



Part 6: System supporting capacities

Chapter 16:

A workforce that delivers quality services

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Key points

- The child protection and family services workforce operates in a complex environment, dealing with some of the most difficult and complex cases of serious child abuse and neglect.
- Different components of the workforce contribute to protecting vulnerable children. They include:
 - a government workforce that is primarily focused on statutory child protection;
 - a community sector workforce that delivers a range of out-of-home care and intensive family services;
 - volunteers and households that support the family services activities and provide the vital foster and kinship care segments of the out-of-home care system; and
 - a wide range of other professions that interact with vulnerable children.
- While there are different issues affecting these components of the workforce, there is a set of key common issues that affect the workforce, including:
 - the need for increased skills and professional development;
 - the need to address issues with recruitment and retention; and
 - the need for clear pay structure and career pathways.
- There are a number of ongoing policy developments that may address some of the issues affecting the child protection and family services workforce, including reforms to the Department of Human Services structure of statutory child protection services and the equal remuneration case currently before Fair Work Australia.
- The Inquiry considers that a number of workforce issues can be addressed by improving the professionalisation of the child protection workforce via a process that is qualification-led.
- Two recommendations are made in relation to the education and professional development needs of the workforce, including the need for a training body to oversee development of an industry-wide workforce education and development strategy and the need for greater cultural competence training.

16.1 Introduction

The child protection and family services workforce deals with some of the most difficult and confronting cases of serious child abuse and neglect. They work with families with complex and often multiple problems. By its nature, the work they undertake can be disturbing, stressful and at times threatening, and it is in these circumstances that workers are expected to exercise a high degree of expertise, skill, and judgment. The work undertaken by the child protection and family services workforce is important, and when done effectively, it can have a significant effect on the lives of the children and families they work with, as well as the general health of the community.

The Inquiry had extensive consultation across Victoria with the child protection and family services workforce. It clearly emerged that there are many members of the child protection and family services workforce who are dedicated and committed to meeting the needs of vulnerable children and their families. Many positive and constructive outcomes are achieved, often unacknowledged and unpublished. It is also true that there have been serious failures and lapses by some who work in the sector, sometimes with tragic results. This Inquiry addresses ways of sustaining the good work performed by the workforce across Victoria, and of minimising the failures that have occurred.

Child protection and family services is not a normal labour market. The demands on individuals are dictated by often unexpected changes in the circumstances of the families they are working with. To be effective at protecting vulnerable children from the impacts of abuse and neglect, the child protection and family services workforce requires exceptional support from organisations that recognise the difficulties inherent with this kind of work and support the workforce accordingly. It is also reliant on the contribution made by the volunteer workforce, particularly those who work as carers for children in home-based care.

16.2 The child protection and family services workforce

The child protection and family services workforce includes both the government and non-government or community sectors. The government component of the workforce is employed by the Department of Human Services (DHS) and mainly supports the delivery of the statutory child protection program. The non-government or community sector component of the workforce is typically employed in community service organisations (CSOs) that are funded to deliver child protection and family services, including out-of-home care and intensive family services.

There is no industry classification unique to the child protection and family services sector, meaning that information on the sector workforce is often not readily available. Based on the Australian and New Zealand Standard Industrial Classification used by the Australian Bureau of Statistics (ABS), both the government and the non-government components of the workforce would most likely fall into the categories of 'Other Residential Care Services' and 'Other Social Assistance Services', but these classifications also include a broader range of social services, for example community mental health, some drug and alcohol services and relationship counselling (ABS & Statistics New Zealand 2006, pp. 348-349).

Based on information provided by DHS, the Inquiry estimates that the total child protection and family services workforce in Victoria is in the order of 3,000-4,000 people. The following sections provide a discussion of the government and non-government components of the workforce.

Beyond the specific child protection and family services workforce there is also a much broader workforce that contributes to the safety and wellbeing of vulnerable children. This broader workforce includes:

- Health and allied health professionals, including doctors, nurses, midwives, psychologists, social workers, occupational therapists and dentists;
- Education professionals, including primary and secondary teachers, principals and early childhood education providers;
- Legal and law enforcement professionals, including lawyers, police and the judiciary;
- Salaried and non-salaried carers; and
- Providers of social and family services.

The large and diverse number of professionals who play a role in the protection of children was highlighted in the recent Munro Review of Child Protection in the United Kingdom (UK), where a case study showed that a child may come into contact with no fewer than 46 people involved in their case within a relatively short period of time (Munro 2011a, p. 33). While the Inquiry has no similar Victorian evidence, it has heard from a number of agencies that spoke about the large number of individuals and service providers that a family may interact with.

The level of involvement that these other professions have in relation to child protection varies, some are legally required to report suspected abuse, while others interact with children who may have been the victims of abuse and neglect.

While this chapter is primarily focused on the issues facing the dedicated child protection and family services workforce in Victoria, it also considers issues facing this broader group and the role they play in protecting vulnerable children and young people.

16.3 The government workforce

The DHS employed child protection workforce consists of 1,180 full-time equivalent (FTE) child protection workers (CPWs) (June 2011). These CPWs are typically female (88 per cent) and are often relatively young, with 35 per cent aged 25 to 34 years. The workforce is structured into six levels (see Table 16.1). It is CPW-2 and CPW-3 workers who undertake the majority of case-carrying work, dealing directly with children and families. These workers make up just over 60 per cent of the total child protection workforce (see Figure 16.1).

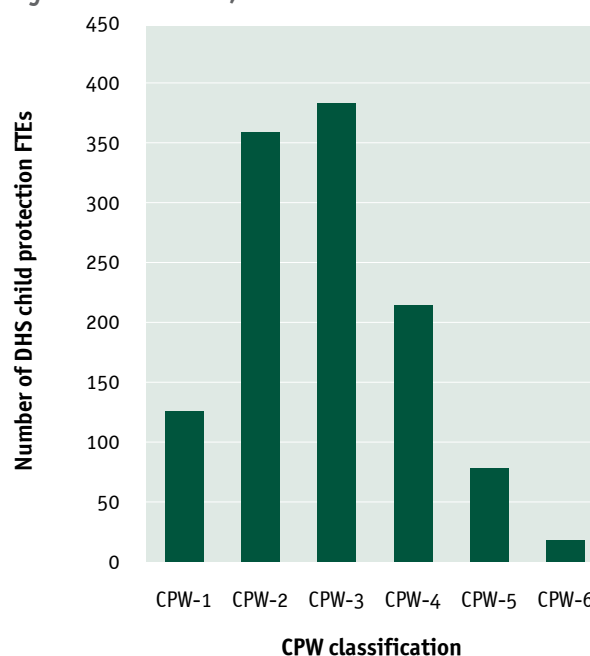
All DHS CPWs are tertiary qualified, with the exception of CPW-1 workers. The typical qualifications held by the workforce include Bachelor of Social Work, Diploma of Child Welfare or Bachelor of Psychology, with the Bachelor of Social Work being the most commonly held qualification. All graduates must have completed a practical component in their degree to be eligible for employment in child protection. Although tertiary qualified, the DHS case-carrying child protection workforce has not typically been employed in their roles for a long period of time. Historically high levels of turnover mean that 45 per cent of case-carrying workers have less than two years of experience in their roles, while only 23 per cent have greater than five years' experience.

Table 16.1 DHS child protection workforce: classifications and roles

Classification	Role (typical only)
CPW-1	Support role, non case-carrying
CPW-2	Entry level, case-carrying
CPW-3	Experienced case-carrying
CPW-4	Team leaders and specialists
CPW-5	Unit manager
CPW-6	Child protection manager

Source: Information provided by DHS

Figure 16.1 DHS child protection workforce, by classification, June 2011



Source: Information provided by DHS

The DHS child protection workforce is distributed between the eight DHS regions, including three metropolitan and five rural regions. Overall, 63 per cent of CPWs are located in the metropolitan regions, with the remaining 37 per cent in the rural regions (see Figure 16.2).

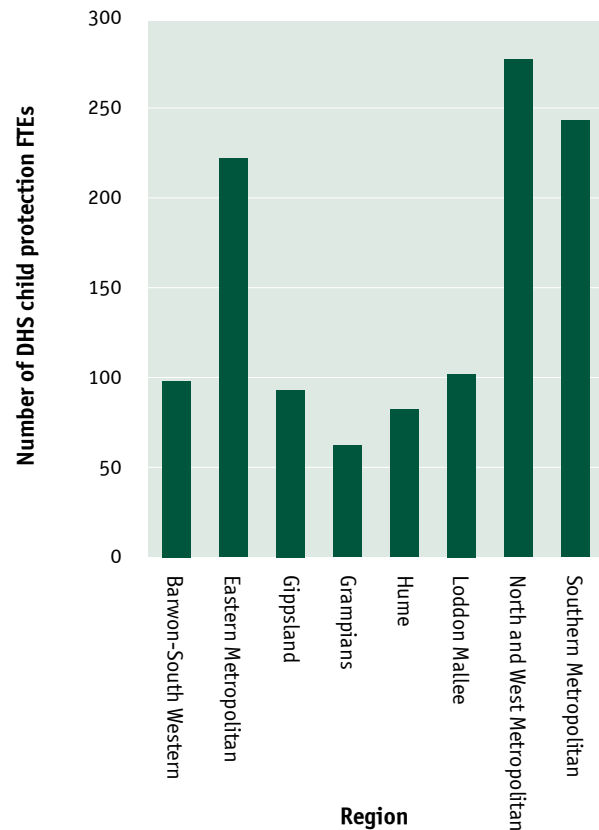
There has been significant growth in the DHS child protection workforce in recent years. Over the past five years the workforce has been growing by around 5 per cent per annum, resulting in an increase in the total number of FTEs of 26 per cent from June 2006 to June 2011. In absolute terms, this resulted in an additional 241 CPW FTEs in 2011, compared with 2006.

The majority of the increase in DHS child protection FTEs between 2006 and 2011 has been in the CPW-1, CPW-3 and CPW-4 classifications, while there has been a slight decline in the number of CPW-2 FTEs (see Figure 16.3).

Overall, between June 2006 and June 2011, the DHS case-carrying workforce (CPW-2 and CPW-3 levels) increased by 17 per cent but declined as a proportion of the total child protection workforce from 68 per cent to 63 per cent. To compare this with increases in child protection activity, over approximately the same time there has been a 27 per cent increase in child protection reports, a 16 per cent increase in investigations and 13 per cent decline in substantiations (Steering Committee for the Review of Government Service Provision 2011c, Table 15A.5). Caseloads and the capacity of the statutory system are discussed in more detail in Chapter 9.

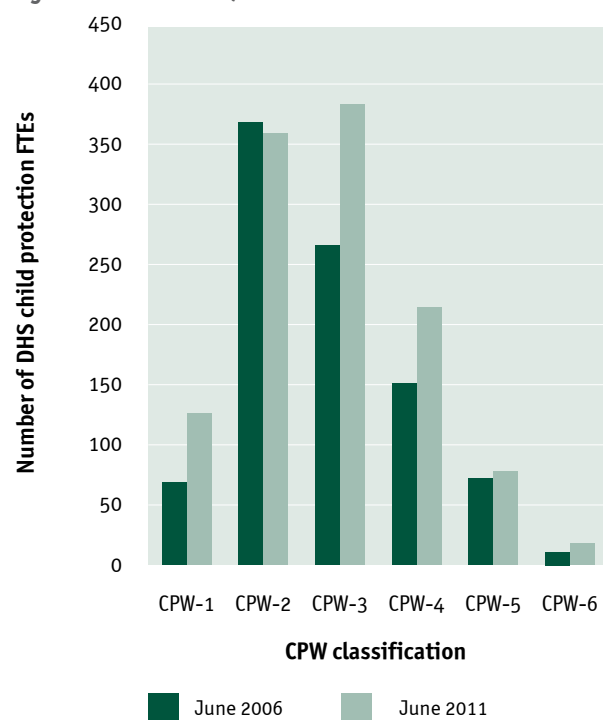
On a regional basis, the largest increases in CPW FTEs between 2006 and 2011 were in the three metropolitan regions, while the largest proportional increases have been in the Southern Metropolitan Region (39 per cent), Hume (37 per cent) and Grampians (33 per cent) (see Figure 16.4 and Table 16.2). Additional resources are generally allocated by DHS based on need using a variety of indicators. Resource allocation is discussed in more detail in Chapter 19.

Figure 16.2 DHS child protection workforce, by region, June 2011



Source: Information provided by DHS

Figure 16.3 DHS child protection workforce, by classification, June 2006 and June 2011



Source: Information provided by DHS

Figure 16.4 DHS child protection workforce, by region, June 2006 and June 2011

Source: Information provided by DHS

Table 16.2 DHS child protection workforce by region, June 2006 to June 2011

Region	DHS child protection FTEs						
	2006	2007	2008	2009	2010	2011	Change 2006 to 2011
Barwon-South Western	79	84	80	87	84	98	23%
Eastern Metropolitan	176	190	189	205	206	222	26%
Gippsland	72	70	82	79	95	93	29%
Grampians	46	50	49	44	54	62	33%
Hume	60	62	67	71	90	82	37%
Loddon Mallee	85	104	101	106	96	102	19%
North and West Metropolitan	244	248	247	271	246	277	14%
Southern Metropolitan	175	194	220	192	229	243	39%
Total*	938	1,002	1,036	1,055	1,100	1,179	26%

Source: Information provided by DHS

* Figures may not sum due to rounding

16.3.1 Recruitment

The DHS child protection recruitment program operates on a monthly cycle for the recruitment of entry-level CPWs and advertises more senior positions as they become available. For entry-level positions, which account for the majority of child protection recruitment, the recruitment process takes approximately six weeks from date of advertisement to a formal offer of employment. The recruitment of CPWs may be coordinated centrally or at the regional level, in response to particular recruitment needs of a region. The Inquiry was made aware during the course of the consultations of the difficulty of attracting quality candidates in non-metropolitan areas.

DHS advertises for the recruitment of CPWs through a variety of channels, including newspapers, internet and social media.

DHS also provides a Student Placement Program, which provides tertiary-level students with an introduction to child protection work and acts as a significant source of supply to entry-level positions in child protection. In 2010, 181 students participated in the Student Placement Program, most of who were in the final year of study. At the conclusion of their placement, 30 of these students participated in an end-of-placement survey. These students were generally positive about a career in child protection, the majority of them had applied for a child protection practitioner position (56 per cent), or intended to apply in the future (39 per cent). Students were positive about a career in child protection for reasons, including:

- Working directly with families;
- The opportunity to develop interpersonal skills in high conflict/emotion situations; and
- Exposure to a range of practice interventions (DHS 2010c, pp. 2-6).

Since 1989 DHS has also conducted several recruitment campaigns aimed at attracting CPWs from overseas. This includes a centralised campaign in 2008 and 2009 attracting advanced practitioners from the UK and Ireland and a 2010 campaign organised by the Gippsland region aiming to address that region's specific recruitment and retention issues.

Overseas recruitment programs have been conducted in the UK, Ireland, Canada and New Zealand, and overseas employed candidates are primarily from these countries. A small number of CPWs have also been employed from the United States and South Africa.

The precise retention rate for overseas recruits is not available; however, according to DHS 186 CPWs have been recruited from overseas since 2008, with 138 currently employed. This would suggest that around three-quarters of overseas recruits have been retained in child protection, which is relatively high when compared with attrition rates in the sector.

Overseas recruitment, including travel relocation packages, marketing and administration, has cost DHS \$1.64 million since 2008, equivalent to \$8,800 per recruit. DHS has advised the Inquiry that the attraction and retention of domestic workers is the primary focus of child protection recruitment but that overseas recruited staff are likely to remain a small but consistent source of experienced practitioners for the Victorian child protection workforce.

16.3.2 Professional education and development

All case-carrying CPWs in the government sector are degree-qualified. There are also a range of professional education and development opportunities available to the government child protection and family services workforce, coordinated by DHS at the certificate, graduate and post graduate level, as well as other internal education and development programs. Some of these programs are also available to members of the non-government workforce within the CSO sector.

DHS provides three main streams of professional education and development, primarily for the government workforce. They are:

- Beginning Child Protection Practice;
- Advanced Child Protection Practice; and
- Leading Child Protection Practice.

Beginning Child Protection Practice

The Beginning Child Protection Practice program is provided to new entry-level practitioners and covers the first 18 months of practice. The program is also available to new child protection practitioners who enter the child protection workforce at advanced practitioner or team leader level. The program consists of three mandatory courses:

- Beginning Practice Clinics (formally known as Beginning Practice in Child Protection);
- The Prevention and Management of Occupational Violence; and
- Attachment Development and Trauma.

The Beginning Child Protection Practice program includes four days (out of a total of 12) dedicated to court processes. It aims to develop an understanding of the role of CPWs in a legal context. These sessions are provided by DHS, a DHS lawyer, a representative from Victorian Legal Aid (VLA) and a barrister. The training is also open to VLA lawyers.

Legal training for CPWs also includes preparation for Children's Court matters, as well as assessment of and intervention in child sexual abuse. The former is designed to provide a practical understanding of the roles and responsibilities of CPWs when interacting with the judicial system, while the latter is intended to provide an understanding of evidence required for the Children's Court regarding a sexual abuse investigation.

It is essential that CPWs receive relevant and sufficient training in court processes, both to assist the court and to equip them with knowledge of court processes and procedures. As discussed in section 16.5.2, court processes are an area of concern for many CPWs.

Advanced Child Protection Practice

The Advanced Child Protection Practice program is delivered with the intention of maintaining and further extending the training program for experienced practitioners. Training sessions are facilitated by the Child Protection Youth Justice Program Development Unit, in the form of full-day training in specific areas of practice, for example court skills.

Leading Child Protection Practice

The Leading Child Protection Practice program is provided for senior child protection workers in the roles of team leader, unit manager, child protection managers or specialist roles. Workers in these roles can also access the Advanced Child Protection Practice stream. It is compulsory for team leaders to undertake team leadership and supervision training (which also includes a court component), while other training is not mandatory but is highly recommended. The training is based on the *Child Protection Capability Framework* (DHS 2011d).

Graduate Certificate and Graduate Diploma courses

In 2009 DHS provided funding for the development of two graduate-level courses delivered by La Trobe University, namely:

- Graduate Certificate in Child and Family Practice; and
- Graduate Diploma in Child and Family Practice Leadership.

The goals of the courses are to enhance the quality of practice with vulnerable children and families and to further develop the professionalism of the workforce by integrating theoretical frameworks and research into practice. DHS anticipated the courses would improve staff retention and the perception of the Victorian community services sector as an attractive career choice.

The Inquiry received a joint submission by Associate Professor Frederico at La Trobe University, The University of Melbourne, Take Two Berry Street Victoria and the Victorian Aboriginal Child Care Agency. The submission stated that both courses provide the opportunity for the child protection and family services workforce to upgrade skills, enhance reflective practice, prevent burnout and further develop a professional career. The courses provide exposure to a range of specialised knowledge areas that are relevant to child protection and family services work, including substance abuse, social work, family therapy, trauma, attachment, developmental psychology and neuropsychology (Frederico et al. submission, p. 2).

The courses first began in the second semester of 2009. Both courses have had strong retention rates. In the case of the Graduate Certificate, 27 of the 30 students enrolled graduated in June 2010, including 17 child protection practitioners, nine family service workers and one Aboriginal community controlled organisation (ACCO) worker. In the case of the Graduate Diploma, 30 of the initial 35 continued to the second year of the course, including 20 child protection team leaders or unit managers and 10 from family service organisations or ACCOs (Frederico et al. submission, p. 1).

An evaluation of the course provided to the Inquiry found that participation in the courses led to enhanced confidence and greater competence to operate as a front line case practitioner in child protection or family services as well as enhanced confidence and competence as a leader. The participation of both government and non-government workers was found to lead to a greater appreciation of their respective roles and responsibilities (Frederico et al. submission, p. 3).

Currently there are 31 students enrolled for the 2011 to 2012 intake of the Graduate Certificate course, and a further 31 students are enrolled for the 2011 to 2013 intake of the Graduate Diploma course. At present, neither of these training courses have recurrent funding.

The DHS Child Protection Capabilities Framework

The DHS *Child Protection Capabilities Framework* outlines the capabilities required to work within the statutory system, as well as the knowledge and skills required for child protection work. The capabilities identified by DHS include:

- Thinking clearly;
- Engaging others;
- Managing oneself;
- Delivering results; and
- Leading and inspiring.

The capabilities framework is incorporated into *Leading practice: A resource guide for Child Protection frontline and middle managers*.

16.4 The community sector workforce

There is generally less information available on the non-government, community sector workforce. This is partly due to the fragmentation of the sector. In 2009-10 there were 221 organisations that received funding from DHS to deliver child protection and family welfare services, ranging from multi-million dollar organisations to small volunteer organisations with no paid staff.

DHS does not collect information about the community sector workforce but provided the Inquiry with estimates of the size of the workforce, as being in the order of 2,000 people based on approximately 1,200 staff in out-of-home care and 700 FTEs working in Integrated Family Services. Although this figure is only an estimate, it suggests that the non-government child protection and family services workforce is in the order of 50 per cent larger than the government child protection workforce.

At the end of June 2011, there were 900 households providing foster care and 1,700 kinship care households. Many of these households were caring for more than one child or young person. As discussed in Chapter 10, Victoria does not operate a system of professional foster care where carers are paid a salary. As a consequence foster carers and kinship carers are generally not included in official workforce data or in surveys. Issues affecting foster and kinship carers are discussed further in Chapter 10.

As noted above the community sector workforce mainly delivers out-of-home care and family services. Like the government workforce, the non-government workforce is predominantly female (78 per cent) (ABS 2010a) but is typically older and more experienced than the government workforce, with a median age of 44 (Australian Services Union submission, p. 7).

Due to the fragmentation of the community sector workforce, information on the level of qualifications held by these workers is not readily available; however, based on figures for the broader community services sector, around 80 per cent hold some qualification, with 21 per cent being degree qualified (ABS 2010a).

A range of professional education and development programs are available to the community sector workforce (including some of the ones previously mentioned for the government workforce). Much of the training specifically provided to the non-government workforce by DHS is provided in the out-of-home care sector, relating to either residential or home-based care.

Residential care training and professional development

The level of training for workers in the residential care sector was frequently raised as an issue in submissions and during consultations, with many commenting that the most troubled children (those in residential care) are left in the care of the least qualified workers. The Inquiry has had difficulty sourcing up-to-date information on the qualifications of community sector workers generally; however, a study of these qualifications from 2006 would seem to confirm this assertion.

The study found that, while nine per cent of family services workers had no further qualification beyond secondary school, this figure rose to 24 per cent for residential care workers. Residential care workers were also less likely than other family services workers to have completed diploma or degree qualifications (DHS 2006b, p. 2 & appendix 1). In addition, issues with the recruitment of residential care workers have often led to the use of agency-based staff with minimal qualifications and experience.

Training for residential care is coordinated through the *Residential Care Learning and Development Strategy* (RCLDS). Recurrent funding for the strategy is currently around \$520,000. Management of the strategy is contracted to the Centre for Excellence in Child and Family Welfare. The RCLDS has enabled CSOs and DHS to use the *Australian National Training Framework* to design and deliver competency based training to non-government, residential care workers.

Between 2008-09 and 2010-11 approximately 2,000 residential care workers participated in courses through the RCLDS. Training courses provided under the strategy are typically run for one to two days, with topics including:

- Youth mental health;
- Supervision skills for residential care managers;
- Conflict management;
- Managing sexually abusive behaviours; and
- Therapeutic care, including trauma and attachment theory.

Home-based care training and professional development

DHS provides home-based care training separately from the RCLDS. This training consists of mandatory training in foster care assessment, as well as training for a therapeutic approach to care. Table 16.3 outlines this training, and the funding allocated in 2010-11.

In relation to home-based care training, a major CSO observed that, 'while the RCLDS had been successful in the residential care setting, there is no equivalent ... for home based care staff and volunteers' (MacKillop Family Services submission, p. 17).

Chapter 10 discussed the need for more specialised therapeutic provision, training and support for out-of-home care staff and carers.

16.5 Issues raised in consultations and submissions

The Inquiry consulted on issues affecting the child protection and family services workforce with frontline workers from DHS and CSOs drawn from metropolitan and regional locations. A summary of these consultations is contained in Chapter 5.

The consultations revealed a high level of commitment from child protection and family services workforce in both the government and CSO sectors. When asked about the best parts of the job, workers from both sectors often cited 'working with families', 'facilitating change with those families' or the 'satisfaction of making a difference' (Inquiry workforce consultation).

The high level of workforce commitment to children and their families is well established. Surveys of the child protection workforce from 2010 show that 'making a difference' and 'working with children' were the main reasons for workers entering child protection (Hall & Partners 2010, p. 2).

In spite of this high level of commitment, the consultations with frontline workers revealed a number of common issues facing both the government and non-government workforce (Inquiry frontline worker consultation). These issues include:

- High caseloads;
- Difficulties with court processes;
- The challenge of working with difficult and complex families;
- The need for a defined career path and more training; and
- Difficulty with the administrative burden of their work.

Table 16.3 Home-based care and out-of-home care: training and funding, Victoria, 2010-11

Program	Funding 2010-11
Mandatory staff training in foster carer assessment, including: <ul style="list-style-type: none"> • Mainstream foster care; • Aboriginal foster care; and • Development of materials for the above. 	\$99,000
'A therapeutic approach to care', including: <ul style="list-style-type: none"> • Mainstream kinship care training; • Aboriginal kinship care training; and • Development of materials for the above. 	\$655,000
Total	\$754,000

Source: Information provided by DHS

High caseloads

Caseloads were commonly raised as a significant issue for DHS and CSO frontline workers, with the perception that high caseloads were contributing to worker burnout and fatigue. CSO workers reported that they were being ‘pushed’ by DHS to take cases, while workers from both sectors raised the issue of balancing caseloads with the other tasks expected of child protection and family services workers, such as administration and court attendance. Consultation with DHS and CSO workers from regional Victoria revealed additional demand pressures associated with travelling large distances to visit clients or attend court proceedings.

The Inquiry was provided with information about the average caseload of DHS child protection workers from October 2009 to September 2011. The calculations provided to the Inquiry exclude non case-carrying workers, such as managers or intake workers. Since late 2009 there has slight decline in the average caseload, from around 13.5 to just over 12 cases per CPW, as shown in Figure 16.5.

There is considerable regional variation in the average caseload per region, as shown in Figure 16.6. The Barwon-South Western, Loddon Mallee and Gippsland regions had comparatively high average caseloads. An analysis of this variation showed that regional differences in average caseloads were persistent from October 2009 to September 2011.

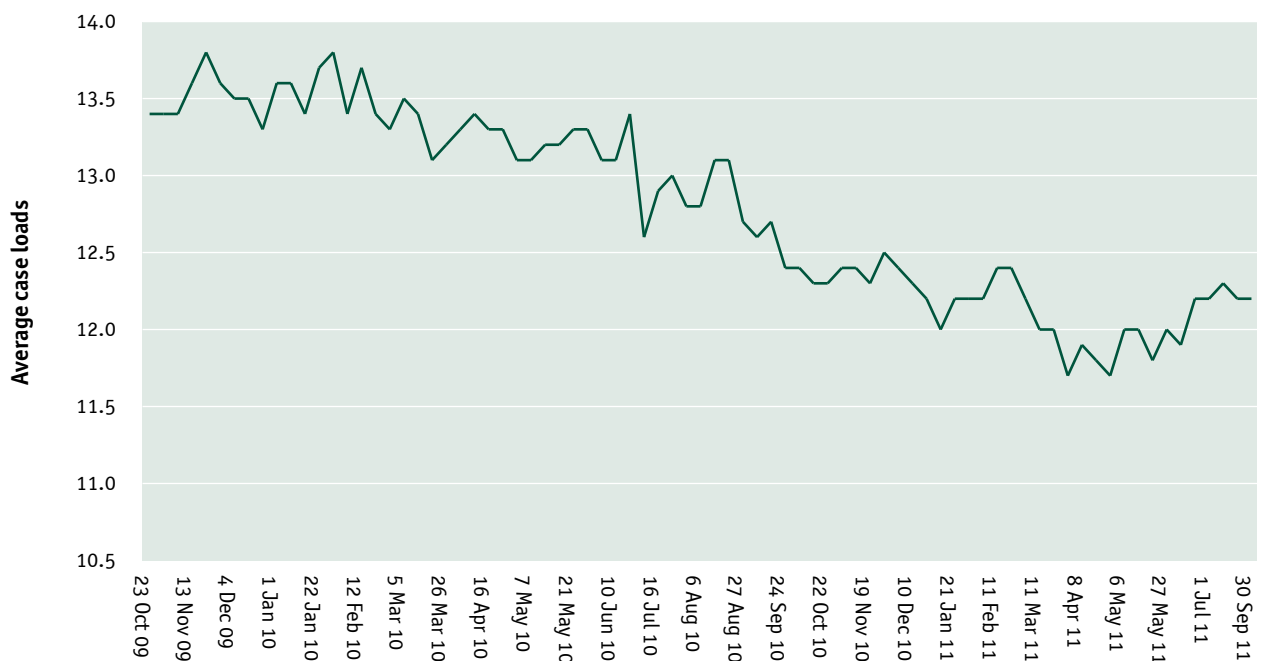
Average caseloads are influenced by a number of factors, including recruitment and retention patterns and the experience profile of the regional workforce. They are also influenced by the mix of cases and the phase of those cases.

DHS was not able to provide the Inquiry with a distribution of caseloads for individual staff; however, they advised that these caseloads are influenced by workers’ level of experience, where less experienced workers are allocated fewer cases, and also by the resource intensiveness of cases.

The Inquiry also heard evidence of further regional differences in workloads as a result of providing after-hours services. A major issue raised during workforce consultations was the pressure to perform after-hours work in some non-metropolitan regions. The Inquiry heard that staff in some regions may be required for after-hours work, including on-call work, which may involve travelling lengthy distances. At times when staff are required to attend court the following morning they may have had little or no sleep. The after-hours on-call system was described during consultations as particularly burdensome and potentially dangerous for staff in rural areas where there was no dedicated after-hours service. This issue was not as prevalent in the metropolitan regions, which are covered by a dedicated after-hours service.

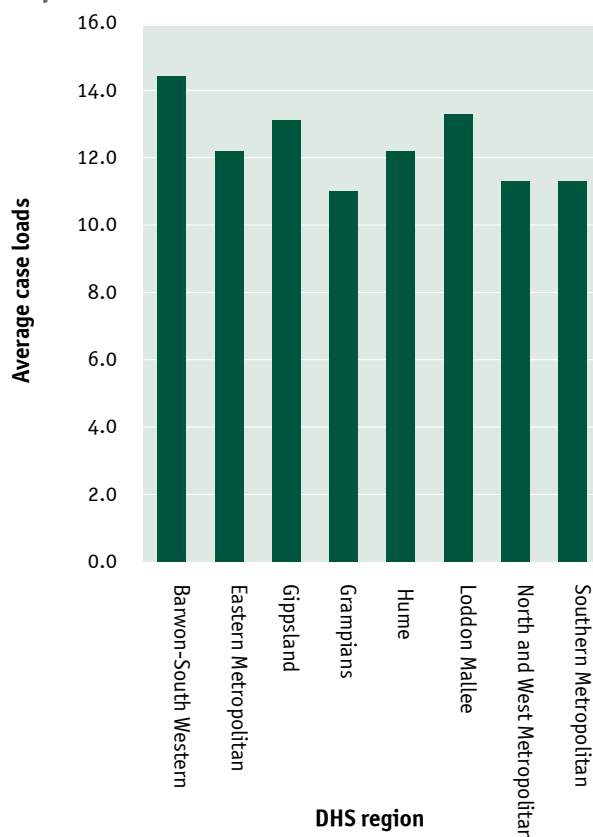
Chapter 9 discusses the capacity of the system in more detail, with reference to the workforce and other measures of capacity.

Figure 16.5 Average caseloads of child protection workers, Victoria, October 2009 to September 2011



Source: Information provided by DHS

Figure 16.6 Average caseloads of child protection workers, by region, year to September 2011



Source: Information provided by DHS

Difficulties with court processes

Workers, particularly frontline workers from DHS, consistently nominated issues around court processes as being one of the greatest difficulties they experience at work. At consultations with frontline workers, they frequently expressed a belief that CPWs' assessments are undervalued by some magistrates and lawyers and there is a lack of respect for the profession of CPWs. On the evidence presented to the Inquiry, this view was more likely to be held in metropolitan areas than rural ones.

The amount of time frontline DHS workers spend preparing for and attending court, including frequently for cases that are adjourned, was also raised during consultations. There is a perception from workers that these processes required them to take more time than is necessary away from assisting children and families. Similarly, feedback from CSO workers revealed frustration that Children's Court Clinic assessments were being given precedence in court over a foster care worker's assessment. These workers felt they had greater familiarity with the child or family and this should be fully considered by the court.

Some of these frustrations seemed to demonstrate a misunderstanding of the role of the CPWs in the court setting. This may reflect insufficient training for the workforce in court processes. The Community and Public Sector Union (CPSU), in its submission to the Inquiry, reported a number of complaints from CPWs about the lack of time they spend in training, and the impact this has on covering important topics such as court or the *Children Youth and Families Act 2005* (CPSU submission, p. 18).

The Inquiry recognises that interactions with the courts are a significant issue for the child protection workforce and issues relating to court processes have therefore been given substantial consideration. The Inquiry has made several recommendations in this area, outlined in Chapter 15. The Inquiry also considers that more accredited professional education for CPWs to assist them with preparing for and attending court would increase the workforce's understanding of court processes and reduce the frustrations that the workforce experiences in this area.

Administrative burden

The amount of administrative work required by frontline workers from both DHS and the CSOs was also an issue raised frequently during workforce consultations. Several examples were provided, with one worker noting that kinship care referrals require the same data to be entered into three separate databases, while another worker reported that there were seven databases relating to foster care. An excessive amount of time spent on administrative tasks is seen as taking workers' time away from clients.

Frustration with DHS systems and processes was also raised in submissions. In relation to one key DHS system (the Client Relationship Information System or CRIS), the CPSU noted that workers have struggled to use the technology and that DHS had not factored sufficient training or sufficient time into the implementation of the system (CPSU submission, p. 18).

Career path and professional education and development

Concerns about career paths, as well as a lack of professional education and development opportunities for workers in child protection and family services, were a major issue raised in consultations with frontline workers. Participants felt that pay in the sector was low and that career progression usually involves 'moving away from direct client work'. This was particularly the case for CSO workers, who felt their pay was generally lower than DHS workers.

While mentoring is available for inexperienced workers, there was a perception that more could be done in this area, in particular to help workers ‘debrief’ about the personal impact of their work. There was a mixed perception of the Bachelor of Social Work, with some participants feeling that the qualification does not sufficiently prepare graduates for the specialised field of child protection. Some suggestions for improved training opportunities raised during the consultations included:

- More specific training for court attendances;
- Greater use of mentoring programs for inexperienced workers; and
- More training in risk management.

Consistent with the feedback from the workforce consultations, some CSOs submitted that a perceived lack of career path was a major issue affecting workforce retention. For example:

Presently there is not a career path for the workforce in family services and out-of-home care. The model of skilled practitioners that exist [5] in education doesn’t in our sector. There are no higher levels according to qualifications and expertise that allows for staff to remain in the program (Upper Murray Family Care submission, p. 4).

Workers in the SACS [Social and Community Services] industry experience limited career paths and this is often cited as a reason for leaving the industry (Australian Services Union submission, p. 17).

The St Luke’s Anglicare submission argued that workforce development was a key issue facing the non-government sector and this required serious resourcing and planning:

We need a practitioner stream that staff can advance through, incentives and encouragement for staff to remain as practitioners and ensure staff are well remunerated for this professional decision (p. 26).

Further issues

In addition to the issues mentioned above, the public perception of CPWs in the statutory system was an issue frequently raised in consultation with DHS workers. Workers felt there was an ‘unrealistic community perception of workers’ and that media attention was solely focused on ‘when things have gone horribly wrong’.

In addition to feeling under-valued by the courts, frontline CPWs frequently spoke of issues with the way the public value their work, and the sometimes adversarial nature of dealing with vulnerable children and families. This view was reiterated in submissions, for example, Odyssey House Victoria’s submission reported that focus groups had found parents reporting mutual distrust with child protection and difficulties working with the service (p. 4).

Frontline CSO workers from both the regional and metropolitan consultations identified the collaboration they have with other agencies as one of the best parts of ‘the job’. However, CSO workers expressed concern that DHS is sometimes slow to take action when they have identified a risk to one of their clients and that the level of inexperience of many DHS workers and high levels of turnover was seen as creating additional challenges for the relationship between DHS and CSOs.

16.6 Key issues, observations and recommendations

Based on the evidence presented above, the Inquiry has identified the following three categories of issues affecting the workforce:

- Skills and development;
- Recruitment and retention; and
- Pay structure and career pathways.

These issues and the Inquiry’s observations and recommendations are discussed below.

16.6.1 Skills and development

Identifying and recognising the skills and development needs of the child protection and family services workforce is required to ensure the delivery of quality services and also to improving the overall professionalisation of the sector.

The Inquiry shares the view presented in a number of submissions that there is a need to improve the professionalisation of the child protection workforce and that this process should be qualification-led (Frederico et al. p. 1; Ms Johns, p. 1; Take Two Partnership, p. 4). Increased professionalisation will have a number of benefits, including enhanced standing before the court as an expert witness.

While there are a number of education and professional development programs available to the government and community sector workforce, currently these programs are not coordinated with the overall needs of the sector and are not always mindful of the intersection between their roles. There is presently no overarching workforce education and development strategy for the child protection and family services sector. This point was highlighted in the joint submission from Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission):

There has never been a comprehensive overview study of the role and responsibilities of the child protection workforce and/or the community sector workforce, no assessment or consideration of their intersecting roles and the consequences of this for requisite skills, further skill development, training or career structure, salary levels, and employment conditions.

Given the increasing collaborative nature of the work undertaken by both sectors, we believe the time has come for a comprehensive workforce strategy (p. 83).

The Inquiry supports the recommendation put by The Salvation Army, which identifies the need to establish a training body to 'ensure that training is relevant across the human services sector' and to coordinate the training provided by a range of registered training organisations (RTOs), Technical and Further Education (TAFE) institutes, universities and industry providers (The Salvation Army submission, p. 27). In addition, the Inquiry has identified several areas where there is a need for additional workforce training and development. These are outlined below.

Supporting increased training for carers

In Chapter 10, the Inquiry recommended that the government establish a comprehensive plan for Victoria's out-of-home care system. Chapter 10 also identified the need for significant investment in the funding and support arrangements for out-of-home care, including mandating training and skill requirements for residential care workers as part of an overall move towards increasing the overall professionalisation of the out-of-home care system.

Addressing the need for increased education and training for carers, as described in Chapter 10, should be a priority of the recommended training body described above. This should include opportunities for foster, kinship and residential carers to participate in further training.

Training for professions that interact with vulnerable children

This chapter identifies a much broader workforce that contributes to the safety and wellbeing of vulnerable children. This workforce includes a diverse range of professionals from the health, education, legal and other sectors, who, in the course of their work, are likely to come into contact with vulnerable children and families.

The Inquiry recognises the important role that this broader workforce plays in protecting vulnerable children. In Chapter 14 the Inquiry recommended that the Government expand mandatory reporting requirements to include a broader range of professions named in the CYF Act that are not yet mandated. Not all of these professions are adequately skilled to fulfil this expanded role, for example, psychologists are not likely to have undertaken any specific units of study in the prevention, identification and professional response to child abuse and neglect (Crettenden et al. 2010, p. 1).

There is a need to identify the education and training requirements of the broader range of professionals who interact with vulnerable children and determine their ability and any training and development requirements for identifying and responding to child abuse and neglect. This training should also be made available to other professionals who come into contact with vulnerable children and families.

Recommendation 67

The Government should establish a child and family welfare sector training body to oversee development of an industry-wide workforce education and development strategy. This strategy should focus on consolidating the number of separate training budgets and strategies relating to child protection and family services.

This body should focus on:

- Developing the professionalism of the sector;
- Providing opportunities for continuing professional education including training and career path opportunities for workers entering at the Child Protection Worker-1 level;
- Addressing the education and training needs of the out-of-home care sector including carers;
- Overseeing and evaluating current training and development efforts, with an initial emphasis on assessing the adequacy of the Beginning Practice training offered to new child protection workers;
- Ensuring relevant training is consistent with national training frameworks and appropriately accredited;

- Identifying opportunities for providing combined training to government child protection workers, the community sector workforce and other professions;
- Coordinating the delivery of internal Department of Human Services courses;
- Procurement of other courses from external providers; and
- Collaborating with professional bodies and universities in disciplines that interact with vulnerable children to develop curriculum content relevant to the prevention of and response to child abuse and neglect.

The training body should be established as a public entity, with dedicated funding and staffing resources and governed by a board drawn from the government and non-government sector. It should be led by an independent chair with expertise related to the professional education and training needs of the sector.

Increasing the cultural competence of the child protection workforce

The Inquiry considered issues specific to Aboriginal children and children from culturally and linguistically diverse backgrounds in Chapters 12 and 13 respectively. Chapter 13 of this Report highlights the importance of culturally competent service provision and the need to improve cultural competence of child protection workers through better training and education. Chapter 12 observed that fewer than half of CSOs were rated as having met the registration standards for respecting Aboriginal children and youth's cultural identity.

Chapter 13 highlighted the diverse nature of Victorian families and the large number of culturally and linguistically diverse groups, while Chapter 12 identified some of the cultural issues that are unique to working with Aboriginal families. While there is a need for all child protection and family services workers to have a level of cultural competence, it is not practical or efficient to provide the entire workforce with training that covers the breadth of cultural issues they may face. Opportunities for cultural competence training and access to cultural competence resources should therefore be made available to child protection and family services workers as they are required.

Recommendation 68

The Department of Human Services should improve the cultural competence of integrated family services and statutory child protection services, including through:

- Applying leadership accountability for culturally competent services and client satisfaction at regional service delivery level through performance agreements;
- Requiring cultural competence to be a component of all training;
- Providing culturally appropriate training, assistance and support to carers of children and young people from culturally and linguistically diverse backgrounds in the out-of-home care system;
- Encouraging local child and family services to draw links with relevant culturally and linguistically diverse communities as part of area-based planning reforms;
- Recruitment strategies to attract suitable candidates from Aboriginal and culturally and linguistically diverse backgrounds into child protection including through the use of scholarship schemes to undertake relevant tertiary-level training; and
- Exploring staff exchange and other joint learning programs on an area basis to build knowledge and respect for Aboriginal culture.

16.6.2 Recruitment and retention

Throughout the Inquiry, workforce recruitment and retention has emerged as a key issue in both the government and CSO sectors. Both of these sectors have highlighted difficulties in attracting skilled staff and retaining those staff. These can have a major impact on the delivery of child protection and family services.

Research has identified the relationship between child protection and family services workers and the families with whom they work as a key factor in protecting children and arguably the most important (Alexander 2010, p. 15).

This point has been further recognised by DHS:

No single strategy is of itself effective in protecting children. However, the most important factor contributing to success was the quality of the relationship between the child's family and the responsible professional (DHS 2011f, p. 8).

Currently, in Victoria, 43 per cent of children subject to child protection orders for less than two years experienced three to five case workers, while 39 per cent who were subject to orders for greater than two years experienced six or more case workers (DHS 2011f, p. 8).

Clearly, high turnover has an impact on the quality of care that is provided. DHS has identified that frequent changes in case worker are likely to result in suboptimal system performance, namely:

- Compromised relationships between vulnerable children and young people, their families, carers and the allocated case worker;
- Loss of detailed knowledge of the child's circumstances and family history; and
- Less than optimal case outcomes and greater likelihood of adverse incidents (DHS 2011f, p. 8).

Retention

As identified earlier, the retention of CPWs in the government sector is unacceptably low, with one in four entry-level case-carrying workers leaving every year over the past five years.

Poor workforce retention has a significant impact on Victoria's system for protecting children. It affects practitioners and team leaders, who remain responsible for the workload of a colleague who has left until a replacement can be recruited and trained. It also affects the efficiency of the system. DHS estimates that recruitment costs \$3,200 per FTE (estimate provided to the Inquiry), but this does not include significant costs associated with additional training or loss of efficiency. The low level of retention in the child protection workforce has previously been estimated

to reduce workforce productivity across the whole workforce by as much as at 15 per cent and increase the cost of program delivery by around \$5 million per annum (Boston Consulting Group 2006, p. 49).

There is less verifiable data available about retention rates in the CSO sector. This could be partly due to the fragmentation of the sector and also the difficulty separating retention rates in child and family services activities from other activities that CSOs may provide.

On the evidence that is available, there are similar difficulties with the recruitment and retention of staff in the CSO sector. One estimate of turnover, taken from the Australian Council of Social Services (ACOSS), in its *Annual Community Sector Survey 2011*, estimates that the average organisational turnover for child welfare services in Australia was 19 per cent but does not provide a figure for Victoria (ACOSS 2011, p. 44).

The Inquiry considered issues in relation to the child protection and family services workforce in an evolving policy context. Since the Inquiry was announced on 31 January 2011, the Minister for Community Services has released two key policy documents relating to workforce reform, *The Case for Change and Protecting Children, Changing Lives*. They are summarised below.

Retaining a quality workforce is difficult in any sector, particularly at a time of low unemployment. However, turnover rates in the child protection workforce of 25 per cent per annum are unacceptably high, and attempts to improve retention should be considered.

The Case for Change

The Case for Change was released in June 2011.

Recognising the important role that the child protection workforce plays in protecting vulnerable children and families, *The Case for Change* draws on exit studies, workforce surveys and an independent evaluation of an alternative operating model in the Eastern Metropolitan Region to build the evidence base for reform of the child protection workforce.

Some key findings presented in *The Case for Change* include:

- There are many strengths of the child protection workforce, including an extremely high level of commitment to the work by current staff, rising levels of postgraduate qualifications and a commitment to continuous improvement through professional development; and
- That staff turnover in the child protection workforce is unacceptably high, with one in four entry-level workers leaving every year. High levels of staff turnover can compromise the client and practitioners relationship, including the loss of information of the child's circumstances and family history, increasing the risk of adverse events to the child

The Case for Change identified four critical areas for action:

1. Valuing the work and developing the professional;
2. More support for, and supervision of, frontline workers;
3. Reducing the statutory and administrative burden; and
4. Supporting staff to balance the demands of the job (DHS 2011f).

Protecting Children, Changing Lives

Following on from *The Case for Change* the Minister for Community Services released *Protecting Children, Changing Lives* in July 2011, which outlines reforms to the statutory child protection workforce model. These reforms aim to address the four critical areas for action identified in *The Case for Change*, and include changes to the existing child protection operating model, depicted in Figure 16.7.

Under the new model, practice guidance and support are intended to be provided by senior child protection practitioners, practice leaders and principal practitioners. All practice positions will also have a case-carrying component. DHS envisages that the new structure will provide less experienced practitioners with more support and better access to expert advice for complex case decisions. In particular, the principal practitioner role, of which there is to be one per region, is intended to provide child protection practitioners with more practice leadership and expert help on complex cases.

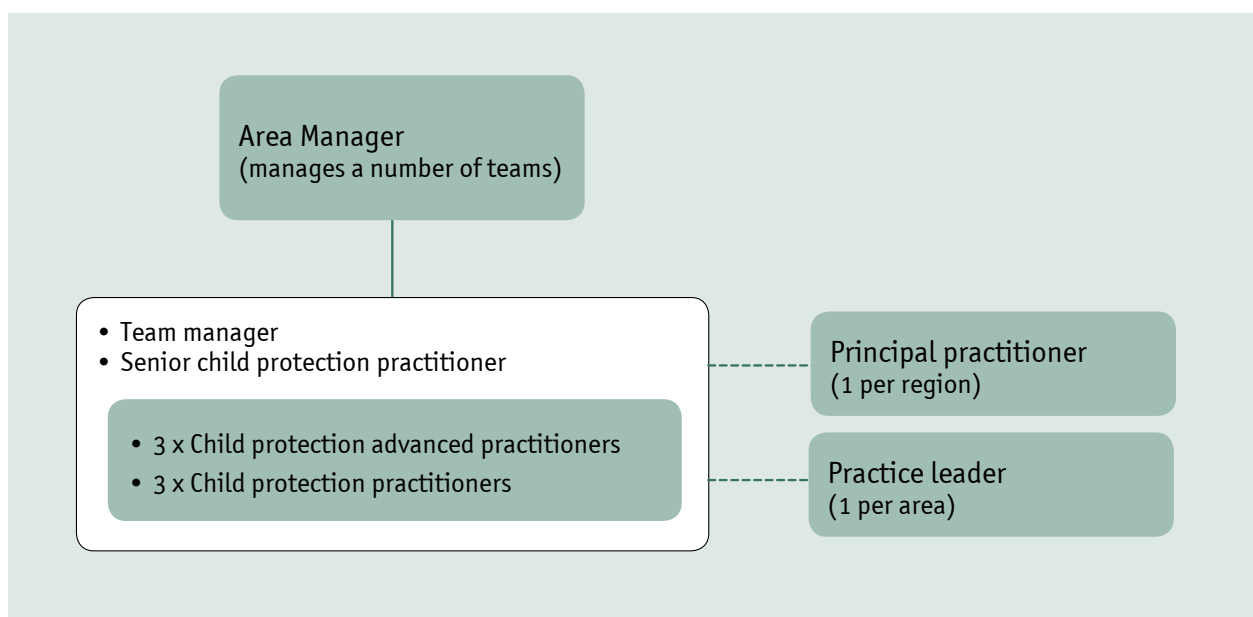
The role of senior child protection practitioner in the new structure is intended to provide better support for and more supervision of new or inexperienced child protection practitioners. Overall, the changes in workforce structure are expected to increase the involvement of senior practitioners with case work.

The new structure will result in the redeployment of a number of existing specialist roles to the roles described above. This includes existing high-risk infant specialists, adolescent specialist workers and family decision-making specialists. DHS has indicated to the Inquiry that the existing Aboriginal family decision-making specialists, community-based child protection workers and case contracting teams will be retained.

As part of *Protecting Children, Changing Lives*, DHS also proposes replacing the existing CPW structure with new classifications, known as child protection practitioners (CPPs), to more clearly define the career structure for the child protection workforce. The new CPP structure would be aligned to the Victorian public service (VPS) classifications; however, this is currently subject to the outcome of an enterprise bargaining process.

According to *Protecting Children, Changing Lives*, the changes are intended to address the reasons why staff leave child protection, including stress, lack of supervision, lack of access to professional development, and too much time spent on administrative work at the expense of working with children, young people and families.

Figure 16.7 Proposed Department of Human Services child protection operating model



Source: DHS 2011m, p. 14

Inquiry observations

The Inquiry's consultations with the DHS child protection workforce found it to be highly committed and motivated by the outcomes it achieves for clients. This is consistent with other research, for example the 2011 *Organisational Culture Survey* found 'high levels of commitment to the role and the Department', while workers consistently nominated the work they do as the thing they like most about working for DHS (Right Management 2011, pp. 17, 28).

Notwithstanding this level of commitment, the Inquiry's consultations with frontline DHS workers raised a consistent set of issues to those identified by DHS in *The Case for Change*, namely, that workers need:

- More training and development;
- More supervision and support;
- A healthier workplace culture;
- Assistance with paperwork and administration;
- Opportunities to debrief;
- Help to stabilise the demands of the job;
- More professional support;
- Less time in court; and
- More realistic perceptions of the child protection worker's role.

The workforce reforms announced by the Minister for Community Services in July 2011 will aim to address the issues impacting on retention in the government sector by:

- Creating a CPP job classification to replace the broader CPW classification, involving aligning the CPW-1 to CPW-4 levels with the VPS-2 to VPS-5 levels;
- Establishing of a 'principal practitioner' in each region;
- Funding to support 47 new practitioners and an increase in overall case carrying capacity of the workforce through changes to roles and reduced staff turnover;
- Improved pay and conditions, subject to agreement through the VPS Enterprise Agreement process; and
- A proposed new operating model for child protection, to give more support, greater flexibility, better pathways and more time with children and families.

The Inquiry acknowledges the government's work in developing *Protecting Children, Changing Lives*. These reforms are aimed at addressing a number of the workforce issues identified during the course of the Inquiry.

However, the proposed structure involves the integration of a number of previously specialist roles, for example, high-risk infant specialists, into more generic senior practice roles. As noted in Chapter 2, infants are a particularly vulnerable group who are over-represented in child protection reports. The Inquiry considers there is a need to monitor this integration closely to ensure that specialist skills are not diminished over time.

As discussed earlier, child protection and family services deal with a wide range of difficult and complex issues that may arise at any time and in an entirely unpredictable manner. As a consequence the organisational structure and workplace arrangements need to allow for significant flexibility in responding to these issues. In recent times a number of professional workforces have increasingly realigned their practices and arrangements to enable greater flexibility and effectiveness in responding to the needs of their client groups. In keeping with these trends, the Inquiry therefore considers that, in the longer term, there is a need for DHS to continue to explore and implement a range of flexible workplace practices that better responds to the needs of vulnerable children. In Chapter 10 the Inquiry has noted the limitations posed by current industrial structures in the development of salaried foster care.

Additionally, the scope of *Protecting Children, Changing Lives* only deals with issues affecting the DHS workforce and not the broader child protection and family services sector. As such, it does not propose changes based on the skills or requirements of the sector as a whole.

Matter for attention 14

The Inquiry brings to the Government's attention the need to monitor the integration of previously specialist roles into more generic senior practice roles to ensure that specialist skills are not diminished over time.

16.6.3 Pay structure and career pathways

The pay structure and career pathways available to child protection and family services workers were frequently raised in submissions and during consultations as a major issue affecting the government and community sector workforces.

The *Protecting Children, Changing Lives* reforms announced by DHS have the capacity to alleviate some of these issues in relation to the government workforce, although there are other issues that affect the community sector workforce.

While consultations and submissions revealed many issues common to the government and non-government workforce, the issue of remuneration was more frequently raised in relation to the community sector, as noted by one submission:

The existing financial incentives are inadequate and symbolically send a message that current or prospective worker skills or contribution aren't respected or valued (Youth Support and Advocacy Service submission, p. 21).

The Australian Services Union (ASU) submitted to the Inquiry evidence that wages paid in the non-government sector are below the equivalent levels in the government sector. This was using a comparison of wages paid in the non-government sector, based on the Social and Community Services Award 2000, and the public sector comparator. The ASU submitted that wage rates for social workers in the community sector are 23 per cent lower for graduate-level staff and 30 per cent lower for more experienced staff than for the comparable CPW level in the government sector (ASU submission, p. 21).

In some cases differences in the level of salary for community sector workers may be somewhat offset by beneficial salary packaging arrangements that are available to community sector workers. An estimated one-third of community sector workers utilise these arrangements, compared with 13 per cent of the overall workforce (Equal Remuneration Case 2011).

There is evidence that inadequate pay levels are a significant contributor to high turnover in the non-government workforce. For example, salary was identified in the ACOSS *Australian Community Sector Survey 2011* as the leading factor making attracting and retaining staff more difficult (68 per cent of respondents) (ACOSS 2011, p. 45). Other leading factors included job security (44 per cent) and career path (42 per cent).

Since the Inquiry was announced there have been significant developments in relation to community sector remuneration for social and community service workers through the Fair Work Australia pay equity case. The case is currently before Fair Work Australia.

Fair Work Australia Equal Remuneration Case

The case before Fair Work Australia was brought by unions seeking to correct what was argued to be a gender-based disparity between the pay of social and community service workers and employees in state and local government.

On 16 May 2011 a full bench of Fair Work Australia issued a decision that outlined its preliminary conclusions about the making of an equal remuneration order for the Social, Community, Home Care and Disability Services Industry Award 2010.

Fair Work Australia has preliminarily agreed that such gender-based disparities do exist in the social and community service industry and has sought further submissions from parties on the extent of changes to wage classifications needed to correct the gender bias (Equal Remuneration Case 2011).

The Equal Remuneration Case before Fair Work Australia may result in significant wage increases for non-government workers in the child protection and family services sector, potentially addressing some of the remuneration issues identified with respect to the non-government workforce. This increase, however, has the potential to have an impact on the delivery of services provided by the non-government child protection and family services workforce. Fair Work Australia did not take into account the benefits that some employees in the community sector may derive from salary packaging, as two-thirds of workers in the sector derive no benefit from this (Equal Remuneration Case 2011).

Child protection and family services delivered by the non-government sector are largely funded by the Victorian Government, as such, an increase in wages would increase the cost of delivering services provided by CSOs. In submissions to Fair Work Australia, the Commonwealth noted that 'any increase in wages for the industry could impose significant cost pressures that could have adverse impacts on service delivery' (Equal Remuneration Case 2011). A survey of CSO workers, undertaken by DHS in 2006, indicated that 55 per cent of CSO workers are covered by the Social and Community Service Award (DHS 2006b, p. 5).

In mid-November 2011 the Commonwealth Government announced that it would, with the ASU, make a submission to Fair Work Australia that argues for rates of pay that fairly and properly value social and community sector work. This was expected to affect 150,000 social and community sector workers at a cost to the Commonwealth Government of \$2 billion.

Finding 17

The Inquiry notes the potential implications for all governments of the outcome of the Equal Remuneration Case currently being finalised by Fair Work Australia.

Nonetheless, the issues being addressed by Fair Work Australia are largely separate from those that are the focus of the Inquiry's report and recommendations, namely, reforming, enhancing and expanding Victoria's policy and service response to the needs of vulnerable children and families.

16.7 Conclusion

Victoria's child protection and family services workforce operates in a demanding and stressful environment, dictated by the circumstances of the families with whom they work. The Inquiry's consultations with workers revealed a workforce that is highly dedicated but affected by a range of issues that detract from their employment and in turn affect the performance of Victoria's system for protecting children.

Ongoing developments in the sector, such as the proposed reforms to the child protection operating system and the Equal Remuneration Case currently before Fair Work Australia, may address some of these issues. However, the Inquiry has identified a general need to improve the professionalisation of the sector by increasing the level of professional education and training that is available.



Part 6: System supporting capacities

Chapter 17:

Community sector capacity

Chapter 17: Community sector capacity

Key points

- Community service organisations have long played and continue to play a critical role in responding to and providing services to vulnerable families and children.
- Reflecting the changes over time in Victoria's approach to vulnerable children and families, the Government provides funding and is dependent on community service organisations to deliver critical services and interventions. In particular, community service organisations play the major role in providing out-of-home care and family services.
- Over time, government funding to community service organisations has increased significantly and represents the dominant source of funding for many community service organisations. The current pattern of Department of Human Services funding indicates a small number of community service organisations receive a significant proportion of the funding for family services and placement and support services, while a large number of community service organisations receive relatively small amounts of funding.
- The Inquiry considers that the structure and capacity of community service organisations needs to be strengthened if Victoria's approach to vulnerable children and families is to be improved and the broad strategic directions outlined in this Report are to be effectively implemented.
- The Inquiry also considers that the Government should adopt an updated and clearer framework for its relationship with the community sector in line with its policy leadership and accountability role.

17.1 Introduction

Community service organisations (CSOs) in Victoria have a long history in providing assistance and support to families and children in need. Indeed, the involvement of CSOs protecting and supporting vulnerable children and young people pre-dates that of government. Although major changes have occurred since the 1970s in Victoria's approach to protecting vulnerable children, as outlined in Chapter 3, CSOs continue to have a pivotal role in protecting and supporting Victoria's vulnerable children and families.

In Victoria, more than 200 organisations, the majority of which are CSOs, are currently funded by the Department of Human Services (DHS) to provide a range of child, youth and families services including:

- Family and community services such as community-based child and family services (family services), placement prevention and reunification and family violence services; and
- Specialist support and placement services such as home based care, residential care and leaving care support services.

These organisations include some 22 Aboriginal community controlled organisations who are funded to provide family and community and specialist support and placement services to Aboriginal families, children and young people.

As outlined in Chapters 4 and 8, there has been a significant expansion in the funding provided to CSOs in recent years, arising from the establishment of Child FIRST and family services, the continued increase in the number of children and young people in out-of-home care and a range of early intervention, specialist support and leaving care initiatives.

This chapter considers, in turn, the broader context and roles of CSOs including: recent trends in the relationships with and perspectives of governments; key dimensions of the broad funding arrangements and the government funding of CSOs providing relevant child protection and family services in Victoria; the capacity and performance of CSOs including issues raised in submissions to the Inquiry and at Public Sitings; and the major conclusions and recommendations of the Inquiry on the roles and capacity of CSOs and the nature of the relationship between CSOs and government.

A number of aspects of the Inquiry's Terms of Reference are relevant to the consideration of the capacity of CSOs. In particular, the Terms of Reference require the Inquiry to consider ways to strengthen the capabilities of organisations involved in services and interventions targeted at children and families at risk. The Inquiry is also tasked with considering the more general issue of the appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's child protection policy and systems.

17.2 An overview of community service organisations in Victoria

CSOs form part of the broader not-for-profit (NFP) sector in Victoria and Australia. As outlined in the Productivity Commission's 2010 *Contribution of the Not-for-Profit Sector* report, the NFP sector is made up of a diverse range of entities established for a wide range of purposes.

NFPs deliver services to their members, to their clients or to the community more broadly, such as welfare, education, sports, arts, worship, culture and emergency services. Some NFPs build or maintain community endowments such as biodiversity, cultural heritage and artistic creations. Some engage in education, advocacy and political activities, while for others the focus is on activities that create fellowship (Productivity Commission 2010, p. xxv).

Compared with the NFP sector generally, CSOs in the human services sector are distinct in that they rely heavily on governments as their main source of funding. In turn, governments in Australia rely heavily on CSOs to deliver many human services in the aged care, disability, and child, youth and family support areas. For its 2010 report, the Productivity Commission conducted a survey of Commonwealth, state and territory government agencies with significant engagement with the NFP sector in the delivery of human services. The main findings were:

The survey response confirmed the perception that high shares of many human services funded by government agencies are delivered by external agencies:

- For all but two categories of human services (health and emergency), about half of the government agencies reported that at least 50 per cent of their services (by value) were delivered by external organisations;
- NFP organisations are major providers in most human services areas. Of the services delivered by external organisations, almost half the government agencies reported that over 75 per cent of their program value is delivered by NFPs. Indeed, for 66 per cent of programs NFPs were the only non-government providers; and

- The most commonly cited reasons for this heavy reliance on NFPs were that they: provide flexibility in service delivery; are better able to package their services with other services for the target group; give value for money; and are representative of the clients the program is targeting (Productivity Commission 2010, Appendix D, p. D.1).

In Victoria, CSOs – more so than in many other states – are often the only providers of children's and family services in a number of key areas such as placement and support services and family support services. As outlined in Chapter 3, the current role of the community sector as provider of, largely government funded, child protection and family services stands in sharp contrast to their initial beginnings.

Berry Street, one of three largest providers of placement support and family services, indicate:

Established in 1877 as the Victorian Infant Asylum, Berry Street's core activity has always been protecting children in need, and strengthening families, so they can provide better care for their children ...

... In the early days, our greatest challenges were high infant mortality and poverty. Our primary roles were supporting unwed or rejected mothers and their babies and finding new homes for babies and children who were abandoned (Berry Street 2010 p. 1).

Another significant service provider, MacKillop Family Services, indicates similar beginnings but also highlights the major changes it has seen over time in service orientation and overall governance:

Over 150 years ago the Sisters of Mercy, the Christian Brothers and the Sisters of St Joseph commenced their work in Victoria and established homes for children who were orphaned, destitute or neglected and for mothers who were in need of care and support. Throughout the years, the original model of institutional care evolved into different support services. In 1997, MacKillop was formed as a re-forming of the earlier works providing a range of integrated services to children, young people and their families (MacKillop Family Services 2011).

Anglicare Victoria, formed in 1977, represents another major service provider established following the consolidation of several long standing child and family welfare agencies. The agency was formed by joining together three agencies – the Mission to St James and St John, St John's Homes for Boys and Girls and the Mission to the Streets and Lanes – that had a combined history of over 260 years in providing care and support to Victorian families and children.

These histories underscore the essential core feature of CSOs, namely their long established missions to focus on and assist disadvantaged groups. Berry Street describes their mission and values in the following terms:

Today, our greatest challenges are: to help children and young people recover from the devastating impact of abuse, neglect and violence; to help women keep themselves and their children safe from violence; and to help struggling mothers and fathers to be the parents they want to be; and to contribute to, and advocate for, a fairer and more inclusive community.

Berry Street's five core values are Courage, Integrity, Respect, Accountability and Working Together. These values guide everything we do and require us:

- To never give up, maintain hope and advocate for a 'fair go': Courage
- To be true to our word; Integrity
- To acknowledge each person's culture, traditions, identity, rights, needs and aspirations: Respect
- To constantly look at how we can improve, using knowledge and experience of what works, and ensure that all our resources and assets are used in the best possible way: Accountability
- To work with our clients, each other and our colleagues to share knowledge, ideas, resources and skills: Working Together (Berry Street 2010 pp. 1, 2).

While the historical circumstances, scope and focus of CSOs and their size all vary, the overall mission of assisting the disadvantaged – regardless of the associated circumstances – and their non-profit nature are a common thread. In doing so, many CSOs access a range of funding and in-kind resources including volunteer workers.

Arising from the significant changes in the approach to child protection and support in the 1980s, particularly the move away from large state-run institutions and the growing involvement of governments in a broader range of social issues, Victorian governments have increasingly relied on and funded CSOs to deliver child, family and youth services. The growth in government funding of CSOs has reflected three factors:

- The outsourcing of services previously provided by government, particularly residential care;
- Increased funding of services already provided by CSOs, such as family support services; and
- The funding of new services in response to emerging trends and needs, such as, the provision of therapeutic care as part of placement and support services.

These trends in funding and service delivery arrangements have, in turn, led to a growing focus on the nature of the relationship between government and CSOs. In particular, explicit performance requirements, funding arrangements and detailed capability and accountability standards have been developed covering CSOs. An outcome of this focus has been the move from government funding of CSOs on a grants basis to the now widely adopted performance-based service agreement or contract basis covering a defined period.

The move to service agreements in the 1990s, and the associated debates regarding purchaser/provider and competitive tendering, has generated periodic concerns by CSOs about the alignment between their mission and values and being the delivery vehicle for government funded and specified services.

From their perspective, governments have recognised that dependence on CSOs as the major deliverers of human services, combined with the inherent nature of many of these organisations, requires a broader and longer term strengthening of both the relationship and the sector overall.

For example, at the departmental level in Victoria, DHS has an explicit commitment to partnership and collaboration with the community services sector. Under the banner of 'How we work with funded organisations', DHS describes the present approach as follows:

The Department of Human Services is committed to working in partnership with our funded organisations to deliver high-quality community and housing services that are in line with the government's vision for making Victoria a stronger, more caring and innovative state.

This is achieved by working cooperatively with funded organisations to sustain, strengthen and build working relationships that enable them to provide services that accommodate and value diversity, address the particular needs of vulnerable and marginalised people, recognise regional and rural differences and contribute to demonstrable high-quality outcomes in accordance with agreed standards.

To support working cooperatively a number of protocols have been developed that reaffirm the ongoing commitment to shared vision and a strengthened relationship between the department and the sector. These protocols acknowledge that the best service outcomes are the product of collaboration, inclusive planning, efficient public policy and clear service funding agreements:

- Human Services Partnership Implementation Committee (HSPIC); Memorandum of Understanding 2009 to 2012 between the

independent health, housing and community sector and the Department of Human Services;

- Partnership Protocol between the Department of Human Services, Department of Health and the Municipal Association of Victoria 2010; and
- Collaboration and Consultation Protocol (HSPIC 2004).

The HSPIC, a joint committee of peak bodies and DHS established in 2004, is the governance structure that supports the implementation of a memorandum of understanding. An annual work plan is developed to guide the activities of the committee that, to date, have focused on reviewing and improving relevant business processes and providing a point of contact for discussions/negotiations on sector-wide funding issues, and hosting partnering dialogues to look at sector-wide issues and share learning.

The role and activities of the committee was not the subject of significant comment by the CSOs or representative organisations during the Inquiry process other than reference by Berry Street in their public submission to the role of the committee in the recent review of the pricing of family support services (Berry Street submission, p. 40).

In 2008 the Victorian Government, as part *The Victorian Government's Action Plan: Strengthening Community Organisations*, established the Office for the Community Sector to support the Victorian NFP sector to be sustainable into the future (Victorian Government 2008a). The office, which is located in the Department of Planning and Community Development, has two stated responsibilities: driving cross-government activity that reduces unnecessary burden related to government accountability and compliance requirements; and supporting the sector to build their capacity to continue to be responsive to the needs of Victorians. The office has focused on the following range of practical and supportive activities for the broader NFP sector:

- A common funding agreement to be used by all departments when funding NFPs;
- Developing a Victorian Standard Chart of Accounts to make accounting terms and definitions uniform throughout state government and agencies;
- Providing free publications and tools such as a workforce capability framework to help NFPs recruit, manage and develop their workforce;
- Assisting Victorian community foundations to enhance their profile, stimulate local fundraising and increase their grant-making capacity; and
- Funding, resources and training to enable community organisations to establish relationships with philanthropists and improve their fundraising effectiveness.

The focus on reducing and improving regulatory arrangements is also a priority of the Office for the Not-for-Profit Sector established by the Australian Government in October 2010. A key action in this regard has been the announcement of a national regulator for the NFP sector entitled the Australian Charities and Not-for-Profits Commission. The commission will commence operations from 1 July 2012 and will be responsible for determining the legal status of groups seeking charitable, public benevolent institution, and other NFP benefits on behalf of all Commonwealth agencies.

The Office for the Not-for-Profit Sector is also responsible for overseeing the National Compact between the Australian Government and the NFP sector. Launched in March 2010, the National Compact *Working Together* is a high-level agreement setting out how the Australian Government and the sector aim to work together in new and better ways to improve the lives of Australians (NSW Government 2010).

These developments, at the state and national levels, reflect the growing recognition dating back to the mid-1990s that the NFP sector and CSOs perform significant social, economic and community roles. This chapter is confined to the capacity of Victorian CSOs as part of the overall state response to families and vulnerable children. In doing so, it is acknowledged that CSOs often undertake a broader range of activities using various funding sources, resulting in significant community and individual benefits.

17.3 Government funding of community service organisations and community sector capacity: key issues and funding patterns

Against the background of community sector capacity, this section briefly identifies some key issues arising from and impacting on DHS as the sole funder or 'purchaser' of a range of key services for vulnerable children and their families such as Child FIRST, family services and out-of-home care. The section then analyses available information on the levels and patterns of DHS funding of CSOs.

17.3.1 Government funding of community service organisations in Victoria: key issues

The role of DHS as the sole funder or purchaser of services and the dependence by DHS on CSOs to deliver these services – in a complex area such as vulnerable children and their families – can give rise to a range of issues and interdependencies that adversely affect the effective and efficient delivery of services. As the sole or principal funder of the services, DHS has the dominant role in determining what services are provided, where and by which agency, and can significantly influence the structure and culture of the sector.

As noted in the previous section, this dominant funding role of government, coupled with the adoption of service performance-based agreements and contracts and increasing reliance on government funding, has been viewed by the NFP sector as having a number of negative consequences. The Productivity Commission in its 2010 report on the NFP sector summarised these concerns as follows:

- There is a strong perception in the sector that governments are not making the most of the knowledge and expertise of NFPs when formulating policies and designing programs.
- Many participants argued that, as a model of engagement, purchase of service contracting has some inherent weaknesses, including:
 - creating incentives for community organisations to take on the practices and behaviours of government organisations they deal with (or so called 'isomorphism');
 - distracting NFPs from their purpose thereby contributing to 'mission drift';
 - creating a perception in the community that NFPs are simply a delivery arm of government; eroding the independence of NFPs in ways that make it difficult for them to remain responsive and flexible to community needs; and
 - being inherently biased in favour of large organisations and thereby contributing to a loss of diversity in the sector (Productivity Commission 2010, pp. 309-310).

It is clear that governments as the sole purchaser or funder of services provided by CSOs can have an adverse impact on or introduce unnecessary impediments to effective service provision through, for example, overly prescriptive and short-term service agreements and contracts.

However, it is also clear that capacity and structure of CSOs can impact on or provide impediments to the overall quality of service provision being purchased and funded by government, particularly in complex human services areas. These aspects can include:

- Inadequate capacity among CSOs to meet the service needs of government and the specific needs of vulnerable children and their families, due to lack of resources, skills and knowledge and inadequate governance arrangements;
- Absence or scarcity of CSOs in key geographical areas; and
- Limited capacity or willingness of CSOs, due to size and other factors, to explore and adopt innovative or new approaches.

These limitations can be exacerbated by an inappropriate or immature regulatory framework that does not establish the appropriate standards or expectations of CSOs or promote a quality improvement approach to service provision.

Overlaying these considerations from the perspectives of the CSO sector and governments as the purchaser of services are the fundamental issues of achieving the best value in terms of overall client outcomes from the resources made available and meeting the public accountability requirements.

Government as the sole purchaser or funder of services has a broad set of public objectives and accountability requirements to meet. It also has the capacity through service specifications and funding arrangements to lead and encourage CSOs to achieve better outcomes and more effective and efficient service delivery. The complexity of the issues faced by vulnerable children and families, the unique attributes of CSOs and the inherent difficulties of achieving lasting impacts, underscores the need for government to work strategically with these organisations. However, this strategic relationship needs to be long term and based on an explicit understanding of the respective and different responsibilities and roles of government and the community sector.

17.3.2 Community service organisations and government funding patterns

The departments of Health and Human Services provided the Inquiry with information on the annual service agreement funding provided to organisations across a range of health and human services programs and activity areas for 2009-10. These programs cover a broad range of areas such as mental health, drug services, family services, Aboriginal family services, family violence services, enhanced maternal and child health, youth justice, placement and support services and homelessness services.

For these services, funding of around \$243 million was provided to external organisations, the majority of which were CSOs, to deliver Aboriginal family services (\$14 million), family services (\$76 million) and placement and support services (\$153 million). These services, along with the internal statutory child protection services, are key direct services areas.

An analysis of Victorian Government funding provided for these services indicates that 141 organisations in Victoria received funding for either family services (including Aboriginal family services) or placement and support services, with 106 organisations receiving funding for family services and 71 organisations receiving funding for placement and support services. In 2009-10, 36 organisations received funding for both family services and placement and support services.

A number of these organisations were also funded by DHS and the Department of Health to provide other human and health services. In 2009-10, about two-thirds of the organisations that were funded to deliver family services (including Aboriginal family services) or placement and support services also received funding for a range of other human and health services. These included:

- Homeless services (35 per cent of organisations);
- Drug services (33 per cent);
- Mental health (28 per cent);
- Youth justice (21 per cent); and
- Family violence (21 per cent).

Funding for these other services totalled \$134 million in 2009-10, equivalent to just over half of the amount that these organisations received for providing family services and placement and support services.

Of the 10 organisations with the largest funding for family services and placement and support, nine received funding for at least one of the other services listed above. While these organisations received 55 per cent of family services and placement and support funding, they received 28 per cent of the \$134 million funding provided to organisations for the provision of other human and health services.

This broader view of the other government funding received by CSOs who are funded to deliver family services and placement and support services raises a more general question about the consistency of the standard, service and performance requirements for the community sector and NFPs across all government departments. This matter is outside the Inquiry's Terms of Reference but nonetheless is an issue the Inquiry considers would benefit from consideration over time to ensure a consistent and uniform approach to the engagement of CSOs by government – directed at achieving better and more efficient outcomes.

The levels of funding received by organisations to provide family services (including Aboriginal family services) covered a wide range, with 27 organisations receiving family services funding of less than \$100,000 and 23 organisations receiving funding of \$1 million or more, of which three received funding in excess of \$6 million (see Figure 17.1 for detailed information). The 10 organisations receiving the highest funding received nearly 60 per cent of the total funding for family services.

As with family services funding, the funding for placement and support services was also significantly dispersed, with 18 organisations receiving funding of less than \$100,000 and 26 organisations receiving funding in excess of \$1 million of which seven received funding in excess of \$6 million (see Figure 17.2 for detailed information). The 10 organisations that received the highest funding received 65 per cent of the total funding for placement and support services.

Table 17.1 sets out the total funding received for family services and placement and support services at the regional level, the total number of funded providers and the proportion of funding received by the largest four providers.

As expected, a regional analysis indicates there are a considerably smaller number of providers of family services and placement and support services in non-metropolitan regions. For example in the Grampians region there are five funded providers of placement and support services with the four largest providers receiving over 99 per cent of the funding. In the Hume region, there are eight funded providers of placement and support services, with the four largest providers receiving 98 per cent of the funding.

Three major observations emerge from this analysis of the 2009-10 funding patterns of funded organisations:

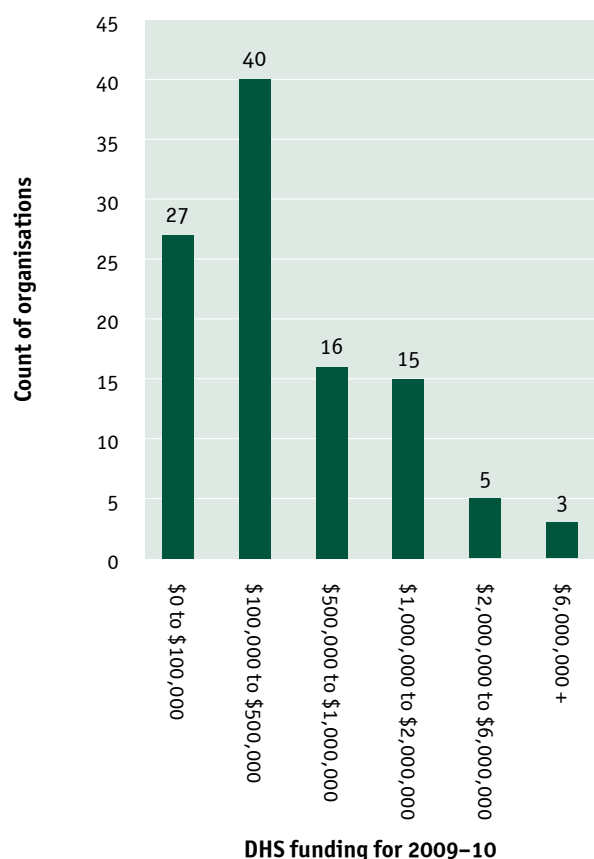
- There are a significant number of organisations, 33 or more than 25 per cent of service providers, that receive less than \$100,000 of the total funding provided for family services and placement and support services;
- At the same time, a smaller number of organisations, 10 in total, receive significant amounts of funding (in excess of \$6 million) for the provision of either or both family services and placement and support services, of which four organisations received funding excess of \$16 million (which in total represented 40 per cent of the overall funding); and
- In non-metropolitan regions in particular, DHS is dependent on a small number of organisations to deliver, what is arguably the most complex of tasks, namely placement and support services aimed at reducing the impact of abuse and neglect.

Funding for the provision of family services and placement and support services involves the use of public funds to assist some of the most vulnerable children and their families in the community. Notwithstanding the history and mission of CSOs, these factors alone mean that assessment and verification of the capacity and performance of funded CSOs should be an essential feature of the policy and service delivery framework. Chapter 21 sets out, in detail, the legislative and other regulatory requirements relating to CSOs. These arrangements include that to be eligible for registration to provide out-of-home care services, community-based child and family services or other prescribed categories of services, a CSO must:

- Be established to provide services to meet the needs of children requiring care, support, protection or accommodation and of families requiring support; and
- Be able to meet the performance standards established under legislation that apply to CSOs.

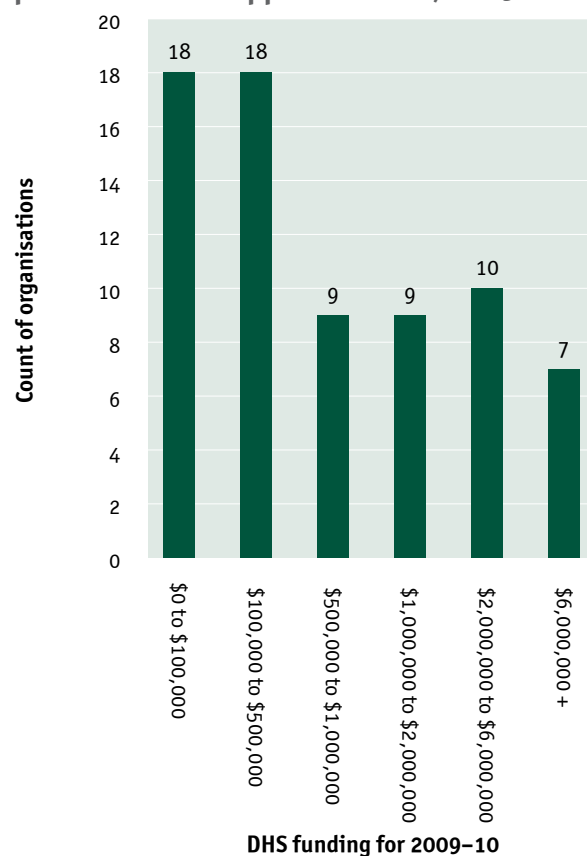
As part of the development of service-based funding arrangements (referred to as service agreements), DHS has instituted a requirement for funded organisations to report their financial position on an annual basis. These requirements are known as the financial accountability requirements and provide a check on the financial capacity of funded organisations. Relevant organisations are currently required to provide a certification by an authorised officer from the organisation, an annual report containing audited financial statements or, in lieu of financial statements, financial or cash indicator statements.

Figure 17.1 DHS funding of CSOs for family services (including Aboriginal family services), 2009–10



Source: Inquiry analysis of information provided by DHS

Figure 17.2 DHS funding of CSOs for placement and support services, 2009–10



Source: Inquiry analysis of information provided by DHS

Table 17.1 Family services (including Aboriginal family services), funding by region and number of funded organisations, Victoria, 2009–10

Region	Total funding for family services and placement and support	Funded organisations	Percent of regional funding to top four funded organisations
Barwon-South Western	\$ 18,385,775	19	80%
Eastern Metropolitan	\$ 30,724,029	25	74%
Gippsland	\$ 20,400,452	17	66%
Grampians	\$ 14,418,776	11	88%
Hume	\$ 15,376,600	13	90%
Loddon Mallee	\$ 23,006,934	24	67%
North and West Metropolitan	\$ 66,048,535	42	56%
Southern Metropolitan	\$ 48,314,737	30	49%
Statewide services funding	\$ 6,542,132	5	NA
Total	\$ 243,217,970	141*	

Source: Information provided by DHS

* The total number of organisations is lower than the total of funded organisations by region as a number of organisations provide services in more than one region

DHS provided the Inquiry with a 2008-09 analysis of all DHS funded organisations. The analysis covered the total range of DHS funding: child protection and family services; housing and community building; concessions; disability services; and youth justice and youth services. The analysis, in line with the above analysis of 2009-10 funding, found that the child, youth and family services area funds a substantial number of small organisations and that the top 10 funded organisations accounted for more than half of the total expenditure. Compared with other areas, child, youth and family services had the most concentrated funding patterns.

In addition, the 2008-09 analysis examined the financial information provided as part of the financial accountability requirements. This analysis found:

- There was no apparent relationship between an organisation's financial viability and its level of dependency on DHS funding;
- The surplus of organisations that had a primary focus on children, youth and families services was an average of one per cent of total revenue, a significant decline on the average surplus in the previous year; and
- Overall the financial ratios, such as current assets to current liabilities, assets to liabilities and debt ratio, indicated a high level of financial stability within the sector.

Two interrelated factors influence the funding patterns identified in this section. These are the approach adopted by DHS to the specification and funding of services and the range and spread of available and interested CSOs with the capacity and the objective of assisting vulnerable children and their families. Given the policy responsibility for assisting vulnerable children and their families and the statutory child protection system, a legitimate issue for consideration by government is whether the separate funding of a large number of organisations represents or will continue to represent the most effective structure of service provision for Victorian vulnerable children and families.

17.4 Community sector capacity: roles, constraints and performance

17.4.1 Roles

The Inquiry considers that the expectations of CSO capacity should be linked to a clear and accepted understanding of their roles and responsibilities.

In submissions, a number of CSOs focused not only on factors that impact on their capabilities and capacity to provide effective and efficient services and interventions but also the capacities that CSOs bring to the issue of vulnerable families and children including broader policy and program development.

Jesuit Social Services summarised the role and capacity of CSOs in the following terms:

Governments have a role to ensure the most vulnerable in the community are protected but as discussed throughout this submission, Jesuit Social Services would argue that a broad approach needs to be adopted to effectively pursue this outcome.

There is an obvious role for Community Service Organisations (CSOs) to assist government achieve the aim of protecting vulnerable people.

CSOs bring a range of community assets which would (generally) not otherwise be offered to government. CSOs motivate and facilitate the contribution of an organisations resources, mostly their people, to concerns of common interest.

CSOs bring a community awareness and engagement (from members, supporters and media) that would not be available to government. Indeed CSOs' interest in child protection pre-dates that of governments.

Jesuit Social Services has a history of opposing the for-profit sector entering into the direct provision of government services to vulnerable people and submits that the introduction of 'for profit sector' into child protection would be deleterious (Jesuit Social Services submission, p. 21).

The joint submission by Anglicare Victoria, Berry Street, MacKillop Family Services. The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission) identified a set of outcomes to be achieved to better protect and care for vulnerable children and young people in Victoria including:

For the community services sector – that it is the primary vehicle by which services are provided as part of a balanced and effective partnership with government to achieve positive outcomes for vulnerable children, young people and their families; and

For the government – that it has overall responsibility through an effective partnership with the community services sector to reduce the incidents of harm and the numbers of children and young people requiring protection and care (p. 7).

Consistent with these perspectives, and particularly with their perception of demonstrated capacities, a number of CSOs proposed that the child protection system be fundamentally changed by focusing the work of statutory child protection on the forensic work of child protection and transferring the responsibility for casework with children, young people and families to CSOs, with appropriate oversight from the child protection service.

Berry Street submitted:

From our perspective, allowing the Department of Human Services to do what it does best, statutory Child Protection work, and the sector to do what it does best, direct service delivery, is in the best interests of the child and young people (Berry Street submission, p. 49).

On the broader issue of the need for a relationship with government that recognises the capacities of CSOs in both policy development and service delivery, a number of submissions proposed formal arrangements to enhance the role of community sector and other key stakeholder organisations. On policy development, Berry Street recommended:

That a formal mechanism or body involving all key stakeholders be established, if necessary under the Children, Youth and Families Act, for collaborative long term policy development on the care and protection of vulnerable children in Victoria (Berry Street submission, p. 49).

On the issue of service delivery, the Joint CSO submission proposed the establishment of Children's Councils to give effect to a multidisciplinary service response:

The operating structures we envisage – which we call Children's Councils – could be aligned to the Child First catchments. While roles and responsibilities would need to be formalised, what we are proposing are joint governance arrangements at a local, regional and statewide level to deliver better outcomes for children, young people and families.

Children's Councils would be led by government and community services sector jointly, and comprise all services that work with children and families including education and early childhood and health (and mental health services). Children's Councils would be responsible for developing a plan for addressing outcome deficits, implementing changes and approaches to address (sic) established in legislation (Joint CSO submission, p. 76).

On an enhanced role of CSOs in case management, Chapter 9 considered the issue of the transfer of case management responsibilities to CSOs and concluded that a robust case did not currently exist for the wholesale transfer of case management responsibility. However, it was also noted the adoption of a differentiated or segmented approach to the handling of child protection investigations and cases may facilitate increased case management by CSOs. The issue of community sector involvement in policy development and system planning is considered in the concluding section of the chapter.

17.4.2 Constraints

Regarding the factors impacting on their capabilities and capacity to deliver effective services to vulnerable families and children, relevant submissions commented on three main areas: funding levels and arrangements; workforce or skill constraints; and regulatory arrangements.

These issues are in line with the constraints on the growth and development of NFPs outlined in the Productivity Commission's 2010 report. The constraints, which were analysed at a more general level, can be summarised as:

- Regulatory constraints, particularly legislative constraints;
- Contracting constraints, for example, restrictions on the delivery of the funded activity including specification of quality standards and staff and volunteer qualifications;
- Funding and financing constraints, which, for example, make it difficult to make investments such as information systems, housing, training for staff and major capital investments; and
- Skill constraints, for example, in the community services sector related to low wages and lack of career paths.

In the area of skills constraints, the report also identified the need for governing boards of CSOs to develop their governance skills as their tasks become more complex with delivery of government funded services and demands by donors, members and clients for greater accountability. The Productivity Commission referred to research that found that many NFP failures stem from inexperienced, weak or sympathetic supervisory groups and the important role that boards play in ensuring robust decision making and appropriate controls (Productivity Commission 2010, pp. 25–26).

Chapters 16, 19 and 21 consider workforce and skill constraints, funding levels, funding arrangements and regulatory arrangements issues in more detail and generally from an overall system perspective. However, the following extracts from submissions convey the perspectives of the community sector on the constraints arising or potentially arising from funding arrangements and regulatory approaches.

On funding levels and funding arrangements, the Centre for Excellence in Child and Family Welfare submitted:

While some progress has been made by the Department of Human Services in the development of Funding and Service Agreements and in the development of Unit Costing for key program areas including family support services and out-of-home care, these programs are not fully funded ...

Additionally, The Centre believes greater consideration around funding models is required. Systems focused on targets alone enforce a greater emphasis on records administration adherence as opposed to demonstrating improved outcomes for children, young people and families. A move to funding outcomes and with greater flexibility at the service delivery level for implementing the necessary service mix to achieve outcomes is the next obvious step. An approach that would result in specified levels of funding from government should be based on new resource allocation methodologies, for the achievement of outcomes (Centre for Excellence In Child and Family Welfare submission, pp. 46-47).

On the issue of regulation, the Victorian Council of Social Services (VCOSS) emphasised:

A key issue for the Panel will be to ensure that any reforms do not increase the regulatory burden on community service organisations. VCOSS wishes to highlight to the Panel the significant work that is underway at both a State and national level regarding reducing the regulatory burden in the not-for-profit sector ...

Any systems change must reduce regulatory burden to improve service delivery and in turn outcomes for children. As we move towards a more integrated and cross-Departmental, agency and jurisdictional way of service delivery, it is vital that processes are put in place to ensure quality service delivery and accountability (VCOSS submission, pp. 51-52).

17.4.3 Performance

From a practical perspective, a test of the capacity of a CSO is their performance in achieving client outcomes or, as an intermediate measure, meeting service standards and quality expectations. A range of anecdotal evidence indicates that there are gaps in the current capacities of a number of CSOs to meet these standards or reasonable performance expectations.

Chapter 21 sets out in detail a range of information on the performance of CSOs covering performance in relation to registration standards and the number of quality of care complaints.

The results of the first external reviews of organisations registered to provide relevant services under the *Children, Youth and Family Services Act 2005* indicated that nine of the 99 CSOs were found not to be meeting one or more standards. The nine were re-registered on the condition that they complete an action plan within six months to address the relevant shortcoming, and a subsequent reassessment found the nine CSOs had met or partly met the relevant standards.

Chapter 21 also sets out the available information on quality of care concerns. This includes information on the quality of care reviews held as a result of quality of care concerns relating to 159 clients in out-of-home care in the period from July 2009 to June 2010. The most significant issues of concern in these reviews were inappropriate discipline (30.8 per cent), issues of carer compliance with minimum standards (17.6 per cent) and inadequate supervision of child (14.5 per cent). The majority of these reviews related to residential care services for vulnerable children and young people.

Quality of care in residential facilities has also been the basis for interventions in 2011 in three CSOs funded by DHS to provide residential care services. All three organisations focused largely on residential care and were small or medium-level agencies in terms of funding received. To date, the total funding received by two of the organisations has been transferred to two other currently funded service providers while DHS is continuing to intervene and support the operations of the other two agencies.

While a range of trends and factors impact on the recruitment, screening and shortage of foster carers, it is also relevant to point out responsibility for the recruitment of suitable foster carers rests largely with CSOs.

17.5 Conclusion

CSOs have long played and continue to play a vital role in responding and providing services to vulnerable children and families. In particular, they are overwhelmingly the major providers of the statutory out-of-home care services and the community based child and family services covered by the *Children, Youth and Families Act 2005*. Their capabilities and capacities are obviously critical to the performance of the system for protecting Victoria's vulnerable children, as they are in a number of other health, human services, justice and community development areas.

As outlined in Figures 17.1 and 17.2 many CSOs receive considerable funding from the Victorian Government. Therefore, it is reasonable to expect and demand that they have the appropriate governance and other arrangements in place to provide effective services and be fully accountable for protecting vulnerable children and achieving positive outcomes. At the other end of the spectrum, relatively small amounts of funding are provided to a significant number of smaller and largely single service agencies. Their size and relatively low levels of funding impact on their governance and infrastructure capacity.

The Inquiry received a number of submissions seeking to expand the role of CSOs in service delivery to vulnerable families and children and in the policy development and service planning processes, particularly at the area level.

The history and involvement of CSOs delivering services funded by and on behalf of government, particularly for statutory functions such as out-of-home care, has and continues to raise significant public accountability issues. The provision of these major services is outside the traditional structures of public administration governance; however, DHS remains accountable for both the performance and ethical conduct of the CSOs concerned. These issues have implications for proposals emphasising the partnership nature of the relationships between government and CSOs and the arrangements for joint responsibility for planning, implementation and oversight. At the same time the capacities and capabilities of CSOs need to be recognised and harnessed to achieve improved, sustainable outcomes for Victoria's vulnerable children and their families.

The Inquiry considers that these issues surrounding policy leadership and, ultimately, public accountability for service delivery and expenditure of public funds, require that the relationship between CSOs and the Victorian Government should be viewed as a long-term collaboration, not from a joint partnership or joint responsibility perspective. An important element for this long-term and effective collaborative relationship, which is considered further in Chapter 19, is fair and equitable service-based funding of CSOs.

Recommendation 69

The future relationship between the Department of Human Services and community service organisations should be based on a model where:

- The Victorian Government is responsible for the overall policy leadership and accountability for the structure and performance of the child, youth and family support and service system; and
- The capacities and service delivery roles of community service organisations for the provision of vulnerable children and families are reflected in collaborative service system planning and performance monitoring at a regional and area level.

The Inquiry considers that to effectively engage in the policy planning and service delivery framework, CSOs will need to consider and collectively strengthen their capacity to represent their interests in these forums and in any statewide arrangements. While the Inquiry received many valuable submissions from CSOs, particularly the larger CSOs, on major aspects of the Inquiry's Terms of Reference, there were very few submissions that presented considered positions on the totality of the Terms of Reference, the relationship between government and CSOs and the perspectives of the community sector as a whole as opposed to individual CSOs.

As outlined, DHS both funds and is dependent on CSOs to deliver critical services and interventions on behalf of government. However, the Inquiry considers that this dependence, and the underlying missions of CSOs, should not implicitly or explicitly act as a deterrent to penalise poor performance. In Victoria, a relatively small number of sizeable organisations provide the major share of family services and placement and support services. These organisations should validly be expected to have strong governance arrangements around critical risks and performance areas for their organisations, for example, in areas such as the quality of foster care and residential care. If there is clear evidence that CSOs are failing to address the needs of vulnerable children, then government has a clear obligation to intervene – in whatever way is necessary – to ensure that these services are provided to Victoria's vulnerable children and young people and their families.

At the same time, the Inquiry acknowledges that there are a large number of small CSOs currently funded by DHS, many in non-metropolitan regions. The Inquiry considers, therefore, there is a strong case for government to take a more proactive role than it has to date, aimed at improving the overall structure and capacity of CSOs. A focus for these activities would be the governance, quality, financial viability and the number and capacities of these small service providers.

Recommendation 70

The Department of Human Services should review and strengthen over time the governance and performance requirements of community service organisations providing key services to vulnerable children and their families, while also playing a proactive facilitation and support role in community services sector organisational development.

In Chapter 10, the Inquiry recommended a more comprehensive service approach be adopted, including client-based funding. This will have implications for the service capacity expectations of CSOs including the capacity to provide a broader range of services or link with other service providers.

Recommendation 71

The Department of Human Services should:

- Consult with the community services sector on the implications of the future system and service directions outlined in this Report for the future structure of service provision and requirements of community service organisations; and
- Establish one-off funding and other arrangements to facilitate the enhancement and adjustment of community service organisations.



Part 6: System supporting capacities

Chapter 18:
Court clinical services

Chapter 18: Court clinical services

Key points

- A statutory clinical service that provides expert advice during child protection proceedings has an important role in assisting vulnerable children and their families, carers and decision-makers to understand the child's health and wellbeing needs during a traumatic time in their lives.
- There is an ongoing need for a statutory clinical service; however the current clinical service model should be reformed. The current governance, quality assurance, structure, statutory processes and location of the Children's Court Clinic does not meet the needs of vulnerable children and their families. In particular, the current model is failing children and families from regional Victoria.
- There are divided views as to the quality of current clinical assessments and the performance of the current Children's Court Clinic, but there is insufficient research or data to support an Inquiry finding on this aspect.
- A newly created statutory clinic should consist of a clinic board of eminently qualified professionals with a range of expertise to coordinate and monitor the provision of future clinical services. The Inquiry considers the new board should determine the most effective arrangements for the delivery of services.
- The ultimate goal is for the new statutory clinical service to undertake a broader role within the statutory child protection system by assisting the Department of Human Services and parents to reach agreement early on proposed interventions by the Department of Human Services without first requiring a court order.
- As an immediate priority a statutory board should be established and responsibility for the current Clinic transferred from the Department of Justice to the Department of Health. The current Clinic should be physically relocated from the Melbourne Children's Court to another location to remove it from a litigious environment to one that is more child and family friendly.
- Under the guidance of the new board, there should be an increase in the level of statutory clinical services provided in rural and regional Victoria either at the child's home or from easily accessible, child-friendly facilities.

18.1 Introduction

The Children's Court of Victoria (the Children's Court) deals with some of Victoria's most vulnerable children, both in the Family and Criminal Divisions.

Within the Family Division, the Court's decision making process is focused on what is in the best interests of the child. Once protection matters reach the Court, very serious decisions may be made, such as whether a child should be removed from their parents, or the setting of contact hours between children and parents. Like any decision which requires the application of clear and distinct rules to complex, changeable and opaque situations, the Court's decision will be assisted by expert evidence.

The evidence of expert clinicians will often be provided by the parties. However, in considering the best interests of the child, the Court may also wish to seek psychological and psychiatric assessments and advice on the circumstances of the child and their families or carers that are independent of any clinical assessments or evidence provided by the parties. Since 1994, the Children's Court Clinic (the Clinic), in its current form, has provided this advice to the Court.

This chapter considers whether the current clinic model, as the current system for providing assessments, advice and recommendations to the Court, is the best model for assisting parties to make care decisions that meet the needs of children and young people. The chapter considers comments provided to the Inquiry through consultations and submissions, and the *Review of the Children's Court Clinic: Report to the Secretary* prepared by Mr Peter Acton (DOJ Report) on behalf of the Department of Justice (DOJ).

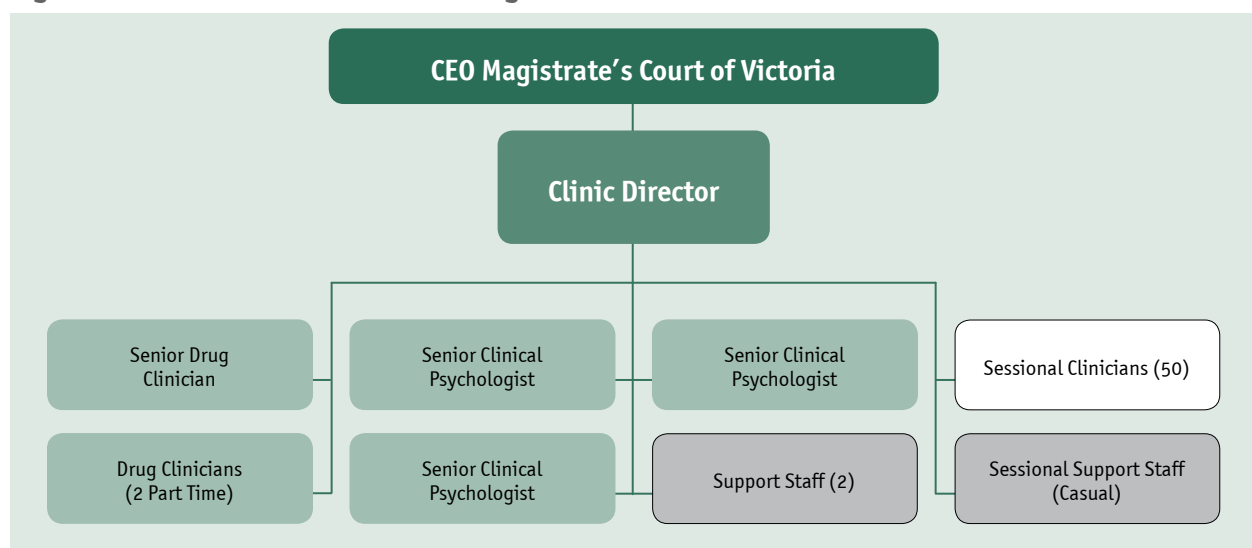
18.2 Status and structure of the Children's Court Clinic

The Clinic, which sits within DOJ, is established by section 546(1) of the *Children, Youth and Families Act 2005* (CYF Act). The Clinic has operated in one form or another for over 60 years (Clinic 2010a, p. 4). The Clinic was formally recognised by statute by section 37 of the *Children and Young Persons Act 1989* (CYP Act). At that point, the Clinic was located within the Department of Health (DOH). In 1993 the Clinic was moved into the Protective Services Division of the amalgamated Department of Health and Community Services - now the Department of Human Services (DHS).

Following debate about the positioning of the Clinic within DHS, the Clinic was relocated to the Courts Administration division of DOJ. The Clinic is physically located in the Melbourne Children's Court, and is funded from the court's budget (Children's Court submission no. 2, p. 46). The Clinic operates on a budget of approximately \$1.2 million per annum. The Clinic presents an annual report on their business as an addendum to the Children's Court annual report.

The Clinic is headed by a Director, who is a Senior Technical (Child Clinical/Forensic) Specialist. The Director oversees the work of three full-time senior clinical psychologists and three drug clinicians. The Clinic also engages approximately 50 private clinicians on a 'sessional' basis to assist with case work as necessary (Children's Court Clinic 2010a, p. 7). The Director reports to the Chief Executive Officer (CEO) of the Magistrates' Court (who is also, at present, the CEO of the Court). The current organisational structure of the Clinic is set out in Figure 18.1.

Figure 18.1 Children's Court Clinic: organisational structure



Source: Adapted from Acton 2011, p. 16

Independent status of the Clinic

The Inquiry notes that the Clinic's work remit is perceived as being activated solely through the jurisdiction of the Court:

The Clinic ... sees its role as working only for the judges and magistrates and not for any party in proceedings before the Court (Children's Court of Victoria 2007, chapter 12.2).

Under section 560(b) of the CYF Act in relation to protection matters in the Family Division, a Clinic report is formally a report from the Secretary of DOJ to the Children's Court and is made on the order of the Court. However, as noted in the DOJ Report, it is not clear from the legislation that the Clinic should be reporting exclusively to the Court, that it be independent of the parties to the proceeding, or whether such independence can only be achieved if the Clinic is part of the Court (Acton 2011, p. 14).

The focus of court processes and clinical services should be on the best interests of the child or young person. The idea that the Clinic must be independent (in the sense that it works only for the Court) assumes that their expert reports are more impartial than those expert reports provided by DHS or families, and is anchored in a traditional, adversarial approach to Family Division court proceedings. The Inquiry notes that a strictly adversarial approach to court processes and clinical services is inconsistent with the new direction for proceedings before the Family Division promoted by the Victorian Law Reform Commission (VLRC) and by key stakeholders including the Court.

In Chapter 15, the Inquiry canvasses a new, less adversarial model for resolving disputes arising from protection applications based on the findings of the VLRC's *Protection Applications in the Children's Court: Final Report 19*. The shift away from court-centred outcomes means a broader role for any clinical service provided as part of the statutory child protection system. For example, in the interests of an early solutions focus, it should not be necessary for parties to first seek a court order to obtain a clinical assessment.

Clinical services provided in the course of protection applications should be directly engaged with DHS and families. Subject to appropriate safeguards, clinic services should be available to assist DHS and families to reach an early resolution of their differences.

Under the new model, clinical services will demonstrate independence through a clear governance structure and by the capacity to provide frank assessments to a requesting party, even where those assessments might be prejudicial to the requesting party's case.

The Inquiry sets out its recommendations regarding the future provision of clinical services at section 18.7. It is not contemplated that a 'user pays' arrangement

would apply for clinical services in the proposed new system nor is it considered appropriate to do so.

18.3 Clinic assessments and treatment

The Clinic's functions are stated in section 546(2) of the CYF Act to: make clinical assessments of children; submit reports to courts and other bodies; provide clinical services to children and their families; and carry out any other functions prescribed by regulations. No additional functions are currently prescribed under the Act. The Clinic also offers treatment services in selected cases. The court also describes the Clinic as a teaching facility (Children's Court of Victoria 2010, p. 32).

Assessments for the Criminal Division of the Court

In the Criminal Division of the Court, if ordered by the Court under section 571 of the CYF Act, the Clinic provides pre-sentence reports to the Court under section 572 of the Act. The Inquiry understands from its consultation with the Court and the Clinic that the Court does not refer to the section under which it is making a referral to the Clinic in its order. However, the Clinic deems referrals from the Criminal Division as 'assessments' under section 546(2) of the CYF Act. In 2009-10, the Clinic made 337 assessments and in 2010-11, the Clinic made 300 assessments.

Although the Inquiry has received some comments on the role of the Clinic as it relates to the criminal jurisdiction of the Court, the focus of this chapter is the provision of clinical services within the Family Division of the Court. As was noted in the DOJ Report, 'views on the Clinic's contribution to Criminal Division cases are generally positive and criticisms are minor' (Acton 2011, p. 12).

Assessments for the Family Division of the Court

The Clinic, through the Secretary of DOJ, provides reports to the Family Division of the Court as an 'additional report' under section 560(b) of the Act. An additional report is provided when a disposition report is required to be provided by the Secretary of DHS under section 557(1) of the CYF Act and the Court is of the opinion that an additional report is necessary to enable it to determine the proceeding.

It is understood, following consultation with the Court and the Clinic, that the Court does not refer to the section under which it is making a referral to the Clinic in its order and that the Clinic deems Family Division referrals as 'assessments' under section 560(b).

In 2009-10 the Clinic made 725 assessments (approximately 7 per cent) from a total 9,915 protection applications before the Family Division and in 2010-11, the Clinic made 613 (approximately 6 per cent) of a total 10,483 protection applications.

As demonstrated in Figure 18.2, the number of Clinic referrals from the Family Division over a 10 year period from 2000-01 to 2010-11 has generally been steady but has decreased in proportion to the total number of applications before the Court.

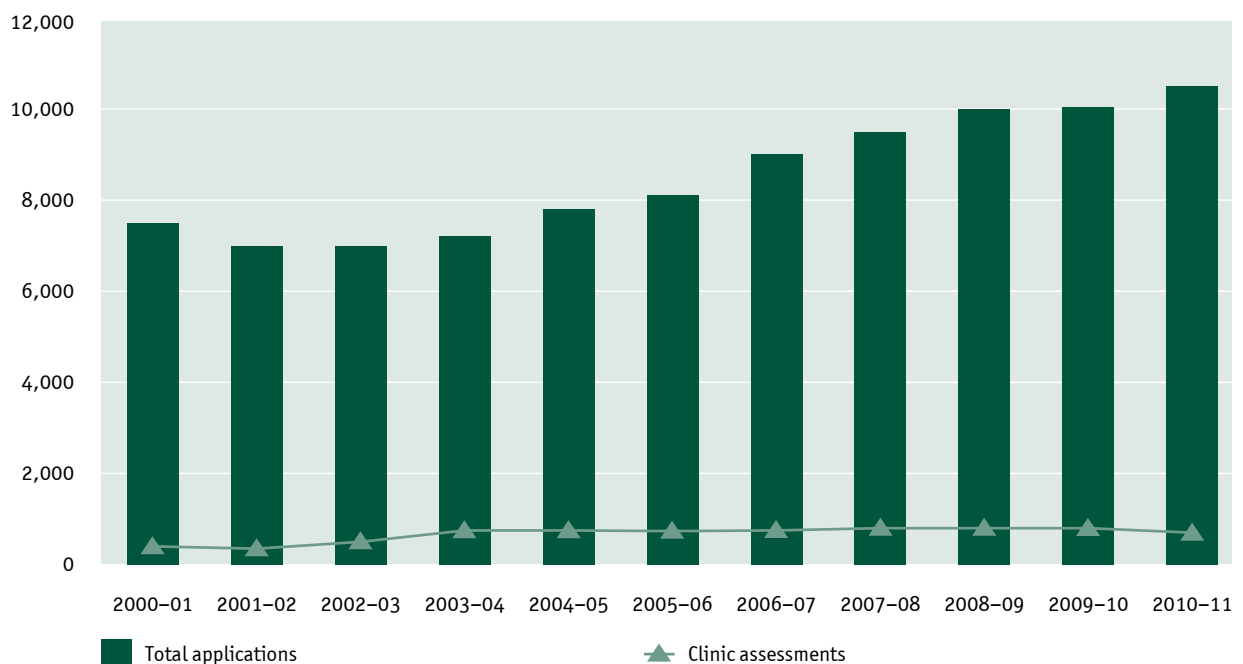
18.3.1 The use of clinical assessments in the Family Division

Within the Family Division, clinical assessment of a child will typically include an assessment of his or her parents and family. The purpose of an assessment is to give the Court a more informed view of the child's circumstances, including any factors that may affect their emotional and psychological wellbeing, such as parental drug or alcohol abuse, the presence of any protective factors within the family, the willingness of parents or caregivers to engage in therapeutic intervention, and the relative risk to the child's long-term emotional and psychological wellbeing if she or he is removed from the family home. Assessments may also be used to gauge what degree of contact between a child and his or her parents is in that child's best interests. The Clinic also makes disposition recommendations to the Court and this is considered further in section 18.6.

Section 562(2) of the CYF Act permits the Clinic, if it is of the opinion that information contained in a Clinic report could be prejudicial to the physical or mental health of a child or a parent of the child, to forward a statement to that effect to the Court with the report. Section 562(3) requires the Court to release a copy of the report to the child, the parent, DHS, a party to the proceeding or any other person specified by the Court. However, under section 562(4)(a), the Court may refuse to release all or part of the report to DHS, if satisfied the release of the report could cause significant psychological harm to the child.

The Inquiry notes that the restriction on the release of information was introduced with the CYF Act. The Inquiry is concerned that this provision presumes that DHS' knowledge of a child's assessment could cause psychological harm to a child without any explanation as to its purpose and effect and, that in some way, sharing the knowledge with DHS would not be in the child's best interest. From the extrinsic material attached to the legislation (and its predecessor) it is unclear in what types of circumstances the Court would make a finding that issuing all or part of a report to DHS would cause psychological harm to a child. The Inquiry also understands following consultation with the Court that the Court is not aware of any application having ever been made under section 562(4)(a) at least at the Melbourne Children's Court and at the Moorabbin Children's Court. The Court also noted it is extremely unlikely to make such a determination of its own accord without some form of trigger – such as a statement from the Clinic under section 562(2) of the Act.

Figure 18.2 Total applications in the Children's Court and Children's Court Clinic assessments, 2000-01 to 2010-11



Source: Information provided by the Children's Court of Victoria

This provision appears inconsistent with the obligation on DHS under section 8 of the CYF Act to make decisions in accordance with the best interest principles, and particularly when full access by DHS to clinical reports would best assist DHS to fulfil its responsibility under section 8 of the Act. Moreover, this prohibition would be made redundant by the new model for the provision of clinical services that is discussed in the following sections of this chapter.

Recommendation 72

Section 562(4)(a) of the *Children, Youth and Families Act 2005*, which confers a discretion on the Children's Court to not release all or part of a clinical report to the Department of Human Services if satisfied that the release of the report could cause significant psychological harm to a child, should be repealed.

18.3.2 Clinical treatment services to children, young people and their families

The Clinic is empowered to provide clinical services to children, young people and their families under section 546(2)(c) of the CYF Act. Where a child or young person is in the Criminal Division of the Children's Court and presents with substance misuse the Court may order the Clinic to provide therapeutic treatment through its Children's Court Clinic Drug Program (CCCDP). This program provides treatment services either in conjunction with the Australian Community Support Organisation or a local community drug treatment agency (Children's Court of Victoria 2007, chapter 12.4.6). In 2009-10 there were 55 referrals to the CCCDP from the Criminal Division (Children's Court Clinic 2010b, p. 1).

The Inquiry notes that in the Family Division the Clinic also provides a short-term treatment service where the Court, on the recommendation of the Clinic, believes it is an appropriate condition of an interim order. This includes treatment services to parents with drug problems (Children's Court of Victoria 2007, chapter 12.3.4) and in 2009-10 there were 45 referrals from the Family Division (Inquiry consultation with Clinic).

18.4 Comments to the Inquiry on the Clinic's role

In addition to submissions that were made to the Inquiry on the Clinic, the Inquiry also met with the Director and the Acting Director of the Clinic and the CEO of the Magistrates' Court of Victoria and discussed its role. The Inquiry has also received comments on the Clinic from DHS. Stakeholder perceptions of and experience with the Clinic are varied.

DHS raised the following with the Inquiry:

- The Clinic makes recommendations without consulting DHS. This means that the Clinic sometimes makes assessments that miss crucial information. The processes by which the Clinic accesses and uses relevant information from child protection practitioners and other professionals to inform their assessments and recommendations should be clear and publicly available;
- The Clinic is not perceived as having a consistent approach to assessments and recommendations. A framework that outlines the clinical service approach to assessments and recommendations would assist in addressing this perception. A framework would include guiding principles consistent with the best interest principles outlined by section 10 of the CYF Act;
- The Clinic would benefit from a formal clinical governance structure comprising mental health experts and other experienced professionals who would provide some clinical oversight of the Clinic's work;
- There is currently no formal mechanism to issue a complaint about the professional practice of the Clinic. A formal clinical governance structure could support and oversee a formal complaints mechanism whereby clinical practice by clinicians could be subject to scrutiny and review; and
- The Clinic, being located at the Children's Court, is not an ideal environment for children. Presently, children and families and child protection workers from regional areas are required to travel to Melbourne to participate in assessments as there is little use of local area-based professionals. Clinical services should be flexible and, where appropriate, assess children and families in their home environment.

Submissions and comments made in Public Sitings

It was also asserted to the Inquiry that the Clinic does not appear to approve of, or accept, permanent care as an option for children and the Clinic often adopts a position that there is a relationship between birth parents and children that should be promoted and preserved notwithstanding the evidence of its destructiveness in some situations (Ms Smith submission, p. 5).

The Victorian Forensic Paediatric Medical Service (VFPMS) contended that reports from the Clinic should be subject to the same level of scrutiny and cross-examination by parties as is the case with other professional reports produced by parties and that magistrates should not be 'quasi-delegating' their decision making to the Clinic in protection matters (VFPMS submission, p. 19).

Berry Street raised concerns about the quality of the information and advice from the Clinic and suggested that Clinic advice was unreliable and often based on a less complete understanding of a child's trauma experiences, circumstances and development than could be obtained from the collaborative input of agencies, the Take Two program and child protection (Berry Street submission, p. 119).

On the other hand, the Inquiry also received favourable feedback on the work of the Clinic. For instance, the Law Institute of Victoria noted the Clinic provided vital support to children and families in the Family Division and recommended the possibility of tasking DHS with sourcing funding for the Clinic and overseeing its maintenance and expansion (Law Institute of Victoria submission, p. 11). Others commended the need for independent mechanisms such as the Clinic to strengthen the more inquisitorial approach needed to get to the heart of a dispute (Mr Noble, Bendigo Public Sitting).

The Court acknowledged the work of the Clinic in providing expert reports and its independence of all the parties involved with the case (Children's Court submission no. 1, p. 6) and noted that the Clinic required additional resources to maintain its ability to provide high-quality services to the Court (Children's Court submission no. 2, p. 46).

Inquiry consultation with the Clinic

At a meeting with the Acting Director of the Clinic and the CEO of the Magistrates' Court of Victoria, it was put to the Inquiry that there have been a number of assertions and anecdotal comments about the Clinic and the quality of its service. These should be evidence based and properly tested. The Inquiry has viewed preliminary independent research commissioned by the Court indicating that the allegation that magistrates are somehow quasi-delegating or adopting Clinic recommendations without independent judicial consideration is unfounded (Children's Court submission no. 2, pp. 45-46).

The Clinic and the Courts Administration Division note that current funding constraints do not allow the Clinic to conduct in-home assessments and provide regional outreach services. This results in traumatised children and their families from regional areas having to travel considerable distances into Melbourne in order to obtain a clinic assessment. This is an aspect of the current clinic model that is of particular concern to the Inquiry as it clearly does not meet the needs of children and young people in regional Victoria, nor does the Inquiry consider that this is in the child's best interests.

The Inquiry also sought and has been assisted by additional materials provided by the Court and DOJ but acknowledges that aside from the DOJ Report, there is little available longitudinal research or commentary on the role and performance of the current Clinic. This means the Inquiry is unable to make any conclusive findings on the quality of current clinical assessments without first undertaking, or having recourse to, a detailed review of Clinic case files and its reports over a period of time.

18.5 Review of the Clinic

Two reviews preceding this Inquiry in 2010 by the Child Protection Proceedings Taskforce and by the VLRC did not comment in detail on the Clinic, but both reports noted a separate internal review was being undertaken by DOJ (Child Protection Proceedings Taskforce 2010, p.18; VLRC 2010, p. 30). The DOJ Report was provided to the Inquiry on 17 October 2011.

The Inquiry highlights the following themes brought to light by the DOJ Report:

- The Clinic provides a service to the Children's Court that is highly regarded by Magistrates but contentious among others;
- There are several opportunities for the Clinic to adopt best practice in relation to governance, management and service delivery;
- The Clinic's role needs to be aligned with the new directions for conflict resolution identified by the VLRC;
- In the short term, the Clinic should not (organisationally) continue to be located within the Courts Administration Division but in the first instance become an independent unit within DOJ in the same way as the Office of the Public Advocate;
- In the short term, the Clinic should come under the direction of a board that includes at least one appropriately qualified psychiatrist and one psychologist;
- In the longer term, the Clinic could build formal arrangements with universities or teaching institutions for sharing resources and promoting research-based knowledge transfer and better peer group interaction with a view to the Clinic being incorporated into the academic faculty of a leading university. The Clinic's board could then be part of that larger peer organisation's board or council and could sit as a sub-committee;
- The Clinic could align with the Victorian Institute of Forensic Medicine and other forensic organisations such as Forensicare to strengthen its research collaborations and professional development but also to establish a comprehensive centre of forensic excellence in Victoria;

- The appointment responsibility of sessional experts for the Clinic should come under the Clinic board and there should be a board committee including external experts that define appropriate tests and protocols for selecting sessional experts;
- The current fee scale of \$44 per hour for sessional experts is significantly lower than that paid in the New South Wales (NSW) Children's Court Clinic (at \$130 per hour) and in other types of services such as for Medicare (at \$206 per hour) and Transport Accident Compensation or WorkCover assessments (at \$175 per hour);
- The Clinic board should either formalise a process for complaints to be directed to the Health Services Commissioner or other appropriate body, or establish its own complaints process involving a panel of respected professionals not connected with the Clinic;
- The Clinic lacks formal training and induction processes for clinical staff and sessional providers about assessment practices and should introduce a formal program including formal guidelines or a handbook;
- Clinical services should be involved early in the dispute resolution process. Consistent with the principles outlined by the VLRC for child-centred, agreement-focused outcomes at court, the Clinic should contribute its expertise earlier in the process, should make its assessment available to all parties, and except as agreed between the parties/their representatives, DHS should be empowered to release Clinic assessments to carers and to other organisations associated with case management;
- With the guidance of the Clinic board and subject to stringent recruitment criteria, clinical services should operate from four or five important centres from regional Victoria and recruit a number of clinicians in each area on a part-time basis to carry out at least 80 per cent of assessments expected from those regions; and
- The Clinic should be physically relocated from the Melbourne Children's Court to another location, preferably with access to parkland or playgrounds, or share premises with another facility that already provides an enjoyable and safe environment for children.

The Inquiry also considered comments in response to the DOJ Report from the Children's Court Clinic. While the Clinic disagreed with certain findings in, and the research methodology of the DOJ Report, the Clinic agreed that:

- A new governance board was required;

- It needed more funding to provide quality clinical services in regional Victoria; and
- There was the need to review the current salary and payment schedules for Clinic staff and sessional providers (Inquiry Children's Court Clinic consultation).

Independent expert advice

When making far-reaching decisions that affect a child or young person and their families, it is appropriate for the Court to have recourse to independent sources of expert advice in order to assist the Court to determine what is in the best interests of the child. Indeed, no submissions to the Inquiry argued for the abolition of court clinical services, or that the Court should rely only on expert evidence provided by the parties to a protection matter.

The Inquiry considers the ability of the parties to access an independent service that provides expert clinical assessments would help avoid lengthy contested disputes between protective interveners and families over expert evidence called on behalf of each party during court proceedings and further damage relationships in an already tense environment. A clinical service that is accessible to the Court, as well as to DHS and families, is consistent with a problem solving and less adversarial approach to resolving protection matters. A clinical service should also assist the Court to work with parties to address the child or young person's needs. However, as discussed next, this does not mean acting as a 'third advocate' to the proceedings.

18.6 Disposition recommendations by the Clinic

Section 557 of the CYF Act requires DHS to provide a 'disposition report' to the Court under certain circumstances set out in that section. A disposition report is an outline of what one party thinks the Court should order, and what would happen under such an order. For example, a DHS disposition report might include recommendations concerning the order that DHS believes the Court should make, a draft case plan, and an outline of the sorts of services that DHS would provide to the child and their family.

Under section 560(b) of the CYF Act, in any proceeding where a DHS disposition report is required, the Court can order the preparation and submission of an 'additional report', including a report from the Clinic through the Secretary of DOJ. While the Act (and its predecessor) does not specify what matters this additional report should address, consultation with the Court and the Clinic would suggest that as a matter of practice, section 560(b) is also used by the Clinic to make disposition recommendations and the Clinic almost always makes disposition recommendations in reports to the Family Division.

Currently, the Clinic makes disposition recommendations to the Court. According to the Children's Court, the recommendations in the report will be discussed with the child's legal representative and DHS, if the recommendation made is one that would involve DHS. In making the recommendations, the Clinic maintains the right to offer opinions to the Court that differ from those of the other parties/agencies (Children's Court of Victoria 2007, chapter 12.3.3).

However, the Inquiry queries the ability of the Clinic to make well-informed disposition recommendations due to the current resource constraints preventing clinicians from conducting in-home assessments and spending as much time with the family and the child as DHS workers when preparing their assessments. Further, as is noted in the DOJ Report, the Clinic may be dealing with families and children who may have travelled some distance to be assessed and their behaviour on the day may be atypical (Acton 2011, p. 10).

The Inquiry considers that the provision of disposition reports to the Court by the Clinic is an inappropriate practice. This is because reports from the Clinic are, formally, reports from the Secretary of DOJ to the Court. This means that the Court is hearing what DHS considers is in the best interests of the child, what the parent(s) believe is in the best interests of the child and what, in effect, DOJ considers is in the best interests of the child. In this situation there are two agencies of the State working under the CYF Act to meet the needs of a child or young person, yet potentially providing conflicting views on those needs to the Court. This is an untenable arrangement and perpetuates nothing more than an artificial concept of independence that has led to some of the more questionable practices by the Clinic in an effort to reinforce its independence of the parties. The system should be simpler.

It is properly up to the parties or to the Court or the Victorian Civil and Administrative Tribunal (VCAT), based on the parties' involvement with the child, or on the court or tribunal's independent decision-making, to decide what outcomes would be in the child's best interest. These decisions are taken using various sources of information, which may include Clinic assessments.

In the statutory child protection system, clinical services should be focused on the Clinic's observations of the child, the interactions between the child and his or her family or caregivers, and should include any historical information provided by the parties that may assist the Clinic in making its observations.

The Inquiry considers that involving clinical services in disposition recommendations creates the perception that the clinical service is involved in the substance of the litigation. An independent clinical service should not make disposition reports.

Victorian Medical Panels

The Inquiry considers the Medical Panels assessments process under the *Wrongs Act 1958* as instructive. Under the *Wrongs Act*, a specialist medical panel is convened to determine whether a claimant's degree of impairment (either physical or psychiatric) meets a statutory threshold for impairment set under that Act. A Medical Panel does not make a recommendation on damages or recommendations on future treatment of the claimant or what the claimant should be doing to improve their current condition. The statutory threshold determines eligibility for damages and a court decides what damages are appropriate. The *Wrongs Act* specifies the use of the *American Medical Association Guide to Permanent Impairment (Fourth Edition)* by the Medical Panel to assist parties understand how Medical Panels assessments are undertaken.

Recommendation 73

The Children, Youth and Families Act 2005 should be amended to:

- Empower the clinical service provider to provide a report at the request of the Children's Court, or at the request of the Victorian Civil and Administrative Tribunal, or at the request of the parties to the proceedings;
- Prohibit the clinical service provider from making any disposition recommendations in its report;
- Enable the Department of Human Services to release clinic reports to carers or case managers who have a direct involvement with the child or young person subject to appropriate safeguards around the use and dissemination of those reports; and
- Require a clinical assessment to take into account information provided to the clinical assessor by the parties, particularly where the clinical assessor is unable to assess the child, young person or the family within their home environment.

18.7 A new child-friendly model of court clinical services

The Inquiry is unable to comment on the quality and practice of current clinical assessments due to an inability to examine this matter within the Inquiry's reporting timeframe. However, the DOJ Report reiterates some of the concerns expressed by DHS to the Inquiry, which includes a lack of formal assessment protocols and guidelines, and a lack of formal training and induction programs for new staff and sessional assessors. The DOJ Report observed that these practices are not in keeping with peer bodies such as the NSW Children's Court Clinic, the Victorian Mental Health Review Board or Forensicare (Acton 2011, pp. 35-36).

The Inquiry has confined its consideration to whether the current Clinic model is the most contemporary and most suitable model for the provision of independent expert advice to the Court and to the parties to protection applications. Based on the views and material put to the Inquiry, and in light of the Inquiry's proposals for a new system for early dispute resolution of protection applications as outlined in Chapter 15, the Inquiry considers that the current Clinic model, both in its legislative and administrative setting, is not the optimal model for providing children, families, protective interveners and the Children's Court with independent expert advice.

The Inquiry, with the benefit of reviewing the DOJ Report, agrees with that report's findings at least with respect to the deficiencies to be addressed in the short term. Some of these matters have also been identified to the Inquiry by the Clinic and by the Children's Court. As a result, the following areas for reform should be prioritised:

- Reforming the current structure and governance model for the Clinic including the removal of the Clinic from the Courts Administration Division of DOJ;
- Facilitating greater provision of clinical assessment services for children and families in outer metropolitan Melbourne and in regional Victoria;
- Increasing remuneration rates for the current pool of sessional clinicians and permanent clinical staff and considering other ways in which to expand the pool of experts available to assist children and families, particularly in regional Victoria;
- Physically re-locating the Clinic away from the Melbourne Children's Court building, having regard to other organisations or buildings with existing child-friendly spaces and facilities; and
- Implementing formal assessment protocols, guidelines in the form of a practice handbook and formal training programs for clinical staff and sessional assessors.

It is critical that a framework that would uphold the quality of service provided to the parties and the courts in the statutory child protection system is established. This requires a strong level of clinical service oversight and direction based on the most contemporary professional standards. This necessitates the provision of professional peer review and some form of clinic assessors' accreditation process that requires staff and assessors to undertake continuing professional development.

From its meeting with the CEO of the Magistrates' Court and the Clinic, the Inquiry understands that planning is underway to address some of the concerns, particularly regarding governance and oversight and the appointment of sessional assessors with the development of a business plan. The Inquiry has also been advised by DOJ that it is proposed to remove the current Clinic from the Courts Administration Division of the department and to amalgamate the Clinic with two other business units under a new Forensic Health Services Unit. This new unit will be headed by a Director and will comprise the current Clinic, the current Justice Health Unit and the National Coronial Information System.

In view of the broader role the Inquiry conceives for a new statutory clinical service, the Inquiry does not support the continued placement of the current Clinic within DOJ and considers that the government should first address the options put forward in this Report.

The Inquiry has identified the following options for improving the current Clinic model:

- Abolish the Clinic and, in the short term, establish a statutory Clinic board which oversees a clinical unit within DOH. In the medium to long term, retain the board but abolish the Clinic as an administrative unit within government. The role of the board will be to:
 - engage suitable external service providers to provide clinical services to the Children's Court consistent with contemporary standards of clinical practice;
 - ensure appropriate clinical services are available throughout Victoria; and
 - support the development of a range of suitable service providers across Victoria.
- Abolish the Clinic as an administrative unit within government but re-establish a similar model of clinical services provision within an independent institution such as a teaching hospital or university and subject to clear governance arrangements (as contemplated by the DOJ Report); and
- Abolish the Clinic model altogether and establish a recognised panel from existing service providers that can be called upon by the Children's Court, or by the parties, depending on the type of expertise and assessments required.

These options are discussed below.

18.7.1 Option 1: Abolish the current Clinic and re-establish as an administrative unit within the Department of Health

Under this option, which would broadly resemble the model of clinical service delivery in NSW, the Clinic and its staff would be relocated as a business unit within DOH. Ministerial responsibility for the provision of clinical services in the statutory child protection system would be transferred from the Attorney-General to the Minister for Health. The Clinic would be headed by a director who reports to the Secretary of DOH. However, specialist oversight of, and directions for the Clinic, its appointment processes, the performance of its statutory functions and the quality of its assessments would lie with an independent statutory Clinic board as contemplated by the DOJ Report (Acton 2011, pp. 17-18). The Inquiry considers that a multidisciplinary board must consist of eminently qualified professionals with expertise in: infant, child and adolescent physical and mental health; child abuse and neglect and trauma; children's law; youth justice; and public administration and management. The clinic would retain permanent clinicians and use external sessional clinicians in accordance with protocols established by the board. The sessional clinicians will be based throughout the state and be available, where possible, to assess children and young people closer to that child or young person's location.

The Inquiry sees a broader role for a Clinic within the realigned court processes outlined in Chapter 15. The Clinic would provide services not only to the court but also to the parties. Pre-court or pre-tribunal clinical assessments should be provided to the child (or their representative as appropriate), DHS, the parents and any other non-party who has a relevant interest in the child's safety and wellbeing. To ensure a degree of structure around the commissioning of reports, consideration should be given to allowing a clinic assessment to be requested by DHS or by one or both parents or primary caregivers who are a party to the proceedings. This could happen prior to, or during a Child Safety Conference, where parties believe a clinic assessment would help resolve conditions around intervention and care planning. The Clinic would retain its statutory functions with respect to supporting the Criminal Division of the Court.

As the Clinic would retain its statutory ability and authority to provide reports to the Court or VCAT at the request of those bodies and retain its independence, as discussed in section 18.2, there is no reason why the integrity of Clinic reports provided at an earlier stage of the application process should be called into question. Indeed, it would be expected that the earlier use of Clinic reports will further reduce the number of matters that ultimately proceed to contest.

The Inquiry acknowledges, however, that with an expanded role, there will be demand pressure on the clinical service providers to meet the requirements of the Children's Court, VCAT and the parties to the proceedings. The concern is the potential for delays in protection proceedings due to a lack of clinical services. The Inquiry considers that in circumstances of high demand, where clinical resources are to be prioritised, the Children's Court and VCAT should be accorded a higher priority for clinical assessments and services.

Further, the Inquiry considers that appropriate protection is required against potential misuse of clinical resources by parties in order to delay or otherwise frustrate child protection proceedings. The Inquiry considers that a key aspect of the oversight and governance function of the board would be to monitor and intervene where necessary to protect against the misuse of clinical services. These are matters that should also be addressed in the formal guidelines or handbook that should be published as stated earlier in this section.

The Inquiry considers that the transfer of the Clinic from DOJ to DOH would be an improvement on the current system for the following reasons:

- The relocation of the Clinic from DOJ to DOH would bring a degree of independence to its involvement and would satisfy the concerns of stakeholders' – it would not be relocated to DHS, it would not be perceived as being too closely aligned to the Children's Court, and it would reflect a service being provided by health professionals not just in support of the Court but to the parties within the statutory child protection system;
- The direction and role of the Clinic would be more easily adaptable to any future policy changes in the statutory child protection system; and
- Historical and current data collected by the Clinic would remain easily accessible by the government and, where appropriate, the new Commission for Children and Young People and should be used to inform future reforms.

However, the Inquiry considers that this option means that the State, which is responsible for intervening in a child and their family's life, will continue to be responsible for providing day-to-day clinical assessments that may determine the outcome of a protection application. Although the future clinic will not make disposition recommendations, its assessments would amount to a service provided by DOH to the Court and now, under the processes proposed in Chapter 15, also directly to all parties to the application.

The maintenance of a unit within DOH also means two reporting lines for the Clinic, on operational matters to the Secretary of DOH and on policies and practices to the statutory board. Further, there is likely to be some overlap between the DOH governance structure and the statutory board on issues such as handling complaints or disciplinary matters. In the long term, this option is not the Inquiry's preferred option for an independent clinical service provider. The Inquiry's long-term option is canvassed in Option 3.

18.7.2 Option 2: Abolish the Clinic as an administrative unit within government and re-establish as a separate statutory entity

Under this option the Clinic would be constituted by a statutory board supported by a secretariat of clinical and administrative staff but attached to a paediatric teaching hospital or university with established expertise in child health and clinical practice. The Clinic secretariat could draw in staff on a permanent or rotational basis, including graduate students. Even though the entity would be located within that organisation, staffing arrangements should include local area-based or accessible sessional assessors for outer metropolitan and regional locations. The Clinic would also retain its statutory functions with respect to supporting the Criminal Division of the Children's Court.

Organisational relocation of the New South Wales Clinic

In 2008 the *Report by the Special Commission of Inquiry Into Child Protection In New South Wales* (the Wood Inquiry) made the following key recommendation concerning the New South Wales (NSW) Children's Court Clinic:

- That there should be a feasibility study into the transfer of the Clinic [from the Department of Attorney-General and Justice (DAGJ)] to NSW Justice Health that should also investigate ... an extension of the matters dealt with in current assessments so as to provide greater assistance in case management decisions (Special Commission of Inquiry into Child Protection Services in NSW 2008, p. 462).

The Wood Inquiry also made the following findings:

- The work of the Clinic should be expanded to assist caseworkers' decision making and be used as a basis for discussion between the parties which may result in matters being finalised without a court order (Special Commission of Inquiry into Child Protection Services in NSW 2008, pp. 455-456); and
- That the NSW Children's Court should advise parties when a Clinic report is received and the Court should be empowered to release a copy to a person who is not a party to the proceeding but nevertheless had an interest in the safety and wellbeing of the child or young person (Special Commission of Inquiry into Child Protection Services in NSW 2008, p. 457).

In early 2011, due to the changes of the structure of NSW Health with the formation of Local Health Districts, the NSW Government reviewed the operational location of the NSW Clinic. Following discussions between NSW Health and Sydney Children's Hospital Network (SCHN) it was agreed that the Clinic would be administratively located within the SCHN when transferred from the DAGJ to NSW Health.

While it is understood that the NSW Government's consideration of the Wood recommendation initially raised considerable anxiety for staff at the Clinic, particularly as NSW Justice Health dealt with the assessment and treatment of prisoners and those recently released from prison, the proposed move to the health portfolio through the SCHN addressed some of that anxiety. The Inquiry understands that access by clinical staff to like-minded professionals within the SCHN was viewed by the NSW Government as a positive outcome.

The new arrangements took effect on 1 July 2011 when responsibility for the Clinic was transferred from the Attorney-General's portfolio to the Minister for Health.

A critical advantage of this option is that it would allow an ongoing dialogue between clinicians and related professionals to ensure contemporary professional knowledge and standards are maintained. Further, it would allow Clinic staff to engage with broader research work undertaken at the facility. It would also enable a system of peer reviews to be undertaken between the clinical body and other members of the teaching hospital or university and facilitate the accreditation of assessors. In turn, assessors would be able to undertake continuing professional development courses to maintain accreditation. This option was recommended in the DOJ Report (Acton 2011, p. 19).

The Inquiry considered this to be a strong model for the provision of future clinical services in the long term. However, the disadvantage of this model is that the Clinic would be tied to one organisation and may not have the benefit of accessing a range of knowledge, viewpoints or practice cultures that might be offered through a range of providers or expert bodies.

18.7.3 Option 3: Abolish a single clinic service model and establish a statutory clinical board that would oversee service provision by a panel of providers

Under this option the Clinic would be constituted by a statutory board supported administratively by DOH. The legislation will provide the structure and process for the board to enter into services tender arrangements with established and respected service providers depending on the treatment or assessment required to meet the particular needs of the child or the family. The board would be responsible for determining the direction of, and monitoring the quality of, services. It would have regard to the expertise offered by the service providers and their ability to meet the needs of children and families in outer metropolitan and regional Victoria.

As it is contemplated that there may be more than one clinical service provider under this option, consideration would need to be given to ensuring that the authorised service provider or providers are capable of providing the necessary expert clinical assessments to the Criminal Division of the Court. The board would need to consider specific arrangements in consultation with the Court to ensure that the service model is appropriate for that jurisdiction.

In the long term, the Inquiry prefers this option as its model for the provision of clinical services within the statutory child protection system. The Inquiry considers this model to offer the following benefits:

- Clinical assessments are provided by organisations and individual practitioners whose professional focus is children's health services;
- The responsibility for sourcing clinical assessors will lie with organisations external to the State, and subject to the qualification and appointment criteria overseen by an independent statutory board;
- There should be greater opportunity for developing the flexibility and capacity for the provision of in-home clinical services and consistent services to all parts of Victoria; and
- The availability of a broader range of practice experience, expanded knowledge and research base, and exposure to peer review, than would be available under a single Clinic model.

To ensure there is consistency in conducting assessments and meeting the needs of the parties and the Court in the statutory child protection system, the Board would be responsible for developing and publishing guidelines, directions, and assessment criteria in consultation with the Children's Court and DHS. Further, the board would be responsible for monitoring authorised service providers' performance against the guidelines and criteria and would be responsible for determining complaints against individual practitioners or organisations.

Recommendation 74

The scope, governance and oversight of the provision of clinical services in the statutory child protection system should be reformed:

- As an immediate priority, the current Children's Court Clinic should be abolished and re-established as an administrative unit within the Department of Health; and
- In the medium to long term, the administrative unit should be replaced by a statutory clinical services board that will oversee service provision by a panel of providers. The parties to protection applications or the Children's Court or the Victorian Civil and Administrative Tribunal, should be able to use a panel clinical service provider to provide a clinic report.

Recommendation 75

The Government should implement the following legislative and administrative changes to support the recommended reform of clinical services.

Scope and governance

The *Children, Youth and Families Act 2005* should be amended to:

- Set out the new statutory board's and clinical service provider's objectives and tying these objectives, where appropriate, to the best interest principles in the Act;
- Define the type of clinical services to be provided within the statutory child protection system and the services to be provided within the criminal justice system; and
- Require the statutory board to publish an annual report.

Clinic access and environment in the immediate term

- The administrative unit should be relocated from the Children's Court but the Government should ensure the Court still has access to on-site counselling and support services to deal with children, youth, and families who may be experiencing acute stress in the court environment; and
- Clinical services should be decentralised as a priority to ensure the needs of children, young people and their families are met across Victoria, as outlined in the 2011 report on the Children's Court Clinic prepared for the Department of Justice.

Resourcing of the Clinic in the immediate term

- The administrative unit should be resourced to: expand the current pool of assessors available to the Clinic; provide the proper level of remuneration to both permanent and sessional Clinicians commensurate with their professional expertise; implement the process and quality assurance reforms as recommended in the 2011 report on the Children's Court Clinic prepared for the Department of Justice; and provide therapeutic treatment services, where appropriate, for children, young people and their families by agreement of the parties, or at the request of the Court, or the Victorian Civil and Administrative Tribunal; and
- The Government should, in consultation with the new statutory board, ensure the new administrative unit is properly funded and resourced to provide the necessary services to meet its statutory objectives with a view to establishing a panel of clinical service providers in the medium to long term.

18.8 Conclusion

There is an urgent need to reform the current model for the provision of clinical services to the Children's Court. The Inquiry considers the changes are required to create robust governance and clinical structures to support high-quality assessments to assist vulnerable children and their families, carers and decision-makers to understand the child's health and wellbeing needs during protective proceedings.

The reforms proposed will take place in a system realigned to meet the needs of children in statutory intervention and protection proceedings before the Children's Court and VCAT as contemplated in Chapter 15. Reforming the structure, services, accessibility, governance and oversight of future clinical services is another step in strengthening Victoria efforts to protect vulnerable children.



Part 6: System supporting capacities

Chapter 19:
Funding arrangements

Chapter 19: Funding arrangements

Key points

- There is evidence of increasing demand for services in all areas of statutory child protection and family services. These increases have been driven by a variety of longer term factors, including changes to the *Children, Youth and Families Act 2005*, a broadening of the definition of abuse and neglect, the introduction of mandatory reporting, as well as population increases.
- Funding for statutory child protection and family services is not explicitly linked to past or projected demand for those services.
- The Inquiry has identified a strong geographical component to vulnerability in Victoria. While the Department of Human Services already allocates funding based on a formula that incorporates a measure of disadvantage, there is no consistent approach to the regional distribution of statutory child protection and family services funding.
- The current system of funding community service organisations is predominantly service-performance based, where community service organisations are provided with funding to provide a level of services output, based on a uniform unit price.
- Community service organisations have requested more flexibility in their funding, advocating for some form of outcomes or client-centric funding.
- The flexibility of service funding and a fair and appropriate basis for service funding are critical to the future effective, innovative and robust provision of services to vulnerable children and families.

19.1 Introduction

The Inquiry's Terms of Reference and the approach adopted in this Report places emphasis on statutory child protection being viewed as part of a broader policy and service framework focused on Victoria's vulnerable children and families.

Consistent with this approach, a comprehensive analysis of funding arrangements would necessarily involve a consideration of a broad range of programs and services spanning the human services, health and education domains. Included would be: public health (including mental health, disability and maternal and child health services); housing and homelessness; education; family violence, juvenile sex offenders and crime prevention; drug and alcohol and other adult-focused services; Aboriginal health and social services; child care and early childhood services; and employment and income security.

However, as outlined in this Report, the issues of vulnerable children and their families are complex and represent the outcome of a wide range of factors and influences. As a consequence, the issues of vulnerable children and families often form an element or component of a wider set of objectives and issues being addressed by the wide array of public health, education and other programs.

This chapter on funding arrangements focuses on the programs and services of the Department of Human Services (DHS) that form part of or are directly linked to the statutory child protection system. The chapter is organised as follows:

- First, an overview of the current funding arrangements for statutory child protection and family services, including the amount of funding provided, how this funding is distributed and the process of funding community service organisations (CSOs) for delivering services;
- Second, a description of the recent trends in funding for statutory child protection and family services and the relationship between funding and the level of service provision; and
- Third, the chapter identifies key issues in relation to funding, including the adequacy of existing funding, the distribution of funding and the method of funding services.

The chapter contains a number of recommendations relating to the key issues identified by the Inquiry.

19.2 Current funding arrangements

There are two main program and government funding streams for Victoria's child protection and family services activities. These are:

- The government operated statutory child protection services; and
- Out-of-home care and family services largely delivered by community service and other non-government organisations.

There is some cross-over between the services provided by DHS and CSOs; for example, DHS provides or oversees components of out-of-home care services such as secure welfare services and a proportion of case management of kinship care.

19.2.1 Aggregate funding for Child Protection and Family Services

DHS is allocated funding for Child Protection and Family Services as part of annual Victorian Government budgetary processes. In line with the output budgeting approach, DHS receives funding to deliver an agreed range of services, with performance measured against targets.

Total funding allocated for Child Protection and Family Services in Victoria for 2010–11 was \$651.6 million, with the majority of funding (\$330.9 million) being spent on Placement and Support (out-of-home care). The overall level of funding in 2011–12 is expected to increase to \$702.9 million (refer to Table 19.1).

Overall, funding for Statutory Child Protection, Placement and Support, and Family and Community Services outputs equates to slightly less than 2 per cent of the total Victorian State Budget.

Table 19.1 Funding for Child Protection and Family Services outputs in Victoria, 2009–10 to 2011–12

Output area	2009–10	2010–11 expected outcome	2011–12 target
Statutory Child Protection (\$ m)	151.1	160.7	170.8
Placement and Support (\$ m)	313.1	330.9	362.3
Family and Community (\$ m)	147.8	160.0	169.8
Total	612.0	651.6	702.9

Source: Victorian Government 2011b, pp. 222–224

19.2.2 Regional funding allocations

DHS allocates the funding it receives for Statutory Child Protection on a regional basis across the eight DHS regions, while funding for Placement and Support and relevant Family and Community Services forms part of the separate service agreement process with funded organisations.

Regional funding for Statutory Child Protection is based on a DHS assessment of need in an area, known as the Equity Resource Allocation Formula, or equity formula. The formula, which is based mainly on the number of children in families receiving Family Tax Benefit A, was phased in by DHS from 1998-99. In recognition of the additional service delivery costs and other considerations, the formula also contained a loading for rural regions, as well as for the Aboriginal population.

When the equity formula was introduced in 1998-99, there was a very strong correlation between child protection activity (measured by reports to child protection) and families receiving this particular tax benefit. At the time of its introduction, the equity formula was intended by DHS to be used as the method for allocating future funding for child and family services; however, this has not always been the case, as is demonstrated in the example in the box.

While the equity formula has been used as the basis for the allocation of child protection funds, the formula is not updated regularly, due in part to difficulties obtaining Family Tax Benefit information from Centrelink. As a consequence, the Inquiry understands that funding continues to be allocated based on either historical levels or on the basis of a point-in-time assessment of the needs of each region.

19.2.3 Funding for the delivery of services through community service organisations

In dollar terms, CSOs deliver around 60 per cent of the child protection and family services budget allocation. Funding for CSOs is generally provided on a service-performance basis, with organisations receiving funding from DHS based on the number of services they provide and the unit price of those services.

DHS operates a standard three-year service agreement process with funded organisations and the current three-year cycle is from 1 July 2009 to 30 June 2012. Organisations are offered three-year service agreements except where:

- The funding is time limited and commences after or ceases before the three-year cycle; or
- Other circumstances exist that warrant a shorter agreement period with the reason(s) advised to the organisation.

Allocation of additional Child FIRST funding

In 2009, when additional funding was made available for Child FIRST, this funding was distributed between the 24 Child FIRST catchments on the basis of an assessment of demand for Child FIRST services. According to DHS, regions reported back on overall demand pressures in the Alliances and the strategies undertaken to manage demand pressure and, from this, DHS assessed demand in the catchments as being either:

- Very high demand pressures – demand management strategy implemented;
- High demand pressures – demand management strategy implemented;
- Demand pressures – demand management strategy not implemented; and
- Consistent demand.

The demand assessment was combined with regional population forecasts to distribute additional Child FIRST funding, rather than by using the equity formula (information provided by DHS).

In the time since the introduction of the equity formula there have been some significant changes to the formula, including some driven by changes to eligibility for Family Tax Benefit A, which is determined by household income. The income thresholds to be eligible for the benefit vary depending on the number of children in the household and the age of those children.

As outlined in Chapter 17, more than 200 organisations receive funding to provide child protection and family services. It is not uncommon for these organisations to also receive funding to deliver other DHS services, for example disability services or housing assistance.

Funded organisations vary in size from multi-million dollar, often church-based or philanthropic organisations such as Berry Street, MacKillop Family Services, Anglicare Victoria and the Uniting Church, to smaller community-based organisations. As outlined in Chapter 17, a relatively small number of large organisations deliver the majority of funded services.

Funding allocation

A variety of approaches have been used by governments in funding not-for-profit organisations for specific services or other activities. These include:

- Funding renewal;
- Direct allocation;
- Advertised submissions;
- Invited submissions; and
- Competitive tender.

In relation to DHS funding of child protection and family services, the most common form of funding allocation is 'renewal', which is used when performance management and needs-based planning processes demonstrate that CSOs are meeting a continuing need and the agreed service specifications, and are operating efficiently and effectively. When new funding is being allocated DHS will generally invite submissions from existing providers to compete on quality of service or innovation in service delivery. Open competitive tendering is rarely used by DHS, except in cases where competition on price is a desired outcome and outputs can be tightly specified. Competitive tendering can be seen as counter to the (often) collaborative nature of community service provision between CSOs (Special Commission of Inquiry into Child Protection Services in NSW 2008, p. 1,011).

Funding is provided in the form of set unit prices paid by DHS for specific service outputs. Service providers receive payment for outputs delivered as set out in their service agreement with DHS.

Determining unit prices

Unit prices are applied consistently for all funded organisations delivering the same services or outputs. Outputs are generally measured in terms of the number of clients receiving a service. In the case of out-of-home care, this is measured as placements, with an additional unit price per fortnight of care. Unit prices vary depending on the level of care provided, for example in relation to foster care the rate of caregiver reimbursement for general home-based care for a child aged 0 to 7 is \$261.83 per fortnight, while the equivalent rate for intensive home-based care is \$316.38 per fortnight (DHS 2010b, p. 74).

Unit prices for the funding of all child protection and family services are determined annually by DHS and have been indexed since 2003. This indexation is based on the non-government organisation indexation rate, which is calculated by the Department of Treasury and Finance (DTF). The rate is based on a formula of 85 per cent salaries and 15 per cent operational costs, with the salaries component indexed according to Victorian Government wages policy, and the operational component indexed according to the Departmental Funding Model, based on the Consumer Price Index.

In addition to the indexation arrangements, unit prices are reviewed periodically based on feedback from the sector or the following factors:

- Evidence of substantial increases in costs;
- Evidence of technological changes that have a significant impact on service delivery and costs;
- Evidence of structural changes in inputs such as qualifications and staff ratios now required by service standards;
- Practical considerations such as the size and date of the last review, materiality and complexity of the review in light of price reviews already underway; and
- Evidence of the substantial redevelopment of a service model, new legislation significantly impacting on the service model or changes in client complexity (DHS 2008b, p. 2).

Unit prices are largely determined by DHS (usually involving consultation with the community services sector) based on a calculation of salaries, on-costs and operational costs that are incurred in providing units of service. DTF plays a review role with respect to DHS activity prices, when they are part of an overarching budget proposal. This role is focused on analysing the various cost drivers underpinning proposed activity unit prices. Where a budget proposal is ultimately implemented, the activity unit price is then applied to the relevant activity.

19.3 Recent trends in funding arrangements

In nominal terms, the overall level of funding for Child Protection and Family Services has more than doubled over the past decade, from just over \$300 million in 2001-02 to an estimated \$700 million in 2011-12. Over this time the proportion of funding available to Family and Community Services has stayed relatively constant, at about 25 per cent of the Child Protection and Family Services budget. Funding for the child protection components of the system (including Statutory Child Protection and Placement and Support Services) accounts for the remaining 75 per cent of funding (see Figure 19.1).

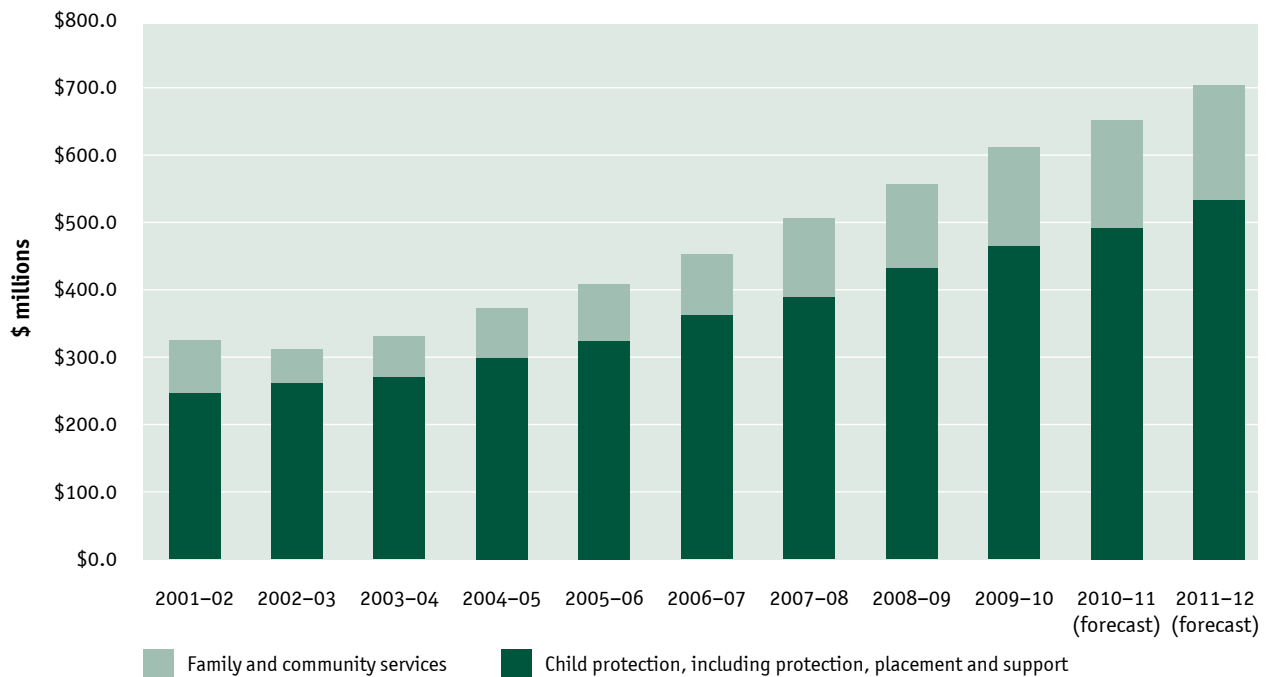
In real terms, after approximate allowance for inflation (measured by the Consumer Price Index), funding for child protection, including placement and support services and family and community services, increased by 5.3 per cent and 5.1 per cent per annum respectively over the period 2001-02 to 2009-10.

19.3.1 Child protection funding

Funding for the child protection components of the system, including Statutory Child Protection and Placement and Support, increased from \$246 million in 2001-02 to \$464 million in 2009-10 (see Figure 19.2).

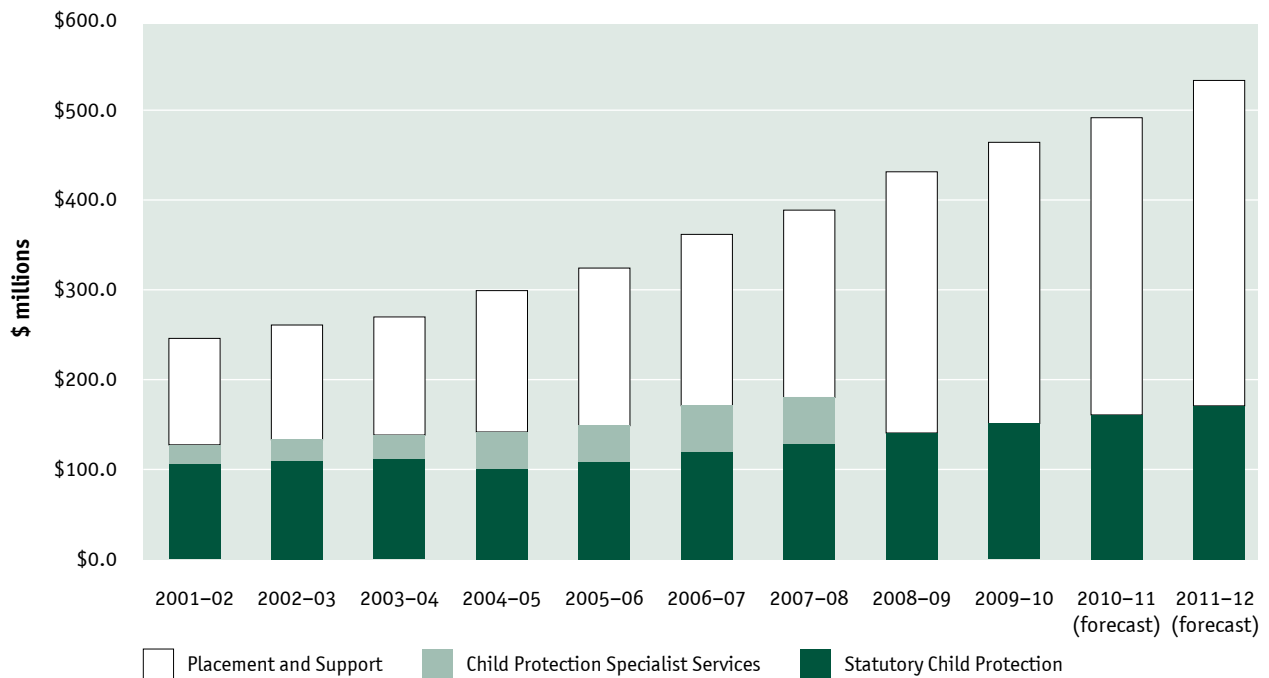
The majority of this additional investment has been directed towards Placement and Support services, which includes out-of-home care. Funding for these services has more than doubled from \$119 million in 2001-02 to \$313 million in 2009-10. As a result of the increase in funding for Placement and Support, the proportion of total Child Protection and Family Services funding directed to Statutory Child Protection has decreased from 43 per cent of statutory care costs to 32 per cent.

Figure 19.1 Victorian Government funding for Child Protection and Family Services, 2001-02 to 2011-12



Source: Victorian Government, *Victorian Budget* (multiple editions 2001-12)

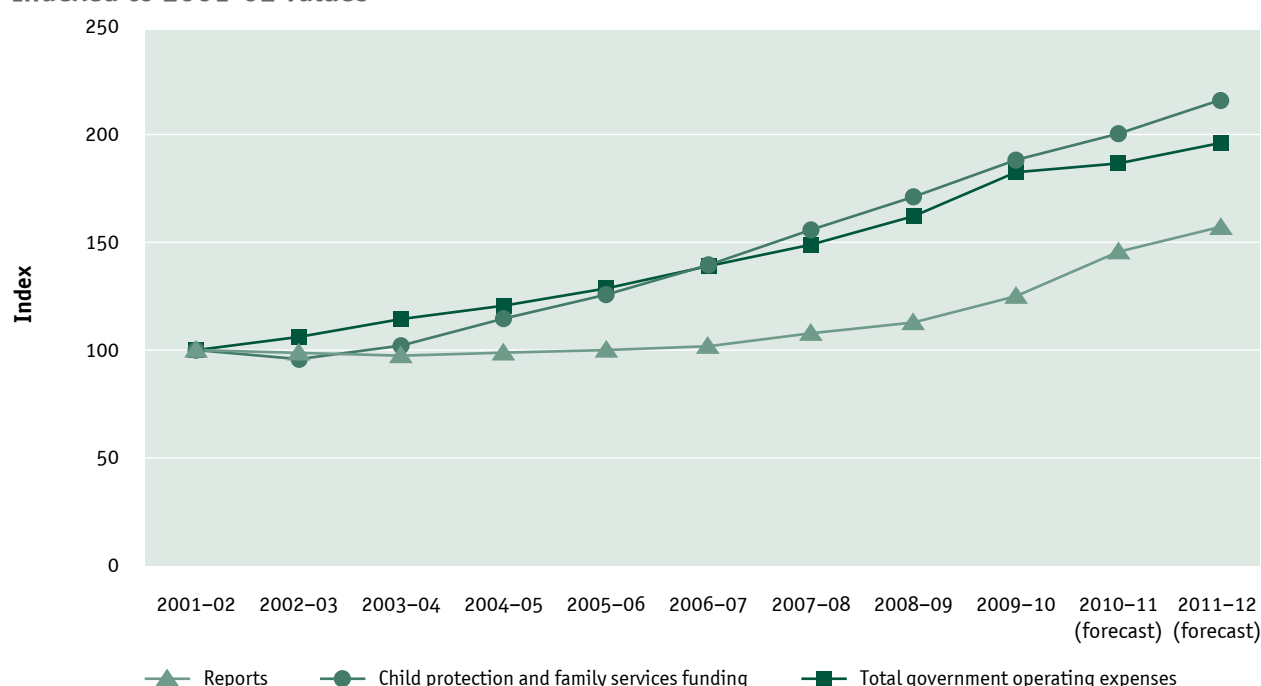
Figure 19.2 Victorian Government funding for Statutory Child Protection, 2001-02 to 2011-12



Source: Victorian Government, *Victorian Budget* (multiple editions 2001-12)

Note: Child Protection Specialist Services category discontinued in 2008-09 and largely absorbed within Placement and Support.

Figure 19.3 Child protection reports, Victorian Government funding for Child Protection and Family Services and total Victorian Government operating expenses, 2001-02 to 2011-12: Indexed to 2001-02 values



Source: Analysis of information provided by DTF

Funding for child and family services has increased significantly over the decade to 2011-12 (by an average of 8 per cent per annum). In nominal terms, the recent growth in expenditure has outpaced growth in total government expenditure over the past decade by about 1 per cent per annum. Expenditure growth has also outpaced growth in the number of reports of suspected child abuse, which has increased by about 4.3 per cent per annum over the past decade (see Figure 19.3).

After approximate allowance for inflation, the increases in funding have not been as significant. While the number of reports received by DHS increased by around 45 per cent from 2005-06 to 2010-11, real funding for Statutory Child Protection services increased by 28 per cent. Real funding for Child Protection and Family Services increased by 31 per cent over this time, mainly due to additional expenditure on Placement and Support.

Future outlook

The 2011-12 Victorian Budget projects that child protection reports to DHS will increase by a further 7 per cent in 2011-12 to 59,700. This comes on top of growth of 13 per cent and 15 per cent in 2009-10 and 2010-11 respectively. In 2011-12, real funding for Statutory Child Protection is expected to increase by only 6 per cent, while real funding for the overall, Child Protection and Family Services output is expected to increase by 8 per cent.

While increases in the number of reports and substantiations give an indication of increasing demand for child protection services, there have also been increases in activity in other areas of the statutory system. Table 19.2 shows that in June 2008 there were 11,815 active cases, while three years later this figure had increased by 6 per cent to 12,543.

Although significant, the increase in the number of open cases understates the increase in workload. Most noticeably there have been increases in the number of cases in the investigation, protective intervention and protective order phases (the activities relating to each of these phases are explained in Chapter 9).

The increase in open cases in these stages is somewhat offset by a 53 per cent decrease in the less resource-intensive closure phase. Case closure is a largely administrative exercise aimed at ensuring it is appropriate to cease child protection involvement with the child and family and that all necessary activities associated with the case have been completed. It may also include referrals to appropriate support services.

Table 19.2 Open child protection cases, by phase of case, June 2008 to June 2011

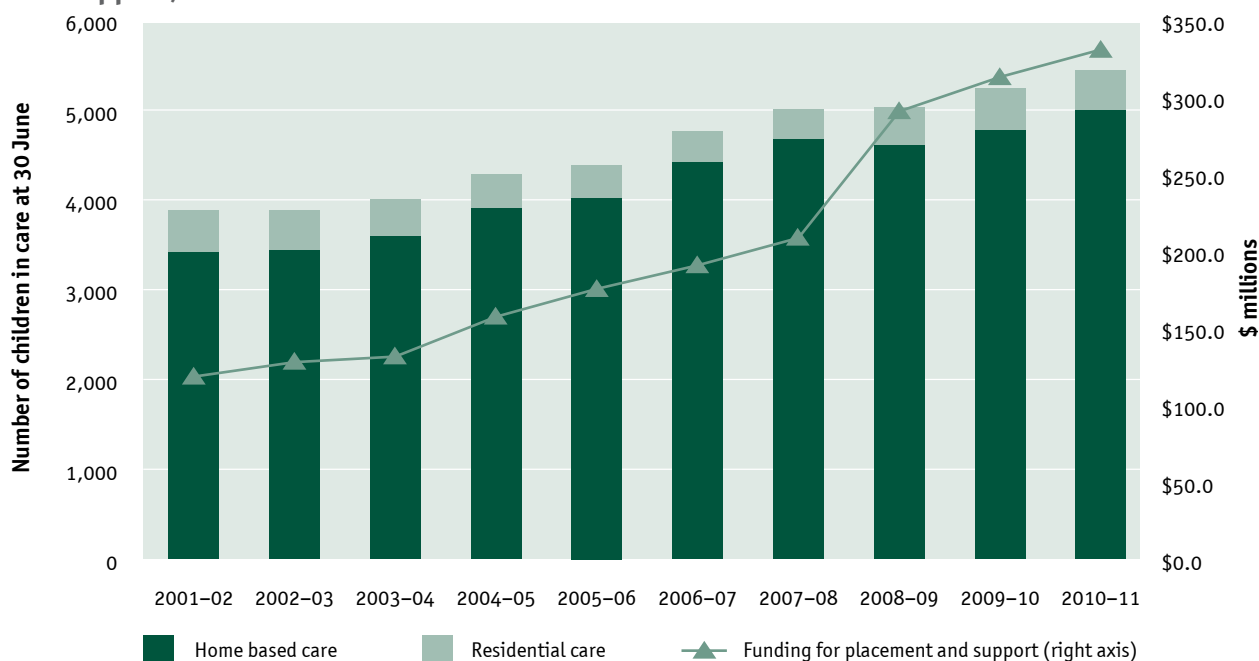
Case phase	June 2008	June 2011	Change
Intake	1,637	2,085	27%
Investigation	2,011	2,303	15%
Protective intervention	1,696	1,926	14%
Protective order	5,152	5,614	9%
Closure	1,319	615	-53%
Total	11,815	12,543	6%

Source: Information provided by DHS

19.3.2 Placement and support funding

Similar demand issues exist in relation to out-of-home care. Funding for placement and support services has increased substantially over the past decade, more than doubling between 2001-02 and 2010-11. Although funding has increased, there has also been a significant increase in demand for out-of-home care services, with the number of children in care increasing by 45 per cent from 2001 to 2011, including by 29 per cent since 2005.

As illustrated in Figure 19.4, the growth in nominal funding for out-of-home care has outpaced the growth in the number of out-of-home care placements.

Figure 19.4 Children in out-of-home care and Victorian Government funding for placement and support, 2001-02 to 2010-11

Source: Steering Committee for the Review of Government Service Provision 2011c, Table 15A.57 and information provided to the Inquiry by the DTF

19.4 Key issues relating to funding arrangements

The adequacy and distribution of funding for statutory child protection and family services has been a key issue for the Inquiry and was raised numerous times in submissions and during the Inquiry's public consultation process.

This addresses three key issues identified by the Inquiry relating to funding, namely the:

- Adequacy of existing funding;
- Distribution of funding; and
- Method of funding services.

19.4.1 *The adequacy of existing funding*

In Victoria funding for statutory child protection and family services is allocated annually as part of the annual budget process; however, there is no automatic link between funding and the level of demand for services. The disjunction between funding and demand can mean it is often difficult to quickly respond to increases in demand for services, without first having regard to issues of capacity.

Linking funding to the level of demand

Funding child protection services based on the actual or projected level of demand for those services would potentially enable decisions about the appropriate pathways for children, whether through family services, statutory child protection or other interventions to be made with less regard to system capacity at a given point in time. Adoption of a demand-driven approach, it is argued, would mean these decisions would be focused on the needs of the child, rather than the system capacity at a point in time.

A number of submissions also argued that the disconnection between demand and the level of funding available extends beyond the statutory system, affecting performance in other areas. The Berry Street submission argued that: Setting a somewhat arbitrary and capped figure for out-of-home care, including Kinship Care and Permanent Care, funding for each financial year across the system simply rations those available resources between children and young people in the system in a particular year ... It also perpetuates the increasing use of responses which are unplanned and temporary and further damage children (pp. 42-43).

Similarly, the submission received from Anglicare Victoria notes that 'excess demand for Child FIRST services has resulted in a capping of referrals at a number of service locations, particularly in ... Melbourne's growth corridors where the demographic reflects a high proportion of families with children and

a high birth rate'. Citing concerns about future growth in demand for Child FIRST services, Anglicare Victoria recommended that a 'family welfare service formula' be developed to address the expected growth for Child FIRST operations in growth corridors (pp. 10-11).

Demand-based funding in Western Australia

Western Australia has moved some way towards a demand-based funding mechanism for its statutory child protection services. In Western Australia the Department for Child Protection caps case loads per worker and ties demand into the funding model.

The Western Australian Department for Child Protection advises that the case-capping model highlights when resources do not match demand and provides a basis for linking funding to case service requirements (Inquiry meeting with Department for Child Protection).

Capping case loads was supported by the Community and Public Sector Union (CPSU) in their submission to the Inquiry. The CPSU stated that without case-caps staff, who are already under pressure with a high number of cases, are being assigned more cases as the unallocated list grows and there is increasing political pressure to be seen to be getting the unallocated list down (p. 53).

Case-capping has not been supported by DHS in the past. Case-capping can be seen to reduce flexibility within the child protection workforce, including:

- Not taking adequate account of differences in the complexity of cases and the impact this has on workloads – there are examples of cases where the complexity, or risk to the child requires the almost full-time attention of a worker, whereas others may be reaching the closure phase and require much less time from workers; and
- Reducing the flexibility of DHS to respond to significant child protection events within prescribed caps – for example, in May 2010 it was found that there were some 300 registered sex offenders that were living with, or had unsupervised contact with children, requiring an additional 739 investigations by DHS in a short period of time (Victorian Ombudsman 2011b, p. 19).

While case-capping has been the main mechanism used by Western Australia to incorporate demand into their funding model, ensuring that demand is properly funded can be achieved without the need for case-capping. The Inquiry's preferred position is that increases in the level of demand for child protection and family services be incorporated into Victoria's system for protecting children through improved planning and anticipation of these increases.

Summary

Chapter 9 considers in detail the question of statutory intervention capacity and the range of relevant factors and considerations that need to be taken into account in arriving at an informed assessment. In particular, Chapter 9 identifies that, while up-to-date information on many of these issues is not available, there is prima facie evidence of increasing demand for services in all areas of statutory child protection and family services.

These increases have been driven by a number of long-term factors, including changes to the *Children, Youth and Families Act 2005*, a broadening of the definition of abuse, the introduction of mandatory reporting as well as population increases. Specific increases have been seen in the number of child protection reports received by DHS annually, the number of children in out-of-home care and also the over-representation of Aboriginal children in Victoria's system for protecting children.

While statutory child protection and family services funding has increased substantially over the past decade, new budget initiatives and capacity funding have generally come as a response to demand pressures, rather than in anticipation of them. The Inquiry expects the demand for child protection and family services will continue to increase for the foreseeable future and additional funding will be required to address meet this increase in demand. Over time the reforms and enhancements proposed by the Inquiry will impact on this growth in demand.

Recommendation 76

Future funding of child protection and family services should recognise and anticipate the underlying growth in demand in future budget processes for statutory child protection, out-of-home care and family services.

19.4.2 The distribution of funding

Concerns and issues with the geographical distribution of funding were raised in a number of submissions to the Inquiry. The matters raised included:

- Problems with historical resource allocation;
- Planning for regional growth;
- Inadequate funding for rural and remote areas; and
- Inadequate funding for indigenous services.

Problems with historical resource allocation

A joint submission prepared from Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare (Joint CSO submission), noted that:

The location of services for vulnerable children, young people and families is largely historically driven and the distribution of services has not matched patterns of population shift and growth. The result of this is that there are large areas of the state, often the areas that vulnerable families reside, that have no support services available (p. 41).

These concerns with the current method of resource allocation are reiterated by the Victorian Ombudsman. In 2009 the Ombudsman commented that:

[T]he threshold of risk to children tolerated by the department varies across regions and according to the department's capacity to respond. In my opinion it is unacceptable that the geographic location of a child should dictate the risk to their safety that is considered (Victorian Ombudsman 2009, p. 11).

Planning for regional growth

In its submission to the Inquiry, CatholicCare identified issues with the adequacy of funding allocated to growth areas, including the western corridor of the North and West Region and the Southern Region. According to CatholicCare, their programs are 'unable to cater for the population growth now, with ongoing population projections a cause for concern'. In the Southern Region, CatholicCare has had to implement case load controls in response to Child FIRST being 'overloaded' (CatholicCare submission, p. 9).

Inadequate funding for rural and remote areas

The Take Two Partnership observed particular difficulties with providing adequate coverage of services in rural areas, noting that current recruitment and funding models ‘commonly underestimate the additional demands placed on rural staff due to reduced access to infrastructure, greater distances for travelling and fewer services to collaborate with’ (Take Two Partnership submission, p. 8).

Inadequate funding for Aboriginal services

The submission prepared by the Victorian Aboriginal Child Care Agency (VACCA) cites the need for funding to be weighted in recognition of factors that uniquely affect Aboriginal Victorians, including ‘ongoing trauma arising from past government policies and practices’, the ‘complex family size and structure’, ‘disadvantage within families and communities’, as well as ‘more limited fundraising capacity’ in Aboriginal communities (p. 55).

Further, submissions also raised issues with the current funding arrangements for CSOs, often in connection with broader governance issues. This included issues with the level of administrative burden associated with the funding and delivery of services:

Where a large sum of money is involved, it is naturally accepted that tender and acquittal processes will be comprehensive. Where tender and acquittals are for smaller amounts Jesuit Social Services would submit that there should be a proportionate reduction in the administrative processes (Jesuit Social Services, p. 16).

Alternative methods of resource allocation

There are many options available for determining the regional allocation of resources that may enhance the current model used by DHS, including the Socio-Economic Indexes for Areas developed by the Australian Bureau of Statistics to facilitate assessments of the welfare of Australian communities. An option that was not available to DHS when the equity formula was developed is the Australian Early Development Index (AEDI). Incorporating the AEDI into the resource allocation model for child protection and family services is one of a number of options for channelling funds to the neediest areas of Victoria.

The Australian Early Development Index

The AEDI is a population measure of young children’s development. Similar to a census, it involves collecting information to help create a snapshot of children’s development in communities across Australia. Teachers complete a checklist for children in their first year of full-time school, measuring five key areas, or domains, of early childhood development:

- Physical health and wellbeing;
- Social competence;
- Emotional maturity;
- Language and cognitive skills (school based); and
- Communication skills and general knowledge.

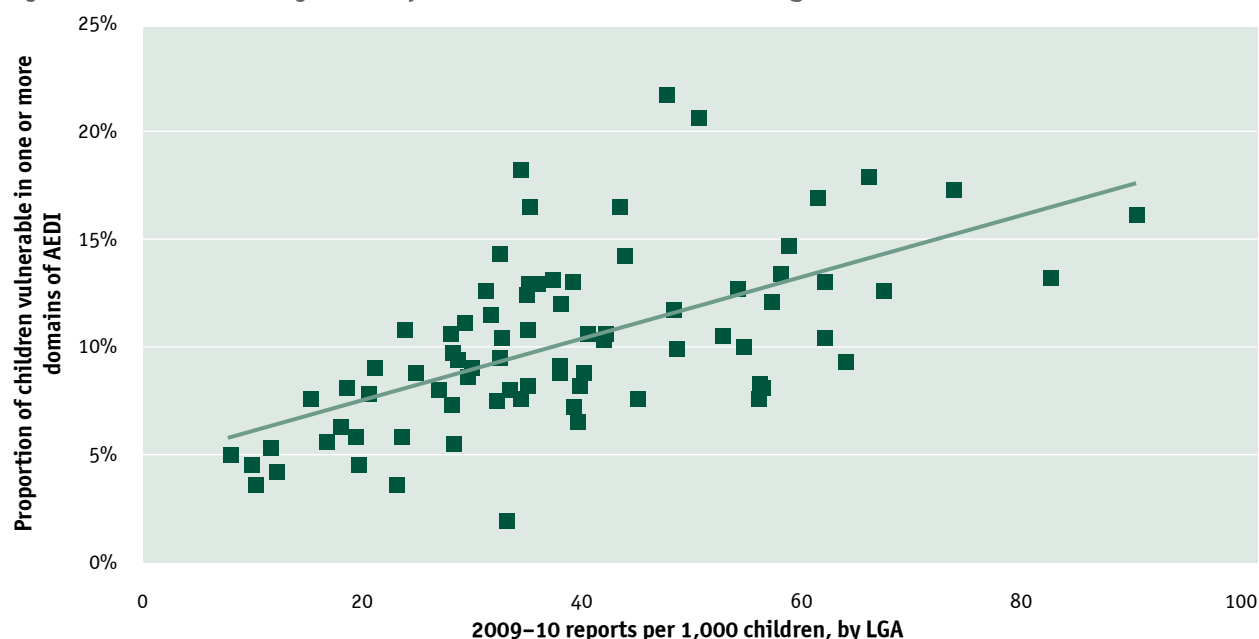
These areas are closely linked to the predictors of good adult health, education and social outcomes.

Although the AEDI is completed by teachers, results are reported for the communities where children live, not where they go to school. AEDI results allow communities to see how children are doing relative to, or compared with, other children in their community, and across Australia.

The AEDI ranks children as being either developmentally vulnerable (below the 10th percentile), developmentally at risk (between the 10th and 25th percentile) or developmentally on track (above the 25th percentile). A preliminary analysis of the relationship between child protection reports to DHS and the results of the AEDI, by local government area (LGA) suggests there is a strong correlation between the two.

Figure 19.5 shows that, in LGAs where the rate of reports per 1,000 children is higher, the proportion of children that are vulnerable in one or more domains of the AEDI is also likely to be higher. The AEDI may be an appropriate alternative to the current system of allocating funds based on Family Tax Benefit A. It is scheduled to be updated every three years.

Figure 19.5 Relationship between child protection report rates and vulnerability, as measured by the Australian Early Development Index, Victorian local government areas, 2009–10



Source: Information provided by DHS, Department of Planning and Community Development Preliminary Population Projections (unpublished) and AEDI information provided by the Department of Education and Early Childhood Development

Geographic mechanisms

Other measures that could be incorporated into resource allocation include the geographic size of the region. DHS and CSO workers in regional areas often travel large distances to visit children, or to attend court hearings or supervised visits, increasing demand on the amount of resources required to deliver services in these areas.

The method for allocating resources employed in Alberta, Canada provides a useful example of one potential way to incorporate geography into one distribution of resources. In addition to measures of population and poverty, in Alberta, 5 per cent of resources for child protection are distributed based on the land mass of the service regions.

In Chapter 2 of this Report, the Inquiry found evidence of a strong geographic component to the distribution of abuse and neglect in Victoria. In developing the broader policy framework (Chapter 6) the Inquiry found that an area-based policy and program design and delivery is most likely to address vulnerability and to protect Victoria's vulnerable children. The Inquiry recommended area-based policy and program design and delivery, reflected in the proposed Vulnerable Children and Families Strategy.

Regional resource allocation in Alberta, Canada

The Canadian province of Alberta determines regional funding allocations for the 10 Child and Family Services Authorities based on the following formula:

1. The child population of the region – 45 per cent of regional funding;
2. The rate of poverty (measured by the percentage of the region's population living below the Low Income Cut Off) – 50 per cent of regional funding; and
3. Access to services (measured by the region's percentage of total provincial land mass – 5 per cent of regional funding.

Alberta also reserves 0.5 per cent of the total funds available for regions to be invested in innovative means of delivering services based on the region's local priorities and unique operating environments.

Source: Commission to Promote Sustainable Child Welfare 2010b

Recommendation 77

Funding for child protection and family services should be distributed in accordance with an area-based approach and according to a common methodology.

The Department of Human Services should develop this methodology so that funding is distributed on an equitable basis to the areas that need it most. The methodology should take into account :

- The population of children in a region;
- The level of vulnerability of these children, including the Aboriginal population; and
- Factors that increase the cost of service delivery in regions, such as remoteness and the geographic size of the area.

The method should be able to be regularly updated and should be incorporated into future system planning.

19.4.3 The approach to funding services

Many submissions by CSOs and representative organisations cited a lack of flexibility in the current output and service agreement funding approach, expressing the view that the funding of services outputs is overly prescriptive compared with an outcomes-based or a more client-centred approach.

The alternative governance framework advocated by some of the largest CSOs argued there is a need to move to funding for outcomes, and with greater flexibility at the service delivery level for implementing the necessary service mix to achieve outcomes.

Alternatives to the current funding model

Models for funding statutory child protection and related services vary significantly by jurisdiction across Australia. As noted above, the Victorian approach is to fund CSOs on the basis of their level of service activity, or output, with total funding for services determined based on unit prices for services and the number of services provided.

Outcomes-based funding

Outcomes-based funding can be construed in a number of ways. However, generally an outcomes-based approach aims to shift the emphasis from the services that are provided to what outcomes they will achieve. An outcomes-based approach can link the level of funding to performance against these outcomes, but this is not a prerequisite of an outcomes-based approach.

Several submissions, including the Joint CSO submission, have argued for a switch to an outcomes-based method of allocating funding for statutory child protection and family services. These submissions were supportive of a model providing more flexible funding to purchase services aimed at achieving a desired outcome, rather than one that directly link the level of funding to the outcomes of their activities. The Joint CSO submission stated that:

An outcomes-based funding model could potentially involve outcomes related to health, wellbeing and emotional development, being looked after, safety, educational attainment and participation in social and community life (p. 59).

A number of submissions by CSOs argued that changing from the current approach of funding outputs to a system of funding based on outcomes is consistent with an approach focused on 'the needs of the child'.

Outcomes-based funding is seen as allowing a more tailored service response or course of action to be adopted in conjunction with child protection to support placement prevention. One example provided is that of a depressed single mother whose two primary school aged children are not receiving regular meals or attending school. Under the current funding approach, if the assessment is that the children are suffering significant harm and there are no suitable relatives to provide care, foster care may be considered the only option. Under a more flexible outcomes-funded approach, an alternative pathway could be developed that could include intensive support. A worker might visit daily and assist in parenting tasks and caring for the children by, for example preparing the evening meal, supervising homework and other services. It is argued that this level of assistance can be more effective and provided over a much longer period of time for the same cost of a short-term placement in foster care (Joint CSO submission, p. 59).

There are a number of practical considerations that flow from the implementation of any change in the funding arrangements for CSOs, such as the implementation of outcomes-based funding, including:

- Difficulty of defining, agreeing and accurately measuring 'outcomes' or success; Broader system impacts, including consistency with DHS and Victorian Government funding practices;
- The cost of implementing changes compared with the benefits that are hoped to be achieved; and
- Many outcomes can only be observed in the long term.

Jurisdictional comparisons

In practice, reforms to secondary support programs in Western Australia provide an example of a system focused on achieving outcomes, within what ultimately remains an output-based funding mechanism.

Western Australia is currently reforming its procurement of secondary family support programs, including shifting the focus of funding inputs to outcomes. However, in the *Western Australia Review of Secondary Family Support Funding Programs*, it is noted that 'it is not possible to purchase outcomes. They occur later and the extent to which they are achieved is the measure of the effectiveness of the purchased service' (Department for Child Protection 2011b, pp. 38-40).

Western Australia is instead proposing that future service agreements define the outputs that agencies are contracted to deliver in order to achieve desired outcomes but with sufficient flexibility in funding arrangements for those outputs to be renegotiated as new needs emerge or more effective service responses become evident (Department for Child Protection 2011b, pp. 38-40).

Other jurisdictions in Australia are also moving towards more output-based funding mechanisms for community services. For example, in Queensland the Department of Communities is transitioning its disability funding from an input-based mechanism based on the resources required to produce an output, that service providers must acquit against line items in a budget at a program or grant level (Department of Communities 2011).

Similarly, in New South Wales, development of fixed prices for CSOs delivering out-of-home care is an ongoing process as part of a broader reforms to out-of-home care resulting from the *Keep them safe report* (Family and Community Services 2011).

19.5 Conclusion

Having reviewed the merits of an outcomes-based approach, the Inquiry does not consider that an overall transition to outcomes-based funding would be of practical benefit to Victoria's vulnerable children, young people and families, nor is it practical to administer an outcomes-based approach.

However, the Inquiry has identified a number of improvements that could be made to the funding arrangements for statutory child protection and family services delivered through CSOs, including (as outlined in Chapter 10):

- Increasing the flexibility of funding arrangements through greater use of client-based funding for out-of-home care; and
- Referring the design of a client-based funding approach to the Essential Services Commission (ESC).

As discussed in Chapter 17, DHS both funds and is dependent on CSOs to deliver critical services and interventions on behalf of government. CSOs are in turn dependent on government, as the sole purchaser of the services they deliver, to fund them at price levels that are sufficient to meet performance standards set by DHS. Currently there is no independent oversight over the pricing of services delivered to CSOs.

Moreover, the Inquiry accepts the general view put forward in a number of submissions from CSOs that there is a need for a more flexible approach across the board to the funding of the services these organisations deliver.

The Inquiry considers these two issues of the flexibility of service funding and a fair and appropriate basis for service funding are critical to the future effective, innovative and robust provision of services to vulnerable children and families. DHS has, over time, modified the range of discrete services that are funded and included in the service agreements with CSOs. However, particularly in the placement and support area, there is a significant range of discrete placement types and add on services (discussed in more detail in Chapter 10). This will be addressed by the recommendation to move to a client-based funding approach. However, the Inquiry considers there are other service areas where adopting a more generic or broad-banded approach will facilitate more client centric services.

Recommendation 78

The Department of Human Services should review the list of individual placement and support, and community and family services activities provided by community service organisations. The number of these activities and their funding arrangements should be consolidated as part of adopting a more client-focused approach based on broader service types.

An appropriate basis for service funding requires consideration of all relevant and indirect costs including, for example, relevant staff development and infrastructure.

In this regard, the Inquiry agrees with the general position put forward in the recent Productivity Commission research report on the contribution of the not-for-profit sector.

Australian governments should, in the contracting of services or other funding of external organisations, determine and transparently articulate whether they are fully funding particular services or activities undertaken by not-for-profit organisations, or only making a contribution towards the associated costs and the extent of that contribution.

Australian governments should fully fund those services that they would otherwise provide directly (allowing for co-contributions from clients and any agreed contributions by service providers). In applying this criterion, governments should have regard to whether the funded activity is considered essential, as part of the social safety net or an entitlement for eligible Australians (Productivity Commission 2010, p. 290).

In particular, the Inquiry considers the provision of statutory-related services to vulnerable children and their families represents a core and essential role of governments and the CSOs providing them should be funded accordingly.

Recommendation 79

The Government should adopt an explicit policy of fully funding child protection and family services delivered through community service organisations, including provision for infrastructure and other relevant indirect costs.

On an ongoing basis, there should also be a greater level of independent oversight of the Government's role as the sole purchaser of services delivered through community service organisations. The Essential Services Commission should be given an ongoing role to periodically determine the appropriate prices for child protection and family services that are delivered through community service organisations.

