Protecting Victoria's Vulnerable Children Inquiry
Wimmera UnitingCare's Submission

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 What is the appropriate role of adult, primary and universal services in responding to the needs of children and families at risk of child abuse and neglect? Please provide comment in relation to any of the services listed below or any additional services that you regard as relevant to this Term of Reference.

2.1.1 Universal and primary children's services such as general medical practitioners, antenatal services, maternal and child health services, local playgroups, early childhood education and care services, primary schools, secondary schools, and telephone and internet based services for children and young people seeking information and support.

2.1.2 Targeted child and/or family services such as enhanced maternal and child health services, children's disability services, specialist medical services, child and adolescent mental health services, family support services, family relationship counselling services and Aboriginal managed health and social services.

2.1.3 Specialist adult focused services in the field of drug and alcohol treatment, domestic violence, mental health, disability, homelessness, financial counselling, problem gambling, correctional services, refugee resettlement and migrant services.

Early intervention services are required to work with families with in their own communities. It's about communities 'looking after' their own.

Vulnerable children are identified through the MCHN, and kindergarten, primary school settings. This is where professionals are needing to do the 'hard talk' with families, they need to approach families to discuss their concerns, and link families into services. This provides an opportunity to work with families to address the ongoing, often generational, symptoms of vulnerability.

Key service providers need to have education/professional development around what constitutes vulnerability, how to identify and work with families that are considered the vulnerable in our community. This education needs to commence at a Tertiary level. Potential school teachers, MCHN, any early intervention service providers need to be educated before they work in the field in regards to the growing number of vulnerable families in the community.

There is a clear deficit in service providers not being aware of where to refer families to assist families. Another factor that prohibits/prevents referrals tends to be the time factor. Professionals experience a lack of time to make a referral, as this is viewed as an extra on top of their core role or service provision.

Over the years we have experienced, particularly within the rural area, a centralising of services. Services no longer providing outreach to outlying rural country towns. We have seen this Child Protection centralising

their Intake within Regions to be based in the largest regional town (becoming a phone service), we have seen the Adult Mental Health workers retreat from local hospitals where they once co-located, to larger regional centre based. Mental health now only providing outreach to provide crisis intervention (CAT team) only. Drug and Alcohol Services no longer provide regular outreach and again are being provided by larger regional towns only.

The whole notion that people have to travel to access a service in a larger regional town does not provide the option for people to access a service immediately should they require a service in a crisis or that they have finally acknowledge that they require help and seek assistance autonomously. By having to ring to make an appointment and travel some distance does not encourage families to access assistance. Financially it costs families to access what is supposed to be a fee free service, due to travel and also the travel time commitment.

It is our experience that professionals lose contact with distance, communication is via phone or email. This loss of contact leads to service providers not being aware of each other's role or actual service provision. This then leads to families falling through the cracks. Many complaints received from other service providers is that they don't know what we do or that we do not keep them informed when they are jointly working with a family with in their town/service provision area.

2.2 How might the capacity of such services and the capability of organisations providing those services be enhanced to fulfil this role?

Ideally co-location of services in rural towns in either or a service hub or the local hospital is more enticing for families to access assistance as the service is local and available. Local service integration is easier to achieve than numerous workers from other towns.

2.4 What are the most cost-effective strategies to enhance early identification of, and intervention targeted at, children and families at risk?

School teachers in their tertiary studies should be provided with education regarding vulnerable families. Early intervention in the primary and secondary schools: Welfare officers placed in the school setting. They would will have the ability to provide consultation to teachers in relation to identifying at risk children early, the capacity to outreach families and conduct joint visits with Child FIRST to complete Best interest assessments to determine the least intrusive approach and service required, provide education, advice and strategies to teachers on dealing with and engaging with children who display challenging behaviours.

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 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 addressed?

Child FIRST commonly is confused with Child Protection by families and service providers. Community Education just has not addressed the difference between the two services adequately.

Firstly the name of Child FIRST needs to consider a re-branding to address the name issue. It needs to be more user- friendly. The name needs to be something that families can identify with, and feel able to make contact with to seek assistance. Currently 40% of our referral base is that of self referral from the community.

Community Education needs to clearly state the difference between Child Protection and Child FIRST. The possibility of ongoing community education needs to be considered also. The initial roll out of community education coincided with the first round of Innovations Programs being introduced. Then we saw the further extension of the program when the new legislation was implemented, and the new name of Child FIRST.

The role of community education is viewed as very important, however EFT base funding does not afford to allow workers to travel to provide this education and also meet our client's needs. Funding should be considered to support the ongoing roll out of community education, so that the community and professionals are highly aware of the role of Child FIRST and to increase the referrals of vulnerable families. It may be a little like the initial introduction of mandatory reporting with a marked increase in referrals, but families need to be afforded the opportunity to be assisted to address their issues.

Our Child FIRST provides a unique service to families that are referred to our service by providing an outreach to visit the family to complete a Best Interest Assessment (BIA). It is acknowledged that other regions complete the BIA via a phone call, however we have found that we are able to actively engage families in the process and they are able to partake in the planning of how their issues can be addressed. Our BIA are completed where possible with the referring body, if they are a professional, to assist in the engagement of families. By completing the BIA in the family home, we are able to assess the home environment, but also families are not inconvenienced by having to travel a great distance or to have to divulge personal information over the phone to a worker they have never met.

In regards to out of home care using a care team approach has demonstrated the ability to provide a significant amount of knowledge pertaining to a child or young person's wellbeing. It provides service providers with up to date information, identifies gaps, and ensures services work together to provide quality outcomes for children and families.

A difficulty experienced since the commencement of the care team approach is worker continuity, due to worker retention. The ability to get everyone around a table at the same time, due to availability, geographical distance and the perception of priority of such meetings. A Greater importance and education needs to be put forth into the care team approach.

In regards to 'out of home care' we propose that contracting case management be considered to Community Service Organisations (CSO) on a greater number. With the roll out of Kinship care is has become evident that CSO's have been able to provide a higher level of support to carers and also have case managed cases to achieve outcomes for the children and young people.

Child Protection cases that have been case planned for non-reunification, should be considered to be contract case managed by CSO. This should be considered based on funding to support this function and also with a view to place allocation caps on caseloads. We have witnessed the issues faced by Child Protection facing large caseloads and unallocated cases. CSO can case manage and provide quality service to families by not having high case loads.

Example:

Child protection would retain the statutory role of intake, response and long term reunification cases. CSO's would provide a specific case contracting team to manage the ongoing non reunification cases across out of home care.

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

A higher emphasis on the skills and knowledge of support staff is becoming more common.

There is an identified lack of skilled workers in the rural sector. The identified issues are:

- Complexity of the work, lack of services to refer to in rural and remote sectors. Geographical distance for clients to access services.
- Under current award rates Re-numeration level compared to metropolitan counterparts makes it difficult to attract skilled works to the rural and remote welfare sector. Location also plays a fundamental role in attracting and retaining skilled/qualified workers to the region.
- Career paths are limited due to less service providers in the rural and remote regions.
- Pressure on placement areas is quite high due to targets exceeded and no further funding available. This leads to high case loads, poor client matches within placements, making the placement themself difficult to manage and support.
- Training is predominantly facilitated in metropolitan areas and the costs associated with sending staff to Melbourne are significantly increased due to travel, accommodation and worker time.

Distance education options to be explored and consideration to provide training to workers in the rural and remote regions.

Current funding arrangements do not address or take into account the differences between rural and metro regions. Funding is based on targets with no allowance for the geographical distances that have to be travelled by rural workers nor any acknowledgement of the lack of services to refer to in small towns.

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 Given the very broad range of professions, services and sectors which need to collaborate to achieve the best outcomes for vulnerable children:

4.1.1 Are current protocols and arrangements for inter-organisational collaboration in relation to at-risk children and families adequate, and how is the implementation of such protocols and arrangements best evaluated?

The current ChildFIRST model, with the Community Based ChildFIRST worker as the conduit/consultation between service providers and Child Protection, is a good model. It allows for effective collaboration and consultation to achieve the most effective and appropriate response for vulnerable families in need of support.

This model needs to be extended/enhanced/replicated to bring Primary Services across the community eg. Early Years services, MCHN, schools, into the same level of collaboration with service providers and consultation with statutory bodies.

Primary Services eg. schools often have a close relationship and intimate knowledge of the issues facing vulnerable families and have the greatest opportunity to engage with those families. A higher level of consultation with service providers and statutory bodies may well provide opportunity to work more effectively and at an earlier intervention stage than is current.

This is particularly true for rural and remote areas where service provision is difficult to provide and access, making it essential that existing local services are engaged and utilised.

4.1.2 What needs to be done to improve the quality of collaboration at the levels of policy development and implementation, local and regional service planning and delivery, and direct service to individual children and families?

There has been a lot of discussion, meetings and planning over many years about forming local and regional alliances that will enhance and drive collaborative/integrated service delivery that has never really been effective or produced strong outcomes.

For earlier intervention and better outcomes for at risk children and families at the local level, there needs to be a far greater emphasis at policy making level of departments eg. DHS, DEECD, Community Health to collaborate and plan integrated service delivery. This would require a high level of planning, resourcing and education to make sure there is universal understanding across service providers of roles and responsibilities, the services available, and a willingness to interact and share information and resources. Once again, this is particularly true for rural and remote areas where service provision is often difficult and collaboration with local communities is essential.

4.1.3 Are there specific models of inter-professional, inter-organisational and/or inter-sectoral collaboration which have been shown to be effective or promising, and which may be worthy of replication? This may relate to two organisations (for example, child abuse issues in which both police and statutory child protection services need to collaborate in an investigation) or to a much broader service network.

Development of MOU's between service providers has been demonstrated to improve outcomes for at risk children and families. For example, in rural and remote communities MOU's have been developed with MCHN to work in collaboration with CSO's that have contributed to earlier and more effective interventions with vulnerable families. Although at times MOU's between agencies have not been adhered to, leading to breakdown in communication and service provision to clients. Often it is demonstrated that current adopted policies are not affectively implemented hence fail to achieve desired outcomes. Eg. Fax backs.

4.1.4 How might professional education prepare service providers to work together more effectively across professional and organisational boundaries?

Early Years Services and schools hold great potential for early intervention for children at risk. Currently there is a lack of resourcing and education for these services to be able to understand and access other services, and statutory limitations on their capacity to intervene. There needs to be a far better understanding across

all Primary Services of the services provided by different organisations to support at risk children and families. This would require resourcing of education and training universally across Primary services and community organisations so that effective and appropriate collaboration could occur. This training needs to be integrated across all service sectors and provided locally.