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Submission to Protecting Victoria's Vulnerable Children Inquiry

Merri Community Health Services (MCHS) welcomes the opportunity to contribute to this inquiry. This submission highlights key issues from the perspective of an Integrated Family Services provider with the aim of delivering high quality, flexible and appropriate services to effectively meet the needs of vulnerable children and families in our community and also provide opportunity for sustained family growth and development. The MCHS Integrated Family Services (IFS) team has worked with and supported many families through the current services system and this submission aims to capture some of our experience by highlighting system benefits, systemweakness and gaps, and make recommendations towards system improvements that will transpire in better client outcomes.

Background

Merri Community Health Services Limited (MCHS) formerly known as Moreland Community Health Service Inc is a multidisciplinary community health service andprovides services in Moreland and surrounding LGA's. MCHS aspires to make a positive difference in people's lives by being an innovative and integrated health, community and advocacy service provider. We operate within a social model of health context to provide high quality services and build the strength of our community.

MCHS provides a range of services including: dental, varied allied health disciplines, generalist and specialist counselling programs, aged and disability services, case management, family support and carer support programs, and social support programs for people with a mental illness as well as health promotion programs.

MCHS has been a provider of services to families and children in the region since the early days of establishment through its diverse cohort of service provision including:

Family Program – family centred early intervention and prevention to vulnerable families;

RAFT - Relationship and Family Therapy program providing therapeutic and supportive counselling for families dealing with Alcohol and Other Drug issues;

TRACKS – youth outreach program focussing on early intervention and preventionwith substance misuse;

Family Violence service provision to women and children;

Interchange North West – Support, recreation and respite opportunities for children and young people with disabilities and their families;

Child Health Team encompassing allied health, child psychology and paediatrician services;

Youth Health Team – provides a range of youth specific services and programs targeting young people including counselling, school focused youth service, education and support for schools and individuals with regard to physical and mental health, sexuality and relationships;

Foundations Early Childhood Intervention services - assessment, intervention and support for preschool aged children with developmental delays, and their families;

HIPPY – home-based parenting and early childhood enrichment program for parents and youngsters;

Victims Assistance and Counselling Program - practical assistance and support for victims of violent crimes including young people and children;

Carer Links North - Young carers 'at risk' respite program;

Mental Health service provision to families and individuals.

Furthermore, MCHS has undertaken innovative and targeted health promotion and research with children, young people and families through a number of initiatives including:

- Fun n" health in Moreland - Community based research in partnership with Melbourne University to encourage healthy eating and physical activity in primary schools

- Smiles 4 Miles - Improving oral health in early childhood through a range of strategies
- Teeth Tales - Community based research in partnership with the University of Melbourne to better understand the cultural appropriateness of oral care strategies and health of children.

Integrated Family Services

In March 2008the MCHS 'Family Program' became an Integrated Family Service (IFS) provider as part of the Hume –Moreland Child First Consortium and delivers services to vulnerable children and families in alignment with the 'Best Interest' Framework as outlined in the Children, Youth and Families Act 2005.

This submission addresses the following Terms of Reference: 3.1, 3.2, 3.3, 4, 5 and 7.

Submission:

Terms of Reference 3:

The quality, structure, role and functioning of: family services; statutory childprotection services

3.1 Integrated service approach to service delivery for vulnerable children and families. Strengths and weaknesses?

The integration and closer alignment of services for vulnerable children and families brings increased benefits to clients as increased communication generally results in the implementation of more effective and comprehensive interventions and strategies (treatment plans) targeting holistic family needs rather than addressing individual needs in isolation. This approach generally transpires in improved client outcomes as the child and family can receive high quality care with all facets impacting on the child and family being addressed.

Diversity in non-government organisations (NGOs) who deliver IFS transpires in both strength and weaknesses. For MCHS, being a diverse 'community health provider' IFS forms part of a much bigger service delivery platform thus the program can be better supported and have access to other services thus able to draw in appropriate skills and knowledge as required for improved service delivery. For some agencies, 'Family Services'

are the core and often only business the NGO delivers, thus not having access to a broader sweep of services/expertise. This disparity often can result in different priorities that are needed to be met with different timelines by these diverse agencies.

Whilst client benefits due to increased communication and integration are widely acknowledged, weaknesses in the current service approach include:

- The difficulty of balancing the management of core business (service delivery) with resource requirements to ensure partnership/integration demands are adhered to. These include Weekly (Client) Allocation meetings, Monthly Management Operational meetings, bi-monthly Executive meetings, participation on internal and external working groups, projects and initiatives. Also time is required for catchment planning, service development/training and strengthening linkages with other services.
- The interface between IFS and Child Protection (CP) is not always conducive to better outcomes for vulnerable children and families as there isn't clarity around roles and expectations.
- Interface between CP and IFS also needs clarity and a shared definition of 'risk' as often there is great diversity in each agencies articulation of this leading to poor and/or time delays in service commencement and provision.

MCHS recommends:

- A review of IFS funding to assess the impact of service integration and increased collaboration on direct service delivery; a cost- benefit analysis.
- Funding body clarification of respective agency roles, responsibilities and expectations and an agreed shared definition of 'risk' that sets the cornerstone for interaction.
- An evaluation of the integrated approach to treatment planning re effectiveness in both resource utilisation and also client outcomes.

3.2 Skilled Workforce. Current issues and needs?

Workforce issues are a primary concern for NGOs and more particularly for services such as IFS. Our experience to date suggests that employees do not view these roles as attractive as they are being aligned along the same continuum as Child Protection (CP). Key concerns include:

- Job Definition. The key scope of the role of IFS employees has expanded over time with no set boundary and skill articulation.
- Staff retention: workforce shortages and increased competition for labour.
- Inadequate remuneration. Increasing demands placed on staff in terms of job roles has not been aligned with increased remuneration to compensate for expansion of 'family support worker' roles and responsibilitiesdue to complexity of presentations and workload demands.
- Training and support. Whilst staff is expected to undertake a range of diverse roles with this profession – counsellor, advocate, case manager, family therapist, etc, professional development is sometimes compromised by increased service demands, high workloads and attending to external requirements as part of partnership requirements.

MCHS recommends:

- A scoping exercise of the IFS job function and departmental direction re IFS role and parameters.
- A review of and clearer articulation of minimum skill and qualifications for IFS employment.
- A review of remuneration for this sector and particular job function.
- Ongoing and planned training and professional development opportunities.

3.3 What are the strengths and weaknesses of current services designed to assist families who are at risk of becoming involved in the statutory child protection system (for example ChildFIRST)?

The MCHS Family Services program, since its transition to an IFS provider has witnessed a shift away from preventative work , where the clients were often self referrals and willing to engage, to a milieu or working environment were the work is dealing with families who are often in perpetual crisis and much more grounded in a crisis intervention approach. Often these clients do not wish to have IFS involvement and reluctantly engage which leads to poor outcomes. The service provided is often reactive rather than proactive due to the nature of complexity and ongoing, compounding variables.

The current service design has resulted in a vast increase in more marginal “at risk” families being referred directly to ChildFirst rather than going to CP Intake. Furthermore, notifications which are unsubstantiated at CP Intake are referred on to community based services via ChildFirst allocation processes for immediate service. This puts the system as a whole under enormous strain with little or no capacity to do any early intervention work that would prevent families from falling into the statutory child protection system. This is part of the ongoing challenge IFS experience in being ‘stuck’ in a secondary system where they have no control over. There is few universal service options for family referrals for clients whose needs are low compared to other ‘complex’ clients. Thus, the questions that need addressing are:

- Where else do these families go now for support?
- Will we be seeing this clients in the CP system or at our own door step with high and complex needs down the track?

The other cohort of clients that MCHS has identified is the ‘chronic’ and ongoing high risk families who due to unfortunate and often generational issues will, in most cases, never exit the current service system. These clients, whilst require intense and ongoing ‘family support’ drain current resources and halt service throughput. A question for consideration is whether these clients are an appropriate referral to IFS or whether another specifically tailored level of intervention would be more appropriate?

Current resourcing is insufficient and need to be increased at all levels of the service system. The perpetual focus of the current service system on diverting ‘at risk’ families away from the statutory child protection system has done very little by the way of increasing family outcomes. Instead, it has shifted a service delivery/capacity issue that has always existed in child protection onto community based family service providers who now experience the chronic and crippling effects of working with families with such high needs except without the statutory powers CP holds.

MCHS recommends:

- Review and increase in resources across this service sector to ensure service demand can be effectively met.

- Specific funding and tailored service responses attached to distinct client sub-groups, i.e. ‘chronic’, complex and low-need.
- A review and analysis of referrals from CP to IFS and their appropriateness and vice versa.

4. The interaction of departments and agencies, the courts and service providers andhow they can better work together to support at-risk families and children.

In principle the legislative framework and best interest principles set out by the Department provide a comprehensive and integrated approach to meeting the holistic needs of vulnerable children and families. The implementation of this framework ‘on the ground’ however is questionable as individual agency contractual obligations instil different approaches.

Whilst there is a commitment to producing better outcomes for vulnerable children and their families this is not always the case as service sectors do not always work in collaboration. The relationship between Child Protection (CP) and IFS is at times adversarial rather than collaborativeoften leaving IFS in a powerless position to advocate for client needs. Inadequate resourcing of CP is the perceived reason for this ‘blocking’.

There needs to be a clear commitment to supporting the ‘family unit’ from all service sectors. Services involved often only address parts of the issue and at times have very different views in regards to what would be beneficial in supporting parents, children and the family unit. Information that is provided across services can be skewed by individual opinion and agency mandate. Thus, comprehensive assessments with clear recommendations regarding what treatment and support services are needed for the entire family, not just vulnerable children. This would reduce conflict between services (CP & IFS) and individual workers and assist greatly in children, parents and families receiving the treatment and support needed. A lack of shared current client information is also often a problem thus there is aneed for a better and shared client record system.

5. *The appropriate roles and responsibilities of government and non-governmentorganisations in relation to Victoria's child protection policy and systems.*

One of the most obvious challenges for MCHS is the increase in the numbers of high risk clients we are now working with, both children and their families. IFS is not a mandated service so more and more we are engaging with reluctant families with chronic and complex issues where the level of risk is high and CP involvement is essential. It is our experience that there has been transference of risk (and cases) from CP to non-government support agencies to manage and whilst this may provide many benefits to vulnerable families, it raises concerns at where the divide between legislative and voluntary service provision begins and ends. Agencies are now much more inclined to be engaging with reluctant families which often result in poor outcomes and an ineffective use of resources.

Whilst there is a commitment to a partnership approach in this sector, increased consultation and discussion between government and non-government stakeholders can only lead to enhanced service delivery. NGOs should be given the opportunity to provide input into government policy and decision-making and share their experiences – both positive and negative – as a learning tool for service enhancements. Feedback should be viewed as constructive rather than destructive.

MCHS recommends:

- A review and clearer definition of the role of non-government voluntary agencies and CP.
- A clear definition of expected 'risk' to be carried by respective agencies.
- Increased opportunities for NGOs to input into government policies, procedures and future service planning/enhancements.

7. *Measures to enhance the government's ability to: plan for future demand for familyservices, statutory child protection services and out-of-home care; and ensure a workforce that delivers services of a high quality to children and families.*

MCHS acknowledges the difficulty in planning for future service delivery in this area however a few key indicators need to be taken into consideration inclusive of whether current resources allocated to this target group are accurate and meet demand. MCHS submits that

current resource allocation to this sector is insufficient and demand for services far exceeds capacity. This is evident from the four contingencies the Hume-Moreland Alliance has had to implement to manage the growing demand and expectations from the sector and effectively 'shut' the door to new referrals for periods of time to effectively balance the demand/capacity ratio. Also, it can be argued that there is also a 'hidden demand' within the sector as the threshold for acceptance into Child First has risen dramatically, leaving families and children whose issues are considered 'less' critical/complex in search of other support services. Furthermore as population growth is projected to increase in the region a corresponding push on current demand can be expected, thus sustainability of the current service system is a question that needs further exploration.

MCHS suggests the following are considered to enhance the government's ability to plan for future demand for family services and the broader sector:

- Review of current funding and demand in this sector.
- Ongoing review and analysis of basic demographic data inclusive of projections in population growth and urban sprawl to ensure funding is directed into appropriate regions.
- The implementation of a funding model similar to the Aged Care sector whereby for every percentage increase in the birth rate(proportion entering 65 years and older in Aged care) a corresponding increase occurs in the funding percentage.
- Development of a state-wide policy and procedure on unmet demand to minimise risks to agencies and clients.
- Development of key workload and/or performance indicators which highlight trends such as: catchment population growth, referrals to ChildFIRST, numbers of individuals / families receiving services, numbers of ATSI and CALD children/families supported and staff numbers and their retention.

This submission is completed by:

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