Submission to Protecting Victoria's Vulnerable Children's Inquiry

A response from the Victorian Aboriginal Health Service

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Introduction
The Victorian Aboriginal Health Service provides primary health care health services, principally to the Aboriginal community, including some of the most disadvantaged and marginalised members of society.

In preparing a response for the Inquiry Panel, we have identified a number of issues which are particularly relevant to the Indigenous community, but others are more general and likely to be concerns shared with mainstream organisations.

We have attempted to shape our response under the Terms of Reference headings but many of our concerns are relevant to more than one area.

VAHS take a holistic approach to health and well being, with a whole of community perspective, (meaning the individual is not viewed as an individual alone, but as a member of the community) and therefore the health of the individual is integrally bound up with the health of the community and the relationship to place (the land) and social and spiritual connectedness.

In practical terms, this operational philosophy means our services are seeking to address the causes of ill-health, and not just the symptoms. Therefore our service approach takes account of the social determinants of health. Our service delivery goes beyond medical and works to address the impact of poverty, homelessness, employment and maintaining the social, emotional and spiritual well-being of the individual, their immediate family and the community.

As a consequence, of our holistic approach to health and well-being, the Victorian Aboriginal Health Service is necessarily involved in addressing issues across a number of domains.

The Victorian Aboriginal Health Service runs a number of programs designed to support and nurture children and their families.

Significantly – many of the VAHS staff experience regular contact with the Child Protection System as part of their daily work caring for children and families.

This occurs in many capacities. Examples include the VAHS Maternal and Child Health and maternity program, Paediatric program; VAHS comprehensive Primary Health care (medical) service as well as the VAHS Family Counselling Program that operates a CAHMS modelled service assisting families.

This brief submission has been prepared with input from several units within VAHS that all have had significant experience in the area of child protection.

VAHS actively and proactively supports better outcomes for the most vulnerable children of all – the children of the Aboriginal community.

Some general overarching comments
One of our strongest areas of concern is in relation to the lack of focus or effort to reconnect families who have been part of the child protection system.

The parallels between the Government response to bushfires and poor response to vulnerable children have been highlighted by several VAHS staff. Many of the staff most directly involved with child protection, regard the situation as it currently affects our most vulnerable children, as a crisis of similar proportions.

For example the response to the bushfires was to allocate a case manager for every family to work across all areas of loss and needs – i.e. holistic approach to housing, employment, education counseling, and financial support - one stop shop. This was offered for as long as families needed it – at least two years.

Our question is: *Why do our families deserve less? Imagine what we could do with even a fraction of that kind of commitment!*

Reflections of our experiences and concerns regarding working with the Child Protection system

- Across a number of VAHS program areas there is consensus that we only get 'half the picture' from DHS regarding child protective concerns of clients. Yet, on the other hand, DHS have been insistent that VAHS provide all relevant information on clients. The sharing is all one way, from us to DHS – not 'two way'- even though we have shared interests in the children and their families.

- DHS expects VAHS to be very forthcoming about client information –they want all the information from us - yet it is not reciprocal. Why?

- Referral information from DHS regarding context/background of clients is frequently too scant and completely inadequate.

- This can really undermine the therapeutic work we do and have an impact on client outcomes.

- Clinicians and Aboriginal Health Workers frequently report that they are required to 'pick up the slack' and fill in the gaps. Clients express a lack of trust towards DHS and so prefer Victorian Aboriginal Health Service personnel to carry out particular DHS related tasks. Sometimes DHS workers also request our services due to their own insecurities in dealing within the community.

- We need a care team approach to our work with clients. Communication and liaison with DHS and other agencies needs to be improved.

Case Planning
In our experience the current practice perpetuates inadequate case planning

Case planning is rudimentary and rushed at best. In some cases it appears almost non-existent.

There are frequently clients that we work with closely who are subject to child protection policies. VAHS is often not invited to attend case review/planning meetings. When attempts are made to engage with us – this usually occurs at the later end of DHS involvement.

We believe there is a close correlation between earlier involvement of our services and better outcomes for vulnerable children.

Victorian Aboriginal Health Service is increasingly frustrated by the delays and often the complete failure of DHS to respond to our requests for case meetings. We urge the review to look at mechanisms to improve communication and facilitate support for improving this.

In our experience “care team meetings” tend to be held only when a case is about to go to court and tend to fully focus on the DHS agenda, rather than any real case planning or support.

This includes virtually no contact with the Indigenous team at Preston due to their roles being overstretched.

Effective case planning needs care teams. In order to improve the quality, structure role and functioning of the system, care teams need to be inclusive and regular. Care teams need to be to be systematically scheduled, planned, collaborative and properly resourced.

Cultural Safety education and practical cross-cultural familiarization
Our service wishes to particularly highlight specific shortcomings of a number of DHS offices.

Certain aspects of our experience with one particular regional office is outlined below:

- Just making physical contact is difficult and building relationships has been both frustrating and unsatisfactory.
- Historically we did have a lot more contact.
- More recently, and particularly in the past two years, VAHS staff have had difficulty in maintaining good liaison with the DHS staff with the exception being when a case is going to court and we are summonsed.
- Reception seems inadequate. We can rarely get through to anyone on the phone, messages we leave tend not to be returned and often we cannot find out which worker we need to contact.

- Referral processes are inadequate.
- The unit manager has been quite hostile towards us at times and has appeared to hold negative and stereotyped views of Aboriginal clients.

Cultural Safety education and practical cross-cultural familiarization would perhaps break down some of these barriers. Beyond Cultural Safety is the need for continuous improvement and growth of cultural competency. This involves the need for keeping cultural safety and cultural sensitivity awareness in the forefront with on-going training for DHS staff.

Inadequately planned and supported return of children to families after periods of removal
There is insufficient emphasis on reuniting families.

We have experienced multiple examples of families who have had children returned and they have received no or little support or there have been significant gaps in support. For example, families have often not been provided with support until a month or more after the children's return or have only been provided for a short period after return and then a long gap before less, intense, ongoing support is provided. This happens too frequently when there is a hostile relationship between the family and DHS or when DHS has been unsuccessful in gaining further custody orders – it is hard not to see the lack of support as punishment

Support for families to re-unite with their children needs to be addressed.

Reliance on standard responses to problems rather than proper assessments and individual planning for children and parents
We often get referrals for parents for "anger management" or "drug and alcohol counseling" or "counseling to deal with recent trauma". Very often parents have histories of trauma or mental illness and require a comprehensive assessment and response, not a piecemeal response to specific issues in isolation.

Insufficient recognition of professional advice
Victorian Aboriginal Health Service staff wish to express serious concerns about DHS workers dismissing the views or advice of professional clinicians who have significant involvement with clients.
For example – a client was in ongoing counseling dealing with complex issues of trauma and family difficulties. The counseling addressed drug and alcohol issues as part of the complex picture – DHS worker wanted separate D&A counseling and did not accept the clinician's assessment that the client was making major progress.

Risk and Protective factors
VAHS Pediatrician Dr Peter Azzopardi has identified the following factors that increase the risk of abuse and neglect occurring, and effective preventative strategies

The risk and protective factors for child abuse and neglect are complex and well described. Rather than elaborate on these, I would like to share my personal observation as a non-Aboriginal paediatric doctor working with Aboriginal families that **housing** is a major recurring issue for Aboriginal families in Victoria.

Secure housing is a major social determinant of health (World Health Organisation, 2005). It is difficult to address child abuse and neglect without addressing at the most basic level the environments that these families and children live in.

Some specific examples to highlight the housing problems that I have witnessed working with Aboriginal families in Victoria;

- **Emergency accommodation is difficult to access**. For example, an Aboriginal young man released from juvenile justice and homeless; while he had been linked in with Bert Williams (Aboriginal service provides emergency accommodation for young Koori males 15-25) they have limited resources and were unable to shelter him. He was provided with accommodation at George Wright (provides accommodation for homeless people of all ages) however he did not feel safe here and organized his own accommodation on a friend's couch in the outer suburbs. Being in the outer suburbs made it difficult to link him in with services, and he then fell outside the catchment area for Bert Williams and other regional support services.

  As another example, a young Aboriginal family with a number of young children became homeless after a significant argument with a family member they were staying with. Multiple attempts at mediation were unsuccessful. This family borrowed money to stay at a hotel in the outer suburbs (because it was cheaper) which then resulted in them being 'out of the catchment area' for emergency accommodation services (the fact that they were homeless and not living at a fixed address did not seem to register).

  The parents' employment was interrupted (and job lost) so that they could care for the children during this time of crisis. They were offered emergency accommodation **for only the mother and children** at a hostel (in other words, the father could not stay); they refused as in their words 'at the moment our family is all we have and if we loose this, we loose everything'.

  It would be my observation that hostels are **not** appropriate places for young people or families in crisis.

  There are many families I have seen over the years that are on waiting lists for accommodation. Some request medical certificates justifying to be of a high priority. In my opinion they are all of high priority- **Safe accommodation is a basic human right**.

Most families and individuals need to access emergency accommodation at a time of financial and personal crisis. This is a very real time of risk and we should be doing all possible to support them at this time.

Accommodation provided is frequently inadequate and unsuitable. For example a large family had been allocated a tiny house that was immediately below high tension power lines. The lines were continuously buzzing and they were naturally worried about the potential ill effects to their children. While the access to accommodation is acknowledged, families under duress should not have to carry the additional stress of feeling anxious about sub-standard and unsafe accommodation.

A further example of how damaging ill-thought out actions can be:.

An Aboriginal family with several children and a young mother (victims of domestic violence) under the care of DHS, were placed in a 2 bedroom upstairs flat with no backyard and no room for the children to play.

One of the children had a chronic disease which involved physical supports which could not be easily carried up and down the stairs. They were now traumatized, overcrowded and isolated.

Placing a big family in a tiny flat is, in reality, could be deemed further abuse.

This, unfortunately, is not an uncommon occurrence.

It is not surprising that children growing up in such circumstances are often developmentally delayed.

While DHS often engages a range of additional supports and therapists the fundamental issue is really living conditions. Accommodating families in substandard living conditions perpetuates stress and this does little to support the health of families, communities or individuals.

While housing is often included as part of the ‘care plan’, it is often not recognised as a priority. Efforts to house families are often poorly coordinated. One family had three different agencies working to find housing for this family; when one agency placed the family in short term accommodation and neglected to tell the other agencies. The police were called as their worker believed the family had gone missing. This caused additional distress to a family already under duress.

These are just some examples of poor housing that I have encountered in my short time working with Aboriginal families and sadly there are many more examples. This also

needs to be taken in the context of the other social determinants of health which equally require urgent attention.

I feel strongly that this is an essential component of protecting Victoria's vulnerable children and their families. In the situation of housing Aboriginal families, there needs to be real Aboriginal consultation and involvement in addressing this problem.

Feedback from other staff working with vulnerable children at Victorian Aboriginal Health Service:

High distrust of Child Protection Workers

The experience of VAHS is that child protection workers often withhold information, not follow through with stated and agreed responsibilities or have un-insightful and unrealistic expectations of Aboriginal families.

Low levels of continuity

With the high turnover of staff, an effective knowledge and relationship that is needed to work successfully with Aboriginal families is thwarted.

Poor decision making process in terms of withdrawal of resources

Resources to support families at risk, needs to be extended. The sudden withdrawal of resources when family circumstances improve, or following reunification, is severely limiting and potentially damaging to successful outcomes. A shortsighted and hasty approach to cease resources available to families and the desire to "close" on families, jeopardizes continuous improvement and long term success.

The tick a box approach to referring clients

The tick the box approach is impersonal and disempowering. It is often the experience that a referral to VAHS from CP is not geared towards gaining the expertise of our workers, but is focused on getting through a mandatory list of actions. Generally our staff have a deep knowledge of the context and of the range of issues facing the family. When we speak to the family we often find a difference of understanding of why the referral was made and a lack of informed agreement from the family.
The VAHS experience is that CP staff do not afford a high priority to collaboration with collateral organisations to ensure a referral is supported with a mutual benefit. Collaboration with our workers needs greater emphasis.

Respect & Two-way Communication & Collaboration

We have found that in a number of cases as part of a CP attempt to gain support in mounting a case for a court order, CP will subpoena VAHS files in the hope to gain supporting information. Often there is no information that is not already shared or is relevant.

This practice for an ACCHO is a violation of trust and interferes with how we approach the work (if CP is involved). The therapeutic relationship is fundamental. Incidentally,

building this relationship is something that CP expects us to develop. However the aforementioned action undermines this. Both workers and clients feel uncomfortable about this and building trust with the client is compromised. Both feel under a cloud of uncertainty as client information and privacy may be under threat at the will of a CP team leader. This point goes against the principals of ACCHO and diminishes the relationship between CP and VAHS.

Victorian Aboriginal Health Service Workers Safety at Risk
It also needs to be highlighted that the safety and well-being of VAHS staff can be severely jeopardized by actions of other agencies involved in CP, as it is our staff who live among the community and whose home addresses and relatives are known. Close collaboration is needed. DHS need to be aware and to consult with those who know the families best, and to avoid careless management of CP issues. DHS &and other agencies need to be aware of the potential consequences for Aboriginal staff in these circumstances.

Access & Choice
Aboriginal families must retain a choice in what services they want to be engaged in. Some of our families make a conscious choice for example to not access support services from VACCA and alternatively VAHS. Because of this reality any reform to the child protection system needs to take this into account as there are some significant implications that arise in terms of service capacity building and case management.

NOTE: The term “Aboriginal” wherever used in this report is taken to include Aboriginal and Torre Strait Islanders.

Terms of Reference:
To inquire into and develop recommendations to reduce incidence and negative impact of child neglect and abuse in Victoria, with specific reference to:
1. The factors that increase the risk of abuse or neglect occurring, and effective prevention strategies

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.

3. The quality, structure, role and functioning of:
a) family services
b) statutory child protection services, including reporting, assessment, investigation procedures and responses; and
c) 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

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

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

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

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 a high quality to children and families.

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.