 3 in Chapter 6).

Child FIRST and the local Alliances of family services provide a basis for developing an accessible entry point within a local catchment to a coordinated network of targeted services to meet the needs of vulnerable children and their families. However, the capacity of Alliances to deliver services that meet local needs is being undermined in several catchments because Alliances are not meeting their core responsibility to undertake service planning.

The Inquiry considers that the first step to reform family services should be to establish consistent governance arrangements across catchments to strengthen Alliances' accountability for their performance (Stage 1 of Figure 86). Area Reference Committees should be established in each catchment to oversee the monitoring, planning and coordination of services and management of operational issues. The Committees would comprise a representative of each CSO in the local Alliance, and be co-chaired by the DHS area manager and the chief executive officer or area manager of the lead CSO, ensuring that both DHS and the lead CSO are accountable for the Alliance meeting its responsibilities. The Inquiry anticipates that DHS will need to support some Alliances to develop the capacity to use data to inform service planning.

Accountability arrangements for Child FIRST should be strengthened further by ensuring that DHS' funding agreements with Alliance lead agencies clearly specify the CSO's role, accountability and responsibilities, and include appropriate performance measures. This would allow DHS to hold lead CSOs to account should they fail to meet their responsibilities.

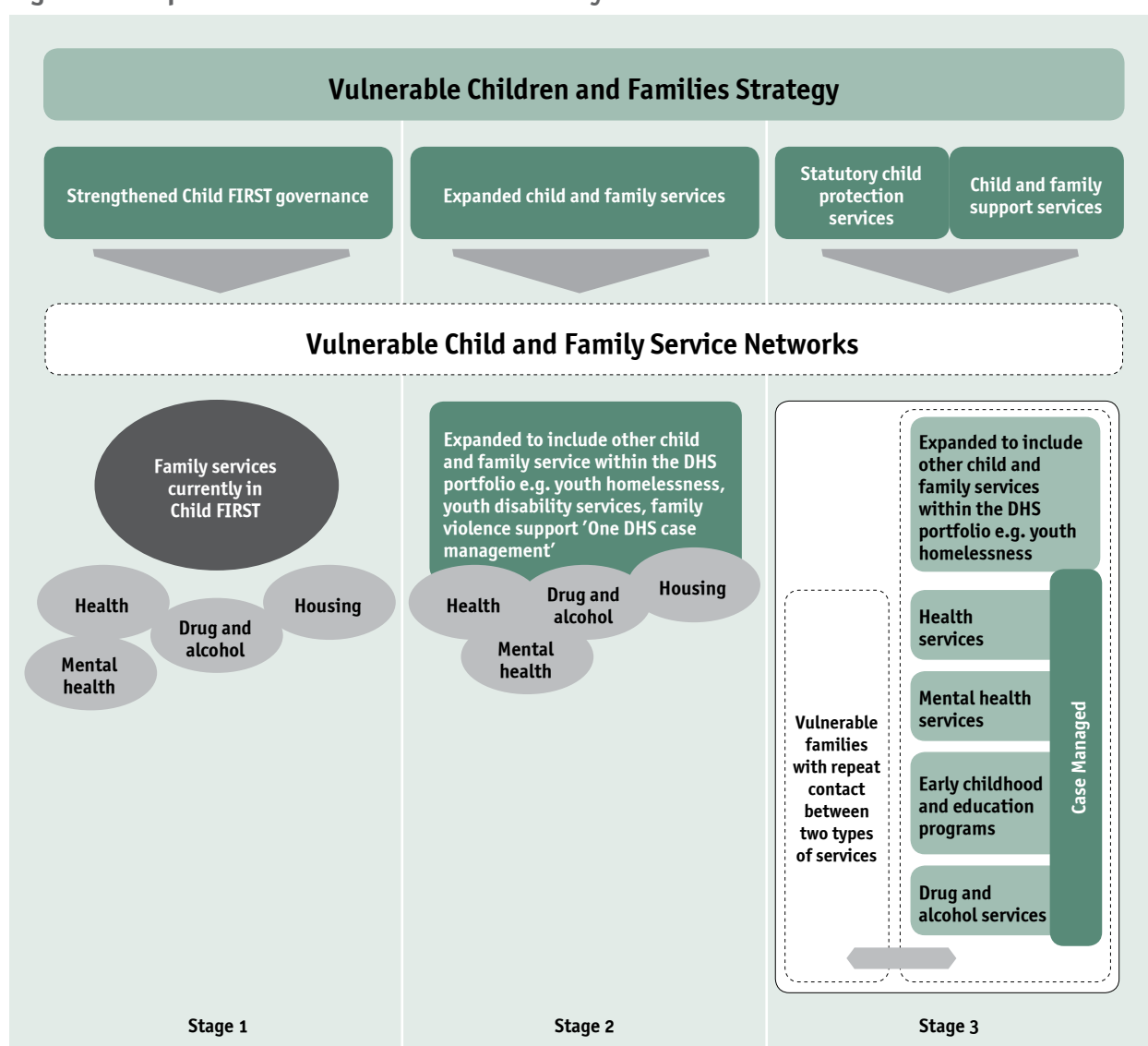
The Inquiry considers there is an opportunity to expand upon the existing Alliances of family services and statutory child protection services to develop broader, more coherent Vulnerable Child and Family Service Networks encompassing specialist adult services, health services and targeted programs linked to universal services. This would support the provision of an integrated package of services that meet the full range of needs of vulnerable children and their families. The networks should be expanded in stages, with the priority to be to include other services within

the DHS portfolio plus specialist adult services that address key risk factors of child vulnerability, such as drug and alcohol services and mental health services (Stage 2 of Figure 8.6).

This reform is aligned with the recommendation in Chapter 9 for the introduction over time of a consolidated intake model where Child FIRST and statutory child protection intake and referral processes are first co-located and then, potentially, combined (Stage 3 of Figure 8.6).

The consolidated intake and referral services would refer vulnerable children and families to the Vulnerable Child and Family Service Networks. Families would only need to enter the service system once, and the intake and referral service would be responsible for ensuring families receive an integrated, comprehensive service response. Families would no longer have to navigate a complex and uncoordinated service system themselves.

Figure 8.6 Expanded Vulnerable Child and Family Service Networks



Source Inquiry analysis

Consistent with the broadening of the Vulnerable Child and Family Service Networks, the Inquiry recommends that the legislative requirement to act in the best interests of children (which currently applies to family services under the CYF Act) be broadened to apply to all network services. As further recognition of our responsibility to vulnerable children and young people, legislation could also require services – particularly specialist adult services – to prioritise service delivery to vulnerable children, young people and their families. These provisions should be placed in the relevant legislation governing the services.

Recommendation 16

As part of a strategy to improve services for vulnerable children and families in need, the Department of Human Services should strengthen area-based planning and coordination of family services and accountability arrangements under Child FIRST by:

- Establishing Area Reference Committees to oversee the monitoring, planning and coordination of services and management of operational issues within each catchment. The Committees would be co-chaired by the Department of Human Services area manager and the chief executive officer or area manager of the lead community service organisation, and comprise a representative of each community service organisation in the local Alliance; and
- Ensuring the funding arrangements for Alliance lead agencies clearly specify the agencies' responsibilities for receiving referrals, undertaking an initial assessment of clients' needs, and facilitating an appropriate service response, with appropriate performance indicators.

Recommendation 17

The Government should expand upon the existing local Alliances of family services and statutory child protection services to develop broader Vulnerable Child and Family Service Networks – catchment-based networks of services for vulnerable children and families, including statutory child protection, family services, specialist adult services, health services and enhanced universal services.

Recommendation 18

The Government should ensure the legislation governing relevant services establishes the responsibilities of services to act in the best interests of children and young people, and to prioritise service delivery to vulnerable children, young people and their families. In addition, health services and specialist adult services should be required to adopt family-sensitive practice guidelines.