Windermere®

everyone is someone
in our community

Submission to the

Protecting Victoria's Vulnerable Children Inquiry

Prepared by
Windermere Child and Family Services

Table of Contents

Executive Summary

Windermere Child and Family Services is a well-established community service organisation (CSO) situated in Melbourne's southern growth corridor, which together with related agencies, provides for a population of approximately 1.2 million people covering 10 municipalities. The agency provides its services from a number of sites with major centres in Narre Warren, Cranbourne, Pakenham, Berwick and Hampton. Windermere works with approximately 4,000 families or children per year.

The demand for Windermere's services are expected to increase as the area it services is currently in one of Melbourne's fastest developing growth corridors. With such demand, the current system of support for families is not adequate and will not be sustainable into the future.

We understand that this Inquiry is about protecting vulnerable children, and it is our contention that all children are vulnerable and not just those who happen to be part of the so called 'Child Protection System'. We believe that the focus needs to shift to building a society that values children, understands the impact of childhood experiences and ensures their wellbeing.

An analysis by Access Economics estimated that the impact of child abuse and neglect cost Australia $10.7 billion in 2007 (Taylor et el, 2008). The lifetime costs cannot be quantified.

For this reason, we strongly support the adoption of a public/social health model applied to child and family wellbeing with the addition of a point before prevention and that being the Promotion of Wellbeing.

Although it is widely accepted that Victoria has a better report card on child protection than other states/territories, we continue to experience increasing numbers of reports, orders and placements. With the population in greater Melbourne reported to exceed Sydney's shortly, and significant spread of population away from central services, changes to all systems designed to support the wellbeing of children and families will need to be considered.

Proposal to the Inquiry

1. **Reconsideration of some of the basic assumptions that underpin the current system**
   Eg. Children's rights? What constitutes 'the system'? What evidence of success?

2. **Appointment of a Task Force which includes government, CSOs, academics.** The role of the Task Force will be to develop an integrated and strategic approach to creating a community that is committed to the wellbeing of all children.

3. **Adoption of a public health approach** to creating a safe, supportive and nurturing society for children and their families. Public health models are based on principles of social justice and direct resources where they make the most difference at each point on the intervention continuum:

   - **Promoting Wellbeing**
     Australia has a number of success stories in this area including 'Slip Slop Slap', Seat Belts, 'Quit' and the Pink Ribbon campaigns to name just a few. Using similar techniques, a statewide (or even national campaign) could create positive messages about the protective value of such factors as strong, stable relationships between parent/guardian and child, strengths based child raising, daily reading to children, and 'it's ok to ask for help'.

- **Prevention** needs to be the focus of universal services such as Maternal and Child Health (M&CH), childcare/pre-school and schools. Regular screening at identified trigger points/events will identify children and families who need some extra attention (especially those that don't access these services). In addition adult services need to be pro-active in identifying impacts of the presenting issues on any child within the family, and as such sharing this with child and family services for input and support: *an integrated systems response*.

  The experience of Windermere's Family Day Care and In Home Child Care services is that considerable prevention work can be undertaken with families when the staff are trained and supported. Role modeling can provide messages of how to develop the wellbeing of children, enhance attachment between parents and children, and build early literacy skills through reading. Parents can be supported through 'minor' disruptions in their life. The focus of additional resources could be directed to employment of a worker who is available across a number of locations to provide training and support to the carers, children and families.

  Intervening at the community level with a range of services is another example of prevention work. Communities for Children in Cranbourne is an impressive example and demonstrates the difference that can be made for children through engaging men in literacy and reading programs, providing opportunities for families to be part of their community and increase their levels of connectedness.

- **Early Intervention** Currently there are many children and families who do not qualify for services because their problems are not yet severe enough however if the intervention were to be made at the earliest point they would be diverted from the secondary and tertiary end of the continuum. For example, families could learn to manage a disability or challenging behaviours in ways that would lessen the need for further services and immediately improve the quality of family experiences.

  One suggestion is to create positions for **Child Wellbeing Practitioners** who would take a role in the universal and early intervention services, including general practices, to connect the necessary supports to the child and family.

  It is our contention that more resources are required at the 'Enhancing Wellbeing', 'Prevention' and 'Early Intervention' points on the public health continuum so that families are less likely to move into the more complex and difficult end of the service system.

- **Secondary Intervention** is where specialist services begin their work and again Windermere has considerable experience in this area. Our involvement in Intensive Family Services, Counselling, and Early Childhood Development informs our commitment to intervening at an earlier point.

  To be proactive we have established a number of groups which engage parents to deal with specific issues in ways that build a support network that can continue after the formal program is finished and complement the individual services that are being provided. Much more work can be done with the use of trained volunteers and mentors for families just outside the tertiary end of the continuum if risks are managed effectively.

- **Tertiary Intervention** is, unfortunately, where most of the Child Protection system is

4. **Development of Regional Planning and Implementation Working Groups:** The most effective place to plan the provision of services is as close to the local level as possible. Allocation of resources, provision of training, all need to occur within the context of the communities in which the services operate.

    - Community organizations and government departments will need to create a collaborative service network, inclusive of the wider system such as mental health, education, drug and alcohol, housing etc. Currently, it is a challenge to engage multiple sectors in conversations at a family level. A true collaborative system should be inclusive of the “whole of family” services.

5. **Building and maintaining a professional staff base:** The quality of the child and family service system can only be as good as the people who work in it. Part of the public message must be to raise the importance and profile of workers in the sector to ensure the community understands the value of their profession. When the community values their contribution, perhaps they will also support a significant increase in the level of remuneration that is built into funding models.

1. Introduction and Historical Context

In 2008-09 over 200,000 children were involved in one or more child protection notifications in Australia; almost 33,000 children were the subjects of one or more substantiations; over 35,000 children were on care and protection orders; and around 34,000 children were living in out-of-home care (Child Protection Australia, 2008-09 released: 21 Jan 2010). In addition, Aboriginal and Torres Strait Islander children were, and remain, over-represented in every area.

Although the statistics indicate that Victoria has a more effective child protection system than other states/territories, this does not lessen the fact that the child welfare system is in crisis, with increasing numbers of children being notified, on orders, or in out of home care with projections predicting even greater numbers in the future; and the system is already unable to cope. (Ombudsman, 2011)

Within an historical context, until relatively recently children's welfare was focused on children who were orphans or abandoned and it was unimaginable that children who were with their family would come to the attention of government, or to the charities that ran the orphanages. Violence, abuse and neglect within the family was not considered to be the business of anyone outside, and children, like women, were considered to be family 'property' (Lamont and Bromfield, 2010; Tomison 2001). Predominately the interest in child welfare in the late nineteenth century was in the physical abuse of children.

Then in the nineteen sixties research raised the issue of child abuse; and the associated media attention made both the public and the political system take notice. Government became a provider of services to abused and vulnerable children a role previously played by the charitable and church organisations (Lamont and Bromfield 2010).

In Australia, the seventies and eighties were a time of rapid change with the women's movement, women's role re-definition and changed expectations about the shape of the 'family'. Increased diversity in the community through immigration and new 'lifestyles' challenged society and added complexity to the demands on the welfare system (Liddell, 1993). During this time the understanding of child maltreatment and abuse broadened to include emotional and sexual abuse and neglect and the age group of the children broadened to cover birth to eighteen years.

During the seventies there was a government decision to either move children from institutional residences into other forms of out of out of home care or make an exerted effort to return children to their family.

The Child Welfare Practice and Legislation Review (Carney, 1984) was established by the then government to look at child welfare practice in Victoria. A significant recommendation was to differentiate between children in need of protection and those who were offenders. Until that time, both groups came into the same court process and often were housed in the same accommodation. Children were brought before the Court and charged with being in need of protection and, if the charge was proved it would be recorded on a police criminal history (Children's Court of Victoria, www.childrenscourt.vic.gov.au).

The underpinning principles and values about vulnerable children shifted and at the same time there was another decision, which would have a huge impact on the service system; the introduction of mandatory reporting (McIntosh and Phillips, 2002)

The twenty first century has seen even more change, with the system being stretched beyond capacity. In 2009/10 the numbers of notifications in Victoria reached 48,000; up from 26,685 in

1993/4 (DHS, see also McIntosh and Phillips, 2002). The demand for services and action on the protection of children is projected to continue growing.

The key policy initiatives in this century have been:

- Adoption of the *Charter of Human Rights and Responsibilities Act 2006,* which came into effect in Victoria on 1 January 2008. The Charter recognises that children are vulnerable members of the community with the right to protection.
- Work by the Council of Australian Governments (COAG) on protecting children.
- Programmatic emphasis on kinship care which now exceeds the combined total of all children in foster and residential care (Ombudsman 2010).
- Responsibility for much of the service provision is now with the community sector rather than with government.

Mandatory Reporting

While mandatory reporting was seen as the solution to a major problem it has created other problems. There are of course some positive aspects of the current system including:

- Children are brought to the attention of the system
- Child and Family services are funded to provide interventions
- There are some successful placements
- Families can access additional resources
- There are now identified pathways to services
- The removal of children can prevent ongoing violence and abuse
- The powers of DHS can be used to ensure some intervention and connection to services
- The understandings of abuse have been broadened
- Child First is a positive move to a more integrated and targeted system.

However there are also many problems with the current system and its underpinning assumptions including:

- The current system is overloaded and children who are in need of care can be overlooked.
- The system is forced to focus on the high profile high need cases which means that those children just below the statutory requirement may be ignored.
- The majority of reports are from non-mandated people
- There has been a diversion of resources away from the actual provision of services and to the pursuit of reports (Scott, 2006).

It could be argued that moving as much of the child protection system as possible into the community sector would be a positive step. The community sector is more flexible in employment practice than government, the turnover of staff is slower, staff are provided a different level of support and supervision and decisions are made closer to the issue. However if this was adopted, the risks (and costs) of managing this highly vulnerable client group would have to be shared equally with the relevant government departments.

Role of the Department of Human Services

The current system has put the Department of Human Services in the position of being the funder, in some cases service provider, as well as the regulator of the child and family welfare agencies. These roles can create tensions and when the roles of collaboration and coordination and gateway to service delivery are added there is high potential for suspicion and conflict. Given the best

intentions on the part of departmental staff these arrangements will always be less than satisfactory.

The COAG report, *Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children 2009–2020* states that:

> *Our children must be able to grow up nourished and supported in loving and caring environments. They must have time to be children with all the wonder, happiness and innocence that childhood should bring. All children have the right to be safe and to receive loving care and support. Children also have a right to receive the services they need to enable them to succeed in life. Parents have the primary responsibility for raising their children, and ensuring that these rights are upheld (p:5).*

In the past few years there has been a search for solutions to this crisis including the application of a public or social health model to the protection of Victoria's vulnerable children.

2. Why a Public or Social Health Approach?

> *Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children. Leading researchers and practitioners – both in Australia and overseas – have suggested that applying a public health model to care and protection will deliver better outcomes for our children and young people and their families (COAG, 2008. see also Holzer 2007; O'Donnell, Scott, & Stanley 2008; Scott 2006; ARACY 2007).*

Public health emerged during the nineteenth century with the realization that there was a causal link between public hygiene and disease control which lead in turn to an understanding of the relationship between the individual, the disease, the way in which it is transferred, the form of transmission and the environment in which this happens both socio-economic and physical.

In health promotion and public health circles the 'Ottowa Charter' is seen as a major turning point in the emergence of 'the new public health', which clearly identified public health as a social justice model and differentiated it from the 'medical model' of health.

According to Wass (1994) the five principles for action of the Ottawa Charter are:

- ***Build Healthy Public Policy*** *– not just health policy alone but all public policy must consider its impact on health.*
- ***Create environments which support healthy living-*** *e.g. living, work and leisure environment organized in a way that does not create or contribute to poor health*
- ***Strengthen community action on health****- communities themselves should determine what their needs are and how best to meet them.*
- ***Help people develop their skills*** *so they can work for more control over their own health*
- ***Reorientate the health care system*** *to promote a better balance between health promotion and curative services*

Since the time of the Ottawa Charter there has been rapid development in addressing a range of health issues. Some of these health promotion and public health campaigns have included:

- Awareness-raising media campaigns: eg.'Slip, Slop, Slap' and 'Stop, Revive, Survive', 'Quit', National Heart Foundation's 'tick' for healthy food.

- Reducing risky behaviour: eg. Bicycle helmet laws, pool fencing, health warnings on cigarette packets, HIV/AIDS Campaign, 'Say No to Violence"

- Maintaining a Healthy Environment: eg. reduced speed limits, unleaded petrol, reduction of chlorofluorocarbons (CFCs), Neighbourhood Watch, Safety Houses, Smoke-free areas

- Addressing specific health problems: eg. National Drug Strategy, National Mental Health Strategy, Medicare Safety Net, Diabetes Awareness, Breast Screening.

As can be seen from the examples above, a public health approach is, in the words of Browne et al:

> *A comprehensive social and political process, not only including actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to lessen their impact on public and individual health. Effective health promotion requires multiple approaches involving many individuals and organisations. Political, economic, social, environmental and behavioural factors all interact in establishing a climate that is fully supportive of individual and community well-being* (2009, p 72) *.*

More recently there have been a number of academics and practitioners who have promoted the benefits of applying a public health approach to the issue of child protection.

A Public Health Model usually defines a range of interventions on a continuum such as the following:

Prevention----------Primary or ----------Secondary----------Tertiary
(Universal) Early Intervention (Targeted) (Targeted)
(Universal)

APPLICATION TO CHILD AND FAMILY SERVICES

The above continuum can be applied to the protection of vulnerable children

Prevention and Promoting strong families: This would occur through media campaigns designed to change or reinforce behaviour. Campaigns would promote the protective value of such factors as strong, stable relationships between parent/guardian and child, strengths based child raising and daily reading to children

Primary (or universal) interventions: An example of primary prevention in child protection would be good parenting programs and changed parenting behaviour around corporal punishment. These would be available through universal services to all families, and include maternal and child health, kindergarten, broader health services and education.

Secondary interventions are aimed at 'at-risk' groups whose behaviour indicates some potential risk such as those in the HIV/AIDS campaigns. In the child protection area such services would be provided to families that are considered to be at risk of poor parenting, abuse or neglect; this group might be teenage parents, parents who are addicted to drugs, or particular high risk families coping with a disability.

Risk factors would be identified and when they are present they would trigger a response from professionals to take some specific action. The targeted responses can be both at the community

(eg Communities for Children) or individual (eg an anger management or alcohol and drug program). Early screening can identify risk factors.

Tertiary Interventions are those targeted at people who are already in the system and where the children have already experienced abuse and are already in care. In protecting vulnerable children tertiary services should be seen as a last resort. (O'Donnell, Scott, & Stanley, 2008). Sammut (2009) argues that many of the child protection reports are ongoing and repeated reports from professionals where inadequate, ineffective and inappropriate action has been taken. These families need to be the subject of intensive intervention.

However, a public health model goes even further than focusing on the behaviour of parents and children and looks at the wider family and community in which the child is raised.

More recent examples of public health approaches to child wellbeing include 'School Focused Youth Service', 'Community Building' Initiatives, Neighbourhood Renewal and Communities for Children. These initiatives promote social inclusion and community connection.

Jane Barlow (2011) describes the emphasis of the public health model as being on the causes of the problems at the population level as well as on the need for change at the community and individual levels. Shifts in societal attitudes to support greater child welfare would include greater valuing of parenting and of children. A child sensitive culture is one that respects the rights, needs and views of children, and has services and systems that work in a coordinated way. These cultures have fewer incidences of child abuse and neglect and actively build safety and wellbeing for children (NAPCAN, website)

According to Higgins and Katz (2008):

> *A public health model offers a different approach with a greater emphasis on assisting families early enough to prevent abuse and neglect occurring. It seeks to involve other professionals, families and the wider community – enhancing the variety of systems that can be used to protect children and recognising that protecting children is everyone's responsibility.*

The driving assumption is that the major resources should be allocated to prevention and early intervention through universal mechanisms and then targeted services should be provided at the right time and in the right place to those families needing support. This would potentially shift the focus of the current welfare model to one of children's rights.

> *The rationale for this is that child abuse and neglect are strongly correlated with other problems such as low birth weight, child behavioural disorders, low literacy, non-completion of school, juvenile crime, drug use, and teenage pregnancy. These share a common set of risk and protective factors (quality of early parent-child attachment, peer and school connectedness, the availability of social support for families, and parental poverty (Durlak, 1998 quoted in Scott, 2006).*

An analysis of a number of state and commonwealth programs demonstrates that there are common underpinning causal factors for each of the 'wicked problems' such as alcohol and drug abuse, youth homelessness, criminal behaviours, child protection and family violence. Each of these programs has its own promotion and prevention strategies which could more effectively be run together (Success Works, 2007) with secondary and tertiary interventions being targeted at the specific population, with the problem, in collaborative action.

In April 2009, the Council of Australian Governments (COAG) agreed on a National Framework for Protecting Australia's Children and the framework states that a public health approach should

underpin any response to children in need of protection.

3. Shifting the Culture

When looking at the assumptions that underpin the public health and children's rights approach to the protection of children, it is clear that a major social and cultural change is required. For example, such statements as 'children's best interests are paramount', 'children's rights are upheld by systems and institutions' and 'the safety and wellbeing of children is a national priority' are at odds with the general attitudes of the society which, while paying lip service, is not committed to these values. In fact even governments do not always uphold the rights of children. In addition, the value of staff working in these fields is significantly undervalued.

Placing the safety and well-being of children in the hands of families without the necessary supports for them and their communities is less than satisfactory when those families may not have the personal skills and resources to undertake the task.

We do not have a culture that supports the rights of children or that promotes their wellbeing. In fact the value of children is increasingly questioned in western society with 50% of respondents to a BBC poll saying that children do not represent value to society and a major shift in attitudes in the USA over the past twenty years on the value of children to marriage.

If society really valued children then we would find the ways to provide **all** children with health and dental care, access to sound education and learning opportunities; we would work to ensure their wellbeing in every aspect of their development; and we would keep them safe from harm because that is their right.

In 2008, the ARACY/ARC NHMRC Research Network Seed Funded Collaboration developed a literature review on children's agency in communities. This review analysed the ways in which children are treated in policy and practice in the Australian context.

> *We argue that a recognition of children's agency is largely absent in the policy, theory and practice which aims to tackle social exclusion through building social capital. This is ironic, given that children, their safety, and their life chances as adults are so central to the justification and assessment of success of these initiatives. We find that in the theory, policy and interventions around tackling social exclusion in Australia, children are conceptualised as objects of protection and for future development, whose voices, experiences and agency are largely excluded (McDonald, 2008).*

The Collaboration claimed that while most government interventions are designed to protect and improve the lives of children the focus of these interventions is the adults. Children are those needing protection and not given the right to speak on the subject of their own lives. Emerging studies are promoting the importance of hearing children's voice in the discussions about the best ways to provide that protection.

> *Children are experts in their own lives and when their input is heard and considered in planning processes, services are more likely to be used. There are many local and international examples of very young children being consulted in the development of early childhood programs, parks, playgrounds, schools and policies, leading to improved service use and effectiveness. (Ibid p18)*

Perhaps it is time to consult them on what will be the best ways to promote their well-being.

4. Windermere Programs

Five years ago, Windermere made a decision to shift the focus of its work with children and their families to promoting wellbeing and preventing further movement towards the need for secondary and tertiary interventions. Having said this it is important to note that Windermere takes a therapeutic approach to interventions as will be seen in the following programs.

Following is a brief description of the Windermere programs and activities which demonstrate the capacity of the organisation and its understanding of the public health approach. It should be noted that Windermere sees two additional points on the continuum, one at either end. At the far right end of the continuum we would see work with those children, young people and their families that is **'post' tertiary interventions** and which hopefully moves the individual or family back to a position of strength and resilience by rebuilding their 'protective' abilities and resilience.

Windermere believes that the focus of working with children and their families should be the promotion and enhancement of wellbeing and that this should be the priority of any intervention. For this reason we have added a point at the beginning of the range of interventions which we describe as '**Promoting Wellbeing'**.

We would like to work towards the creation of a culture that promotes the wellbeing of all children and it is this underpinning value and its evidence in practice that informs Windermere's response to this Inquiry.

Communities for Children
This Commonwealth Government funded program is based on the SEIFA Index and therefore works with high risk families in the Cranbourne community. This primary care/prevention program also undertakes some early intervention work through the actual Cranbourne community identified and managed activities. The range of activities address such issues as literacy, parenting, as well as some basic primary needs such as housing and food.

On the continuum CFC is a targeted early intervention approach in that it is for everyone in a community however the communities are targeted due to identified risk factors.

For programs like the CFC to be effective the organisation needs flexibility, innovation (risk taking) and a commitment to develop relationships with the partners and families. Windermere is able to step 'outside the box' to be pro-active in its responsiveness. Another success factor is to maintain consistency in staffing. CFC has been continuously evaluated, since 2005, by the Centre for Child and Community Health, Murdoch University.

An ecological approach to improving outcomes for children and families
A person's health and wellbeing are influenced by a wide variety of factors - these are called "determinants of health". (Nutbeam 1998, p. 6) They can include individual factors such as our own biological makeup as well as outside influences such as lifestyle, our connections to the community, income and where we live. It is known as the "ecological model of health", or the "Bronfenbrenner model" (named after the person who came up with the idea).

Bronfenbrenner (1979) thought of child development from the perspective of the interactions between the child and its environment (all the things that the child has relations with or is influenced by). His initial work discussed the relationships created between people and their environments. The model works as a series of layers one inside the other. The inside layer begins with the individual child and each subsequent layer represents an influence on that child's development. The further out you go, the less the influence on the child. Therefore, for example, the outside layer of policy, although it plays a role is not as influential on the child as the parents/carers. Although the model is

more complex than this, you need to see beyond and "across" how the several systems interact (family, workplace, and economy).

The Communities for Children Cranbourne (CfC) Committee adopted the Bronfenbrenner model as a way of highlighting how their own work fitted into the ecological approach to improving children's outcomes. The CfC Cranbourne project which has assigned its strategies and outcomes against the different layers of Bronfenbrenner's model aimed to identify and influence a wide range of factors on the child, from activities looking at improving the development of the child in the centre of the model, through to community development activities in an outer layer. By doing this they were increasing the possibility of more wholly and successfully improving the outcomes of Cranbourne's children.

Family Day Care and In-home Care (FDC/IHC)

This is an underestimated and under utilised resource that could be significantly enhanced to provide prevention support. FDC/IHC has the following features:

- Flexible, emergency service such as respite care, care in the home if parent is ill or incapacitated in any way
- 24 hours of care delivered at a standard rate
- Study support for parent completing a course
- Shift work support ie care during night shift
- Carers are recruited from the local population and therefore the scheme generates significant income for the region.
- Parents access to the Child Care Benefit which is at a higher rate than Long Day Care centres,
- The scheme is a significant employer of community members. The Windermere Family Day Care service provides childcare to 770 children and connects with 440 families. Windermere In Home care service provides childcare to 209 children in 44 family homes.

Improvements can be made to the support of Educators (Carers). The level of documentation required from the Department of Education and Early Childhood Development (which doesn't provide any funding) regarding administration and reporting leave very little time for service delivery.

Our experience and knowledge informs us that family day care and in home care can provide a positive influence on parenting in the community. In home care provides the opportunity to role model and mentor parents in their own home caring for their children. With enhanced skills and education, in home care could provide the opportunity to work comprehensively with families focused on achieving sustained growth in parenting skills and long term positive outcomes for children.

Windermere along with McCaughey Centre, Vic Health and the University of Melbourne is currently undertaking research on the promotion of social and emotional wellbeing in family daycare – this project is known as "Thrive". This can be further applied to 'at risk' families.

Biala Early Childhood Intervention Program
Children coming into this program are referred from the Dept of Education and Early Childhood where they are screened. The children involved are 0 – 6years and have a developmental delay or diagnosed disability. Fifty percent have been abused in some way due to parents' lack of understanding of their disability. The staff team includes an occupational therapist, speech therapist, physiotherapist, social worker and psychologist.

This early intervention service (75% of work) helps to keep children and their families out of the welfare system and away from child protection. **The addition of a financial counselor would have a significant additional impact** and prevent families from spiraling into financial distress. **Having a social worker is a major success factor**; as they can refer families to the range of required services and help with interventions into the wide range of issues that are challenging families. All early childhood intervention services should have a social worker to assist as this would take the burden off the services such as Child First. Social Workers or Financial Counselors are not currently seen as part of the funded service mix.

Due to the high quality of the interventions provided, Biala is referred the most difficult cases in the region which means that they are also providing secondary interventions (15%). Child First has made a positive difference to the way in which the program works especially in relation to referrals for parents and could do even more if there was an extended intake system which captured those children and families who fall outside the 'eligibility criteria' and who desperately need a service. These are the families who will come back into the system in a few years when the problems are entrenched.

A public health model would put resources into those groups for whom an early intervention would make a long term difference. The experience of the Biala staff, backed by extensive research can inform this process if resources become available.

Disability Services for Children and Young People
The approach to intervention in disability services is dependant on the age group and the presenting issue however most of the work is in the range of prevention through to early intervention. In general the program is able to provide access to the resources and support that a family needs to build on their strengths.

If we get children early enough and connect them to services, we can hold the family together longer however these children and their families are always at risk. These children are identifiable at 3-4 years and services could be put in place at that point with applied behaviour therapy. The reality is the resources are not available until much later when the family is at high risk of breakdown and siblings are also at risk.

Cultural and Linguistic Diversity
The philosophical and ideological base of Windermere demonstrates a strong commitment to diversity. Windermere is the convenor of the Southern CALD network with 65 members (agencies and ethnic communities).

Over the past five years Windermere has developed cultural planning tools and a Diversity Strategy. As a result there has been a steady increase in clients from CALD background and the number of bi-lingual and bi-cultural staff has also increased

Children and families from CALD backgrounds are at high risk and yet there are very few preventative or early interventions designed to ensure that they do not fall into the hard end of the service system.

Windermere undertook numerous consultations with the community service sector in relation to CALD access to the current child protection service system, which has indicated that data is not available in relation to CALD client's access to child protection services. It appears there is no research or data to indicate the prevalence of child abuse in culturally diverse communities. There are low levels of reporting leading to the assumption that the problem deserves little attention.

There is a need to focus on the following key themes:

- Lack of data kept by agencies
- Inadequate use and availability of interpreters
- Importance of cultural competencies on the part of Child Protection Workers
- Impact of pre arrival experiences for refugee and humanitarian families
- Need for community education and other culturally responsive models

A major initiative is required to develop 'culturally sensitive' practice when working with CALD communities in child protection.

An Australian exploratory study by Kaur, (2007) draws on research to examine caseworker perceptions of 'culturally sensitive' practice when working with CALD communities. The study found that child protection caseworkers employed in the statutory system are confronted by increased complexity when working with culturally and linguistically diverse (CALD) communities due to the diversity and variation between cultures, ethnicities, religions and race. The findings highlighted the belief of child protection caseworkers that to be 'culturally sensitive' they needed access to: cross cultural awareness training; assessment frameworks and resources on various CALD communities.

Working with CALD communities also requires outreach and community development – a move out of the office base and into ethnic communities with targeted messages. Community education and information is required to ensure that CALD communities, particularly new arrivals from migrant and refugee communities understand how child protection works in Australia, and what their rights and responsibilities are. A culturally appropriate community education program should include a focus on positive parenting skills and family strengths.

Integrated Family Services (IFS)

The IFS team assists and supports parents and caregivers when children and young people experience difficulties that affect the family's capacity to function. This team is part of the Child First system.

Around 150 families are moving into this sub-region every week, leading to an unprecedented demand for Windermere and other partner agency services. The IFS works closely with schools, maternal and child health centres, local government, healthcare providers, specialist agencies and other service providers as part of a coordinated approach to improving outcomes for children and families.

At any given time our team of 11 Family Service Case Managers will be working with up to 100 families and 50 individuals in groups. Support given to families at the time they request and require assistance is the crucial factor in sustaining change for children and families.

An important component of IFS is the improvement in individual's well being and coping strategy through groups. The model of intervening earlier with families to equip children, youth and parents with the confidence and skills to cope in an ever changing environment of raising healthy families has high potential to assist families and needs greater exploration.

Due to the range of issues that present to the IFS there is a corresponding range of interventions located at every point on the continuum from early intervention through secondary to tertiary interventions.

Counselling

Windermere provides general counselling and support services for children and adults, and specialist programs for children and families who have experienced family violence and sexual

assault. While these services tend to support people at the 'tertiary' end of the public health spectrum, we also provide a number of early intervention and prevention programs.

For example, our 'child placement prevention' program works in partnership with DHS Child Protection and provides counselling and support for children living at home, who are at risk of entering the out of home care system.

We also work in partnership with Relationships Australia to provide an Early Intervention Service (EIS) family support program. This program adopts a child focussed, person centred approach to help parents understand the attachment needs and developmental needs of their children.

The ongoing success of these programs indicates a significant need for early intervention and prevention based interventions. Our experience in reducing family violence, and growing wellness through healthy relationships and better parenting skills, shows the enormous potential benefit in expanding these programs and growing community access to them.

Victims Assistance and Counselling Program
The VACP is one of the few Windermere programs that is predominately at the tertiary and even post-intervention end of the continuum. In spite of this VACP service delivery takes an holistic approach when working with victims of violent crime. The support provided to a victim is tailored to the individual needs of that person and works within a strengths based model to assist the person to recover from the impact of the crime on their life and those around them.

VACP have developed a group program, "Healthy Relationships/ Healthy Women' for women who have been victims of serious violence in their intimate relationships. Again the focus is positive, enabling and empowering the woman to understand the dynamics of relationship violence and encouraging them to take control of their lives. Both the individual and group work approaches move the client from the tertiary to the other end of the continuum by promoting wellbeing and assisting the client to deal with and move past the negative experience.

Housing
The Housing program has the widest range of activities from prevention work with the innovative 'Mums and Bubs' Project for homeless women with babies, through to the early intervention 'Support for Families at Risk of Homelessness' program. Windermere provides tertiary intervention through Transitional housing support for families who have entered the housing system at a time of homelessness through the Opening Doors Framework. Presenting issues for these families are highly complex and require a skilled response.

We see in this program many opportunities for an earlier intervention that could have prevented the need for such an intensive program. We believe that early intervention and the subsequent prevention of homelessness for families is critical. The provision of a stable home environment is crucial for the well being of children and their carers.

The Value of Early Intervention Group Work
Windermere has been responding to an expressed need from people not yet in the 'system' who have identified concerns and requested assistance. Groups have been developed across a range of issues with outstanding success. This early intervention approach could be strengthened with very few additional resources. Some of the groups include:

- 'Mums and Bubs'
- 'Pairs' A group focusing on establishing sound mother/baby relationships
- 'Birds of a Feather A creative therapy and support group program for women

Research, Evaluation and Special Projects
Windermere has developed strong connections with tertiary institutions which partner with us in a range of research projects, teaching, and academic advice. Some examples of this work includes:

- Building Family and Community Resilience in the Growth Corridor: This research involved a partnership with Monash University and the Shire of Cardinia and included all relevant growth corridor planners eg DPCD, GAA, DHS. It aimed to develop a response to growth corridor human service demands. It will examine and develop ways of establishing relationships with the new communities that are proactive, capacity building and therefore less reliant on intensive services. The project aimed to help all 'stakeholders' build an understanding of the needs and issues facing growth corridors and to recommend on strategies that will eventually assist in the development of a well-resourced, socially connected, resilient and capable growth corridor community.

- Wellbeing Measurement Tool Research: This research investigates whether wellbeing measures can be extended in application and applied to assessing the effectiveness of a service. Specifically, Windermere Child and Family Services worked with RMIT University over two years to answer the following questions "How does one achieve a sense of 'wellbeing'? Does wellbeing change over time and can this change be measured"? If so, then how can we ensure that our service contributes in a meaningful way to our clients' sense of wellbeing?

- Consumer Credit and Financial Stress: In partnership with Centrelink, Sheriff's Office and Consumer Affairs Victoria, Windermere initiated the CALD Consumer Credit Project to provide diverse communities with information on credit, contracts, budgeting, warrants for unpaid debt or fines and Centrelink payments. This has identified a significant gap in knowledge and opportunities for earlier intervention.

- Building Harmony Project in the Growth Corridor: This project has facilitated partnerships between the various government and faith schools in Officer to develop strategies to further raise cross cultural awareness and understanding in the Growth Corridor. The aim is to prevent race related crime and anti social behaviour. The project involves a partnership between the Cardinia Shire Council, Monash University and Windermere Child and Family Services.

- Kids on Track: An Action Research Project In partnership with Victoria Police, Monash University, Gilwell Scouts, SELLEN and Taskforce): The Kids on Track Program assists at risk young people who have been cautioned by Police in the Cardinia Shire to avoid criminal behaviour, reduce recidivism and enhance their connection to community. The action research will document and evaluate the various interventions and approaches to working with this group.

    - Victims of Crime in CALD Communities Research: In 2009 Windermere and MYRIAD Consultants' undertook a research project to determine the key issues and support needs of victims of crime from CALD communities. As a result Windermere developed a culturally appropriate model for CALD community capacity building and has increased the access and participation of CALD communities requiring child and family services The project has been influentional in work with the Department of Justice, the State Wide VACP CALD framework and the current state wide Victims Charter and Guide.

- Action Research on Family Violence: This community education project in the growth corridor is funded by the Legal Services Board. The purpose is to contribute to the prevention/

- Supporting at Risk of Homelessness Families in the Growth Corridor: a community capacity building project to support families who are at risk of homelessness. It is anticipated that this process will build the capacity of the community sector and the local community to improve linkages and networks.

6. Comments on the Inquiry Terms of Reference:

In this section Windermere comments on the Inquiry's main terms of reference. Our comments are based on our own experience working with children, families and communities, our commitment to enhancing the wellbeing of children and our understanding of the research and evaluations undertaken by ourselves and others.

The Inquiry terms of reference are to *inquire into and develop recommendations to reduce the incidence and negative impact of child neglect and abuse in Victoria, with specific reference to:*

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

There are a number of risk factors that have been identified as increasing the risk of abuse, and while any one of them may not place a child at risk, any combination is an indicator of potential harm. It is possible to see the risk factors as being related to:

- The parent or care giver
- The child
- The family
- Community or environmental factors

Considerable research has been undertaken on the protective factors, which assist in the development of resilience, with two specific factors as priority:

- Quality and strength of 'parental'/child attachment. It is important to note however that misunderstanding of this theory has been used to return children to parental relationships where the attachment is not positive and where a consistent and stable attachment with a foster parent or kinship carer might be preferable.

  Creating and maintaining consistent and continuous relationships between a child and caring adult is the first priority and many times the decision to leave a child with one or both of their biological parents has defeated the ability for this to be achieved. While it is agreed that children who are in a stable and positive relationship with biological parents are more likely to thrive, there are circumstances when this is not the case and the constant removal of the child away from non-biological carers and back to dysfunctional parents is detrimental to the child.

- Levels of connectedness to family, school, peers and community. Considerable research, and practical application of this conceptual framework, has led to positive outcomes for individuals, families and communities.

  There have been some very effective programs designed to build connectedness such as the School Focused Youth Service(SFYS). SFYS is also a good example of a collaboration between education, human services, independent schools and the

community sector.

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.

Given the immediate problems in the current child protection system, it would be tempting to make a 'quick fix' however this will not achieve a lasting solution. Instead it will be most important to use this opportunity to recommend solutions, which don't become tomorrow's problems.

We would like to suggest that the focus of any new system be **on promoting and enhancing the wellbeing of all children,** with an understanding that all children are vulnerable and require 'protection'. A positive message is required to have families and communities rethink the place of children in our society and the roles and responsibilities for families and the community in ensuring their wellbeing.

For this reason we are strong supporters of shifting the effort and resources to the prevention and early intervention end of the continuum with the addition of **promoting wellbeing** as is consistent with a public health approach. For example an integrated strategic approach would include:

Public Campaigns with a Universal message:

- Develop a public or social health approach to enhancing the wellbeing of children.
- Focus community campaigns on wellbeing, resilience and building protective factors.
- Strengthen and utilize the primary care/universal health, education and welfare systems such as M&CH, kindergartens, child care services, schools, after-school programs.
- Resource ongoing research into all aspects of an integrated approach to changing the culture to one that values and enhances the lives of children.

Public campaigns, which shift the culture to value children and to have whole of community responsibility for the wellbeing of children, would demand a whole of government/whole of community response. The messages need to be consistent and coordinated as part of a well-managed campaign such as those run by the National Drug Strategy, the Say No to Violence and the HIV/Aids campaigns.

Some of the messages would include that 'It is OK not to know the answer. It is OK to ask for Help'; 'It takes two parents and a village to raise a child'; "Read to your child every day"; 'We are part of your community' – all designed to raise awareness about what children want and need to grow and thrive. These campaigns need to be run over some years. Changing the culture is not a short term task.

Early Intervention and Prevention

Is a more targeted and intensive approach to raising awareness in specific communities such as those identified by research as 'being at risk'. This may be either a specific community, as identified for example through the SEIFA Index, or a particular population group.

- Develop informed and targeted interventions based on identified risk factors at earlier points in family/child development.
- Allocate the best resources to the early intervention aspect of the range of interventions.
- Ensure that all research and evaluation findings are translated into practice principles and provide 'on the job training' to staff so that all learnings are applied in practice.

- Develop an ongoing capacity to undertake detailed research to evaluate the interventions that have a real and positive impact on families who have been identified with children at risk of abuse, harm and neglect.

Secondary and Tertiary Interventions
It is to the detriment of the whole child and family service system that child protection (within government) is characterized by young and inexperienced staff, recently graduated, possibly in their first professional position. The turn over of these staff is legendary whether from burn-out, ambition or frustration.

- Ensure that the best qualified and experienced staff are employed to work with the most 'damaged' children and families..
- Continue the shift to Kinship Care however with higher levels of support and resourcing.
- Increase the capacity of the community sector to take a greater role with this group of clients.

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.

We believe the following suggestions will improve the outcome for children and families:

- All services to children should enable the flexibility to work across government funding streams. A Wellbeing Practitioner located in universal and primary care services can navigate the system on behalf of families or children found to be 'at risk'. This practitioner could be jointly funded by DEECD, DHS and Department of Health.
- Child First is a good example of a collaborative approach to secondary and tertiary interventions and this model could be expanded to act as the gateway to all child and family services.
- Service delivery should be in the hands of the most appropriate organisations, with high calibre staff and adequate resources.
- Competitive tendering is not always appropriate when asking the same CSO's to collaborate.

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

In adopting a public health model to enhance the wellbeing of all children and protect those who are at-risk, a mapping of all services (both government and community based) will be required, including eligibility and clarity of purpose so that a more comprehensive and integrated approach can be developed. This is essential if we are to recognize the opportunities for early intervention and know the most effective point for intervention. A greater sharing of risk and responsibility between government and non government organizations can only occur as long as there is a more sustainable funding model and a greater recognition by political parties and media that human services to vulnerable families are complex.

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

Windermere currently has limited involvement or expertise in this area. However the following observations are made:

The current system has two conflicting interests, which play out in every part of the system and particularly in the courts: 'Children's Rights' and 'Parental Rights'. Parental rights are based in the

historical approach to children as property while the concept of children's rights is based on children being individuals and actors in their own life story.

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.

While previous sections have spoken to the role of Government as that of developing policy and programmatic guidelines and provision of funding, it is critical that this is done as a partnership with the service providers to ensure consistency and the ability to provide what is both ideal and real.

Too often government officials underestimate or de-value the work undertaken by NGOs.

The DHS project *Putting Partnerships into Practice* demonstrated the lack of commitment on the part of management to a true partnering approach, which requires equality and mutual regard. It also requires resources. Partnerships take time and perseverance.

There is no question that the workers in this field need to be highly skilled, experienced and knowledgeable however we need more creative approaches to workforce development that will ensure the best people are in the system. Flexible working arrangements, engaging women whose children are in school, paying reasonable salaries to attract experience including men and women is critical.

We also strongly support the shift of many of the service aspects of child protection to the CSOs so that community and contextual information is included in decision making. This will free government to develop good policies and plan more effectively for the future. However, this will only work if the risks are shared equally and that a more bipartisan approach is taken in order to prevent public blaming of services.

Funding must also reflect the emerging growth in communities so that 'the system' is not always catching up to the need. This will require a more dynamic approach to budgeting and funding.

8. The changes necessary in oversight, transparency, and/or regulation to achieve an increase in public confidence and improved outcomes for children.

Increasing the wellbeing of our children demands a major cultural shift, which requires a new and committed leadership and a whole of government approach.

A model worthy of consideration was that taken by *Partnerships Against Domestic Violence* which brought together Commonwealth Departments, State/Territory governments, business interests and the not for profit sector. *Partnerships* made an enormous difference to understanding the best approaches to prevention, early, secondary and tertiary interventions based on new research with very little in terms of additional resources. Up until that time domestic violence responses were almost totally focused on the tertiary end of the continuum and now the focus has shifted dramatically.

A whole of government approach needs to be overseen by a Task Force with a direct reporting relationship to an **independent Ombudsman or a Public Advocate** for Children. In fact the Public Advocate role in Victoria is a good model to base this on, as it needs to be independent of party politics and have the capacity to critique government actions. The Task Force needs to include education, health, human services, housing, with government and non-government representatives. **At the strategic level it is critical that there is a real partnership and this partnership should then be adopted at all levels of the model.**

The DHS role would be to service the Task Force, ensure that its recommendations are implemented, oversee research projects, manage funding allocations and arrangements and support the regions to implement effectively.

Each region would replicate the Task Force with the responsibility for implementation of more targeted interventions. To be effective, each Regional Task Force will need to:

- Interpret the research,
- Agree on priorities for action,
- Plan the use and allocation of resources,
- Coordinate staff training and development
- Continuously evaluate outcomes

Again at the regional level it is the role of DHS to provide leadership to the partnership; this requires a very different approach to that currently adopted and will require a very different set of skills. For greatest effectiveness, detailed program planning and intake to the service system needs to take place at the sub-regional level especially in growth corridors where the circumstances change regularly.

Quality assurance, quality improvement and regulation should be in the hands of an independent body that reports to the Task Force. Quality improvement and accreditation schemes should focus on the outcomes of the services and should build capacity in the sector by using peer reviewers and technical experts. The role of an independent, not for profit, community based organisation such as Quality Improvement Community Services Accreditation (QICSA) could be enhanced as the primary accreditation agency to ensure consistency of approach rather than multiple providers. It is already based on principles of social justice, client outcomes and good governance.

Based on the experience of Child First, it would be more appropriate to undertake service planning at the local level of sub-regions or for clusters of local government authorities. At this level there needs to be a triage capacity to ensure that children and their families are connected to the most appropriate services and responses even if not eligible for an intensive intervention. In other words more capacity for early intervention.

A truly collaborative model will be transparent and rebuild confidence in the system because all parts of the system will be working together to create a more effective approach. It can not be politically driven and should not be adversarial in nature, however it should be based on sound, ongoing evaluation.

7. References

Access Economics

ARACY Collaborative, *Pulling the threads together – Consultations, conversations and contemplations on child poverty in Australia,* A summary paper from the team undertaking the *Children's Lived Experience of Poverty Project*, including Professor Catherine McDonald (RMIT University), the NSW Commission for Children and Young People and The Benevolent Society.

Barlow Jane, (2011) *Setting the Scene: A Public Health Approach to Child Protection* Professor of Public Health in the Early Years

Brouwer G. E. (26 May 2010), *OMBUDSMAN investigation into child protection – out of home care,* www.ombudsman.vic.gov.au

Browne Stan, Clarke Deb, Henson Peter, Hristofski Frida, Jeffreys Vicki, Kovacs Peter, Lambert Karen, Simpson Danielle, with the assistance of the Australian Institute of Sport, (2009) *PDHPE Application & Inquiry* Second Edition.

Carney T., (1985) *Equity and Social Justice for Children, Families and Communities*, Vic. Gov. Pr., Melbourne, May The Report of the Victorian Child Welfare Practice and Legislation Review Committee

Charter of Human Rights and Responsibilities Act 2006 (the Charter)

COAG, (2009) *Protecting Children is Everyone's* Business National Framework for Protecting Australia's Children 2009–2020 (An initiative of Commonwealth of Australia)

Higgins Daryl J. (June 2010), Community development approaches to safety and wellbeing of Indigenous children A resource sheet produced for the Closing the Gap Clearinghouse

Higgins, Bromfield, Richardson, Holzer, & Berlyn, (2009).xxxxxxxxxxx

Holzer Prue *Defining the public health model for the child welfare services context,* Compiled by National Child Protection Clearinghouse Published by the Australian Institute of Family Studies *ISSN 1448-9112 (Online)*

Jarrah Hoffmann-Ekstein and Annette Michaux (The Benevolent Society); Dr Sharon Bessell (Crawford School of Economics and Government, The Australian National University); Prof. Jan Mason and Dr Elizabeth Watson (Social Justice Social Change Research Centre, University of Western Sydney); and Marie Fox (NAPCAN). (2008) *Children's agency in Communities:A review of literature and the policy and practice context.*

Kaur J., (2009) Developing Practice: The Child, Youth and Family Work Journal no. 23 Autumn/Winter.

Lamont Alister and Bromfield Leah (2010), *History of child protection services,* Australian Institute of Family Studies, October 7 pp. ISSN 1448-9112 (Online); ISBN 978-1-921414-45-

McIntosh, Greg and Phillips, Janet (2002), *Who's Looking after the Kids? An Overview of Child Abuse and Child Protection in Australia* E-Brief: Online Only issued 13 September 2002; updated 16 October 2002.

O'Donnell, Melissa; Scott, Dorothy; Stanley, Fiona, *Child abuse and neglect — is it time for a public health approach?* Australian and New Zealand Journal of Public Health, Volume 32, Number 4, August 2008 , pp. 325-330(6)

NAPCAN **www.napcan.org.au/play-a-part**

Northern Territory Government 2010, *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children*, Summary Report of the Board of Inquiry into the Child Protection System in the Northern Territory, M.
Bamblett, H. Bath and R. Roseby, Northern Territory Government, Darwin.

Sammut Jeremy (2009) *Fatally Flawed: The Child Protection Crisis in Australia,* Centre for Independent Studies, PM97.

Sammut Jeremy (2010) *The Power and the Responsibility: Child Protection in the Post-Welfare State Era*, Centre for Independent Studies, OP117.

Scott, D.A. (2006) *Towards a public health model of child protection in Australia, Communities,* Families and Children Australia, 1(1) 9-16.

Szirom T, Hyde J, Lasater Z, Moore C, (2002), *Working Together – Integrated Governance.* In a report prepared by Success Works and the Centre of Health Outcomes and Innovations Research for IPPA National Research Project, Canberra.

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008).
The Cost of Child Abuse in Australia, Australian Childhood Foundation and
Child Abuse Prevention Research Australia: Melbourne.

Tomison Adam (2001) *A History of Child Protection*, Australian Institute of Family Studies, *Family Matters*, no. 60, Spring/Summer.

Wass A., (1994) Promoting Health: The primary health care approach, Harcourt, Australia