
# North East Metro Child and Family Services Alliance submission to the Protecting Victoria's Vulnerable Children Inquiry

**29 April 2011**

## Aboriginal Acknowledgement

The North East Metro Child and Family Services Alliance (NEMC&FSA) submission recognises the heightened needs of the strong Aboriginal community within the North East local government areas due to their unique culture and historical and continuing experience of disadvantage, including through direct interventions of the community service sector.

All recommendations of the NEMC&FSA apply equally, and more so, to the needs of the Aboriginal community, given their over-representation in both the Family Services and Child Protection client groups. Unique requirements of Aboriginal children and families will be taken up in Victorian Aboriginal Childcare Agency's (VACCA's) own submission which is fully supported by the NEMC&FSA.

## PREAMBLE

This submission will focus on areas directly related to the service delivery model and target group of Integrated Family Services provided by the North East Metro Child and Family Services Alliance (NEMC&FSA).

NEMC&FSA was formed at the April 2007 implementation of the Children, Youth and Families Act 2005 as the governance structure supporting Child FIRST and the partner agencies to provide service coordination and catchment planning for vulnerable children as per the Strategic Framework for Family Services (DHS, 2007). NEMC&FSA acknowledges the important role of the CYFA 2005 reforms and the associated growth funding in extending the capacity of the secondary Integrated Family Service sector to provide necessary support to vulnerable families.

The primary operational responsibility of NEMC&FSA is to receive referrals and allocate vulnerable families for family casework services provided by the Integrated Family Services partner agencies in the local government areas of Banyule, Darebin, Nillumbik, Whittlesea and Yarra. The NEMC&FSA family services agencies are:

1. Anglicare Victoria
2. Berry Street Northern
3. Children's Protection Society
4. City of Darebin
5. City of Yarra
6. Ecumenical Migration Centre (Brotherhood of St Lawrence)
7. Kildonan *UnitingCare*
8. North Yarra Community Health
9. Victorian Aboriginal Child Care Agency (VACCA)

The final NEMC&FSA partner is N&WMR Department of Human Services (DHS), including Child Protection. However, as per the guidelines of the Protecting Victoria's Vulnerable Children's Inquiry, *this submission from the NEMC&FS Alliance has been prepared without input or endorsement of the Department of Human Services (the department) and does not necessarily reflect the views of the department*.

The NEMC&FSA submission will address identified terms of reference and questions raised in the 'Guide to making submissions' as indicated below.

## SUMMARY AND RECOMMENDATIONS

### 1.1.1 What are the key preventive strategies for reducing risk factors at a whole of community or population level?

1 *That a whole of community prevention strategy addressing risk factors for children be developed articulating primary, secondary and tertiary prevention strategies following the VicHealth framework, Integrated Family Violence approach, with specific reference to whole of community prevention approaches to reduce risk and promote the safety, stability and development of children.*

*That the purpose of Child FIRST and Integrated Family Services be redeveloped at a State policy level to explicitly incorporate and fund prevention and early intervention roles as part of the whole of community prevention strategy to ensure sustainability of such initiatives and as befits the purpose of the lead provider of State funded family support services to children and families in Victoria.*

**1.1.5 Some in the sector have argued for the introduction of a 'Public Health Model' in relation to child protection. What are the benefits..? What are the main characteristics..?**

*2 NEMC&FSA endorses development and funding of a Public Health Model for child protection incorporating the three core components of strong tertiary services; strong secondary services; and strong primary prevention and early intervention services. Features of this system are addressed through other aspects of this submission.*

**3.1 Over recent years Victoria has been developing an increasingly integrated service delivery approach to the support of vulnerable children families. From a systems perspective what are the strengths and weaknesses of this approach? How should any identified weaknesses be approached.**

**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)?**

*3 The capacity of Child FIRST to accept referrals and constructively engage families in the community experiencing multiple risk factors but not previously known to Child Protection be acknowledged as a major system enhancement and strength of the Children, Youth and Family 2005 reforms. This important secondary service earlier intervention and diversion role is essential*

*to a continuum of responses to protect children, as advocated in a Public Health Model and needs to be prioritized alongside accepting direct referrals from Child Protection.*

*4 Child FIRST central intake be complemented by local agency intakes that take into account existing relationships with other community services, and provide visibility particularly in areas of high disadvantage to self referrers. A further benefit is to extend capacity for collaborative practice, including primary service interface, with allied agency programs, such as local government Maternal and Child Health .or community health services. Further, the role of local agency intakes is particularly important given the predominance of key referrers, Child Protection, Schools and Hospital Social Work to the central Child FIRST intake point. Capacity to extend the profile of Child FIRST with wider referral* groups*– such as police, mental health, drug and alcohol or family violence – is not possible under current resources as the system is already operating at full capacity.*

*5 The funded capacity for Child FIRST and Integrated Family Services intakes be boosted to provide valuable information and referral roles to link families to appropriate services that can provide the support they need. This is a minimum requirement for an early intervention role within IFS. Any intention beyond this to increase the CHILD FIRST function as an actual intake to a wider service platform than Family Services requires further consideration and extensive resources to enable development and implementation of the protocols, procedures and governance structure required to support any such expansion. Key to this would be the committed buy-in of any other sectors to agree to accept cases for service as determined at the expanded central intake, and to manage demand. Pilot projects to test feasibility would be essential.*

*6: The capacity to provide ongoing service as provided in the CYFA 2005 (s22(f) is endorsed by and enacted within the NEMC&FSA but requires further consideration in terms of adequacy of resources and intervention models. This includes access to brokerage funds and further exploration of evidence based approaches to the intensive support needs of vulnerable families. In addition, NEMC&FSA advocates for the creation of an additional intervention module and appropriate resources to be made available to Integrated Family Services to complement current intervention. This module will be child focused and complement parental capacity to meet children's basic developmental needs in families with extended service and little meaningful change.*

*7 Demand and capacity challenges pose a real constraint to Child FIRST and Integrated Family Services maximising the potential they offer to provide allocated casework or information and referral services to vulnerable families. Impacts of this include increasing thresholds of service to only the most vulnerable; periods where intake for casework allocation is restricted; families seeking help early in the life of their family issues being unable to receive a service; and minimal capacity for early intervention and prevention (see below). Additional resources are required to grow service capacity for vulnerable families.*

*8 Dedicated funding is required to resource and ensure the sustainable viability of the Child and Family Alliance governance and partnership requirements, and for Child and Family Service Alliance Project Manager positions to facilitate both the roles of internal Alliance service coordination and partnership facilitation as well as additional capacity to further develop wider network relationships.*

*Project Manager funding should be independent of the 'catchment funds' that are required to undertake their initial primary purpose of contributing to the development of wider networks. The latter is crucial if the Child and Family Service Alliance is to grow as a platform for such work, as mooted.*

*9 There is a limit to how far Family Services can impact into the tertiary space to provide specialist support to children who have suffered or are at risk of harm. This takes into account reduced engagement outcomes found for children referred from Child Protection and five times higher report back rates to Child Protection of community referrals to IFS of children with previous Child Protection involvement than community referrals without prior known involvement. Greater differentiation is required in identification of appropriate Child Protection referrals for community support to maximise engagement and additional intervention models that establish greater collaboration between the strengths of both Child Protection and Integrated Family Services should be further developed.*

**3.3.4 Are there particular services that best meet the need of vulnerable Aboriginal children and families?**

*10 Given the now pivotal importance of the Aboriginal Liaison Worker role to the Child FIRST/Alliance models and to operationalising the CYFA 2005 Aboriginal Best Interests principle, NEMC&FSA advocates for formal recognition of the role and the provision of dedicated and additional funding within Aboriginal Community Controlled Organisations, in our case, VACCA. This role should be supported by additionally funded training and professional development through state-wide networks.*

*Further, additional resources for capacity building and service delivery within Aboriginal Community Controlled Agencies, in our case VACCA, is required to maximise the choice open to families of Aboriginal controlled service provision, recognising that the majority of allocated casework service to Aboriginal families is currently delivered in the NE catchment by mainstream services.*

**5.1.2 What roles currently performed by statutory organisations, if any, might be more effectively and efficiently performed by non-government organisations and vice versa?**

**5.1.2 What is the potential for non-government service providers to deal with some situations currently being notified to the statutory child protection service, and would it be appropriate (As is the case in Tasmania) for referrals to a service such as ChildFIRST to fulfill the legal responsibilities of mandated notifiers?**

*11 Recommendation: That responsibility for reports to Child Protection, including mandatory reports, remains with statutory Child Protection services. This takes into account privacy considerations with respect to intrusive searches of past child protection history, especially given that a majority or reports are re-reports where prior history is held, and considerations that the child protection intake is in fact predominantly well targeted toward the most at risk vulnerable families.*

*Both tertiary Child Protection and secondary Integrated Family Services, as well as other services within the secondary range, require strengthening to respond to the needs of these and other*

*vulnerable families currently coming to the attention of the combined Child Protection and Child FIRST intake points. Overtime, the strengthening of the wider secondary service system will divert appropriate families and relieve pressure on the Child Protection system, without diluting this community capacity through the transfer of statutory roles.*

**3.2 Providing a quality service to vulnerable children and their families is dependent on having a skilled workforce. What are the strengths and weaknesses of current workforce arrangements eg. working conditions, training and career paths? How might any weaknesses be addressed?**

**5.1.4 Is it necessary to strengthen the capability of organisations in the non-government sector to better equip them to work with vulnerable children and families and if so how?**

*12 Workforce recruitment, retention and remuneration require critical attention in the context of the degree of vulnerability, including complex and intensive service needs, of families and the matched intensity for workforce skills, compassion and personal and professional development and support. Resources are required to further develop and reinforce in practice best evidence based models, including appropriate levels of training and ongoing, post implementation support and skill development for the workforce.*

**5.1.6 What are the strengths and weaknesses of current Commonwealth and State roles and arrangements in protecting vulnerable children?... What should be done to enhance existing roles or address any weaknesses?**

*13 Recommendation: Policy and program coordination and/or integration between and within local government, State government and the Commonwealth requires urgent attention to maximise access to service for vulnerable children. Within this, needs of children in the most disadvantaged areas require special attention, to secure and maintain appropriate levels of support to infants and children through the critical early years. SEIFA and AEDI data could be provide a basis for adjusted funding in this manner.*

**8. The oversight and transparency of the child protection, care and support system and whether changes are necessary in oversight, transparency and/or regulation to achieve an increase in public confidence and improved outcomes for children.**

*14 An independent Children's Commissioner with full investigative powers be appointed to report directly to Parliament on all deaths and significant injury of child protection clients up to 12 months after termination of protective services. That the Commissioner highlight any findings regarding systemic issues and failures and that these issues be broadly shared to improve child protection and child safety practices*

## 2. The factors that increase the risk of abuse and neglect occurring, and effective preventive strategies

### 2.1.1 What are the key preventive strategies for reducing risk factors at a whole of community or population level?

The work of the NEMC&FSA has been exclusively positioned through the Victorian government reforms at the heart of secondary, Integrated Family Services (IFS) responses to vulnerable children. The primary funded service model is family casework with some potential for limited group work and referral and advice services to families outside the core vulnerable families target group of the IFS program description.

Specifically, in describing the purpose of Child FIRST, the Strategic Framework for Family Services (DHS, 2007) specifies:

> "It is likely that a wider group of families beyond the vulnerable families will access or be referred to Child FIRST. Child FIRST can provide an important preventative role to these families or the professionals that may have referred them. This will focus on linking or connecting the families to relevant universal or secondary services that can meet their needs.
>
> Child FIRST is not intended, and will not have necessary capacity to, provide a service response beyond the provision of basic information and advice to such families".

As seen, the preventative role by Child FIRST is limited to the provision of information and advice. This is a far cry from defining 'key preventive strategies for reducing risk factors at a whole of community or population level'. NEMC&FSA welcomes and endorses this emphasis as essential to real preventive activity and as a missing plank in the government reform of child and family welfare to date.

NEMC&FSA advocates for a whole of community preventive strategy that extends from consideration of structural concomitants to abuse and neglect – such as poverty, unemployment, housing, social exclusion and more - to community education strategies promoting healthy childhood, for example, the importance of reading, hugging and playing with children to promote emotional, social and cognitive development as supported by neurobiological science.

There is extensive literature across this continuum that requires researching and collation to identify an appropriate platform and approach for Victorian State funded initiatives. State (or Commonwealth) funding is essential to secure ongoing and sustainable commitment to prevention, to complement and build on current community innovations sourced predominantly through private philanthropic foundations (such as the Early Learning is Fun (ELF) program at Berry Street targeting children's early learning, cognitive, social and emotional development) or business partnerships (such as the Kildonan *UnitingCare* poverty initiatives of Hospital based financial counselling and Energy audits for disadvantaged families majority funded by major energy suppliers eg Origin). Prevention strategies such as these lack security and sustainability, and draw resources from the field to secure further funding from a patchwork of sources.

By contrast to this absence of a prevention framework in DHS funded family services, prevention is a core funded component of the Victorian Government's Integrated Family Violence reform, drawing on the VicHealth model for primary, secondary and tertiary prevention. It is such a framework that requires articulation and funding with specific reference to a whole of community approach to the prevention of risk and abuse to children.

1 *Recommendations:*
*That a whole of community prevention strategy addressing risk factors for children be developed articulating primary, secondary and tertiary prevention strategies following the VicHealth framework (that is utilized in the Integrated Family Violence approach), with specific reference to whole of community prevention approaches to reduce risk and promote the safety, stability and development of children.*

*That the purpose of Child FIRST and Integrated Family Services be redeveloped at a State policy level to explicitly incorporate and fund prevention and early intervention roles as part of the whole of community prevention strategy to ensure sustainability of such initiatives and as befits the purpose of the lead provider of State funded family support services to children and families in Victoria.*

**1.1.5 Some in the sector have argued for the introduction of a 'Public Health Model' in relation to child protection. What are the benefits..? What are the main characteristics..?**

Consistent with the above comments, NEMC&FSA strongly endorses a Public Health Model in relation to child protection. Our understanding of the requirements of a Public Health Model in relation to child protection follow Jordan and Sketchley, 2009[1] as per the box below.

"The application of a public health approach to child abuse and neglect emphasises providing services at the population level in order to foster healthy children, families and communities (e.g., the Communities for Children Strategy, see Edwards et al., 2009). However, a public health approach recognises that prevention is not always effective and there is a need for coercive (i.e., child protection) interventions (Council of Australian Governments, 2009; O'Donnell et al., 2008). Thus, the essential elements of service provision under a public health model applied to child abuse and neglect are:

- the use of universal services for children and families as a "platform" for preventing neglect and abuse (primary);
- the provision of specialist services addressing specific risk factors that compromise parenting in vulnerable families (secondary); and
- the protection and treatment of children who have experienced abuse and neglect, including statutory child protection services (tertiary) (O'Donnell, et al., 2008)".

(Jordan & Sketchley A stitch in time saves nine..)

http://www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html

[1] *Brigid Jordan and Robyn Sketchley, 2009, A stitch in time saves nine:Preventing and responding to the abuse and neglect of infants, Child Abuse Prevention Issues No. 30*

Following Jordan and Sketchley, NEMC&FSA understands the components of a Public Health Model for child protection to be

- Strong tertiary services (Child Protection)
- Strong Secondary services (Family Services and other specialist services)
- Strong early intervention and prevention (primary and whole of community, as per 1.1.1)

In this submission NEMC&FSA will focus on the features of a strong secondary, Family Services platform as relevant to our operational domain, which includes the Child Protection interface. Wider aspects of a strong tertiary system will not be considered by this submission. However, implications for characteristics of strong tertiary or strong early intervention/prevention level responses will be illuminated through our secondary lens. These will be described in response to selected Inquiry questions to follow.

*2 Recommendation: NEMC&FSA endorses development and funding of a Public Health Model for child protection incorporating the three core components of strong tertiary services; strong secondary services; and strong primary prevention and early intervention services. Features of this system are addressed as follows:*

**3.1 Over recent years Victoria has been developing an increasingly integrated service delivery approach to the support of vulnerable children and families. From a systems perspective what are the strengths and weaknesses of this approach? How should any identified weaknesses be approached.**

**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)?**

NEMC&FSA response will consider these questions together as they overlap.

**Strengths and weaknesses of the current service design and integrated service delivery approach with specific reference to the roles of Child FIRST, Integrated Family Services and the Child Protection inter-face.**

**Strength One:**
**The North East (NE) Child FIRST (CF) intake system has opened an important alternative access point to services for very vulnerable families and strengthened community capacity to protect children outside of the tertiary child protection system.**

This is evidenced through North East 2010 data:

- In 2010, 92% of all referrals to NE Child FIRST in 2010 and 92% of all cases allocated in the NE catchment (includes families referred though local agencies combined with CF referrals) included one of more 'complex' issues or significant wellbeing concerns.
    - Complex issues are issues recorded on the IRIS database of CP involvement, Mental Health, Physical or Intellectual Disability, Family Violence, Substance Abuse, Sexual Assault, Juvenile Justice involvement
    - Significant wellbeing concerns are as per the CYFA 2005

- Of these only 28% of referrals to Child FIRST and 13% of all allocations across the catchment were as a result of Child Protection referrals.

- 13% of allocations resulting from Child Protection referrals is low compared to other North and West Child FIRST catchments – this is due to the high volume of non-Child Protection referrals received and allocated in the NE (see strength two below), as Child Protection referrals to NE are received at comparable rates to the other N&W catchments.

- Only 41% of Child FIRST referrals and 39% of all cases allocated in NE in 2010 had known child protection involvement (current referral or previous).

This means that the majority of the 92% of complex or significant wellbeing concerns referrals or allocations were of families with no known prior child protection history. These families present with multiple risk indicators, with high likelihood of adverse developmental outcomes for children if support is not provided. As seen further below, these families are being strongly engaged by Family Services to address risk factors. Examples of families with risk indicators but not Child Protection involvement are:

[Case example removed]

**Family Services is overall effective at engaging complex, vulnerable families in services - 67% engaged, 13% did not engage, 20% indeterminate** (NE Engagement Outcomes data 2010 – see Attachment One for description of terms)

- These rates improve further for professionals other than child protection (70% engaged, 12% did not engage, 18% indeterminate) and self referrals (67% engaged, 3% did not engage, 30% indeterminate (more than half identifying other service needs or moved) as compared to Child Protection referrals (57% engaged; 25% did not engage; 18% indeterminate). Child Protection outcomes are further discussed below.

**Family Services is very successful at diverting families with complex issues and no prior Child Protection involvement away from the Child Protection service:**

- Only 8% of families referred from non-Child Protection sources with no previous history (total 202 families) were reported to CP within 6 months of service
- This means that only 16 of 202 families previously unknown to Child Protection became known after up to 6 months of Family Services intervention (when the data was collected)

*3 Recommendation: The capacity of Child FIRST to accept referrals and constructively engage families in the community experiencing multiple risk factors but not previously known to Child Protection be acknowledged as a major system enhancement and strength of the Children, Youth and Family 2005 reforms. This important secondary service earlier intervention and diversion role is essential to a continuum of responses to protect children, as advocated in a Public Health Model and needs to be prioritized alongside accepting directing referrals from Child Protection*.

**Strength Two:**
**A balance of central and local agency intakes in providing broader visibility and accessibility, including the strong role of local government providers, is important to enabling community referrals, particularly self referrals, and to promoting collaborations with allied agency programs, such as Maternal and Child Health.**

The NE catchment has high numbers of community as well as Child Protection referrals. Part of the reason for this is the strong presence of local agency intakes. In total, 35% of families allocated for a casework service in 2010 originated as local referrals.

Local agencies remain the key point for 'self' referrals for family casework services in the NE. Specifically, in NE 4% of referrals to Child FIRST are self referrals, but 21% of all NE allocations result from self referrals once local agency referrals are included in final catchment allocation numbers (2010 NE allocations data). All cases requiring allocation are prioritized against each other and allocated on the basis of highest need.

The local agency profile within the NE is bolstered by the inclusion of a community health service (North Yarra) and two 2 Local Government Family Services providers (Yarra and Darebin)within the Alliance, including strong community profiles and a relationship with its citizens that operates both within the formal DHS/Strategic Framework for Family Services and beyond to provide a wider reach to families. As with Child FIRST, the 'wider reach' is predominantly expressed through intake information and referral roles, with allocated casework services now restricted to the most vulnerable. Both Yarra and Darebin City Council contribute own funding to complement the DHS funds to work with the vulnerable families in their municipalities. This has provided an essential boost to capacity in the North East with Yarra and Darebin more able to meet demand than other NE LGAs.

Further reasons for the strong community referral profile in the NE includes the community population and service profile, with high rates of disadvantage within the NE LGAs, coupled with population growth through Whittlesea. Further, there are long established welfare/ community services and networks in Darebin and Yarra, and to lesser extent Banyule and in older regions of Whittlesea such as Thomastown and Lalor.

These relationships and visibility provided through local agencies is important to preserving a wide referral base to Family Services, especially in light of the dominance of key referral groups to Child FIRST for whom a central intake point is particularly attractive – 64% of all Child FIRST referrals in 2010 came from 3 sources, Child Protection (28%), Hospital social work (21%) and Schools (14%). This was a consistent pattern across all N&W catchments.

Demand pressures limit the capacity for Child FIRST to develop its profile with other potential referral groups – such as police, mental health, drug and alcohol or family violence – as there is no capacity to provide casework services beyond already stretched limits. This is described further below.

The community profile and reach bought by strong local agency intakes is a two way street- facilitating both referrals to IFS but also referrals from, or collaborative service responses between, IFS and allied services within the partner agencies. This is true for all NE agencies who deliver a wide range of programs other than Integrated Family Services, but is particular strong in our local government and community health partners. Embedding IFS in a range of community services de-stigmatises accessing the services for families and eases referral/engagement and also allows earlier intervention work within the primary service system.. For example, when families are already known to the Community Health service they are easier to engage in Family Services work and vice versa, facilitates referrals to co-located medical or paediatric services. The direct and seamless link between Maternal and Child Health and Family Services that are co-delivered through local government in the NE catchment has been a further example of this – for instance in supporting young isolated adolescents during the antenatal phase of their pregnancy

to engage and develop trust, to assist in preparation for the birth of their infant, to access good antenatal care, to provide early intervention to reduce the risk to the infant at time of birth and to link with the MCH service to provide a seamless and ongoing provision of service.

*4 Recommendation: Child FIRST central intake be complemented by local agency intakes that take into account existing relationships with other community services, and provide visibility particularly in areas of high disadvantage to self referrers. A further benefit is to extend capacity for collaborative practice, including primary service interface, with allied agency programs such as local government Maternal and Child Health .or community health services. Further, the role of local agency intakes is particularly important given the predominance of key referrers, Child Protection, Schools and Hospital Social Work to the central Child FIRST intake point. Capacity to extend the profile of Child FIRST with wider referral* groups*– such as police, mental health, drug and alcohol or family violence – is not possible under current resources as the system is already operating at full capacity.*

**Strength 3:**
**Child FIRST and local agency intakes provide valuable information, advice and referral roles.**

A key purpose of Child FIRST, as per its name (Child and Family Information Referral and Support Team) is to provide information and referral as well as support roles.

Capacity to deliver on these objectives has been constrained by available funding. In the North East the inception funding to Child FIRST was $280,000 or approximately 2.8 EFT. Since that time, Child FIRST funding has been complemented to the current staffing level of 4.6 EFT by diverting funds from partner agencies' family services casework capacity. This however depletes capacity to provide sustained support to services – a 'robbing Peter to pay Paul' scenario. Given these funding constraints, the primary purpose of NE Child FIRST therefore has been constructed as a dedicated central intake to Family Services rather than as a broad based information and referral team, including important secondary consultation roles.

Despite these constraints, NE Child FIRST, supported by local agency intakes, provides valuable information, advice and referral roles. Specifically,

- 36% of referrals closed in NE Child FIRST in 2010 had a recorded outcome of referred to another service (46% of the 532 referrals to Child FIRST in 2010 were closed at Child FIRST without allocation)
- As well, NE Child FIRST undertook a further 1849 brief contacts (under two hours), recorded on IRIS as non-substantive contacts. These contacts include pre-referral contacts, professional consultations, information, advice or referral roles as well as other miscellaneous work.
- 533 non-substantive contacts in NE Child FIRST in 2010 recorded a 'referred on' outcome, linking families to other services.
- Another key North East local agency intake that records outcome data for non-substantive contacts (Darebin Family Service) recorded a further 558 non-substantive contacts of which 243 were 'referred on'
- The non-substantive referral and advice roles are the closest to 'early intervention' allowed within the DHS funded Family Service model. At times, the referral to another service is necessitated, however, by a lack of capacity to provide a required allocated casework response within Family Services.

In a number of recent forums with DHS, mention has been made about the concept of further developing 'Child FIRST as a platform'. While it remains unclear what this means, it is important to distinguish *information and referral* roles that link families or a professional to relevant other services from a formal *intake* role to these other referral points, if relevant to these considerations.

Under an intake role, the family is *accepted for service on behalf of the other agency* as currently happens within Family Services. That is, Child FIRST determines the referral is appropriate for Family Services, and as agreed within the NEMC&FSA operating model-itself an expression of mandatory requirements within the funding and service agreement with DHS – another otherwise independent agency within the Family Services partnership accepts the determination of the Child FIRST intake to provide the family with an allocated casework service.

This is different to providing information or even facilitating a contact that directs the family or professional to another service. By contrast, the more complex *intake* transaction is enabled by a number of key mechanisms to achieve this outcome of a direct service linkage:

- Legislation that establishes the intent, for example through s22 purposes of a community based child and family services agency and s67 to prioritise on the basis of need
- Service specifications as to the required model to operate the system and which 'bind' or obligate partner organisations to accept cases from the intake
- Ongoing funding and service agreements that reinforce the requirements to participate
- Memorandum of Understandings between participating partner agencies, including the in-practice operating model
- Governance structures and processes to support the operations
- Training and knowledge building within the extended central intake team about the other service or services on whose behalf the intake is determining service eligibility and intake.
- Demand management agreements to manage demand including backlogs as the intake (a common complaint of call centres such as DOCS in NSW) or lack of allocation capcity
- Partnership facilitation and coordination functions, through a project manager role, or team, depending on the complexity of the service agreements and operating model
- Ongoing resources through staff time to participate in the governance and coordination structures
- Shared vision and good will to bolster ongoing commitment and participation in all the above

Any move to broaden Child FIRST as a 'platform' for intake to services wider than Family Services – as opposed to extending the current information and advice functions – would require extensive resources and commitment to enable, as per the above points. The current Child FIRST staffing and operating model, including unfunded project management, has no capacity to develop such scope. Nor does existing governance or catchment planning provisions have the legitimacy or authority to transact such arrangements. The web of required procedures and processes across sectors would be highly intricate and sophisticated and could not be entered into without the backing of higher order enablers (legislation or at minimum explicit funding and service agreements), as well as on the ground commitment and adequate resources to get the job done. This investment would need to be offset by clearly established gains to children through enhanced service access and outcomes to justify the expenditure of money and time to operate such an integrated intake. Pilot projects to test feasibility would be essential.

*5 Recommendation: The funded capacity for Child FIRST and Integrated Family Services intakes be boosted to provide valuable information and referral roles to link families to appropriate services that can provide the support they need. This is a minimum requirement for an early*

*intervention role within IFS. Any intention beyond this to increase the CHILD FIRST function as an actual intake to a wider service platform than Family Services requires further consideration and extensive resources to enable development and implementation of the protocols, procedures and governance structures required to support any such expansion. Key to this would be the committed buy-in of any other sectors to agree to accept cases for service as determined at the expanded central intake, and to manage demand. Pilot projects to test feasibility would be essential*

**Strength Four:**
**Family Services has capacity to provide sustained support to families**

- 47% cases still open after 6 months (5% pending closure)(NE Engagement Outcomes data 2010)

While pressure to close cases and create throughput to meet service demand is a real pressure and tension for Family Service providers, NEMC&FSA balances this pressure against the legislative authority for community based child and family service agencies "to provide on-going services to support vulnerable children and families" (CYFA 2010 s22f).

***A core reality, however, is that the more families that are engaged and provided with ongoing service at the back-end of the program, the less capacity there is for new families to receive service at the front end.*** This is further impacted by a small but increasing need to allocate more than one worker to families in light of the level of complexity of myriad child and parents' needs and circumstances, with further impacts for front end allocation capacity.

NEMC&FSA protects capacity for ongoing and intensive service as far as is possible given demand pressures through the operations of the NEMC&FSA extensive demand management strategies. These strategies provide capacity to flexibly allocate cases across the catchment to optimally meet demand, but when this is not possible, restrict NEMC&FSA capacity to accept new cases for allocation.

Definitive data on length of service is not currently available in NE beyond the six month snapshot reported above (there is difficulty extracting this data from the IRIS data base due to the confounding effect of group work cases). Anecdotal reports from agencies, however, speak to an important sub-group of families with service lengths extending beyond 12 months, and longer. An example of such perceived service need was collected within the NE Child FIRST case audit (2008)

[Case example removed].

Families in circumstances such as the above require intensive and informed long term interventions to deal with complex issues such as childhood trauma, ongoing loss and grief issues ,mental health, physical health and disabilities that are affecting multiple family members,. This must be done in a trauma informed, relationship based practice stance towards the family's needs, together with skilful navigation and coordination of the complex service systems involved. – both of which take time. Caseloads cannot be high (ideally 8 families per worker) and multiple visits per week can be required. *The more Family Services provides this intensity of service under current funding agreements and resource levels, the less families are able to receive service.*

Moreover, Family Services does not and cannot operate alone to halt the trajectory toward tertiary services for the most intensive need child and young people. Increased access is absolutely required for secondary service community clients to services such as intensive parenting programs, adolescent mental health services, Family Coaching, trauma and attachment programs and adequate, appropriate housing. Currently the only avenue open to accessing some of these services is to escalate to Child Protection – though, this is itself provides limited access for such services for even the most vulnerable children, given the low investigation and substantiation rates as noted further below (21% investigated, 14% substantiated of all reports, 2009-10, N&WMR, DHS April, 2011).

A further and real gap in Family Services capacity to engage and resource families such as these is lack of access to brokerage funds, as originally included in the Family Support Innovations Projects funding model but disappearing in the translation to Child FIRST and Integrated Family Services. Such funds can provide access to transport to assist families in attending the multiple appointments required, or get children to school or child care; purchase household utilities such as white goods or pay essential bills; as well as purchase specialist assessments. The inclusion of generous brokerage funds within the pilot Family Coaching project in the NE (located at Kildonan) have been used to great effect for purposes such as these to assist children's development. For example, an infant thought to be developmentally delayed began to crawl soon after the family was bought a vacuum cleaner with brokerage funds – the floor had previously been too dirty to place the infant on. Such funds should be made available to Family Services to assist some of the most vulnerable children to improve their potential.

Questions however are raised about the extent to which some families are able to make adequate changes to ensure the safety, development and stability of children, and about the appropriate Family Service role in these families. Grave concerns are often held for children if Family Services was to close out of these families as, while little change is effected, some support and monitoring can at least be provided.

Discussions within NEMC&FSA often return to cases of this kind that can be the most burdensome and worrying in workers' caseloads. From this perspective, NEMC&FSA launched a practice research project in 2009 in partnership with the Parenting Research Centre and funded through the Ian Potter Foundation to explore what research could tell us about evidence based approaches to helping vulnerable families change. The result has been the development of a package *Helping Families Change – Evidence Informed Actions* that includes 22 individual practitioner guides of actions associated with positive change in families. These are grouped under four units:

- Strengthening engagement and motivation to change
- Goal setting and feedback
- Supporting the parent-child interaction
- Child safety

Workers from the 8 mainstream agencies and Community Based Child Protection within the NEMC&FSA have received initial training in these actions with implementation in its initial phase (commenced March 2011). Further planning is occurring about how to consolidate the package as an accredited training base for use across the VACCA workforce. It is hoped that over time this package of Evidence Informed Actions can contribute to both the sector's understanding of practices associated with change in families and to ongoing training and support needs of the workforce. This being said, the Evidence Informed Actions are designed for use within wider

practice frameworks and approaches within Family Services and more research is required about alternative approaches to different family circumstances beyond the reach of these *Actions.*

The practice reality of supporting families with very high needs and complex circumstances suggest, however, that changes to parenting capacity is not always a realistic goal – or at least, not change in time to keep apace with the critical milestones of the young child's development clock. The example below is typical of these families:

[Case example removed]

NEMC&FSA advocates that for families such as these, a trigger point be identified – such as number of episodes of service or length of service, combined with the worker's assessment of minimal change in parenting capacity– where additional resources become available to complement the level of care parent's can provide and which are specifically targeted at supporting the child's development. Such options include funding for continuous child care; breakfast and homework clubs; respite care; tutors for children falling behind at school; recreational activities; mentors and more.

*6 Recommendations: The capacity to provide ongoing service as provided in the CYFA 2005 (s22(f) is endorsed by and enacted within the NEMC&FSA but requires further consideration in terms of adequacy of resources and intervention models. This includes access to brokerage funds and further exploration of evidence based approaches to the intensive support needs of vulnerable families. In addition, NEMC&FSA advocates for the creation of an additional intervention module and appropriate resources to be made available to Integrated Family Services to complement current intervention. This module will be child focused and complement parental capacity to meet children's basic developmental needs in families with extended service and little meaningful change.*

**Weaknesses**

**Weakness One: Demand and capacity challenges**

Demand and capacity challenges pose a real constraint to Child FIRST and Integrated Family Services maximising the potential they offer to provide allocated casework or information and referral services to vulnerable families.

NEMC&FSA operates a sophisticated demand management system that introduces a number of contingency responses triggered by capacity alerts at time of over-demand. This is a constantly recurring scenario across the NEMC&FSA in response to either high referrals at Child FIRST or lack of allocation capacity for casework allocation within the partner agencies. Contingency responses include diverting intake assessments from Child FIRST to partner agencies; throughput reviews of agency caseloads and case closures; and flexible allocation of cases from higher demand areas to lower demand areas (these change at different times).

At times, however, these actions are inadequate to balance demand and capacity and the extreme step of restricting intake of families requiring a casework allocation service is taken. This has happened 8 times in the four years NEMC&FSA has operated with respect to either the full catchment or particularly high demand areas, most notably Whittlesea and Banyule.

The net effect of tightening of practices in order to manage demand is the increasing threshold for service. The number of families allocated for casework in the NE catchment with complex IRIS issues or significant wellbeing concerns has increased every year since Child FIRST was implemented – 73% 2008 (data available July-Dec only); 88% 2009; and now 92% 2010. The same trend is demonstrated through Child FIRST referrals 78% significant wellbeing concern or complex IRIS issues 2008, 91% 2009 and 92% 2010.

This impact of increased service thresholds has been most notable in Whittlesea. Over 2009, demand pressures were so high in this high population growth corridor, that new cases could not be accepted for casework allocation for five of the six months from July to December. This situation has been alleviated over 2010 by the addition of 2 additional EFT (as a result of Victorian Government boost funding package of $77 mil to child protection announced in 2009) – but also the absolute tightening of thresholds. Over 2010, not a single family with other than significant wellbeing concerns or complex IRIS issues was allocated in Whittlesea in the whole year.

The other high demand area in the NE is Banyule. Like Whittlesea, casework allocation was restricted to Banyule (and the linked LGA of Nillumbik) for 5 of the last 6 months of 2009. This high demand scenario has continued over 2010. While intake for allocation was not directly restricted, demand was managed by diverting Banyule Nillumbik families to services in other parts of the catchment, unfortunately therefore, outside their local communities, or by increasing families wait for allocation through extended periods of active holding. Unlike Whittlesea, no additional resources were available for Banyule – the problem being more entrenched historical disadvantage such as in the West Heidelberg community, rather than the spotlight issue of new growth.

Finally, a real and adverse impact of increased service thresholds means there are some families who sought help early in the life of their family issues but could not get a service. The long term effect of this lack of capacity can be that these families return into the system when their problems are much more entrenched. For example, in the early months of 2011, three families were re-referred to Child FIRST who had been unable to receive a service through the period of extended intake restrictions in the NE over 2009 as a result of lack of allocation capacity. One was referred back after a Child Protection report, two others were community referrals. In all instances circumstances had deteriorated further impacting children's safety, development and stability.

*7 Recommendation: Demand and capacity challenges pose a real constraint to Child FIRST and Integrated Family Services maximising the potential they offer to provide allocated casework or information and referral services to vulnerable families. Impacts of this include increasing thresholds of service to only the most vulnerable; periods where intake for casework allocation is restricted; families seeking help early in the life of their family issues being unable to receive a service; and minimal capacity for early intervention and prevention (see below). Additional resources are required to grow service capacity for vulnerable families*.

**Weakness Two: Minimal capacity for early intervention and prevention**

Family support has historically contributed to agencies roles in early intervention, advocacy and prevention with respect to child and family welfare.

These roles are now limited to some group work capacity – though groups are increasingly targeted at complex needs of vulnerable families – and the advice, information and referral roles reflected through the non-substantive contacts or referral rates from Child FIRST and other catchment intakes, as described above.

No state funded DHS casework in the NE LGA is now provided to families without high and/or complex needs and established problems impacting on the safety, wellbeing and stability of children. Families experiencing relationship difficulties, child behaviour problems or learning difficulties without the co-presence of complex issues will rarely if ever get a casework service funded through the Victorian government in the NE catchment. Often when the designated complex issues are not present, other issues such as new settlement, health, housing or isolation will combine to create likely harm for children.

As seen above the number of families allocated for casework in the NE catchment with complex IRIS issues or significant wellbeing concerns has increased every year since Child FIRST was implemented. Capacity to provide casework services to all but the most complex cases has therefore been squeezed further out every year.

*Recommendation – see above and as for 1.1.1 and 1.1.5*

**Weakness Three: Inadequate resourcing of partnership, specifically to operate Alliance governance processes and provision of specific funding for Project Managers**

The recently reported KPMG evaluation of the *everychildeverychance* reforms included observations that Alliances performed best when able to put collective needs above those of individual agencies and where there were dedicated project managers or officers to progress Alliance objectives, including partnership facilitation, data management, program documentation and interface activities. These outcomes or functions are, however, not directly funded and to date are reliant solely on good will and/or pragmatic choices that redirect resources from other priorities in order to deliver.

This includes the following un-funded activities

- Roles and time commitment of Chair people and agencies in the Executive and Operations Groups in the Alliance governance structures – responsibilities include managing meeting agendas; cross agency consultation, negotiation and problem solving; representation of Alliance on other groups or committees, including DHS, strategic planning or cross sector
- Roles and time commitment of agency senior management in participating in Alliance governance processes. For NEMC&FSA, Operations Group meets monthly and Executive meets quarterly, not including additional extraordinary meetings and working groups - and flow on activities
- Roles and time commitment of agency team leaders in coordinating and prioritizing weekly allocations processes (commonly including attending a meeting) and in monthly *practice consistency* meetings to better coordinate practice across the catchment, increase shared understanding and further develop practice responses.

Given that these activities are unfunded, it is a tribute to the good-will of Alliance members that participation has remained high and motivated across the now four years of the NEMC&FSA operations. Again as noted by KPMG, this participation – and therefore the viability of the

Alliance structures – is very vulnerable to participant turn-over and is highly reliant on strong leadership.

While to date, NEMC&FSA has successfully navigated such transitions, the potential to do so may decrease as more time passes and more of the people originally involved in the original rationale and belief in the reform objectives move on. A new and additional vulnerability will be loaded onto this already vulnerable structure as the Child FIRST/Child and Family Services Alliances structures are potentially built on to create wider platforms for service delivery to vulnerable children. Good will alone is not sustainable to continue to grow the structure and responsibilities of the collective aspirations of Alliances when continually draining individual agency resources to do so.

This is equally true of the Project Manger positions. To date in the N&W region these positions have been fractionally funded through use of the $50,000 'catchment funds' allotted to each catchment annually to undertake shared catchment activities. The original intention for these funds was to focus on cross sector network development as well as support catchment governance arrangements. This is important to remember given both how these funds have been used and the less strong growth in wider network functions by Alliances than originally intended.

Specifically, again as noted by KPMG, much of the originally strong inclusion of cross sectoral models in the precursor Family Support Innovation Projects has fallen away since the introduction of Child FIRST and the Child and Family Services Alliances as these developments have necessarily focused on Alliance intra relationships (Family Services/Child Protection) rather than wider networks. Equally Project Manger resources have similarly been primarily internal Alliance focused, for example in the NEMC&FSA, in negotiating, writing and revising the nine partner agency (plus Child Protection) Operations manual and other operational coordination business, resourcing the governance structure, and managing and reporting on operational data across the nine agencies. A further role of the Project Manger is partnership facilitation, including benefits for smaller IFS providers by supporting more equal participation. By contrast, while wider network roles to date have had positive outcomes, they have been largely limited to inter-facing predominantly with other DHS funded reforms or projects such as Integrated Family Violence and the regional Child Protection-Family Services-Child Protection agreement; a housing project in 2009; sporadic projects with one of the three area mental health services that intersect the North East catchment or more recently the Early Years services through the Early Childhood Development project. The original intent of the 'catchment funds' to facilitate such wider network interface activity has therefore been largely subsumed by the significant requirement to resource the internal partnership and coordination functions of the Alliance, with minimal benefit to cross sectoral network development. All partnership work is time consuming and intricate and requires dedicated funding.

*8 Recommendations: Dedicated funding is required to resource and ensure the sustainable viability of the Child and Family Alliance governance and partnership requirements, and for Child and Family Service Alliance Project Manager positions to facilitate both the roles of internal Alliance service coordination and partnership facilitation as well as additional capacity to further develop wider network relationships.*

*Project Manager funding should be independent of the 'catchment funds' that are required to undertake their initial primary purpose of contributing to the development of wider networks.*

*The latter is crucial if the Child and Family Service Alliance is to grow as a platform for such work, as mooted.*

**Weakness Four: There is a limit to how far Family Services can impact into the tertiary space to provide specialist support to children who have suffered or are at risk of harm**

- Engagement rates are lower for Child Protection referrals at both Child FIRST and post allocation
    - At NE Child FIRST only 46% of Child Protection referrals result in an allocation response, the remainder (54%) were closed at Child FIRST (IRIS, 2010)
    - The greatest reasons for closure of Child Protection referrals at Child FIRST are that the client/family did not engage with service or ceased contact with service or withdrew from service (58% of Child Protection referrals closed at Child FIRST)
    - For families that are allocated, while 10% of community referral do not engage, 25% of Child Protection referrals do not. Conversely 69% of community referrals engage, compared to 57% of Child Protection families (remainder 'indeterminate')
- The greater the involvement with the secondary/tertiary service system, the more likely the family is to not engage: 13% all cases did not engage;16% families with previous Family Services or previous Child Protection involvement did not engage; 25% of Child Protection referrals did not engage; and 28% of families both referred from Child Protection and with prior known Child Protection involvement did not engage.
- Post-allocation Child Protection involvement or re-reports are higher for families referred from Child Protection (38%) compared to other referral sources (17%)
- For families referred by community referral sources, 42% of those with previous Child Protection history were reported to Child Protection within 6 months of Family Services intervention (total 91 families), compared to 8% of families referred by the community with no known previous Child Protection history (total 202 families). That is, *families referred by the community with known previous Child Protection involvement were more than five times more likely to be again reported to Child Protection while involved with Family Services than families with no known Child Protection involvement, despite comparable levels of complexity* (92% of all cases including significant wellbeing concerns or complex IRIS issues)
- Community Based Child Protection Consultation minimally impacts engagement rates (ie about the same numbers engage or not) though is more associated with either or both of the sub-types of *persistent effort* or *patchy engagement* outcomes rather than *open to service* engagement. Community Bases Child Protection may, therefore, assist to hold families in service who may otherwise drop out, but the capacity for constructive progress within the intervention may be more tenuous.
- Statewide IRIS data (DHS 2007-08, 2008-09) demonstrates that lower engagement rates are found for CP intake referrals compared to post-intake referrals; and that all CP referral outcomes demonstrate higher did not engage and lower service plan completed rates than other referral source.

(NE IRIS or Engagement Outcomes data 2010, unless stated)

These findings raise real questions about the nature of Child Protection referrals. Much of current reform directions are founded on co-existing beliefs that Child Protection attracts large numbers of inappropriate referrals that would be better serviced by the community, especially in light of potentially harmful, intrusive outcomes for families who come into contact with child protection as opposed to family support systems (Protecting Children: The Child Protection Outcomes Project DHS, 2003).

*An alternative premise is that the Child Protection system is operating well to identify the most vulnerable children in the State, characterised by a combination of risk indicators to children resulting in the child's experience of actual or likely significant harm, including cumulative harm, and parents who have not demonstrated capacity to address the contributing risk factors to their children (the legislative grounds for a child in need of protection CYFA 2005 s 162). When parents demonstrate this willingness and capacity, secondary services operate effectively to provide required support to families and hold families outside of the Child Protection service. This is demonstrated by Child FIRST allocation rates and IFS engagement rates for most community referrals, and a sub group of Child Protection referrals.*

The introduction of Child FIRST and the increased targeting and resourcing of Integrated Family Services through the Family Support Innovation Project growth funds have added weight to the alternative premise above. Specifically:

- Rather than Child Protection acting as 'a gateway to accessing child and family services' resulting in referrals that 'may be inappropriate' as described in the initial research underpinning the CYFA reforms (An Integrated Strategy for Child Protection and Placement Services, DHS 2002 p.65), the introduction of Child FIRST has uncovered a wider population of vulnerable needs children not previously known to Child Protection – 92% of all referrals to NE Child FIRST included significant wellbeing concerns or 'complex' IRIS issues, yet only up to 41% of these referrals have known previous Child Protection involvement, with 28% referred directly from Child Protection (as described previously).

- Moreover, as reported here, engagement rates are less strong for Child Protection referrals than community referrals, despite comparable complexity, while families with previous Child Protection involvement referred from the community are reported back to Child Protection at five times the rate of community referrals with no known Child Protection involvement.

These combined findings suggest something qualitatively different about families who have come into contact with Child Protection than other families with comparable risk factors who have not.

Previously published Child Protection data can also be differently interpreted to support the alternative premise that the Child Protection service is operating well to identify the most vulnerable children in the State – for example, as included in Protecting Children: The Child Protection Outcomes Project, (DHS 2003), the last major public analysis of Child Protection trends:

1. 62% notifications had been previously notified in 2001-02 (ibid) – replicated in the 2009-2010 data recently reported by the N&WMR (April 2011), N&W own rate being 59% re-reports in this year.
2. 48.7% of children first investigated were 0-4 years of age (DHS 2003 p.4)
3. First investigated children were more likely to have been previously notified (p.21);
4. "(A) statistically significant much higher proportion of cases first investigated cases was substantiated (58.2%) (ibid p.9)
5. A "very high (and increasing) level of re-substantiation, with 40% of substantiations in 2001-02 having been substantiated previously" (ibid p.3) As reported by KPMG

(April2011) the reforms have not impacted re-substantiation rates so this is likely to remain similar (Noting that N&W rates have been historically and continue to be lower, reported at, 33% by recent N&W data (April 2011)

These combined findings suggest a solid and relatively stable core of vulnerable families coming to the attention or re-attention of Child Protection, often early in the child's life, and for whom considerable care is required to assess and manage risk of harm. This is fundamentally the domain of the tertiary child protection service. In this context, decreased investigation and substantiation rates are highly questionable. It is critical to establishing an effective service response to such children *in need of protection* that the level of significant harm these children have suffered or are likely to suffer is clearly named. Only then when will a service range with sufficient intensity, including a proper role and use of statutory authority, be developed. Instead, it feels very much that the harm suffered by these children has become invisible, obscured somewhere between dominant prevailing beliefs within Child Protection about the need for community supports and the Court's unwillingness to act on cumulative harm, with the system remaining geared towards incident based responses and immediate safety.

NEMC&FSA advocates therefore for both strengthened tertiary and secondary services, operating alongside strong primary services as advocated with a Public Health model to better establish this service range. As indicated above, Child FIRST and IFS has a critical role in this service continuum, providing intensive and extended support to families, including *appropriate* Child Protection referrals.

It appears however, that greater differentiation is required as to what are appropriate Child Protection referrals for community based child and family services. Within this, further consideration should be given to the consistent finding of the Family Services IRIS data, that families referred to Family Services from post intake Child Protection teams engage better and complete more service plans than intake referrals (IRIS Annual Reports, DHS, 2007-08; 2008-09; (2009-10 not available)). This finding suggests that an engaged Child Protection relationship with a family facilitates effective transition to the next service as opposed to only phone contact or letters as currently practiced by Child Protection intake. This has enormous practice and resource implications for Child Protection but must be thought through in recognition of both the degree of complexity of families presenting to Child Protection, particularly re-reports and first reports of younger siblings of known clients, and the poor engagement rates of intake referrals in particular in Child FIRST and Family Services.

A further key implication of these findings relates to families 'readiness to change'. Consistent findings within practice audits undertaken within NEMC&FSA – the Child FIRST Case Audit 2008 and the engagement Audit 2009 - were of the importance of 'timing' in referrals that made a difference for families. For example:

[Case example removed]

Finally, in the view of NEMC&FSA further consideration is required about collaborative practice models, beyond the valuable but singular focus of the Community Base CP Workers. As found by the KPMG evaluation, too often Community Based has been the sole face of the integrated system in Child Protection. Considerations for stronger tertiary-secondary integration in response to the significant harm to children may include:

- Greater attention to readiness for change and engagement in families referred by Child Protection to Child FIRST/Family Services;

- Greater preparedness by Child Protection to facilitate and support referrals until engagement is secured and sustained for all Child Protection referrals and families with prior Child Protection involvement in particular;
- Greater acknowledgement and celebration of the constructive and/or essential capacity of the Child Protection service to provide an authorising environment for families to accept service and work towards improving children's safety, stability and development.

  Potential examples of this are, on the one hand, extended and specialist models of Child Protection intervention as piloted in the EMR Demonstration Project and, on the other hand, extension of possibilities for collaborative tertiary-secondary responses. These may include the contracted Supervision Order project recently completed with Berry Street and others; and other examples whereby Child Protection and community service combine to provide a co-response to protective concerns. Careful thought is required to how these roles are constructed to both ensure the ongoing role of Child Protection authority, while not losing the essentially voluntary and co-operative practice relationships bought by the community sector.

These models, similar to the community based child protection role, suggest 'intermediary' type responses along the 'regulation hierarchy' that are seen from this perspective to operate in 'the shadow of the law' to increase compliance within an otherwise voluntary context (see Protecting Children, DHS 2003 for further articulation of the regulation framework). Mechanisms that combine compliance and support require further consideration in the establishment of such service approaches.

*9 Recommendations: There is a limit to how far Family Services can impact into the tertiary space to provide specialist support to children who have suffered or are at risk of harm. This takes into account reduced engagement outcomes found for children referred from Child Protection and five times higher report back rates to Child Protection of community referrals to IFS of children with previous Child Protection involvement than community referrals without prior known involvement. Greater differentiation is required in identification of appropriate Child Protection referrals for community support to maximise engagement and additional intervention models that establish greater collaboration between the strengths of both Child Protection and Integrated Family Services should be further developed.*

### 3.3.4 Are there particular services that best meet the need of vulnerable Aboriginal children and families?

As throughout this submission, NEMC&FSA will focus only on our direct service delivery, in this instance, in relation to Aboriginal children.

The North East local government areas include the highest metropolitan population rates of Aboriginal people in Victoria. In this context, 7% of families allocated for casework services in the NE catchment were identified as Aboriginal and/or Torres Strait Islander. 62% of allocated families received services from a mainstream agency (ie non Aboriginal) and 38% from VACCA (note the VACCA rate will be minimally higher than this as not all VACCA own referrals are included in the catchment totals). The main reason for mainstream rather than VACCA case allocation is lack of capcity at VACCA to provide all service required, though there are some families who prefer to work with mainstream services.

The role of the Aboriginal Liaison Worker is critical to ensuring culturally appropriate services to this majority of Aboriginal families who receive service through mainstream agencies. The Aboriginal Liaison Worker role was established at the inception of the North East Alliance model to operationalise the Aboriginal Best Interest principle within the CYFA 2005, and to fulfill the parallel obligation in the Child FIRST funding specifications to consult with an Aboriginal controlled organisation. The NEMC&FSA – which includes VACCA as an active and equal partner- developed the role of the ALW to be co-located within Child FIRST (2 half days a week) and to be available to all partner agencies to provide cultural consultation to all referrals and all families requiring an allocated family casework service across the NE catchment (with family consent).

Funding for the position was patched together through combining what at the time was Aboriginal Family Support Innovation Project growth funds topped up by contribution from the mainstream Integrated Family Services agency budgets. Importantly, this funding was then given to VACCA to control the implementation of the ALW role, as noted by Muriel Bamblett, an important step in itself toward Aboriginal controlled agency capacity building as opposed to more usual historical sub-contracting relationships where the mainstream agency holds contract ownership.

This history is important as since its original inception in the North East catchment, the Aboriginal Liaison Worker has gone on to become a standard model feature in all other N&W Child FIRST catchments, and many others across the State. The KPMG evaluation of the CYFA 2005 reforms notes a 43% increase in Aboriginal usage of Child FIRST and Integrated Family Services and the increase in secondary consultations with Aboriginal community controlled organisations (eg. ALW). "Establishing an Aboriginal Liaison Worker in all catchments" is a key recommendation for opportunities going forward by KPMG.

*10 Recommendations:*
*Given the now pivotal importance of the Aboriginal Liaison Worker role to the Child FIRST/Alliance models and to operationalising the CYFA 2005 Aboriginal best interests principle, NEMC&FSA advocates for formal recognition of the role and the provision of dedicated and additional funding within Aboriginal Community Controlled Organisations, in our case, VACCA. This role should be supported by additionally funded training and professional development through state-wide networks.*
*Further, additional resources for capcity building and service delivery within Aboriginal Community Controlled Agencies, in our case VACCA, is required to maximise the choice open to families of Aboriginal controlled service provision, recognising that the majority of allocated casework service to Aboriginal families is currently delivered in the NE catchment by mainstream services.*

**5 The appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's cp policy and systems**

**5.1.1 What is the most appropriate role for government and for non-government organisations… in relation to child protection?**

**5.1.2 What roles currently performed by statutory organisations, if any, might be more effectively and efficiently performed by non-government organisations and vice versa?**

**5.1.2 What is the potential for non-government service providers to deal with some situations currently being notified to the statutory child protection service, and would it be appropriate (As is the case in Tasmania) for referrals to a service such as ChildFIRST to fulfill the legal responsibilities of mandated notifiers?**

These questions will be considered together.

The line at which statutory roles – underpinned by statutory authority, including mandated responsibilities for physical and sexual abuse, should be moved from State to community control is extremely delicate.

As an over-arching principle, the determination of the Public Accounts and Estimates Committee (PAEC)) inquiry into government contracting in the human services, was that government only should intervene in domains that threaten human freedom– such as prisons and child protection, is supported by NEMC&FSA. Thus, while the CYFA 2005 has extended powers for information sharing without consent in limited circumstances (risk assessment; determining appropriate services and consultation by registered community based child and family services with Child Protection), any further encroachment outside government into domains effecting human freedoms – on the one hand, intrusion upon 'the parent and child as the fundamental group unit of society' (CYFA 2005 s10.3(a) Best Interests Principles), on the other, issues of privacy and confidentiality - is further fraught.

Specifically, the greater proportion of reports to Child Protection are re-reports ie re-notifications of children previously reported to Child Protection (59% N&W region, 62% state-wide 2009-10) Such re-notifications would therefore be increasingly included in community referrals should current statutory roles be further transferred to the community. A first requirement of risk assessment is to establish the prior pattern and history of harm (eg Best Interest Case Practice Model, DHS, 2007) and therefore, to check the Child Protection database for documentation of such prior history. To enable this power in the community if erstwhile child protection reports are diverted to the community and as essential to comprehensive risk assessment, is to open a Pandora's box regarding privacy, confidentiality, and individual and family rights. In the view of NEMC&FSA this fails the standard of holding powers for intrusiveness on human freedoms within government. This is particularly true in relation to allegations, substantiations and both Children's and Criminal Court applications or orders regarding physical or sexual abuse – the subject of mandatory reporting.

Moreover, before any further consideration is given to transfer of roles from State to community based services, the real meaning of the current Child Protection threshold decisions in terms of the degree of risk of harm to children requires greater examination. Currently in the North and West region, the great proportion of Child Protection reports are neither investigated by Child Protection nor referred to Child FIRST. 21% of reports only are investigated and equivalents of 8% of reports are referred to the 4 N&W Child FIRSTs (N&W Child Protection data, April 2010)[2]. Outcomes of over 70% of Child Protection reports are therefore currently unknown in terms of presenting family circumstances, service needs or risk.

[2] This 8% equivalent of reports includes post intake Child Protection referrals for example from the CP investigation or Court Order teams. Some of these therefore may not have been reported in the 2009-10 year. 35% of referrals to N&W Child FIRST in 2010 were from post intake Child Protection teams with the majority 65% coming from intake. These were the same proportions as experienced in the NE catchment (N&W IFS Project Managers' report, April 2011).

If the community is to be asked to assume greater responsibility in relation to the service needs of these families, it is important that there is comprehensive understanding of what this entails. This is amplified by the concern expressed in question3.3 above (Weakness regarding how far Family Services can impact on the otherwise tertiary space) about potential discrepancies between the degree of harm experienced by vulnerable children as opposed to the type of beliefs influencing current Child Protection decision making that emphasise diversion, at times rendering the experiences of children behind these decisions invisible. This potential is increased in high demand and resource poor contexts as seen in a number of Child Death reviews and Ombudsman reports that question child protection threshold decisions with findings of premature closures or failures to investigate.

This equates with community experience. [Case example removed]. While such question marks exist about the degree of risk and the appropriateness or not of targeting of current Child Protection reports, it would be premature or even counter-indicated to transfer responsibility and accountability for such decision making away from the statutory authority.

The question of how to respond to the concerns in these families is more critical – as discussed under 3.3 above. A key part of this response is to strengthen the processes for effective transition of *at risk* families to Family Services when referral is indicated. A balanced service continuum within a Public Health model requires strong primary, secondary and tertiary systems. Child Protection must be strengthened to adequately respond to these families, including more attention to change focused intervention models as trialled in the Child Protection Demonstration Project in the Eastern Region. Integrated Family Service (and other secondary services) must be strengthened to continue to grow capacity to engage these families when transitioned to community support, either independently or in collaboration with Child Protection, and to safely hold the other cohort of very vulnerable families outside the Child Protection system as currently evidenced by the Child FIRST/IFS data presented through this submission. These strengths demonstrated of the current IFS service will be at best diluted, at worst overwhelmed, if further current tertiary roles and statutory responsibilities become further institutionalized in the community. As cautioned by Scott (2006[3])

> "At a deeper level is the risk that over time we may kill the goose that lays the golden egg – extend the power of the State to organisations in civil society such that they may come to be seen by families as the wolf in sheep's clothing." (p. 6)

*11 Recommendation: That responsibility for reports to Child Protection, including mandatory reports, remains with statutory Child Protection services. This takes into account privacy considerations with respect to intrusive searches of past child protection history, especially given that a majority or reports are re-reports where prior history is held, and considerations that the child protection intake is in fact predominantly well targeted toward the most at risk vulnerable families.*

*Both tertiary Child Protection and secondary Integrated Family Services, as well as other services within the secondary range, require strengthening to respond to the needs of these and other*

[3] "Sowing the Seeds of Innovation and Sustaining Hope in the Protection of Children" *every child, every chance* event, Federation Square, April 13, 2006 www.dhs.vic.gov.au/everychildeverychance/keepinginformed

*vulnerable families currently coming to the attention of the combined Child Protection and Child FIRST intake points. Overtime, the strengthening of the wider secondary service system will divert appropriate families and relieve pressure on the Child Protection system, without diluting this community capacity through the transfer of statutory roles.*

**3.2 Providing a quality service to vulnerable children and their families is dependent on having a skilled workforce. What are the strengths and weaknesses of current workforce arrangements eg. working conditions, training and career paths? How might any weaknesses be addressed?**

**5.1.4 Is it necessary to strengthen the capability of organisations in the non-government sector to better equip them to work with vulnerable children and families and if so how?**

Again, NEMC&FSA will consider aspects of these questions together.

As stated, "Providing a quality service to vulnerable children and their families is dependent on having a skilled workforce". From the perspective of Family Services it is critical to understand exactly *how vulnerable* are the families being managed within a secondary service context, and under the banner of 'earlier intervention'. As described throughout this submission, the families that the NEMC&FSA workforce manages as 'earlier intervention' are among the most vulnerable and complex need families in the State. Often it is commented by experienced workers that 20 years ago many of these families would in fact have been subject to Supervision Orders within a Children's Court order context. This is no longer the case – and for good reason as it is important to continuously extend and stretch community capacity to constructively engage these families in consent and strength based relationships that enable the potential for positive change .(And again as argued in this submission, it is critical to recognise the boundaries of this approach and combine its strengths with an appropriate use of statutory authority as required to protect children).

Thus, while framed as 'earlier intervention' from a policy perspective, there is little 'early' about the presenting needs of children and families allocated for Family Services casework in the NE catchment. Their problems are often entrenched and mired in sad and disturbing consequences of trauma, exclusion and powerlessness. The practice frameworks, intervention models and associated systems of personal and professional development and support for the workforce must match the intensity and complexity of the problems in the families with which they are asked to face.

As stated previously in this submission, NEMC&FSA, predominantly through philanthropic funding, has run a project over two years exploring evidence based approached to practice in this space. What has become increasingly clear through this exploration of the evidence is that not only must approaches to practice be evidence based, but so too must approaches to implementation. For example, most new practices are introduced to the field through one off training sessions. Research about what is required for workers to actually adopt new learning in practice suggests that this can only be regarded as step one. If training begins and ends here, there is little evidence of flow through to real practice change and adoption of the new skills in practice. Rather in-service training must be followed up by ongoing coaching and consultation to workers on-site as they work with families, as well as staff and performance evaluation to effect meaningful practice change (Fixsen et al., 2005). Providing this level of practice support is itself

resource intensive and costly, but essential if evidence based practice is to be meaningfully enacted.

Nor does this take the place of supervision and other forms of professional development, reflection and support as for example demonstrated through the roles of the Principal and Senior Practitioners as recently implemented within Victorian Child Protection services and recommended for flow through to the Family Services sector by the KPMG evaluation (April 2011). Workers in this field experience a wide range of experiences and emotions in enacting their responsibilities – from compassion, through challenge, to despair and vicarious traumatisation. Organisations must be funded and equipped to deal with this full range of personal and professional developmental needs in order for workers, in turn, to address the intensive and complex needs of the vulnerable families with whom they work and so protect the safety, stability and development of children.

In this context, recruitment, retention and remuneration of staff are further vexed and recurring challenges. The current 'equal pay' case is critical to this, alongside increased funding to adequately resource the development of practice models, training and ongoing personal and professional development and support for the workforce matched to the intensity and complexity of the vulnerable families with whom they work.

*12 Recommendation: Workforce recruitment, retention and remuneration require critical attention in the context of the degree of vulnerability, including complex and intensive service needs, of families and the matched intensity for workforce skills, compassion and personal and professional development and support. Resources are required to further develop and reinforce in practice best evidence based models, including appropriate levels of training and ongoing, post implementation support and skill development for the workforce.*

**5.1.6 What are the strengths and weaknesses of current Commonwealth and State roles and arrangements in protecting vulnerable children?... What should be done to enhance existing roles or address any weaknesses?**

NEMC&FSA brings to the attention of the Inquiry issues arising in enacting the Early Childhood Development Project (ECDP) in the North East catchment. This Project is funded through DHS to improve the interface – both referrals and knowledge building – between early years services (such as child care or maternal and child health) and Family Services.

Major barriers to both constructive policy and program development and families' access to services arise through the multiple points of disjuncture between funding, program and service delivery responsibilities across the early years services. For example, while the ECDP, Early Parenting Services and lead responsibility for vulnerable families are funded and managed through DHS, most other initiatives in the early years domain are funded and managed by DEECD at the State government level. Alongside this responsibility for child care funding rests with the Commonwealth, while most delivery is either at the local government level or privately operated. This chaos is mirrored on the ground as described by the following extract from wortl undertaken by the NEMC&FSA ECD Project:

> The benefit of participation in quality early years programs for vulnerable children and families is now well understood in terms of improved early brain development and improved long term health and well-being outcomes. The Early has considered a range of

methods to ascertain barriers to access and sustained engagement in early years services for vulnerable families.

**Complexity and dis-integration**

Most notable in these findings is the complexity of the intersecting and concurrent barriers faced by families resulting in problematic referral and navigational processes for families and practitioners. Timely access and ongoing participation in services for vulnerable families was therefore reported to be variable and inconsistent with practitioners reporting varying skill levels and understanding of pathways, support/service options for families and best practise approaches for working with vulnerable children and families.

Looking at the vulnerable family as a starting point, funding, service and supports present a web of hard to reach possibilities particularly when attempting a local area response to need. Universal early years services, secondary services, specialist services, Early Start Kindergarten, Special Child Care Benefit, Child Care benefit, Inclusion Support programs and Preschool Field Officer programs, etc. require considerable and in-depth knowledge of state, commonwealth and local agencies.

Dis-integration of policy directions, funding and support pathways for vulnerable families means that practitioners require *overly* specific and up to date knowledge of complex navigational routes through state, Commonwealth and Local support / funding agencies to effect a timely response to a family with immediate and urgent needs.

In sectors characterised by high turn over of staff this requires additional resources beyond those currently available to ensure the full uptake of available funding and support options can be realised and maximised for those families most in need.

Further consideration must be given to ensuring that services in areas of highest disadvantage are afforded increased access to funding and support options for vulnerable families without the requirement to seek submission for increased claims on such resources. Such submissions further drain already stretched resources that could otherwise be directed to child and family actions more directly. SEIFA and AEDI data could provide a basis for adjusted funding in this manner.

*13 Recommendation: Policy and program coordination and/or integration between and within local government, State government and the Commonwealth requires urgent attention to maximise access to service for vulnerable children. Within this, needs of children in the most disadvantaged areas require special attention, to secure and maintain appropriate levels of support to infants and children through the critical early years. SEIFA and AEDI data could be provide a basis for adjusted funding in this manner.*

**8. The oversight and transparency of the child protection, care and support system and whether changes are necessary in oversight, transparency and/or regulation to achieve an increase in public confidence and improved outcomes for children.**

The NEMC&FS Alliance would recommend that in order to ensure a greater degree of oversight and accountability into the child protection system an independent Children's Commissioner be appointed to report directly to Parliament. Further, that this Commissioner have full

investigative powers into all deaths and significant injury of child protection clients up to 12mths after termination of service. In order to ensure a greater degree of impartiality the Commissioner should have their own independent investigative and administrative support staff.

The NEC&FS Alliance would support the Commissioner highlighting any findings regarding systemic issues and failures in particular for unborn children, infants who have been notified to Child Protection in the first year of their life, and children who have been repeatedly re notified.. That the Commissioner also have investigative power into the deaths of children who were not notified to Child Protection when they should have been and that these findings be broadly shared to improve child protection and child safety practices.

*14 Recommendation: That an independent Children's Commissioner with full investigative powers be appointed to report directly to Parliament on all deaths and significant injury of child protection clients up to 12 months after termination of protective services. That the Commissioner highlight any findings regarding systemic issues and failures and that these issues be broadly shared to improve child protection and child safety practices*

## KEY CONCLUSIONS

**Key implications of this submission for strengthening responses to vulnerable children include:**

### ONE

NE data fully supports the KPMG finding of the important value Child FIRST and Integrated Family Services (IFS) have added to the continuum of services for vulnerable children. In NE this is evidenced through:

1. Accessible and visible intake to a wide pool of vulnerable families not previously known to Child Protection
2. High engagement and capacity to hold vulnerable families in the community without recourse to Child Protection reports
3. Capacity for ongoing and intensive service

These outcomes fulfil obligations of Child FIRST within the Strategic Framework (DHS 2007) to provide earlier intervention and diversion roles from Child Protection. Ability to meet demand is however is constrained by capacity.

These roles are complemented by:

4. Extensive information and referral roles

These roles deemed 'early intervention' by the Strategic Framework and are stated as IFS 'preventive role' to a wider group of families than the highly vulnerable population.

This is limited against comprehensive descriptions of early intervention and prevention as included within Public Health Models of for example, the VicHealth Prevention framework – both of which require full articulation of primary, secondary and tertiary level responses.

Given these findings, there is a need to increase the capacity of Integrated Family Services (including Child FIRST) to provide earlier intervention services to vulnerable families in line with community demand.

Moreover, additional resources and program legitimacy within the Victorian State government Strategic Framework for Family Services is required for the current IFS providers to deliver early intervention and prevention services as required within a comprehensive Public Health approach to protecting vulnerable children.

### TWO

Secondary and tertiary service models require strengthening in particular for:

1. Very complex high need families engaged by Family Services over extended and/or multiple episodes of service but with minimal change and grave concerns for cumulative harm suffered by children in these circumstances.

2. Highly vulnerable families who do not engage with Family Services, especially those referred from or with previous involvement with the Child Protection service.

The following reforms are recommended to better meet the needs of these families:

1. Access to brokerage funds by Integrated Family Services

2. Development of child focused services to complement parental care when sufficient change is not effected through extensive service involvement to prevent cumulative harm to children. This includes:
   a. Services such as child care; capacity to take children to child care or school; mentors; homework clubs; breakfast clubs; school tutors; respite care; recreational opportunities and holiday programs
   b. Improved access of children and families within the secondary service system to trauma and attachment oriented therapeutic services; intensive parenting services; Family Coaching; adequate, appropriate housing and other supports

3. Reinforcement of service models across both IFS and Child Protection that are responsive to trauma and powerlessness and combine strengths based approaches with the wise use of authority to maximise engagement and create opportunity to work toward change, such as:
   a. Improved referrals and transitions between services that hand over a relationship as opposed to only information, consistent with finding of better engagement for Child Protection families post intake rather than in intake where there is limited if any contact with families. Focus is on joint visits with families, case conferences and periods of transitional roles.
   b. Positive strengths based models of accessing service through community intake, including local agency intakes that encourage self referrals and complement Child FIRST central intake, recognising the importance of 'timing' to effective referral outcomes and important interfaces with primary services through allied agency programs.
   c. Building on strong evidence base about the role of 'motivational interviewing' in building people's commitment to change by accessing their own values, as well as other evidence based approaches to practice and its effective implementation.
   d. Collaborative practice approaches that combine strengths and authority, such as care teams or co-work of protection orders and which transition case management to the community when appropriate
   e. Reinforcing primacy of Child Protection case management and role when required, particularly in the gap for at risk children not investigated or not substantiated by child protection and whose families are not engaged by family services.

**THREE**

Critical attention and increased resources be given to recruitment, retention, remuneration as well as appropriate up-skilling and personal and professional development of the Integrated Family Services workforce commensurate with the degree of vulnerability, including intensity and complexity, of child and family needs with whom they work.

**Attachment One**

**North East Engagement Outcomes Methodology and Terms**

Over 2009, NEMC&FSA undertook an audit of 40 allocated cases in order to better understand engagement outcomes for families allocated for casework service within Integrated Family Services. Case outcomes were thematically coded by engagement types evidenced within the sample, as detailed further below.

As a result of this initial audit and its finding, NEMC&FSA has implemented routine follow up of engagement outcomes for all cases allocated across the nine partner Family Services agencies, 6 months from the month of allocation. The data referred to in the NEMC&FSA submission to the PVVC Inquiry is the outcome of the first full year (January to December 2010) of data collection. The data relates to 382 families allocated within NEMC&FSA between July 2009 and June 2010, with follow up occurring 6 months from allocation.

Team Leaders complete the required information to track outcomes, using the thematic codes developed through the initial audit process, as well as providing other brief information. This is combined with data collected about the families at the time of allocation (such as referral source, number of children, IRIS case category (significant well-being concerns, complex or other IRIS issues), cultural status and more to provide the data set reported on throughout this submission.

"Engaged" is defined within the NEMC&FSA engagement outcomes follow-up as including both criteria of:

1. Constructive relationship or attitude to service &
2. Constructive activity toward meeting goals

This follows the definition of engagement by Yatchmenoff (2005) as

> An umbrella term that legitimately includes behaviours (eg. service usage, duration and completion) as well as attitudinal or affective dimensions

"Did not engage" within the NEMC&FSA engagement follow-up is defined as the absence of both criteria. The third category is "Indeterminate" outcomes, indicated by the presence of only one criterion, or family performance too weak or variable to satisfy one or both criteria

As well as coding cases by the engagement type (Engaged, Did not engage or Indeterminate) team leaders further code outcomes by specific descriptors to provide more detail (one per case)

**Engaged: specific descriptors**

**Open to services** Family cooperates, motivated & follows through with intervention
**Community & service links, short** Referral and linkage focus, case closed when initial goals met
**Warmed to support** Family initially reluctant or wary but becomes open to support with time
**Persistent effort** Family overall willing to work with services but constant crisis or difficulties; and/or feeling family engagement dependent on worker effort
**Child &/0r YP focused** Focus is child or young person, including where parent is reluctant to become involved themselves
**Established but disrupted** Case closed after constructive progress due to external reason eg worker leaves; report to Child Protection; family moved after engagement; OR family ceases engagement/withdraws after initial progress
**ENG Other**

**Did not engage: Specific descriptors**

**Declined service, closed to offers** - Family actively asserts lack of interest
**Unavailable** - Family indirectly conveys lack of interest eg misses appointments (no show or continual excuses); no or intermittent response to letters or phone calls
**DNE Other**

**Indeterminate: Specific descriptors**
**Family identified other service needs** Family involved with or states preference for other legitimate service need
**Open to support, no identified FS role** Decision that FS role would not benefit family or be the most appropriate service response
**Family moved** - Before intervention established
**Patchy engagement** On-off pattern of contact or follow through; repeated swings between *unavailable* and *open*; multiple disruptions; meets only one engagement criteria or weak on both
**IND Other**

The final data provided by Team Leaders at follow up to complete the profile of engagement outcomes is:

**3 Status at follow-up :** Record as: <**Open**> if case is still open <**Pending**> if closure being actively considered; OR <**Closed**> if the case is closed

**4 Date of closure** Record date if case has been closed

**5 Months since closure** *Subtracts date of closure from date of allocation*

**6 ALW consultation post allocation** Record as <**Yes**> if one or more consults; or <**No**>if no consults with the Aboriginal Liaison Worker

**7 CBCPW involvement post allocation** Record as <**Yes**> if CBCPW has been consulted post allocation; or <**No**> if no consults with the Community Based Child Protection Worker

**8 CP report or involvement post allocation (excl CBCPW)** Record as <**Yes**> if there has been a new report to CP or CP has been involved post allocation; or <**No**> if not

**9 Previous CP involvement (excluding current referral)** Record as <**Yes**> or <**No**> (Current referral will be displayed as referral source)

**10 Previous FS involvement** Record as <**Yes**> if involvement with any FS agency (NE or other catchment) or <**No**>

**11 Brief description of engagement and progress** ***<Free text comment>***
Engagement: Brief rationale of 2. Specific descriptor chosen (ensure comment if 'other') and Progress: Brief description of key interventions/focus of support eg linked to childcare, housing advocacy; strategies for parent/child interactions and child behaviour; counselling re impacts of violence on children & mo's previous trauma. Father present but not involved