Upper Murray Family Care

Protecting Victoria's Vulnerable Children Inquiry

1. The factors that increase the risk of abuse and neglect occurring, and effective preventative strategies.

1.1.1 Key preventative strategies for reducing risk factors at a whole of community or population level.

Given that child abuse and neglect have both psychological and sociological contributing factors, whole of community or population level strategies have to address both.

In practice this means having a clear understanding of the social context of any defined community, its history, its demographics and the cultural profiles of members.

At a psychological level it has to include some understanding of what it means for each individual to identify as being part of such a community.

Understanding how a person perceives their unique status in their community allows for flexible, locally based responses.

So for example, how are children, aged, disabled, women, people from a CALD background, the unemployed, homeless, mentally ill valued and appreciated in their community?

1.1.2 a) Immediate Priorities

This requires identification of the existing vulnerable groups and planning locally responsive strategies. Neighbourhood surveys could be employed as well as current data bases to provide information.

b) Medium Priorities

These would be based on potential vulnerable groups, which allow for more time to evaluate and implement responses. Such groups would include future members of the groups currently identified as seeking immediate responses as well as broader groups on the margin.

c) Longer term Priorities

Would be those strategies that take the most time to have an effect of reducing future membership of vulnerable groups.

1.1.3 The most cost effective strategies have to be those who focus on early intervention. Universal services that reach all children have to be available to enable early identification of problems before they become entrenched.

1.1.4 The broad policy direction seems right, based on the best available evidence/research. Perhaps how it could be improved would be on measures that allow the groups mentioned above to be able to tailor responses suitable to their needs.

What is essential is a clear universal standard that all children are entitled to, so the outcomes are the same for all. What varies are the methods on how the outcomes are achieved. These different methods would be influenced and led by the groups/settings outlined in the question.

1.1.5 The idea of having primary, secondary and tertiary interventions is useful because it allows for a coordinated, systematic response to the problem.

At present we have services at these levels but there is not an explicit recognition of their relationships. So for example, primary services will see child abuse as the responsibility of tertiary services i.e. statutory child protection.

In Victoria we have developed good linkages between secondary and tertiary e.g. OOHC, ChildFIRST, but not with primary services.

This requires much greater cooperation at all levels, starting with the government departments that represent these levels, i.e. DEECD, DHS and Health.

To achieve this also requires common understandings, language, definitions, boundaries.

2. Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services. This should include consideration of ways to strengthen the capability of those organisations involved.

2.1.1 First, to accept responsibility for having a role in identifying vulnerable children.

Second, to have a standard approach for referral.

Third, to have commitment to ongoing involvement with the family

2.1.2 Targeted or secondary services have the primary role of providing services that address the issues that caused/maintain child abuse.

They also have a role as mediators between Primary and Tertiary services.

2.1.3 Specialist adult focused services have a role in assessing the capacity of their clients to discharge their parental/caregiver responsibilities.

Partnership with secondary family services in professional development, ongoing training would assist.

2.2 1. Cross sectoral professional development

2. Common assessment/referral tools

3. Standard feedback reports to each level

4. Shared data bases

2.3

Immediate

1. Allocation of Primary and Secondary Services

2. Local area planning that highlights the priority groups and recommendations of how services will respond.

3. Publications of child abuse rates and outcomes.

Medium

1. Shared data bases between Primary/Secondary services.

2. Shared budgets between Primary/Secondary services.

Longer term

1. Cross departmental planning on service development that reduces duplication, differential boundaries and disconnected programs.

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

3.1 The positive aspects of this approach is

a) Acknowledgement of the skills and capacities existing in the non government sector that enable effective work with vulnerable children and their families.

b) More resources have been directed toward non government agencies

c) Legislative recognition of the role of 'NGOS'.

The weaknesses of the approach include:

a) The biasing of non government agencies toward the statutory end of client profiles and away from the primary and secondary end.

b) Potential confusion in the community between the differences of non government agencies roles and statutory child protection.

To address these weaknesses the solution to a) helps towards b). In other words, family services and Out of Home Care should be encouraged to engage in more primary level interventions. As an example, about 15 to 20 years ago the majority of foster care placements were voluntary, emergency placements. That is parents chose to use the service for respite.

The department objected to this as they believed it to be a waste of resources which should have been directed toward their (i.e. statutory) clients. Their argument was that there was no evidence that the provision of voluntary respite placements had any effect on the subsequent reporting of child abuse. Similarly, family services were criticised for working with 'easy' clients at the expense of 'hard' statutory clients. As a

result the rates of voluntary referrals from the community dropped as caseloads reflected DHS referrals.

3.2 Clearly, levels of funding has to be mentioned in this review. However it is not only to do with pay scales but a broader analysis of the context of the work. Presently there is not a career path for the workforce in family services and out of home care. The model of skilled practitioners that exist in education doesn't in our sector. There are no higher levels according to qualifications and expertise that allows for staff to remain in the program. Given the complex nature of the work, tenure is an important feature as experience is required.

Working conditions also include the physical environment and working with vulnerable children and their families demand a space that is both safe and welcoming. It is a curious fact that unlike private schools and hospitals, community agencies cannot access funding for capital infrastructure. This keeps the sector at a very great disadvantage in being able to offer a safe and welcoming workspace.

Joint professional training with Child Protection would assist in collaborative approaches and shared understandings.

a. Family services

3.3 The strengths of the current services include a more flexible, low key contact with vulnerable families that potentially engages in a more constructive manner than with statutory child protection. The establishment of a supportive relationship can be the basis of ongoing work with the family which may require long term support rather than a short crisis response.

Significant family change requires both time and trust in the service provider

The weaknesses include demand pressure which focuses on throughput and turnover of caseloads and a complex service system with different languages and understandings.

3.3.1 First there can be recognition that some families require long term support. These families can be identified and monitored to ensure progress can be made as quickly as possible (this can be summed up along the 80/20 lines, i.e. a small percentage soak up a majority of resources).

Second more cross sectoral training to better share understandings e.g. the concept of cumulative harm.

3.3.2 The basic structure is appropriate but it could be finetuned according to the local social context e.g. demographic profiles. In a regional setting, rural outreach needs to be considered along with targets. Where there are pockets of disadvantage, community development work can be prioritised.

3.3.3 The short answer is yes, the long answer is they could do even better with appropriate resources i.e. training and access to specialist services like translators.

3.3.4 The North East of Victoria has very little in the way of services to vulnerable Aboriginal Children and Families. In our region of Hume, most of these services are in Shepparton.

b. Statutory child protection services, including reporting, assessment, investigation procedures and responses;

3.4 There are a number of strengths, first there is a good geographical coverage, local staff on the ground (with the caution, relating to vacant positions), good training available and support from senior practitioners and the creation of the community based child protection workers has been very positive.

The weaknesses have been well identified by the Victorian Ombudsman in his November 2009 report.

3.4.1 Many of the Ombudsman's recommendations address this question but in short a stable, experienced workforce is required. Strong collegial working relationships are essential and this is difficult with changes, vacancies and people under stress.

At a broader level these also need to be more community education into the contributing factors surrounding vulnerable children and their families. Too often there is a moral panic to the latest case to hit the headlines at the expense of all the good work going on with such families.

The protection of children requires a whole of community effort and is beyond the capacity of any community agency or government department.

This is where a public health model would be useful, just as we have had campaigns to change behaviour on smoking, exercise, drinking, domestic violence etc, we need similar campaigns on positive parenting and social support.

3.4.2 There appears to be a remaining crisis approach by Child Protection i.e. critical incidents at the expense of the new concept of cumulative harm. This might be a demand management response. The same approach also exists amongst Magistrates with Child Protection workers reporting it difficult to get the concept across resulting in applications being dismissed and the Child Protection referring to Child FIRST when protective concerns still exist.

3.4.3 Mandated reporters express concern that if they do report it may damage any constructive relationship they have with families. In rural areas in particular primary level services e.g. child care may be the only social support available to the child, so any reporting will be easily traced back to the service and the child removed by the parents meaning no external way of monitoring the child. (This actually happened when mandatory reporting was introduced).

Given the complex and sensitive nature of reporting it could be useful to have an interagency assessment meeting to discuss the immediate and subsequent consequences of acting in such cases.

c. Out-of-Home Care, including permanency planning and transitions

3.5 The most serious weakness in Out of Home Care has been the tight coupling with Child Protection. Instead of OOHC being part of a secondary level support to families it has transformed into a tertiary level service to Child Protection. What this means is

that all the deficits associated with CP i.e. crisis responses, bureaucratic processes, staff turnover also now relate to OOHC.

Foster Care which once promised active involvement by the local community in supporting vulnerable children and their families has been taken over by rules and regulations shaped by legislation and child protection. This fails because it is an attempt by government to totally control civil society (foster families). A partnership has been replaced by a contract.

The early intervention capacity of foster care (i.e voluntary emergency/ respite placements) has almost completely gone with statutory placements. This has also changed the relationships between carers and parents whose children are placed as well as between carers/parents and agency staff.

Community Agency staff are no longer clearly differentiated from that Child Protection colleagues.

3.5.1 There should be the uncoupling of home based placements (not residential placements as these should be only for statutory placements) from Child Protection. As foster care placements are not planned to be long term (i.e. children move either back home or into permanent care) the program could reside in another department e.g. DEECD

The educational outcomes for children in OOHC are well known to be poorer than their peers not in OOHC. Given the lifelong negative consequences of this disadvantage, everything that normalises their placement should be considered. Being at risk or vulnerable can be a temporary status with the correct support, being a child with educational needs is a normal ongoing status.

The ramifications for not only children but their parents and the placement agency staff with such a transition would be potentially far reaching and positive.

3.5.2 As above, the structure of OOHC would change if uncoupled from a Child Protection perspective. In a public health model it means shifting the program to the primary, secondary boundary from the secondary, tertiary boundary. As a result more flexible, responsive structures could evolve.

3.5.3 a) More resources need to be available for educational, health and mental health needs of children in OOHC. This population is already identified as having major needs in these areas but no special provision is provided. Usually their needs have to be met within the current resources of these providers.

The suggestion made above of relocating OOHC into another department like education would make it easier to incorporate the needs of children in OOHC.

b) Moving the OOHC sector to the boundary with primary or universal services would also assist in meeting the needs of children from CALD backgrounds. This would occur from the mainstreaming of OOHC and closer linkages with widely available services. One practical method would be in utilising volunteers from CALD backgrounds who in their everyday lives would have contact with this population in OOHC.

c) This seems a mistake in typing but assuming it refers to contact between children in OOHC and their biological family, if so the reorganisation as discussed would allow more natural and wider opportunities for contact and engagement.

3.5.4 Processes and structures must be established to allow such voices to be heard. CREATE is one such body for children and the FCAV for carers. These groups need not only funding but legitimation to be at the table when decisions are being made. It should be mandatory that their perspectives have to be considered in all policy matters of significance.

3.5.5 First there should be some baseline data collected to know where we are now with rates of placement changes.

Second there should be well agreed definitions of planned placement changes and placement disruptions (breakdowns).

Third an analysis of the reasons around placement disruptions.

Fourth, actions arising from three.

In respect of successful reunification there should be data analysis of the reason for placement as there would be different issues if the reasons were different each time.

3.5.6 There needs to be a change of attitude toward foster families wishing to be permanent carers. At present this is seen to be a problem rather than a solution. There also needs to be ongoing support to the permanent care family post agreement. Some foster parents would take on the responsibility if they felt they could continue to call on the placement agency for some support.

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

4.1.1 The most obvious gap at present is the one between State based Child Protection matters in court and child protection matters in family law courts. Work is underway but better transfer of knowledge is required so courts are fully informed on matters such as access.

Similarly better integration between states is required for communities living along state borders. What constitutes the practice in one jurisdiction is different in another. As long as child protection is state legislated and defined there will always be cross border issues.

4.1.2 The Family Law Pathways networks have demonstrated positive support in establishing collaboration at a local and regional level for service delivery and planning. Having all stakeholders able to participate (Federal Magistrates, private solicitors, Community Legal Services and FRSP providers) the capacity to have a common approach and understandings are enhanced.

A similar network could also be established by building on the Child FIRST alliances and having them authorised to have a similar role to the Family Law Pathways.

4.1.3 The study last year of the appropriateness of alternative dispute resolution processes in children's court matters is a model that could form the basis of interprofessional, organisational and sectoral collaboration.

Again this was one of the recommendations arising for the Vic Ombudsman's report which looked at the concerns stemming from the current adversarial approach in the Children's Court. Clearly it is very difficult to have collaborative approaches when the essential process to reach decisions is the opposite.

4.1.4 Cross sectoral professional development that allows for shared understandings of common interests eg the impact of trauma on brain development and the opportunity for professionals to discuss the implication for practice.

These opportunities could also be supported by local and regional data and trends.

4.1.5 One of the changes to funding could be to have a bonus payment to those service providers who collaborated in a given local area and demonstrated by their behaviour that outcomes for vulnerable children and their families were better than the state average.

This could be in rates of school attendance, school suspensions, children court appearances, referrals to child protection and the like.

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

5.1.1 The Current roles are appropriate, where there needs to be investigation of concerns that should rest with the state. The role of nongovernment organisations is to be a connecting link between the vulnerable family and the wider community.

5.1.2 One opinion of the writer is that all residential care should be the responsibility of the state, i.e. delivered by government. The logic behind this is that the children and young people who require residential care are by definition the most vulnerable and in need group. They require the most support and the state has more resources than any NGO.

5.1.3 There is a therapeutic role for child protection where the risk to a child is serious. In these cases the role of child protection needs to be distinct and unambiguous. There is a danger if the role is diluted with a family support focus.

Therefore the Victorian model has the potential to cover both protection and care via the state and NGO's respectively. What is required is that both roles are identified and respected.

NGO's have the capacity to engage and work with all families but there needs to be a separate state authority that has the power to act in children's interests.

5.1.4 Yes, the complex need of such children and families place great stress upon agencies at all levels. There needs to be some objective weighting of this reality in terms of funding, access to training/delivery/caseloads, career path development, research and evaluation that informs program planning and policy settings.

A good starting point would be to look at the balance between administration tasks and direct practice. This would not only consider the time proportions but also the nature of the accountability i.e. how does the reporting inform and support best practice.

One of the outstanding issues for the sector has been the quality standards agencies have to comply with but with no additional funds to assist.

5.1.5 The best protection for children from all forms of abuse is transparency. Abuse can only occur and be maintained in secrecy. Discussions need to take place with all stakeholders over the sensitive means possible to minimise secrecy. One simple example could be for all school aged children to be taught protective behaviour, which includes their own protective network.

5.1.6 There should be much better dialogue between the Commonwealth and States and territories when new services are being introduced to ensure they mesh with what already exists.

At a local and regional level the relevant Service provider should meet with both levels of Government to see how the initiatives can be implemented on the ground.

6. Possible changes to the processes of the courts referencing the recent work of and options put forward by the Victorian Law Reform Commission.

6.1.1 The Victorian Law Reform Commission's final report is a very comprehensive and persuasive document for improving the court processes. The technical aspects of their proposals e.g. new no fault grounds, are beyond this response but the concept of proposal 1.5 in Chapter 7 "Family group conference should become the primary decision making forum in Victoria's child protection system" is welcomed and supported.

Aside from reducing the adversarial nature of decision making, any process that encourages participation by families and children, is to be viewed positively.

6.1.2 This question is beyond the expertise of this writer suffice to say that any time limit is arbitrary but if the existing limit is demonstrated to be too restrictive the analysis must be is the problem the time or the resources available to comply? If the former than an extension based on best practice, if the latter then time changes may not address the issue.

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

7.1.1 There should be sufficient research both domestically and internationally to support planning. What has been lacking has been an integrated systemic approach. The whole system, i.e. child protection, courts, NGO's have never been considered as a linked system in planning. Changes in one affect the others.

So, as a simple illustration an increase in child protection workers will lead to an increase in interventions and subsequent demands on courts and NGO's.

7.1.2 The radical proposal in this submission (home based care to another department, which would require legislative amendments, and residential care to the state) would have workforce consequence consequences. It is suggested in the former by a less restrictive and stigmatising way of working and for the latter by more resources and access to support.

If the placement of vulnerable children is considered on a continuum, with home based care at one end, least restrictive, and residential care at the other most restrictive, then the policy and practice settings should reflect this continuum. At present the regulation of home based care has placed such settings at the wrong end.

Until we move to a totally professional, foster parent model, it needs to be understood that it is based on volunteers. Government has every right to demand quality; it also has an obligation to match the expectation with resources.

7.1.3 The response to 7.1.1 is part answer to this. At present the child protection system is in segments with different attitudes towards the participants. Once it is accepted that all are equally valid and important workforce development and retention can be integrated and some fairness across the segment result. The current ASU case for community sector workers is an example of where we are.

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.

8.1.1 With so many parties already involved it seems difficult to justify adding any more. History would indicate that the shortcomings are well identified what is needed are some new approaches. The only other comment would be the segmentation of the system referred to in this response could also be made about these various bodies i.e. they operate independently of each other and conduct investigation at different times. Some coordination would be beneficial.

8.1.2 Not informed enough to answer but it is probably sensible to consider the whole system and what's missing when considering another piece to be included. The total context should be evaluated when looking at other places both there and here.

8.1.2 Transparency has already been noted as an important characteristic and perhaps the publication of robust statistics that reflected how well the system was working as well as the gaps would be useful.

8.1.4 As above, as well as continued information about the latest research in an accessible manner to promote an ongoing social discussion, rather than wait for the next moral panic.

Appendix 1

Protecting Victoria's Vulnerable Children Inquiry

UMFC Out of Home Care program feedback

Feedback provided from perspective of case workers, assessment and recruitment workers and carers.

3.5 What are the Strengths

Perspective: Caseworkers/Assessment and Recruitment:

- Agency has good working relationships with foster carers.
- Consistent foster carer enquiries/interest in applications
- Agency has achieved good performance in conversion to accreditation
- Increased development of carer support networks (Training etc)
- Increased opportunities for carer networking (camps, morning teas etc)
- Longevity of carers (some over 25 years) – high carer retention-carers who exit the program usually do so for legitimate reasons (moving, taking on permanent care etc)
- A consistent and effective training and assessment process – regularly reviewed
- Excellent outcomes from Circle Program (Therapeutic Foster Care)
    - High carer satisfaction, morale, commitment
    - Effective carer training
    - Low rates of 'return to care' following reunification
- Agency implementation of regular home visits & care team meetings has instilled best practice.

Weaknesses

- Children in foster care for too long.

- Children need a rapid exit from system.
- Lack of worker consistency.
- Staff turnover is high.
- Lack of experienced workers.
- Lack of communication between DHS and agency.
- Lack of consultation between carers and DHS.
- Lack of carers, especially Adolescent Community Placement (ACP) carers.
- Carers put off working with DHS as a result of negative experiences.
- Paperwork process is timely and confusing.
- Very large geographical area to cover; Travel time over region
- high travel times affect worker availability
- Implications for access can affect placement choices (eg excessive travel for a child, DHS unwilling to travel or transport).
- Infrequent attendance of DHS workers at care team meetings. Low wages of staff.
- Carers needing to work as pay for children not enough to care at home.
- Carer availability
- Higher number of carers working full time – households with no stay-at-home carers
- Difficulties recruiting and sustaining adolescent carers, in particular
- Inability to fully service requests for respite placement
- carer availability – using respite carers to support long term placements means voluntary respite requests may be unable to be met
- Limited time to fulfil requirements for effective recruitment to build carer numbers – training and assessment priorities
- 'metrocentric' recruitment strategies – unavailable to/unsuitable for regional areas
- Huge dominance of female staff
- Demands of paperwork leading to increased time in the office for workers and less time with children/carers
- Children remaining in care for long periods (eg 3+ years) prior to permanent placements court processes taking longer.

Carers feedback

- Overall, if DHS received more funding to provide more case workers, support workers and resources to families the system would be much improved.

- Any improvement would flow through to services and agencies.
- Too many children fall through the cracks, and many families can't get the support needed to maintain children in their care.

Strengths:

- Allocated foster care worker
- Allocated DHS worker
- Opportunity to maintain visits to parents
- Opportunity to see "functional families" in action
- Opportunity to experience a sense of peace and relaxation
- Opportunity to socially mix with others in a safe environment
- Long term carers get to benefit from those offering respite care
- Kids in residential care are offered weekends with their families and/or foster carers
- Literature available to children is improving however do all children receive this on entering foster care?

Weaknesses:

- High turnover / burn out rate for staff in child protection ->can result in inexperienced staff being at risk of a highly demanding caseload if supports are not put into place
- DHS regularly make decisions regarding a child's welfare without consultation with carers and child
- DHS are always late to their meetings and their apologies are insincere
- Perhaps more care team meetings should occur
- Medication charts are rarely completed and signed prior to arrival to foster care placement
- Information sheets to foster carers need to come completed and as soon as possible to the placement commencing
- The word "access" should be abolished from the foster care language. Instead, replace it with "visiting" – it is sad when you hear the kids adopt these phrases

3.5.1 Addressing Weaknesses

Caseworker's/Assessment and Recruitment perspective

Carer availability

- Increase carer payments to enable carers to choose to stay at home while caring and to encourage commitment to longer term placements
- Increase support for better carer recruitment
- More worker hours
- Funding for advertising etc.
- Expand central recruitment strategies (eg by FCAV) to cover regional areas more effectively

Servicing respite care

- Increase carer availability
- Streamline 'paperwork' to increase availability of workers

Recruitment

- Extra worker hours – identifying / prioritising targets – media liaison
- Funding for recruitment strategies

Staff gender

- Exposure to career opportunities through schools

Staff turnover

- Maintain effective supervision / debriefing opportunities
- Increase worker morale through
    - Professional development – interest areas
    - Participation in forward planning for program
    - Team building opportunities
    - DHS acknowledgement of agency / program / worker effectiveness (quick to hear the negatives)

Increased 'paperwork'

- Individual worker efficiency – training eg. time management, report writing, CRISSP

- Increased worker hours for admin work associated with recruitment of carers

Geography

- More funding for increased program / agency expenses associated with travel

Metro recruitment

- Regional inclusion in advertising campaigns – general / specific
- Increased agency / program support for recruitment

Time in care

- Magistrates trained in the effects of trauma, abuse and cumulative harm on children
- Working with magistrates / court system to streamline processes

General

- Limited number of reunification attempts.
- More intensive support for parents with a timeline imposed in relation to reunification.
- Added incentives to remain in system (ie increased wages)
    - More support for staff.
    - Streamlined processed to lesson frustration of dealing of system.
    - Increased focus on personal development and seeing things through.
- Including carers as part of care team and showing respect to carers.
- DHS respecting carers and showing courtesy for carers.
- Voluntary respite family's needing referral to child first to lesson likelihood of DHS involvement.
- Review and change to CRISSP system.
- More funding for travel expenses.
- Increased importance as team as a whole.

Carers' perspective

- 'Education, mentoring and supervision with all staff in child protection regularly and funds and study leave and replacement of staff provided to assist with this.
- A higher salary for senior staff as an incentive to remain in the field, an in turn, our new grads are supported every step of the way and retention rates are maintained.
- More consultation with carers in decision making re the child's welfare and future planning

- DHS staff make an effort to be on time to all meetings and there will be no need for apologies to carers especially those who sacrifice their lunch break to attend and then have to remain late at work to make up lost time sitting there waiting for DHS staff to attend the meeting.

- Care team meetings to be scheduled for all placements longer than 2 weeks. These meetings should also take place on a regular basis with an agenda and a plan of action upon completion.

- No medication is administered by foster carers without the provision of medication chart completed and signed (sorry, I do work at a hospital where it is no different and I feel medication should be taken more seriously)

- Foster care workers have a "home visiting folder" that has all documentation (and blank proformas) required at the commencement of each placement . DHS staff should also have such a folder – so these proformas can begin to be completed for placements that commence in out of hours – as it is obvious DHS staff know more than they care to share however this can be detrimental to the placement.

- When speaking to children about spending time with mum & dad, say lets visit mum and dad, not "you get to have access today"! This should be also reflected in written timetables and communication with the child's school.'

3.5.2 Overall Structure

Workers' perspectives

- Expand Circle Program (TFC) to cover all FC placements

- Look at improving time frames for children moving to permanent care – court system and permanent care process itself

Carers' perspectives

'Overall, it is a system that has definitely improved over time. With the requirements such as police checks, WWCC, intensive recruitment processes, we like to believe the system has achieved a beautiful population of foster carers and workers that are in the game for all of the right reasons – ensuring history does not repeat itself and no longer do we not hear devastating stories from children that were abused not only in their own homes, but in their foster care homes as well.

Getting back to the question at hand, the structure supports itself however some improvements may include children (when possible) return to the same carers (if appropriate) instead of living with all of the carers across the state. Communication is also the key – between DHS and the foster care agencies – as DHS seems to know a lot of information that the foster care workers don't and really should – in order to effectively support the child and foster care placement.'

3.5.3 Meeting needs and improving outcomes of children in OOHC/Leaving Care

Workers' perspectives

Structured plan for beginning of placement.

Education / health

- More consistent placements – children not having to change schools
- Greater participation from schools / Edu Dept in Partnering agreement
- Children having greater access to aides
- Better planning for and more consistent access to health and mental health services (long waits for dental appointments, paed. etc.)

CALD

- Increase recruitment of indigenous carers
- DHS developing and reviewing cultural plans consistently and liaising more effectively with agency / workers
- DHS developing cultural plans for all CALD children – not just indigenous

Carers' perspectives

'A care plan should be developed to address a child's health, education and mental health needs. This could be developed by the foster care worker in conjunction with the foster carer, school and GP. This care plan should include access to at least 1 psychologist appt. Upon entering foster care, a dental and medical appt should also be made. Each child should have a folder that can move with them throughout their foster care journey. The care plan could be electronic (eg done on laptop) to save time of transcribing upon returning to the office. Paper copies should then be distributed to all parties with a plan to review regularly.

Likewise, a cultural care plan should also be developed. Children should also have immediate access to an interpreter if required and placed if able with carers from a similar cultural background. When this is not possible or achievable, carers should be provided with as much information including routines and cultural / religious occasions as possible or directed to relevant websites if internet is accessible.'

'Education, Health and Mental health are appropriately addressed via Care Team Meetings.

In some states in the USA children in care are provided with an advocate who has access to all information and files regarding the child, and can make recommendations towards outcomes. (CASA)'

3.5.4 Voice of children and young people

Workers' perspectives

Include carers and children if age appropriate.

- Involvement of children in planning / CT meetings, especially adolescents
- Participation of carers in planning meetings
- Consistent participation by DHS in CTM's

Carers' perspectives

Communication, communication, communication. When you are tired of communication, documentation, documentation and more documentation! In between, effective care team meetings and review of care plans as mentioned above should also help.'

'Young people and carers are kept informed by attending Care Team Meetings.

It is important that both children and carers feel a part of the decision making during these meetings.

Also visits from their workers on a more regular basis.'

3.5.5 Reducing placement instability

Workers' perspectives

- Introduce Circle program process of planning for transition to reunification throughout general FC
- Carer participation in planning processes
- Case plans to be followed regardless of change in workers.

Carers' perspectives

'Continue your brilliant improvements with appropriate matching of the child to the carer should assist with placement instability. Having the full story may also prepare carers for difficult times. Again, an action plan appropriately labelled "When it hits the fan" (lol) should also guide carers step by step through what to do when this occurs. Already, having the ONE on call number should make a vast improvement to recent experiences had by carers.

In regards to reunification, the tables can turn with a change in workers – and this is worrisome. Complete plans for long term foster care arrangements have been turned upside down with the introduction of a new DHS worker. We don't have the solution to this, however should carefully be monitored. Furthermore, we haven't been in the game long enough to provide many helpful resolutions to this area.'

'Good communication – information from workers given to carers before, or at the same time as the child in care.

Involve carers in the decision making.

Workers home visits during re-unification should be increased to allow carers to discuss any issues.

Shorter re-unification periods rather than longer ones to reduce stress on everyone involved. Eg, carers families, child and parents.'

3.5.6 Permanent care

Workers' perspectives

- Identified early to permanent care options, and possible carers.
- Timely assessments.

- More post permanent care support to be available.
- Ongoing permanent carer training and support
- 'Timeliness' determined by DHS and court system – better liaison – magistrates being aware of implications for children of long, drawn out processes and inconsistent decision making – more consideration to agency / DHS recommendations

Carers' perspectives

'Have a data base of carers that are more interested in permanent care – so the child is not passed from pillar to post with carers that are more suited or prefer temporary care arrangements. Appropriate matching should also occur earlier in the foster care journey. Long term plans should also be communicated between all parties as soon as they are known.

Supports should include maintaining regular contact between the child and previous foster care family where appropriate. There are many kids that you think about often, long after they have walked out of your door. We have also had quite successful visits from children that have left our care – and this was much valued by us and them. Connections should be promoted, supported and valued more. This option should not be removed from the child's life as "punishment" to poor decision making as it rarely works and only leads to further problems. We have seen this occur several times in our short time as foster carers.'

'The amount of time a child spends in care should be limited.

Also it would help if the amount of placements were taken into consideration when planning long term goals for a child.

Children are in care for too long, sometimes resulting in emotional damage and behavioural changes.

Therefore permanent placements are at risk.'

3.5.7 Victorian adoption legislative framework

Carers' perspectives

'We know little of the adoption frameworks for Australia, however based on media and publicity and personal accounts, it is apparently very difficult to adopt children in Australia. Why people (including the rich and famous) have to go outside Australia to adopt is beyond us. This clearly reflects the ridiculous hoop jumping people need to go through to adopt. Whilst there are 1000's of children out there that are more suited to permanent care as there is always a chance of reunification, we believe there has to be children out there who are in need of adoptive care and in return, this keeps them out of the challenging world of temporary foster care arrangements.'

Appendix 2

Protecting Victoria's Vulnerable Children Inquiry

UMFC Child FIRST and Family Services Staff Feedback

2.1

- Language barriers- meaning of "Vulnerability" in different services sectors is different….there is a need for a collective understanding.

- The notion of “Shared responsibility”(CY&F Act 2005) within the service system is challenging.
- Services presumptions & way of working targets middle class (eg. Telephone/internet not many families with complex & multiple issues would have access to these).
- Access to these services is limited –waiting lists for all families.
- Services don’t look at cumulative Harm aspects of family’s issues
- Don’t have the same emphasis on preventative approaches (ie. medical model, episodic responses). Example- Mental Health services appear to be still working under a clinical model & not being inclusive of children when discharge planning- People are being discharged from Mental Health Services based on them being ”Well” but not including in their assessment the parent returning home to children.
- Family Services Framework approach – Holistic approach to families & their issues as a whole. Seems to be a specialised area…not many services operate with the same approach or have an understanding of working with the family as a whole & the importance of this in facilitating change.
- Services that work directly with Children are scarce & operate mostly in private capacity which is costly & not sustainable for vulnerable families.
- Aboriginal services in Eastern Hume limited funding & capacity to work collaboratively & complimentary with other services. (No current funded services in Central Hume & limited funded service in Upper Hume)
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2.2

- Shared training between services
- Collaborative approaches & partnerships that are true partnerships…..(difficult when you are meant to have a partnership with your funding body eg. DHS)
- Infrastructure to connect programs & Services SECDC PROJEC Specifications of project contradictory to what is needed in the service sector. Eg Family Services provide case management services to families which requires them to identify & link families into relevant services within the community.
- “Champions” within services to drive & support & process that focus on holistic family work.

2.3

- Immediate- less “Pilot Projects” put funding into sustainable programs/services (eg. DEECD putting solid funding ongoing into Early Start Kinder programs but DHS only 18month funding into SECDC)
- Paying excessive amounts of money to consultants to review services/projects etc coming up with the same evaluations & having no clear actions or outcomes to address the issues.
- Better cost effective strategies – Early preventative work so that issues are identified & worked with early…instead of when “its too late” providing a bandaid approach.

- Long term-
- Unit pricing increase
- More capacity/time to be involved in Policy direction that affects the “on the ground workers” eg. A document produced by DEECD/DHS head office to be used to educate all kindergartens/preschool/schools on concerns for children & the pathways for support/intervention. Stated that a “REPORT” could be made to Child Protection or Child FIRST….where there is already a fear within this network that Child FIRST is aligned with Child Protection (possibly contributing to the low referral rate from schools) there was no consultation with the family Services sector on the document & being involved in the delivery of Education to this sector.

- Split minsters DHS / DEECD better communication needed to ensure better "fit" for new initiatives/policies that affect Vulnerable Families
- Key policy holders not sharing/discussing intersection at a policy level.
- Training being inclusive of Child Centred family focussed practice.
- Compulsory training being rolled out by DHS head office being cancelled in UH & CH catchment, then not re-offered eg. Cultural Competency training.
- More regional perspectives- currently very Metro focussed.

3.1

- Better systems to support work practice (CRISSP still years away from being implemented- but in essence would support & reflect the nature of work being carried out by IFS- a case management tool) current system IRIS is a data tool originally designed to record hours against clients for targeted…DHS currently use this data to support system/policy direction even though its data input from services is limited example- DHS extracting reports that indicate non-engagement rates are High when the limitations of the IRIS system does not allow narrative to explain the reason for family not engaging. Limited to the drop down boxes inbuilt into IRIS.
- The Family Services- Child protection is a complex system modelling the complexity of "our families". Not a transparent system.
- Statewide agreement is needed to guide practice/process between CF/FS & CP. Head office has only just signed off on (this being the 3rd agreement 2007, 2009 & 2010).
- CP is a stressed workforce- turnover- process not being followed. People constantly in acting roles- limited evidence of succession planning.

3.2

- Targeted training needed to support our work- Cultural competency (cancelled not re-offered this is part of the Registration Standards & many services were not able to meet this standard due to this being outside of their control), Best Interest Case Practice Model (BICPM) (change from original Best interest Framework- training not offered when BICM introduced).
- DHS offer internally excellent training (eg. Sexual abuse training)- would be beneficial if this was extended to FS sector- joint training opportunities.
- IFS include in induction process core role plus partner protocols (eg. Statewide Agreement & joint protocols between IFS & CP) so that there is an understanding & expectation that these will be followed to ensure good process for wok with families. This doesn't appear to be a practice at DHS for new staff.

3.3.1

- Predominately the families that we work with are experiencing high levels of trauma. Bruce Perry's theories state that when working with trauma – long term work & providing families with a constant in their lives is effective. However IFS has throughput pressure meaning short timely services to be offered. Private practice can offer long term/constant work, however are costly & not sustainable.
- IFS putting other services in place for families, however the criteria for these services does not meet the criteria for our families. Eg IFS recently linked a family into a specialised service but did not contact the family for 5 weeks after accepting them.
- Services in the Broader service system work within their funded capacity & have limited understanding of the notion of "shared Responsibility". Working only to their funded capacity/targets means more pressure on other services to be flexible & responsive to Vulnerable families.

3.3.2

- The model/philosophy- YES
- System/structure/workforce/time constraints/throughput/geographical location/demographics of areas doesn't always suit the Model.

3.3.3

- No- training cancelled
- Limited services in area.

3.3.4

- NO- current aboriginal services within this area not resourced to work complimentary with system (No funded services in Central Hume, Limited in Upper Hume). VACCA limited capacity to work in this area even as a consultative role.

b.

3.4

- CP Intake don't contact families with concerns to discuss & have a conversation with families.
- CP Risk Thresholds & responses to children vary dependant on the current demand on CP resources. The "overspill" to this is sent to the Family Services Sector, then due to the risk threshod\ld & the capacity for voluntary services to manage families- they are re-repot
- Hume region CP Intake believe that they do a lot of follow up with concerns in relation to families. However the information gathering that CF do is comprehensive & extensive & quite often due to this can change a CP original risk assessment. CF contact professionals as well as the families to build a big picture of the family & concerns.
- CP Intake quite often don't follow up on specialist recommendations- eg. SIPW recommendations are over rules by a CAFW 5 (Heirarchy).
- CP Intake assessing only the "Current Concerns" identified by a reporter but not looking at other issues- eg. Report being on physical abuse- not substantiated & then closing, overlooking environmental neglect. (which potentially be a cumulative harm issue)
- IFS look at families holistically & the whole situation. Cp will focus on the report on one child but not factor in the other children residing in the home.
- Mutual understanding of "cumulative harm" needed between CP & IFS.
- Court system does not seem to "understand" the cumulative harm concept….making it difficult for CP to get appropriate evidence to obtain orders.

3.4.1

- Not a stable workforce (CP) induction to CF & FS does not occur. Limited capacity for succession planning.
- Values & importance of CBCPW not recognised in CP. Eg. CH not having a CBCPTL for over 8 months. Now the current CBCPW about to go on maternity leave with no replacement.

3.4.2

- CP work episodically & appear to be still working under the old ACT- not recognising cumulative harm.
- Court System doesn't appear to have an understanding of cumulative, harm. Difficult for CP to get evidence for appropriate orders so will then close & refer to CF when not all protective concerns pertaining to cumulative harm are addressed.

3.4.3

- Mandated reporters "scared" to report due to potentially damaging relationships with Families.
- Sometimes reporting can jeopardise children's safety if CP don't act on report or concern. Example. CF received a referral from a childcare centre in a rural/farming isolated area. Childcare centre said that they had wanted to report however if CP did not act on concerns the mother would & had threatened to take her child out of the centre (the only place were this child was visible in the community). CF had to be very careful in engaging this mother.
- Doesn't accommodate flexible, sensitive issues or being strategic with families.
- Investing substantial money into the community to educate community members, professional's etc re- Children Rights & wellbeing & the importance of safety stability & development & their future.

Mechanisms exist within the DHS system & structures to be able to have input & influence in Policy direction that affects vulnerable families & the service system. No formal mechanisms built in for Family Services Sector to be included in Policy Direction & participate in policy development – ensuring that the Family Services Sector have a voice & are able to contribute to directions.

Eg. SECDC positions (24 across the state) Specifications of the project state that vulnerable are not being linked into services (Universal Early Years Services). Part of the key role in Family Services working under a case Management Model is part of their role- to link families into relevant services across Universal, Secondary & Primary Services.