Submission:
Protecting Victoria's Vulnerable Children Inquiry, April 2011

MonashLink Community Health Service Limited (MonashLink) is funded by the Department of Human Services Victoria to provide Family Services, predominately (but not exclusively) in the Monash local government area of the eastern metropolitan region of Melbourne. Funding is meager in organisational terms; Family Services funding is less than 1% of the MonashLink operating budget. In operational terms this funding translates to approximately one .8EFT position.

MonashLink is a registered Community Service Organisation under the Children, Youth and Families Act 2005. A successful external review was undertaken by Australian Healthcare Associates in October 2009. MonashLink is also accredited by the Quality Improvement in Community Services Association (QICSA). MonashLink is a member of the Inner East Integrated Family Services Alliance (the Alliance) and participates in the Executive and Operations meetings calendar.

Community Health lends itself to holistic primary care. Victorian government policy framework *Community Health Services –creating a healthier Victoria* (2004) outlines operational principles for conducting business in community health. Among these principles are

- Population based services and planning
- Addressing the social determinants of health
- Responsiveness to the local community
- Multidisciplinary responses in service delivery
- Partnership approaches to ensure best outcomes for a local community

MonashLink sees these principles as important foundations for their work, particularly in working with vulnerable families.

Response to 1, 2 & 5
The factors that increase the risk of abuse and neglect occurring and effective preventative strategies: and
Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services.
The appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's child protection policy and systems.

MonashLink advocates strongly for population health approaches to consolidate lasting community change. Strategic support for whole of government approaches is necessary to consolidate interventions. These approaches require a variety of responses that are long, medium and short term in nature. Some work is incremental and requires ongoing interventions to consolidate outcomes. (The Neighbourhood Renewal initiative commenced in Victoria in 2001 and now coming to a formal close is an important example of long-term commitment to targeted population health outcome strategies. MonashLink recognises the value of this option of intervening in a community to embed practice that is empowering and constructive to community capacity building)

MonashLink is keenly aware that of the seven nominated Victorian health promotion priorities, three in particular i.e.

- Promoting mental health and well-being,
- Reducing and minimising harm from alcohol and other drugs
- Creating safe environments to prevent unintentional injury

impact enormously on the incidence of abuse and neglect of children. *Health promotion priorities for Victoria 2007-2012* (2006)

Primary health strives to identify opportunities for early intervention as well as providing complex care responses. As part of the public health system of primary care, community health is continually striving to intervene at the appropriate time for best outcomes.

We have good examples of both early interventions that assist families in their roles and functions for the safety of the children as well as examples of complex presentations that require strategic, integrated long-term multi-disciplinary responses. We are acutely aware that the trend is towards complexity. While we welcome opportunities to assist families care for their children where there are multiple and complex issues, we are concerned about those families who no longer present for early intervention.

The introduction of Child FIRST and the centralized intake process appear to have tipped the scales in Family Services funded agencies towards complexity. MonashLink would support opportunities to provide more early interventions that can be timely in a family's development; cost-effective in their targeting and encourage the family to acknowledge difficulties before they become entrenched and systemic. The Child FIRST reform has perhaps inadvertently created a 'gap' in continuity of service responses; the service sector that provides early intervention is minimal and decreasing. .

MonashLink relies heavily on its internal pediatric allied health professionals to refer and consult internally when they suspect the best interests of the child are in jeopardy. Pediatric services such as speech pathology; occupational therapy; podiatry and oral health (i.e. dental services) work closely with all disciplines at MonashLink and in particular, Family Services, Family Violence and Alcohol and Other Drugs counselling to ensure children 'at risk' are identified and appropriately supported and referred. The coordinated, co-located services that

are available through primary health can produce a cost-effective model of intervention for the community.

The multidisciplinary approach of community health is invaluable in coordinating strategic responses to particular cases e.g. coordinated care across the Family Violence; Alcohol and Other Drugs - at MonashLink this is the Eastern Drug and Alcohol Service (EDAS); Financial Counselling and Family Services. These services are available under one-roof, can be quickly assembled and coordinated to effect positive intervention strategies.

Community health has strong links to the mental health service system. Primary Mental Health Teams, in particular, and their consultant psychiatrists are readily accessible to community health and can assist in expediting timely referrals when adult (parent) interventions are required. MonashLink also has well established working links with Child & Youth Mental Health Services (CYMHS). Referrals and secondary consultations are routine business.

The Family Violence and the EDAS teams, in particular, are crucial to integrated care for assisting families with children who are at risk of, or have experienced, neglect or abuse.

The reliance in Victoria on concentrating Family Services responses in the welfare sector appears to create a disconnection with crucial multi-disciplinary service links that are everyday, common-place practice in the primary health sector. MonashLink in no-way advocates for the demise of the welfare sector; however a review of resource allocation may see a transfer of more resources into a sector that has multiple entry points, multidisciplinary care planning and integrated treatment outcomes as a primary operating platform.

Summary Points:

1. MonashLink values the importance of actively pursuing health promotion initiatives, particularly when they are designated as State government priorities that impact on good health outcomes for families in our community.
2. Community Health (CH) is part of the primary health continuum. CH looks for opportunities for appropriate, timely interventions and values early intervention as part of a continuity of care response.
3. The introduction of Child FIRST appears to have tipped the scales in Family Services funded agencies towards complex presentations.
4. Has Child FIRST inadvertently created a gap in service response where opportunities for early intervention are disappearing?
5. The multi-disciplinary approach of CH means a variety of service responses can be quickly assembled and coordinated. Family Violence and Alcohol and Other Drugs services are examples of the service responses that are in-house and readily available.
6. Strong day-to-day working links exist between CH and mental health services, especially Primary Mental Health and Child and Youth Mental Health Services.
7. If a review of resources is to occur, CH would welcome the opportunity to receive a greater allocation of Family Services resources in the primary health sector.

Response to 3: The quality, structure, role and functioning of: family services; statutory child protection services, including reporting, assessment, investigations procedures and responses; and out-of-come care, including permanency planning and transitions; and what improvements may be made to better protect the best interests of children and support better outcomes for children and families.

Please note MonashLink will contain its response to Family Services and statutory Child Protection. Out-of-home care is outside our scope and experience.

MonashLink is troubled that since the inception of Child FIRST, presentations to our Family Services program are increasingly complex in nature. This in itself is manageable and MonashLink can respond in a timely and integrated fashion. Our concern however is that early intervention work is diminishing in a noticeable and alarming way.

In the past, families frequently contacted our Family Services program when they first noticed concerns with family dynamics, behaviour patterns or early dysfunctional responses; these presentations are now few and far between. The predominant presentation now is complex, entrenched and requires integrated, multidisciplinary responses. MonashLink is keenly aware that good, targeted health promotion programs, population health knowledge and translation into appropriate interventions and early intervention responses can equip families in the management of concerning issues before they become ingrained and entrenched. Our dilemma is that these families are now, not readily presenting. We are also aware that before the reform most Family Services agencies had lengthy waiting lists. Since the reform many agencies are finding it hard to reach target and have immediate capacity to offer service. (*MonashLink bases these comments on the Inner East Alliance catchments weekly Allocations Wait and Holding List.)*

MonashLink speculates whether the community has 'backed off' from requesting assistance. Anecdotally we hear that families are not being referred and are not self-referring to Family Services because the perception is that "it's really child protection now". The predominant pathway into Family Services, regional or sub-regional 'Allocations Meetings' must be confronting for families to be aware that their personal struggles are shared freely at these meetings until they are allocated to a particular agency. We would speculate that many families and referrers think long and hard before actively choosing **not** to seek help.

MonashLink also notes that there is considerable confusion around reporting procedures within Child Protection. While the intention behind separation of roles and tasks between Child Protection and Community Based Child Protection Team Leaders (CBCPTL) is admirable, the operational reality brings many confusing scenarios. There is an urgent need for clarification of role identification and boundaries. There appears to be a blurring of statutory obligation, particularly in CBCPTL roles. There are frequently vacant Family Services positions in the catchment area due to recruiting issues around child protection. This may account for some of the observable dilemmas in practice listed below.

In our experience there have been times when Child Protection intake workers have 'delegated' their statutory role to the Family Services worker to obtain more facts/evidence to warrant a protective notification. On occasions, CP has directed our agency to undertake certain functions that clearly sit within their statutory role. The therapeutic alliance is one that is slowly developed and carefully constructed; for a clinician to be placed in role of 'de facto' investigator clearly breaches this therapeutic alliance and working relationship. It also

jeopardises the 'best interest' of the child in the context of family treatment. The family may well ask, "Who are we dealing with; a therapist or a protective worker?"

MonashLink has now taken an organisational stance to refuse any further requests to perform 'investigative' functions on behalf of Child Protection. Best practice care always relies on ongoing inquiry and clarification of issues and practices; however directives to call a client into the service in an unscheduled nature, ask a battery of questions, and then report the findings back to CP, is outside the scope and intention of the Act. The Act does not give an imprimatur to delegate statutory roles; on some occasions it appears that the 'best interest of the child' can be translated to 'I direct you to undertake my role'.

There is an urgent need for clarification and training for CP on their legal, professional and moral obligations in this demanding work with children; in fact on-going universal training across the sector would be welcomed.

As a suggestion, structured reciprocal rotations might offer some capacity building across the sector to address role confusion and enhance understanding of each others roles and capacity.

MonashLink would like to highlight the work that has been conducted to date in family violence. *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010-2020* outlines the Integrated Family Violence System under the Family Violence Protection Act. Roles and statutory obligations are clearly defined in this model. Police powers stand firm and are not delegated to community based organisations. Partnership approaches are highlighted. This is still a work in progress and has many barriers to overcome.

MonashLink sits on both partnership platforms, i.e. Family Violence and Family Services and notes clear cut differences around the definition of role and function in statutory roles in both these forums. What is common however to both sectors is the pressing need for funded capacity building activity to undertake this crucial partnership building work. Clinicians, who are stretched juggling the demands of a complex case load, and often part-time employees, are continually conflicted by the requirement to regularly attend and contribute to the development of partnerships. The work is crucial; it needs to be resourced adequately as a matter of urgency.

Summary Points:

1. MonashLink's observation is that families are no longer routinely presenting at the early stages of problems; early intervention work is diminishing.
2. There appears to be a confused community perception that equates Family Services to Child Protection.
3. Is it now too 'risky' to present to Family Services? Are families now actively choosing NOT to present for assistance?
4. The delegation of statutory roles, particularly in Child Protection, is of enormous concern.
5. There is an urgent need for universal and particular training in role clarification of Child Protection.
6. Reciprocal rotations may be a way to enable each party to better understand the role of their partner services.

7. The Family Violence sector has also strategically re-organised; statutory roles however have been clear cut.
8. Partnership approaches such as those required in both Child FIRST and Family Violence reforms urgently need resources that reflect the demands of time and personnel.

MonashLink welcomes this opportunity to provide feedback on the reforms that have been undertaken in Victoria in recent years.

MonashLink re-enforces the roles that primary health, via community health, can play in protecting children in our community. The multidisciplinary nature of community health provides a variety of clinical responses that can be quickly and readily assembled to address the needs of children and families who seek assistance in our community. We particularly note the co-existence of family violence and alcohol and other drug services as part of the suite of community health services.

As well as clinical responses, community health has dedicated staff and resources to ensure population health approaches, health promotion initiatives and multi-disciplinary care underpin our responses to the community. Community Health also has strong working relationships with the mental health sector. These working relationships assist us in expediting timely responses in many cases.

A startling observation for us has been that drop off in early intervention opportunities since the inception of Child FIRST. It appears that the focus on a higher risk and need cohort (as intended through the reforms) has created a service gap, with few available options for those children and families who would have previously received lower intensity support. The possible implication is that these families deteriorate in their functioning without assistance, such that they may come to the attention of Child FIRST or Child Protection at a later point. We now operate primarily in the reality of complex integrated care responses. We observe confusion in the community in relation to roles and statutory obligations of the new child protection system.

MonashLink speculates that Child FIRST might have had an unintended consequence; inadvertently creating a 'gap' in the system. People are not readily presenting for early intervention; the system is now weighted towards complex care.

MonashLink looks forward to clarity around the role and function of child protection in this new environment. Statutory responsibilities need clarification.

MonashLink applauds the partnership approach that has been fundamental to the recent reforms; however we would welcome functional resources that allow unimpeded partnership development.

Thank you for the opportunity to present our observations, concerns and experience.

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