Discussion paper –

Caroline Chisholm Society

Response to the Victorian Auditor General's Review of Early Intervention Services for Vulnerable Children and Families

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Executive Summary

In May 2015, the Victorian Auditor General handed down his report into Early Intervention Services for Vulnerable Children and Families (the VAGO report). The report recommended a comprehensive review of the system, which was announced by Jenny Mikakos, Minister for Families and Children on 6 August 2015.

This discussion paper outlines the Caroline Chisholm Society's (CCS) preliminary response to this process. The following summarises the CCS priorities with reference to the VAGO report and the review process announced by the Minister:

- **A focus on early intervention is critical** because, as the Auditor General found, major deficiencies in both the "quality" and "quantity" of service delivery in ChildFIRST and Integrated Family Services (secondary services) will increase future demand for Child Protection.
- **A balance between demand for high volume early intervention services and more complex support** (i.e. parenting groups v such as home-visiting casework); CCS experience suggests that the balance of clients is shifting in the direction of addressing demand rather than managing it. While complex case management is and must remain a priority, early intervention services will prevent expense for everyone, especially for the children of mothers in need of support without fear of judgement.
- **Measuring outputs *and* outcomes**: while hours are a measure of contact between support services and families (and thus an output measure of risk reduction), measuring case management against outcomes is critical, particularly outcomes of short term and group work interventions against wellbeing scales.
- **The Roadmap for Reform Expert Advisory Group should consider early intervention family and children services on their merits**, so that it can properly focus on providing services to families before issues arise and not be caught up in the Advisory Group for the Road Map to Reform of Out-of-Home Care.

CCS believes that a failure to focus on these aspects will be costly for the system and, more importantly, put families and children at greater risk. It may also alienate mothers and families who are seeking support and information on parenting prior to issues escalating.

The CCS looks forward to being an active and constructive participant in a review process that is focused on the prevention and early intervention framework. To achieve this, the review process needs to communicate as soon as possible how the review's consultation process will work and what will be the role of the Advisory group to the Road Map for Reform.

Box 1: Caroline Chisholm Society

Caroline Chisholm Society (CCS) is a leading integrated family services (IFS) provider in Melbourne's west. They offer support from the moment a woman learns of her pregnancy to the time her youngest child goes to school. In addition to the Department of Health and Human Services (DHHS) funded IFS service, they are also funded to offer homelessness support and have received some education funding to run supported playgroups.

CCS is in a unique position in the family services sector. The majority of its funding is sourced from IFS, but it is neither a ChildFIRST agency nor a provider of out of home care. The agency as a whole is highly focussed on early intervention for vulnerable families. While small, it can provide a detailed understanding of the local implications of the sector at a relatively senior level of the organisation. It is funded for the catchments of Brimbank/Melton and West Melbourne (covering the LGAs of Wyndham, Hobsons Bay, Moonee Valley, Maribyrnong, and Melbourne).

As an agency, the Society's objective is to help women to achieve a safe and nurturing environment for their children. CCS does this by offering:

- new and pre-loved baby & maternity goods to families to alleviate poverty;
- one-off appointments for counselling and support to empower families; and
- ongoing casework to support good parenting while at risk of or facing homelessness, family violence and mental health issues. This is supported with group work, and volunteer mentoring and maintenance.

CCS sees over 1000 clients per year (1226 in 14-15). This varies depending on funds and complexity of client needs. CCS supported families through over 900 one-off appointments in FY14-15 and worked with over 257 casework clients. CCS is a volunteer-led professional social and community service, focused in the communities surrounding Caroline Springs (Melton, Brimbank and Wyndham), Moonee Valley and Goulburn Valley (Shepparton).

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Early Intervention State of Play

Introduction

In May 2015, the Victorian Auditor General handed down his report into Early Intervention Services for Vulnerable Children and Families. The review looked into range of "secondary" services targeted at intervening early to prevent the event of maltreatment, generally involving the processes of identifying, assessing, acting and referring children and their families in these situations. It did so in the context of "tertiary" services being focussed on maltreatment, such as Child Protection, and "primary/universal" services being population wide, such as Maternal and Child Health and education and care. The report was conducted in the context of a three step process of auditing services targeted at vulnerable children.

The VAGO report examined whether vulnerable children and families are able to access the early intervention services provided by Child and Family Information, Referral and Support Teams (ChildFIRST) and Integrated Family Services (IFS), and whether the Department of Health and Human Services (DHHS) can show that outcomes for families have improved as a result of this intervention.

There are two main aspects to these types of interventions – the entry point – through ChildFIRST which assesses and allocates, while IFS provides the substantive intervention through support services and specialist care.

CCS, IFS and ChildFIRST

CCS has been operating at capacity for IFS casework, at capacity for specialist homelessness casework, and four week waiting list for one-off appointments for many years. CCS supports its colleagues in ChildFIRST when their area demand is so high, that the catchments have gone into contingency due to increasing referrals not being matched with resources. CCS is also engaged in outcomes measurement, both through its own drive to use the Outcome Star, but also through the Brimbank Melton Connect project.

Statewide IFS and ChildFIRST

Throughout Victoria, ChildFIRST and IFS have recorded a 10.6 per cent increase in referrals between 2011-12 to 2013-14. This is starkly contrasted against direct referrals to IFS reducing from 34 per cent in 2011-12 to 27 per cent in 2013-14. *This means prevention work has moved closer to crisis work.* As a result, IFS has less capacity. Referrals allocated a family service response following direct referral to a family service has decreased from 33

per cent in 2011-12 to 26 per cent in 2013-14. (Source: DHHS and CSO Strategic Alliance Forum).

Implications of excess demand

The effect of this pressure on the system has been to focus IFS on prevention of engagement with child protection, by virtue of referrals from child protection. The service is, however, designed in such a way as to prevent many different issues requiring intervention. IFS workers are highly trained in comparison to their colleagues in other sectors and as a result skill themselves to prevent children from being effected by family violence, homelessness, the impacts of mental health issues and other prevalent concerns, such as poverty, inter-generational disadvantage and social isolation.

It is also important to highlight the implications for a policy response to the Family Violence Royal Commission. CCS data for 2014-15 shows a doubling of issues listed for current family violence over the previous year. The level of historic family violence reported by clients remains high, with it surpassing the traditional focus for CCS of homelessness. In addition, the indicator of social isolation has also increased two-fold over last year. Anecdotally, some social isolation is linked to current controlling relationships in which IFS staff is working to improve the circumstances for children.

Implications for the review

CCS contends that the focus of the review should be:

- A focus on early intervention strategies not currently delivered due to excess demand and insufficient resources.
- an integrated case management system which would allow for:
    - Growth in case work to both respond to 1) referrals from early intervention mechanisms such as parenting groups, emergency relief services, etc, and 2) the need to support families to stay together as they reunite following interaction with the out of home care system.
    - system wide monitoring, measuring and reporting; this would help address recommendations regarding demand planning, measuring outcomes, and performance management, and
- Separately focussed programs to support children entering and leaving care in order to avoid refocussing early intervention and ‘secondary’ services towards important but ‘tertiary’ interventions.

Evidence supports Early Intervention investment

Finally, any review process should focus squarely on prevention and early intervention on its merits, not as a precursor or backstop to child protection. There is already ample evidence from other Australian jurisdictions and overseas to support strong investment in programs that support families and parents before they become "at risk'.

It is well known that gaps in educational performance open up early and stay constant after 8 years of age, with schools playing only a minor role in changing outcomes, according to well known research by Professor James Heckman. Evidence suggests a mix of targeted and universal programs to prevent and intervene early in families can be effective in getting program reach and reducing the stigma associated with accessing such programs[i]. There is also evidence to support that transition periods in families – such as the birth of a child – are ideal times to engage, as people are often open to new ideas and information at these times[ii].

More specifically, home-based out of home care is cheaper than residential care, hence the social impact bonds projects in UK[iii]. In NSW, a trial of a SIB is underway working with UnitingCare Burnside called "The Newpin Bond". In the 2 years to 30 June 2015, Newpin restored 66 children to their families. This is a cumulative restoration of 61.6% compared to a baseline of 25%. The program also prevented children in 35 families from entering care. As a result, investors received a 7.5% return in the first year and an 8.9% return in the second. Read the investor reports for 2013-14 and 2014-15.[iv]

For Victoria, this is also true. In 2013–14, the annual cost of a residential care placement ranges from $162 880 to $308 028.[v] With regard to other kinds of in home out of home care, such as foster care, the Government spent $352 million in 2011-12 with a per capita expenditure of $56,652.[vi] Support for a family that remains together varies widely in cost, depending on the complexity of the client. In 2013–14, the budget for both the Child FIRST and IFS components was just over $88 million.[vii] While we cannot indicate a per capita against this figure, due in part to the re-referrals and data integrity issues as indicated in the VAGO report, we can indicate that CCS spent $1.2m and helped 257 clients (excluding several short interventions) and estimate their costs per client to be $4,600.

From CCS experience, one FTE of IFS home-visiting staff can see 10-12 families per fortnight, whereas in group work they see 100 per fortnight, and in doing so, identify families for referral into ChildFIRST for home-visiting case management. This allows a broader reach and helps universal services support their more vulnerable families while CCS remains a secondary service preventing engagement with child protection.

Innovation in Prevention and Early Intervention

Adopting innovative approaches to early intervention can broaden the reach of such services, make them more accessible, non-stigmatising and potentially deliver greater efficiencies. Two examples of such approaches currently being considered by CCS are outlined below.

Box 2: Prevention and Early Intervention

Parenting Groups

Child and Family Services staff are highly qualified and highly skilled in parent-child interactions compared to colleagues in other parts of the community sector. They could share knowledge with other professionals by co-facilitating groups. This would also allow the integrated case management teams to be more knowledgeable about other service types and can refer more effectively. These wide reach, low cost activities allow parents to increase skill, workers to identify issues early and there to be better coordination across parts of the sector. To achieve this, DHHS would need to legitimatise use of integrated family services funding to deliver services in groups, rather than only one-on-one.

Multidisciplinary case management

Child and Family Services staff are often social workers that are highly attuned to wellbeing, while nurses and midwives to health and early childhood workers to care and education. They would be well placed to work as part of an intensive and preventive home-visitation program for high risk young parents and their first babies out of the new “Joan Kirner Western Women’s and Children’s Hospital”. An alternative location for such a project could be the Dame Phyllis Frost Women's Correctional Centre. Co-visiting by highly trained nursing and social work staff (as occurs in the “Minding the Baby” project at Yale) would be a creative way of ensuring Health and Human Services are able to work together. It could build on the experiences in Victoria of Cradle to Kinder, the Right at Home Project and enhanced Maternal and Child Health nurse programs.

Conclusion

Ultimately the focus of this review, and consequent policy making and resource allocation should be on minimising risks to vulnerable children and families, providing them with the support and skills to minimise and eradicate vulnerability, and above all avoiding entry into the child protection system.

One of the most invasive, most expensive and least effective public policy interventions is the removal of a child from their parents. In Australia, the stolen and forgotten generations are evidence of this – they and their children and their children's children are over represented in repeat referrals to child protection noted by VAGO. That is, of course, an anecdotal contention backed up only by triangulated data from other policy areas and qualitative evidence in reports by Commissioners for Children in Australia and around the world. If governments were brave enough to do a randomised control longitudinal study of those families with and those without histories of removal, the evidence would – CCS contends – be shocking.

CCS Responses to Findings and Recommendations

1. Inadequate and reactive planning

Findings:

- *Strategic planning for ChildFIRST and IFS has been reactive and rudimentary.*
- *While alliances review their demand management strategies, DHHS has not identified and evaluated the overall implications of these demand management strategies on the effectiveness of service providers' interventions.*
- *ChildFIRST and IFS are operating above their funded capacity in the context of increasing demand and the growing complexity of family needs.*
- *Serious limitations on DHHS performance data, and a lack of sound analysis of the available data, limit its capacity to plan proactively and effectively, and reduce the ability of the alliances to plan effectively.*

Recommendations:

1. *Improve planning by better demand forecasting*
2. *Develop mechanisms identify issues and risks with regular state-wide engagement to plan and problem solve*
3. *Train service providers in catchment planning and data analysis planning*
4. *Review whole of system funding to better meet demand.*

CCS Response:

CCS agrees with these findings and recommendations, and sees the management of the IRIS client record system as significant barrier to progress in this area.

CCS believes that the reactive management of demand in Child Protection has refocused interventions from voluntary services (such as home-visiting case management, office based welfare appointments, group work and other interventions) towards services requirements on families by Child Protection to engage with us.

The ChildFIRST model is a world-leading system that allows the community to refer prior to significant protective concerns and should be driven by supporting families to create a safe and nurturing environment for children. In this context, CCS agrees with the findings and are particular interested to work with DHHS to evaluate local demand management strategies.

CCS also agrees that there has been inadequate demand forecasting. Regular analysis of complexity presenting in universal services would predict future demand in ChildFIRST and thereby IFS. CCS supports wellbeing measures for this purpose over educational (which is measured by SES) or health (which are both highly complex). Longitudinal use of wellbeing surveys of universal services, such as in maternity ward, would assist.

CCS recently analysed its annual data, and the growing issues include but are not limited to family violence and social isolation. Clients living in present situations of family violence doubled in 2014-2015 data. There is a marked increase in social isolation, which is a new trend. CCS believes volunteering and community development can help address this, but funds are limited. Our data also shows a continued risk of homelessness and indeed current homelessness. CCS supports allowing the sector to be more responsive to trends.

Speeding up the slow response to emerging issues requires flexible and nimble funding streams and goodwill from service providers. At present, this is done on an ad-hoc basis and does not allow for broader consultation within the sector where similar issues are likely to emerge. Regular, coordinated processes to identify issues, design consistent solutions would improve resource allocation and remove duplication. Some local councils have rounds of “Responsive Grants”, which allow agencies to apply for funds to deal with the issues they face as they arise. A scaled up version into a State Government program development stream may help the DHHS to more quickly respond to emerging issues outside the budget cycle.

Any review of whole of system funding should be evidence-based and focused on services that are provided to prevent engagement with CP, Homelessness, Family Violence, Mental health. This may include joint service provision which bridges health and community outreach so that nurses and social workers are working together. The current funding model does not reflect represent the expectations placed upon CCS (“worry about hours not cases”), has no rationale for the number of hours allocated to case types, and has divisions between catchments and intervention that are not responsive to demand from complex clients or prevention activities.

This paper responds to the issues of providers delivering above funded level and the limitations of performance data under the following section “Inadequate performance and outcomes monitoring.” This is due to significant concerns about the service record system “IRIS”. Current workloads do allow time for training in data analysis at operational and catchment level to the extent required with a system like IRIS. IRIS requires specialist skills and systems for simple reporting tasks.

2. Inadequate partnerships and governance

Findings:

- *ChildFIRST and IFS rely on multiple providers to deliver services... The DHHS needs to develop an effective state-wide mechanism to engage better with current and potential service providers.*
- *Effective governance requires clear roles, responsibilities and accountabilities. There is great variability across catchments in terms of how coordinated planning is, and in the operational and strategic management of service delivery. The DHHS could be doing more to support the development of these partnerships.*
- *DHHS has identified the need for stronger governance and more clarity around roles and responsibilities between ChildFIRST, IFS and Child Protection as key priorities for its next round of catchment plans.*

Recommendations:

1. *Provide targeted support to underdeveloped partnerships*
2. *Improve communication between DHHS and service providers*

CCS Response:

The hub and spoke central intake model of ChildFIRST and IFS funding provides DHHS a point of coordination and capacity to respond to the local issues faced by individual service providers. It does, however, create some challenges in promoting good will and collaboration. The Auditor General was able to identify some strong and well performing partnerships, but found that some were weak, had poor governance, and there had been inadequate engagement with the service sector over time. Some Alliances are focussed on operations in part because DHHS funds the service providers to deliver a service and encourages this.

Over time, DHHS has shown a marked lack of understanding of the nature of organisational governance. For example, the Services Connect model had been tested within DHHS but not across agencies or entities and was applied across entities with the same model. DHHS has proved unable to work within that paradigm; for example, it has confused the authority of staff of an agency to consult with Child Protection rather than make a report if an agency is registered under the Child Youth and Families Act. DHHS advised that authority applies to some staff and not others due to funding streams. This lack of understanding has been reflected in DHHS' inability to support partnerships in an area where it funds agencies directly and requires them to use a central intake model.

A clear example of DHHS lack of understanding of their relationship with service providers is communications. DHHS staff members speak about, and in some cases write about, “CEO Meetings”. These are meetings of the CEOs of the Chairs of Child and Family Services Alliances. These are critical strategic ‘kitchen cabinets’, and cannot be made larger. However, there is a significant gap in information offered to CEOs and managers of service provision in non-chair agencies.

For CCS, that means they receive $1.2 million to undertake a task and their only communication from DHHS about service provision is through much relied upon chairs. DHHS also holds monthly operational meetings between a local engagement officer and the manager of service provision to discuss performance. This provides no opportunity for DHHS and locally responsive agencies to work together to respond nimbly to demand. It also results in the main voices at small meetings being those from large agencies and are likely to have a focus on the tertiary end of service provisions, such as out of home care or health.

A significant example is the provision of the DHHS response to this very report. CCS was advised by the project officers in each of the two local alliances that the report was out and by the Melbourne Age newspaper. CCS was not advised by DHHS that a major review into a significant funding stream had been released. DHHS needs to quickly agree to a framework for its communications with the sector and deliver upon the expectations in that framework.

The Child and Family Service Alliances have varying levels of sophistication in managing their partnerships. This sometimes reflects the complexity of the needs in the community, the number of agencies in the partnership or the good will around the table, but sometimes reflects a lack of resources for coordination. CCS would welcome information about those Alliances that work well so that the success stories can be replicated.

3. Inadequate performance and outcomes monitoring

Findings:

- *While DHHS has a monitoring framework to assess community-based child and family service compliance with service standards, there is little monitoring of the performance of alliances.*
- *DHHS’s monitoring of services focuses on outputs—such as the number of cases and service hours—rather than positive outcomes for families.*

- *Limited system-level analysis of service data makes it difficult for DHHS to know whether ChildFIRST and IFS are improving outcomes for vulnerable families.*
- *DHHS does not have a framework for measuring the effectiveness of services for vulnerable children and families.*

Recommendations:

1. *Provide explicit requirements for divisional staff to monitor.*
2. *Develop standard analytical data sets to monitor and report on outcomes.*
3. *Undertake statewide performance analysis to facilitate sharing of practices.*

CCS Response

Performance and outcomes monitoring should be easy when there is a central intake model and a standardised service record system (IRIS). Providers should be able to provide two data sets per month, one that acquits funds and one that provides DHHS with the information it needs to plan for service delivery and develop policy responses to demand. Poor management of the IRIS database exacerbates issues of monitoring contracts, outcomes, demand and system performance.

CCS acknowledges that hours are a measure of contact between support services and families. They are an effective way of checking that the agency is doing what the Department funded. Further, if social workers are in the homes of disadvantaged families, there are more opportunities for issues within those families to be identified and managed. While measuring the success of services by reference to the number of hours funded is less than ideal, the challenge of introducing other methods is great.

Nonetheless CCS believes the true measure of the success of its services is the empowerment of women to raise their child, not the mere attendance of staff at hospital or in the home. In that context, CCS measures its case management with an outcomes star. CCS also wants to measure outcomes of short term interventions and group work using wellbeing scales.

CCS is a partner in project known as Brimbank Melton Connect. This allows us to test methods of measurement. An assessment process to measure outcomes is underway and if it proves effective, may be appropriate to apply at ChildFIRST. This would allow services to determine which outcome system to use in their daily practice to suit their community.

With regard to monitoring contracts, the Funded Agency Channel is used at present and this data is sourced from IRIS. This system, however, does not allow standardised

reporting. For example, the funding stream may be selected, but work funded under the same stream can be classified differently at ChildFIRST, resulting in lack of clarity about the nature of report. With every change in a department's name or every desire to track a funded program (even if funded on the assumption of a contribution by IFS) a new input to the drop down menu "Src of funding" is established. Groups are also recorded in varied ways. It is this mixed input of data reporting that results in the impression that services are operating above their funded capacity, combined with good will of the sector. Some agencies are also managing risk by over-performing. Until recently the standard benchmark for contracts was 95%, with that now at 100% some services aim above target.

With regard to service data and system performance, the data is possible to source but is woefully difficult to analyse at an operational and service planning level. CCS understands that DHHS is able to extract data from reports to create required reports, but the agency that owns the data does not have the capability at the desktop interface. So, for example, when an agency runs its full annual issues data list, the exported data requires manual deletion of page numbers to ensure they are not accidently counted as clients. Colleagues within the sector are working towards circumventing this problem. Two projects can be looked to in this area: one in Mallee funded by the Ian Potter Foundation and another in Melbourne under the leadership of MacKillop Family Services and Berry Street.

These issues with data reduce service capacity. For example, the CCS management team has had to create data collection systems so it can prepare reports across systems and that process takes approximately 8 hours per month to report. Their expertise is not data analysis, but responding to effective data. When the project officers from their alliances are able to prepare data from ChildFIRST they willingly engage. Improving systems to allow for more consistency would allow best practice to emerge and be shared amongst service providers.

Conclusion & Next Steps

Overall, ChildFIRST and IFS as a DHHS funded program is failing to provide effective services for vulnerable children and families. This not from lack of good will or skills in the funded sector, but is largely due to increasing referrals of high-priority cases. This has made IFS less available to families who are 'at risk' and qualify for an early intervention response but do not meet a Child Protection level of concern. Professionals across the community seeking to refer vulnerable children and families to secondary services, are unable to do so. Problems are not addressed and, overtime, the issues get worse.

The VAGO report provides the impetus for review so that these services may be better delivered, and also focus on their core objective of address families' and children's needs at early stages. As a specialist provider of early intervention services in Melbourne's West, the CCS welcomes the audit as an opportunity to now provide input to a focused review of the sector so that the key concerns of the audit can be fully examined and resolved.

The CCS looks forward to being an active participant in the review process. To achieve this, the review:

- must immediately advise all current funded agencies of how consultation with service providers and other stakeholders will take place;
- what will be the role of the advisory group to the Road Map for Reform of out-of-home care; and
- how service providers can be brought together to achieve best practice reforms across the sector.

CCS hopes to offer its expertise to the review, with a view to ensuring that its focus remains the prevention and early intervention framework. CCS is in a unique situation of not running out of home care and not being a ChildFIRST provider, but having a large proportion of funding in the IFS stream.

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[i] Kate Butler, *Parenting Programs in the ACT*, Families ACT May 2015
[ii] Emerson, L. (2000). *Stronger families and communities strategy*, Family Matters, 57, 66–71.
[iii] Bridges Ventures. August 2014. *Portfolio - Bridges Social Impact Bond Fund*. [ONLINE] Available at: http://www.bridgesventures.com/portfoliolist/core-assets-group-birmingham-residential-migration/. [Accessed 28 August 15].
[iv] Social Ventures Australia, *Newpin Social Benefit Bond - Annual Investor Report* 30 June 2015.
[v] VAGO, *Residential Care Services for Children* March 2014
[vi] CECFW, *Foster Care Status Report* September 2013
[vii] VAGO, *Early Intervention Services for Vulnerable Children and Families* May 2015, 44-45