High Risk Infants Service Quality Initiatives Project Evaluation
The High Risk Infants Quality Improvement Initiatives (HRI Project), which commenced in 1997 has developed and implemented a number of initiatives aimed providing a better service to high-risk infants and their parents known to Child Protection Services. The project was designed to help parents, Child Protection Workers and other significant adults to recognise and hear the ‘voice of the infant’ more clearly.

This comprehensive evaluation report documents the implementation, consolidation and impact of the first two years of the HRI Project, is an exciting initiative that has been found to be unique within Australia and overseas. The evaluation examines the three main strategies: the Specialist Infant Protective Worker (SIPW), Parenting Assessment and Skill Development Services (PASDS) and the use of a Flexible Budget concept.

Innovative programs such as this take time to be integrated into a complex program such as Child Protection Services. These preliminary findings however, indicate that the initiative has already significantly enriched child protective practice with infants. In addition, the wider systemic effects of infant awareness throughout the child protection service system are beginning to emerge.

The report also presents a number of challenges for the Department to address over the next implementation phase. These challenges include the development of enhanced services for indigenous families; strengthening programmatic links with specialist drug and alcohol, mental health and disability services and further development of the parenting assessment and skills development practice model.

This evaluation document provides a record of the HRI Project’s impressive progress to date and sets out a pathway for future development.

Pam White
Executive Director
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Glossary/Abbreviations
The High Risk Infants Project

The High Risk Infants Service Quality Improvement Initiatives (HRI project) was designed by the Victorian Child Protection and Juvenile Justice Branch of the Department of Human Services in response to internal and external disquiet about the relevance and quality of service to infants at high risk within the Victorian Child Protection Service and the funded service system. In 1998, a recurrent budget allocation of $5.6 million was allocated to service improvements to enable:

• Improved risk and need assessment.
• Better informed case decision making.
• Improved child protection services performance at court.
• Inter-agency and inter-disciplinary communication and coordination.
• Service and practice innovation.

The HRI initiatives seek to strengthen the Victorian Child Protection Services response to infants through three main strategies:

• Appointing at least one Specialist Infant Protective Worker (SIPW) to each Region and to the Central After Hours Child Protection Service (CAHCP). This position would be charged with implementation and oversight of the HRI initiatives in the Regional child protection units, through case consultation, training, external liaison and other program developments.

• Parenting Assessment and Skill Development Services (PASDS) All Regions received a budget allocation for community-based residential and in-home services to facilitate close and practical assessment of parental care and infant wellbeing, and to provide intensive education and support to improve parents’ skills.

• A Flexible Budget A flexible budget, including brokerage, to help tailor assessments and interventions and monies for operational expenses.

To inform the design, implementation and development of these initiatives, the Department of Human Services also commissioned two major reports:

• High Risk Infants Known to Child Protection Services: Literature Review, Annotation and Analysis. (Jackson, Johnson, Miller and Cameron, 1999). This report presented an overview of concepts, issues and programs in the field of infant protection.
• High Risk Infants Parenting Assessment and Skill Development Research Project. Phase 1: Research and Analysis. (Littlefield, Jackson et al., 1999). This report presented a descriptive and comparative analysis of methods and tools for assessing parenting capacity and performance and providing skill development, education and support for parents of high-risk infants.

In addition, the HRI project was to implement Koori and other demonstration projects in selected Regions. These still await implementation.

Purpose of the Evaluation

This evaluation has been undertaken by The University of Melbourne School of Social Work (through the Children, Young Persons and Families Research Unit), in conjunction with Women’s and Children’s Health, through the Royal Children’s Hospital/University of Melbourne Social Work Practice Research Unit.

The evaluation team was asked to examine the HRI project, with special reference to the SIPW role, the Flexible Budget and the implementation phase of the PASDS, in terms of its:

• Implementation (Part 1 of this Report).
• Consolidation (Parts 1 and 2).
• Impact (Part 2).
• Contribution to Child Protection Services results (Part 3).

Further evaluation of the PASDS, including consumer feedback, is being undertaken and will be reported in 2002.

Evaluation Activities

The evaluation team undertook a series of structured activities to gather relevant information, comprising chiefly:

• SIPW role analysis: interviews, document analysis, activity data log analysis and focus groups.
• PASDS models and implementation study: document analysis and consultation with service providers.

Executive Summary

The High Risk Infants Project

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• SIPW role analysis: interviews, document analysis, activity data log analysis and focus groups.
• PASDS models and implementation study: document analysis and consultation with service providers.
• Case file reviews: 158 cases in 1999 and 71 of these repeated in 2000, and an associated worker questionnaire.

• Stakeholder reports: from Child Protection Service staff, SIPWs, external service providers and Maternal and Child Health Nurses.

• Court case survey: structured interviews with Child Protection workers responsible for a sample of 25 cases illustrative of court issues, augmented by consultations with Regional and Head Office staff.

• Flexible budget analysis: of expenditure over a sampled time period.

• CASIS data analysis: analysis of trend data (Statewide and regional) from the Child Protection Services case file data system, over three years—pre-program (March 1997-February 1998), first year of operation (March 1998-February 1999), and second year of operation (March 1999-February 2000).

A series of Interim Reports on SIPW Activity, the first Case File Review, and policy and program issues, has been presented.

The Regional High Risk Infant Teams

Overall, despite uncertainty about specialisation within Child Protection Services, the SIPW role has proven invaluable to improving protective practice for infants. SIPWs, a mix of internal and external appointees, appear to have achieved a widespread level of acceptance and respect, both from the Child Protection teams and from external professionals, as spokespersons for the needs of the infant as a person in his/her own right. There is no clearly emergent model for the ‘best’ deployment of SIPWs, as deployment of the positions varies with changing regional conditions. Within this model, SIPW role expectations are broad and demanding and most SIPWs have demonstrated competence across a wide band of activities. SIPWs have focussed on internal consultation to Child Protection Services staff, using a mix of direct input and experiential learning, with a shift toward more hands-on mentoring and modelling in selective cases in most Regions. SIPWs have also strengthened the infant-relevant service network used by Child Protection workers.

There are several limitations to these achievements. The relative under-staffing of the HRI teams in rural Regions leads to creative community linkages and good monitoring practices, but is operationally difficult and the teams are vulnerable to staff overload. Both these small team issues and specific rural factors mean that the needs of outlying offices are under-serviced. Staff turnover within Regions inhibits diffusion and embedding of learning, and it would be premature to disband these positions. SIPW managers (CAFW 5), as senior Regional staff, have been vulnerable to encroachment by management for other tasks, functions and positions. This has led to a struggle for program integrity, especially in the rising workload of rural Regions. This struggle is unfortunate given the large amount of knowledge diffusion, program development and practice-based research still to be done.

The Parenting Assessment and Skills Development Services

The Parenting Assessment and Skills Development Services (PASDS) appear to perform similar in situ what they were set up to achieve, and are highly valued by SIPWs, other child protection services workers, Department of Human Services Partnerships and Service Planning staff, and the PASDS providers. Most appear to be meeting the modified targets negotiated after the initial implementation phase. Residential PASDS are valued for their intensity and safety. Home-based PASDS are valued for their infant-specific work in situ. PASDS appear to perform similar functions, but vary widely in their assessment approaches, measurement of parenting change and modes of reporting. The possible benefits, as well as the limitations, of diversity of form, orientation and methods have not yet been explored in depth.

PASDS have enabled case resolution through testing the viability of parental care and establishing the kinds of follow-up required. For some families they have been able to dispel the assumption that the parents would be unable to care. PASDS evidence has been critical at court in moving some cases toward a timely permanent care alternative, often with kin. For most PASDS, it appears that the projected distinction between assessment and skill development services is artificial, and there is some agency discomfort with assessment-only service episodes. The degree to which the assessment function outweighs the skill development function is not yet clear and will be pursued in the next evaluation phase.

The brevity of PASDS intervention creates expectations and reveals needs requiring intensive and long term follow-up. This is often scarce in the Regional service systems, especially in rural Regions. The pathways to and from PASDS are being explored in the next evaluation phase.

The Flexible Budget

A large proportion of the HRI Flexible Budget has been spent augmenting the assessment and reporting functions of Child Protection Services. The second largest usage appears to be for a variety of support staff (often contracted from human services personnel agencies), undertaking in-home supervision and parent support, among other functions. The budget appears to have been used well and across most sites. Yet from a program perspective, the HRI Manager’s role has not always been as central as one would like for program integrity purposes. The manager’s role in shaping the use of the Budget is important if, as appears desirable, there is to be a balance between kinds of expenditure-case, program and training uses.

Impact of the HRI Project in Assessment, Planning and Direct Practice

In considering the impact of the HRI project on core protective practices, it is important to note the complexity of the risks faced by the infants referred to the attention of the Child Protection Service. In the case file reviews, it was noted that more than half the families had 10 or more of the risk factors on the HRI risk checklist, with combinations of family violence, parental substance abuse, and parental mental illness or intellectual disability being common and reflected in ‘chaotic lifestyles’. Poverty was so common as to be treated as unremarkable. Despite these complexities, overall the HRI initiatives to date have shown a marked impact in those cases where there has been specific deployment of the HRI initiatives, especially with respect to risk assessment, case planning, and infant-relevant parenting assistance. The 1999 Infant Case File Review (CFR) (a records-based evaluation strategy) demonstrated improvements in documented risk assessment and case planning, with strong adherence to formal procedural requirements for protective case management. Improvement was seen to be needed with respect to risk management in cases of domestic violence, and analysis of the condition of the infant, attention to extended family and social context, and the use of infant-specific services. This CFR indicated that a focus on parental risk does not equate with a focus on infant well-being. While concentrating on the well-being of the infant is likely to enhance the worker’s attention to intervening to reduce family risk factors, and focus on the parental risks will not necessarily results in improvements in the child’s condition or situation.

The 2000 Infant Case File Review (CFR 2000), which focused on cases that had remained open and therefore should have more available information, showed improvements in the documentation of the condition of the infant, and observations of the infant in interaction with parents and caregivers. There was less clear improvement in the translation of this infant assessment into intervention. In the transition between units and Regions, infants still tended to receive less than adequate attention when part of sibling groups, and when their parents were missing. Parental risk factors were well-documented and responses were made to moderate these. There was evidence of the use of a much more sophisticated approach to the assessment of parental capacity and motivation through the use of direct, informed observation and analysis of the effects of parenting interventions.

Both Reviews suggested that infant cases are much more likely to meet the required standards of practice and move toward case resolution when there is a SIPW involved and/or a timely move to a permanent alternative, still appears to be very dependent on SIPW/HRI input to the actual case.

Infant Protection and the Children’s Court

The volatility of Court process contributes to the difficulty experienced by SIPWs in making clear gains in performance and outcomes. Problems are
encountered in preparing child protection workers to
give adequate testimony, synthesising the various
forms of assessment, communicating with the legal
fraternity and securing adequate representation, and
the changing requirements of the Courts. Court
practice on behalf of infants is widely experienced as
fraught with ambiguity and uncertainty, and the Court
process is experienced by child protection workers,
rightly or not, as not appreciative of their role and
efforts. These tensions seem to be linked in large part
with a significant clash of perspectives between
legally-oriented and welfare-oriented practitioners at
the Court/Child Protection Service interface. The
boundaries between the case planning functions of the
Court and Child Protection Services appear to be
becoming increasingly blurred. While these are general
issues, the emotional and predictive problems of
infant cases make these particularly fraught. The HRI
professionals (internal and external to the Department)
are building a strong body of knowledge and experience
with respect to infant Court matters, and there is an increasingly firm foundation for positive
development in this area.

Infant Protection in the Service Network

Satisfactory case outcomes for lower-risk infants who
do not progress to long term orders are created
through a mix of infant-specific community-based
services, specialist adult services, and engagement of
kith and kin in the protection, case monitoring and
family support processes. For higher risk infants, it
appears that PASDS is a critical step in determining
whether longer term protective involvement is
necessary. Good outcomes over the review period for
these infants tended to involve either intensive
parenting service followed by a package of longer term
formal and informal community care, or resolution of
parental inability to care followed by early
confirmation of a plan for permanent care with kin or
another foster carer. Despite these achievements, the
reviewers who undertook the Case File reviews for this
evaluation often noted that inter-agency work could
have been stronger.

Despite the added resources through the PASDS and
the Flexible Budget, and despite the increasing linkage
work and collaborative program development by the
SIPWs, infant Child Protection Services clients and
their families are affected by a number of clear gaps

and inadequacies in the existing service system, only
some of which can be helped by improved
communication and collaboration. These include:

- Parent and child-sensitive drug and alcohol
treatment and rehabilitation.
- Scarce mother-infant foster care (appropriate for
some adolescent mothers and some mothers with
an intellectual disability).
- Insufficient longer-term family support and
parenting – focused support services in rural
regions generally, and accessible to more remote
families in particular; insufficient accessible
paediatricians (a rural issue).
- Too few permanent care placements.
- Few accessible day-stay and other parenting
programs of mid-intensity that bridge the gap
between parenting groups and PASDS.
- Few early intervention/prevention services, such as
playgroups/parenting suitable for more
marginalised families, including adolescents and
refugee families.
- Few developmentally sensitive domestic violence
intervention programs.

Many of these gaps are the focus of inter-agency and
inter-divisional planning efforts undertaken by SIPWs.

Contribution of the HRI Project to Child Protection
Results and Organisational Learning

Child Protection Results

There is some evidence of HRI impact on the larger
infant client population, despite the suggestion from
the Reviews that case outcomes are dependent on
SIPW or HRI direct involvement. CASIS descriptive
statistics comparing the two first years of the HRI
program with a baseline year suggest modest program
effects. Flaws in the data system and multiple changes
in the service system preclude a more definitive claim
for the HRI project as an agent of change. Notifications
of infant neglect appear to have shown a small steady
increase, more dramatic in the rural Regions.

Emotional abuse notifications have strongly increased
(believed to be a result of more police notifications
following domestic violence incidents). Maternal and
Child Health Nurses and hospitals showed an initial
rise in infant notifications, now steadied but still
increasing, with respect to alleged neglect. Infants have
retained their higher thresholds for intervention at
each stage of the protective process. There is some
evidence of a rise in the use of Custody to Secretary
and Interim Protection Orders for infants, replacing
Supervision Orders to a more marked extent than is
true for older children. Court outcomes for both under
twos and over twos appear similar. There appears to
be a small but clear decline in the reinvestigation
within six months of infants and 2-3 year olds.

The very small rate of deaths of infants known to
Child Protection Services has remained low, possibly
decreasing slightly, and the HRI project has provided a
vehicle for planned system response to the issues
raised by infant deaths.

Organisational Learning

The HRI project has given rich information on the
process of introducing more specialised functions into
an already specialised workforce, showing the critical
importance of management support, crossRegional
networking, preparation of the surrounding workforce,
and central resourcing. The impossibility of statewide
uniform models is clear, but the need for more cross-
Regional consistency on the ‘bottom lines’ of data
collection and relationships with external agencies has
decome evident.

The evaluation also found a number of areas where
infant protection practice is not adequately
conceptualised and then operationalised:

- The lack of a robust model for assessing parental
change—the potential for change, the substance of
claimed changes, the durability of change, and
conditions necessary to sustain change.
- Reconciling abstinence and harm minimisation
models when working to protect infants whose
parents are substance abusers.
- Differential assessment of kinds of family violence
and its implications for family change and infant
protection and well-being.
- Early intervention for the very high risk young
first-time mothers and their partners.
- Possibilities for indirect Child Protection Services
early intervention for high need indigenous
communities, with particular attention to outreach
education and support of first-time parents, by
offering resources to, and working in partnership
with, existing community leaders who can provide
positive and credible models of family life.


Recommendations

It is recommended that the High Risk Infants Service
Quality Improvement Initiatives be retained as a core
program within Child Protection Services, with each of the three major program components to continue: the
SIPWs, the Parenting Assessment and Skill Development Services, and the Flexible Budget. It is also recommended that
these initiatives be strengthened by the planned
initiatives yet to be implemented, the demonstration
projects and the PASDS assessment tool development.

Specific recommendations are presented in Section 13
of this report. They cover the following broad areas:
Regional HRI Teams

In relation to Regional HRI teams it is recommended that:

- Regional autonomy should not overshadow the focus on infant protection.
- The Head Office support structure for the HRI stream of service be strengthened.
- The HRI Manager roles in the Regions be retained and protected from encroachment.
- The funding model be reviewed in the light of apparent changes to the rural/metropolitan workload balance.
- Regions plan for SIPW succession, respecting the need for senior workers in these positions, but also the need for advanced training.
- SIPW positions be retained in discrete functional units, unencumbered by line management responsibilities.

HRI Content

In relation to delivering HRI content, it is recommended that:

- Consultation be given priority over supervisory case management.
- Priority be given to mentoring new workers and new team leaders.
- The focus be on infants with multiple risk factors requiring early intervention and protective diversion; on court contest preparation, and on infants caught in care without active progress to reunification or permanent care.
- Attention be paid to increasing and diversifying knowledge diffusion/training strategies by SIPWs.

PASDS

The PASDS will be examined in detail in the next evaluation phase. On the basis of the existing implementation data and stakeholder feedback, a number of interim recommendations are made. It is recommended that:

- Examination of the impact of the PASDS component on providers’ pre-existing service delivery and clientele be undertaken.
- Program links be made with specialist drug and alcohol, mental health and disability services.

Assessment and intervention approaches and protocols across Regions should be shared through the implementation of the planned research into the feasibility, potential benefits, and possible disadvantages of common assessment tools and intervention models.

Options for dealing with spasmodic flow of irregular referrals be reviewed, and the funding formulae in each Region be reconsidered in the light of case flow and the staffing implications of this.

The professional development needs of isolated rural providers be attended to.

The availability of support from SIPWs and HRI Managers be strengthened.

Recommendations Regarding Flexible Budget

The variable quality of data on the Flexible Budget expenditure limits the force with which these recommendations are made, but some possible future directions are indicated, and it is recommended that:

- HRI Managers review expenditures that reflect policy gaps in other parts of the service system that require policy responses.
- An even three-way distribution of Flexible Budget Funds be considered once basic operational needs are met—assessment, case plan implementation and family support, and knowledge diffusion.
- Share Learning across Regions about use of consultants is shared and consistent arrangements about consultancy, including band-width for fees for service, and attention to problem solving protocols are developed.

Recommendations for Policy and Program Consideration

The following recommendations encompass issues the program seems ready to confront at a state-wide level though there are often Regional variants and ramifications. It is recommended that:

Infant Protective Guidelines

Infant protective guidelines for use in consultation, supervision and training be distilled in relation to:

(i) Basic requirements for infant wellbeing and the threshold for protection.

(ii) Assessment and planning process.

(iii) Engagement and narratives of hope and competence.

(iv) Ethical and justice issues.

(v) The role and needs of kin.

(vi) Indigenous infant health and wellbeing in high risk families.

Court Issues

There is already work done in these areas in the Department of Human Services that needs to continue. Priorities for further attention are detailed in Section 13 of this report, which calls for a strategy plan for addressing what appear to be inherent tensions in the existing Court support arrangements. A variety of research questions, priority areas from cross-Regional information exchange, and procedural changes are suggested. There appears to be a particular need to explore the possibility of more continuity in legal representation for cases and resolution of whether market or regulatory principles are to apply in briefing barristers.

Inter-Organisational Network

Specific recommendations have been made with respect to inter-agency collaboration (see Section 13). They concern chiefly the documentation and cross-Regional sharing of existing inter-agency initiatives in pre-birth and ante-natal discharge planning; work with maternal and child health nurses; DisAbility Services—Child Protection Services working arrangements; inter-divisional planning at central and Regional levels to devise funding models for the purchase of PASDS places from Mental Health and DisAbility Services, and preparation of an options paper to initiate cross-sectoral planning for HRI/drug and alcohol service pathways that deal with both acute protection needs and longer term relapse prevention. It is recommended that the HRI project further explore how inter-agency collaboration can be extended to encompass co-working or shared action and case responsibility.

Recommendations for Further Training and Knowledge Diffusion

While there are distinct internal and external training needs, the analysis from the evaluation suggests that the HRI work is increasingly and necessarily conjoint across agency and disciplinary boundaries, and protective training would be enriched by a series of offerings that cross disciplinary and agency boundaries. Suggestions are made for training efforts within the HRI teams (including the PASDS), for the child protection workforce more generally, and across agency boundaries with other professionals, with sessions collaboratively planned and delivered for shared learning. Major themes identified for training include:

- Advanced child development modules including infant observation and assessment.
- Parental drug and alcohol issues covering both the impact and the process of change for the user.
- Assessing and working with domestic violence from the perspective of the infant.
- Inter-disciplinary work at court.
Part One—Program Description

1. Introduction to the High Risk Infants Service Quality Initiatives and the Evaluation
2. Implementation Findings: The Regional HRI Child Protection Teams
3. Implementation Findings: The Parenting Assessment and Skill Development Services
4. Implementation Findings: The HRI Flexible Budget
1. Introduction

The combination of delight, hard work and feelings of responsibility for this new, dependent being, often experienced when a baby is born, is familiar to parents throughout the community. Yet despite this ubiquitous recognition of parental strain and infant vulnerability, and their own noisy claims to attention, babies’ voices may not be heard in the busy, verbal, adult world, even in children’s protection services.

From the time that someone in the community forms a ‘reasonable belief’ that a child is in need of protection and notifies the Child Protection Services, through to the adjudication of protection matters in the Children’s Court, babies—too young to have separate legal representation—rely on the advocacy of child protection workers in this socio-legal process. These workers, therefore, need to be able to see, hear and understand the infant’s needs in context, and to moderate the impact on the baby of harmful living conditions and parenting practices. Yet much of this must be achieved through inference, prediction and experiment. Simultaneously, parents and other legitimate child advocates add their own inferences, predictions and experiments to the child protection process. This dynamic interplay defies simple procedures and clean measures of effectiveness. While the baby’s immediate safety may be achieved, his or her long term development and wellbeing will take time to unfold.

Since early 1998, the Child Protection Service of the Victorian Department of Human Services has implemented the High Risk Infants Service Quality Improvement Initiatives to help parents, child protection workers and other significant adults to hear infant voices, when to ignore them would leave the baby in danger. This evaluation report documents the implementation, experience and impact of approximately the first two years of the High Risk Infants Service Quality Initiatives.

1.1 The High Risk Infants Service Quality Improvement Initiatives

1.1.1 Program Logic

The HRI project was designed by Victorian Child Protection and Juvenile Justice Branch in response to internal and external disquiet about the relevance and quality of service to infants at high risk within both the protection service itself and the funded service system. A recurrent budget allocation of $5.6 million to this end was triggered by similar criticisms from the Victorian Auditor-General (1996) and the Victorian Child Death Review Committee (1997, Department of Human Services Information Service).

The goals of the HRI project were to produce more cautious practice with infants by enabling:
- Improved risk and need assessment.
- Better informed case decision making.
- Improved Child Protection Services performance at court.
- Inter-agency and inter-disciplinary communication and coordination.
- Service and practice innovation.

The HRI initiatives seek to strengthen the Child protection workers’ tools for observation, inference, prediction, change intervention and collaboration with parents and other stakeholders, and to enrich the service system for infants, through three main strategies:
- **Specialist Infant Protective Workers (SIPW)**
  All Regions and the Central After Hours Child Protection Services have a SIPW/HRI manager appointed at the Unit Manager level (CAFW 5 classification), and metropolitan sites and some rural sites also have additional SIPWs appointed at Team Leader level (CAFW 4). These workers are charged with implementation and oversight of the HRI initiatives in the Regional Child Protection units, through case consultation, training, external liaison and other program developments. (The implementation of the SIPW role is presented in Section 2 of this report, and its impact discussed in Sections 6-8.)

- **Parenting Assessment and Skill Development Services (PASDS)**
  All Regions received a budget allocation for community-based residential and in-home services to facilitate close and practical assessment of parental care and infant wellbeing, and to provide intensive education and support to improve parents’ skills. (An initial assessment of the shape and implementation of the PASDS component will be presented in Section 3 of this report, to be developed further in a subsequent evaluation report.)
A Flexible Budget:

A flexible budget including brokerage to help tailor assessments and interventions, and monies for operational expenses. (The uses of the Flexible Budget are discussed in Section 4 of this report.)

In addition, the HRI project was to implement Koori and other Demonstration Projects in selected Regions, and these still await implementation. These reports and demonstration projects are not the concern of this Evaluation Report.

This program logic or conceptualisation is largely ability to avoid, deflect, understand or counter physical or verbal assault, and the danger of enduring physical and emotional, all of which rest heavily on the actions of continuous nurturing adults. Neglect is believed to arise from parental distraction or withdrawal from the child, perhaps as a result of depression, substance abuse, or the distractions of relationship or socio-economic stress, or it may relate to immaturity and/or unskilled or insensitive parenting skills. Both abuse and neglect may be moderated or exacerbated by the availability or lack of availability of supportive adults (lay or professional) who can exercise both support of the family and the child and a degree of social control or norm setting. Intrusive, incompetent, or unresponsive community services may exacerbate risk.

Figure 1: Program Logic in Summary

<table>
<thead>
<tr>
<th>QUALITY IMPROVEMENT GOAL</th>
<th>OUTCOME STATEMENT</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved risk and need assessment.</td>
<td>Unsafe parenting practices are identified and targeted for change.</td>
<td>Risk assessment in high risk infant cases has been deficient or unavailable.</td>
</tr>
<tr>
<td>Better informed case decision making.</td>
<td>Risk is removed from the baby, or the baby is removed from the risk, knowing and in a timely manner.</td>
<td>Case decision making in high risk infant cases has been fragmented and poorly informed.</td>
</tr>
<tr>
<td>Improved Child Protection Services performance at Court.</td>
<td>Court decisions secure infants' safety and long term status.</td>
<td>High risk infant cases have achieved the desired protective outcomes less than, or only as well as, other cases.</td>
</tr>
<tr>
<td>Inter-agency and inter-disciplinary communication and coordination.</td>
<td>Agencies and professionals work together to improve parenting practices, conditions and infant safety.</td>
<td>Poorly coordinated professional interventions have disadvantaged infants and placed them at risk.</td>
</tr>
<tr>
<td>Service and practice innovation.</td>
<td>Practices and services are vigilant, responsive, appropriate, timely, useable and energising.</td>
<td>Existing practice technologies and service systems miss the needs of some infants and families and may exacerbate risk.</td>
</tr>
</tbody>
</table>

This program logic or conceptualisation is largely organisational in content—it looks to program improvement. The substantive arguments about what makes children safer and families more capable, or the even broader discourses around culture and social structures, are to date reflected primarily in the commissioned literature review, in the chosen input for the SIPW training program, and in emerging practice and policy dilemmas.

1.1.2 High Risk Infants in the Child Protection Services System

While the HRI project is organisational in emphasis, it is built on a set of common understandings about infant risk and child protection, many of which are documented in the commissioned HRI Literature Review (Jackson et al., 1999). The evaluation team’s initial understanding of common relevant themes drawn from the copious child protection literature and body of practice wisdom are summarised here to show the conceptual set the team brought to the evaluation.

Infants are regarded as being at particular risk of physical and developmental harm because of their extreme dependence, physical vulnerability and developmental sensitivity. For families, having dependent infants is a time of high stress in the family life-cycle, for reasons connected with maternal health and wellbeing, socio-economic changes, and changes to the family’s social integration. Physical, economic, emotional and social resources may be depleted, leading to parental frustration, withdrawal and conflict. Infancy is also a time of relative ‘ invisibility’ of the child, who is not yet ‘in the public eye’ in kindergarten, school, peer activities and so on. These stresses may devolve into either abusive or neglectful behaviour toward the infant.

It is commonly believed that child abuse tends to be associated with low frustration tolerance and problems with anger management and impulse control, by either parents or their partners. These problems may be associated with other stressors arising in the socio-economic circumstances, the partners’ relationship, or in a parental condition, such as intellectual disability or substance abuse. Abuse may also be associated with delusional or distorted thoughts as a result of mental illness or substance abuse. Abuse may range from a single episode to a pattern of behaviour over time. Infants are particularly vulnerable to harm from abuse because of their inability to avoid, deflect, understand or counter physical or verbal assault, and the danger of enduring physical and developmental consequences. Their early stage of personality formation and lack of concepts and verbal skills makes them unable to counter inappropriate projections and attributions.

Neglect may also be episodic (especially if associated with an episodic parental mental illness or substance use relapse), but tends to be more pervasive. Neglect is considered to be particularly insidious for infants because of their shorter time frames when survival is threatened, and because of their fast-moving developmental imperatives, physical, cognitive and emotional, all of which rest heavily on the actions of continuous nurturing adults. Neglect is believed to arise from parental distraction or withdrawal from the child, perhaps as a result of depression, substance abuse, or the distractions of relationship or socio-economic stress, or it may relate to immaturity and/or underdeveloped knowledge and skill in parenting.

Both abuse and neglect may be moderated or exacerbated by the availability or lack of availability of supportive adults (lay or professional) who can exercise both support of the family and the child and a degree of social control or norm setting. Intrusive, incompetent, or unresponsive community services may exacerbate risk.

Thus the risk of abuse and neglect is comprised of (at least):

- Infant factors
- Parental factors
- Parent-infant dyad factors (including the meanings of the child to the parent)
- Couple and household factors
- Extended family and network factors
- Community factors
- Socio-economic factors
- Service system factors

While neglect and abuse are different in dynamics, causes, trajectories and the responses needed, the harms to the infant may be the same in some cases, such as:

- Physical:
  - Fractures
  - Soft tissue damage including brain injury, burns, nappy rash, and so on
  - Malnutrition (both obesity and wasting)
  - Chemical ingestion
  - Untreated medical conditions, infections, sores.
Developmental:
• Language delay
• Attachment disruptions
• Fear responses, inhibited exploration
• Indiscriminate exploration.

Assessment is therefore seen to involve attention to hazards or risk factors, to actual harms experienced by the child, and to protective factors, if there is to be some estimate of risk—the likelihood of actual or further harm and/or poor developmental consequences.

It is evident, therefore, that when an infant comes to the attention of the Child Protection Service system, the services need the capacity to:
• Assess which of these constellations of stressors/resources/relationships applies.
• Assess how well the family is able to use the natural helping and service systems, and how well these systems are responding.
• Ensure that an adequate balance of social support and social control is in place.

This will require appropriate knowledge, skill and resources relating to:
• Intake/screening/risk assessment.
• Needs assessment and case planning.
• Inter-agency negotiation.
• Engagement with troubled families.
• Tangible resources for assisting families to resolve complex problems.

It is these issues that inform the evaluation process, just as they have informed the construction of the High Risk Infant Initiative. The processes of data gathering and analysis will inevitably be grounded in consideration of specific infant vulnerabilities, family conditions, workers’ practice frameworks and service system operations.

Gough’s (1993) review of the research literature on child abuse interventions found: ‘‘The argument for intervention in the neonatal period is clear; this is a sensitive period in the development of relationships between the parents and the child’’ (1993:7). He found many interventions based on concepts of social support, and pointed to the need for more explicit theoretical bases for interventions, noting that it appeared from the research reviewed that it was ‘‘dangerous to rely on parental measures and parental assessments of children’s progress’’ (1999:92). The HRI program addresses this by focusing on assessment of the infant as a key part of the protective process, seeking to move away from a very adult-centred approach. However, the links between program performance and client outcomes are still not well-understood in this field, as the Dartington summary of child protection research in the UK (Bullock et al., 1995) and Gough (1993) pointed out. The linkages are too complex and variable for their findings to have become significantly dated.

1.2 Method
1.2.1 Evaluation Brief and Context
This evaluation has been undertaken by The University of Melbourne School of Social Work (through the Children, Young Persons and Families Research Unit) in conjunction with Women’s and Children’s Health, through the Royal Children’s Hospital/University of Melbourne Social Work Practice Research Unit. The evaluation team was asked to examine the HRI project in terms of its:
• Implementation.
• Consolidation.
• Impact.
• Contribution to Child Protection Services results.

Such evaluation in child protection services is a daunting affair. In his review of research into routine child protection services, Gough noted that there was little information on the efficacy of routine child protection. It is difficult to undertake such studies because effects may only reveal themselves in the long term, yet research has to contend with considerable numbers of intervening variables, including variation in case types and interactions with treatment modalities. These effects may become masked in the soup of variables that must be taken into account. (1993:210)

In the HRI evaluation, this ‘‘soup of variables’’ at case level is compounded by additional ingredients at the organisational and inter-organisational levels. These include Regional and sub-Regional cultures, staffing, structural rearrangements and service system arrangements; and variable staffing qualifications, experience and turnover rates. In addition, the period under review has seen the parallel introduction of other quality improvement initiatives such as:
• The Victorian Risk Framework (VRF), a staged child protection risk assessment tool implemented across all Regions for clients of all age groups.
• The Enhanced Client Outcomes (ECO) approach to child protection investigation, involving more collaborative practice between child protection workers, staff of other agencies and parents.
• Working Together, an exercise in collaboration across fields of practice (not at this stage focused on infants).
• Strengthening Families, a new case management and service option for families, including those with infants notified to Child Protection Services.
• The High Risk Adolescents initiative, another age-specific service enhancement approach.

All of these might be expected to have affected Regional practices in the core areas of risk assessment, case planning, family engagement, and inter-agency collaboration targeted by the HRI project, hence potentially clouding program effects. In addition, the field was at the same time deeply affected by Compulsory Competitive Tendering, the Youth and Family Services Redevelopment, and their arrest and change of direction with a change of government.

Gough recommended that “Further research should elaborate the nature of child protection, the content and efficacy of routine work, and the potential for implementing the techniques developed by special programs” (1993:12). With these findings and recommendations in mind, this evaluation report attempts to chart the course of the HRI Initiatives with sufficient detail to enable readers to pick and choose implications for different settings.

1.2.2 Approach to Inquiry
The evaluation team adopted the following research approach:
• A practice-research model: involving key stakeholders in an exchange of information and interpretation. (Noted program evaluator Irwin Epstein has referred to this as ‘‘research in rather than on practice’’.)
## Fig. 2 cont.

### Agreed Program Performance Measures

<table>
<thead>
<tr>
<th>Outcomes Hierarchy</th>
<th>Success Criteria</th>
<th>Relevant HRI Components</th>
<th>Extraneous Variables</th>
<th>&quot;Bottom Line&quot; Performance</th>
<th>Illuminative Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key workers are</td>
<td>We use HRI information to inform practice.</td>
<td>SIPWs, PASDS, literature review, Budget.</td>
<td>PS staffing and</td>
<td>Improved audit scores on all domains.</td>
<td>Positive child protection worker team leader and management reports.</td>
</tr>
<tr>
<td>confident and</td>
<td></td>
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<td>operational conditions</td>
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<td>skilled in</td>
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<td>innovative practice</td>
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<td>SIPWs are skilled</td>
<td>SIPWs attend training: PIR, routine training, PIR, ex ante training, training roles.</td>
<td></td>
<td></td>
<td>Exemplary case studies; SIPW interviews.</td>
<td>Positive CP staff reports; case studies.</td>
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<td>and confident in</td>
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<td>role</td>
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<tr>
<td>Effective models of use</td>
<td>Utilisation procedures implemented.</td>
<td>SIPWs, PASDS, Budget.</td>
<td>Competing service system priorities</td>
<td>Service referral and utilisation data.</td>
<td>Positive stakeholder reports; case studies.</td>
</tr>
<tr>
<td>of SIPW and PASDS</td>
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<tr>
<td>SIPWs, PASDS</td>
<td>SIPWs, PASDS, Budget.</td>
<td>Prior service system</td>
<td></td>
<td>Staff appointment and program continuity</td>
<td>Key worker interviews and documents.</td>
</tr>
<tr>
<td>appointed, supported</td>
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<td>dynamics.</td>
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<tr>
<td>SIPWs, PASDS</td>
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<td>appointed and retained</td>
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<tr>
<td>SIPWs, PASDS, Budget.</td>
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<tr>
<td>SIPWs</td>
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<tr>
<td>PASDS Models and Implementation</td>
<td>6. Examination of PASDS planning and operational documents and telephone interviews with key staff in PASDS implementation (see section 3).</td>
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</tbody>
</table>

### 1.2.3 Evaluation Activities

The evaluation team undertook a series of structured activities to gather relevant information, in a loose sequence, as follows.

#### Orientation

1. Examination of program and related contextual documents.
2. Early consultation with informants within the Child Protection Services practice standards in infant cases prior to the HRI project (see section 5).
3. Initial Regional orientation visits to senior Regional staff and HRI managers.

#### SIPW Role Analysis

4. Analysis of existing SIPW records of time expenditure, and collection and analysis of further SIPW activity and liaison data over three separate time periods each of two weeks, in May 1999, August 1999 and February 2000 (see Appendix 1 for data collection form). This material is presented in Section 2.
5. Structured data collection in a forum of SIPWs managers and another of all SIPWs (see Appendix 2 or frameworks) and further discussions in other HRI meetings.

#### Case File Reviews—HRI Impact on Records of Practice:

6. Examination of existing baseline data about adherence to Child Protection Services practice standards in infant cases prior to the HRI project (see section 5). The first of these reviewed 158 cases, sampled to represent the distribution of infant cases across the Regions, and to represent a mix of phases and levels of protective intervention and a mix of infant ages (see Appendix 3 for the list of CFR 1999 questions). The second CFR examined, in a modified form, those cases from the first review that had been open for at least the next six months (71 cases), with a view to considering longer term case planning and resolution issues (see Appendix 4 for the 2000 CFR format), and comparative analyses across these three review periods.

### Impact of the HRI Initiatives—Instrumental Outcomes

**Major program goals addressed:** decision making, Court outcomes, collaboration

- **Development of innovative models of practice.**
  - New forms of Child Protection Services & procedures.
  - Flexible budget; PASDS & PASDS research; administration projects.
  - Competing service system priorities.
  - Expenditure & utilisation data show new resources and new options.
  - Stakeholders describe innovations; exemplary case practice studies.

- **Improved information for decision making reports.**
  - All.
  - Alternative frameworks.
  - Improved audit scores.
  - KPI 90 day resolution.
  - Continuity of care in long-term cases at second audit.
  - Increased accessibility.
  - Increased effectiveness.

- **Better adherence to standards.**
  - SIPWs.
  - SIPWs, PASDS, Budget.
  - Exemplary case practice studies; Team Leader and CP worker reports.

- **High client satisfaction (PASDS).**
  - Parents identify skill.
  - Improvement or increased infant safety; approval of methods.
  - PASDS.
  - Competing pressures on and services to clients.
  - % satisfaction responses on PASDS sample client interviews.
  - Child protection worker and other stakeholder reports.

### Implementation and Consolidation of the HRI Initiatives—Immediate Impact

**Major program goals addressed:** assessment, collaboration

- **SIPWs & PASDS actively influence the field.**
  - HRI materials embedded in Child Protection.
  - Services procedures and accessible to child protection workers.
  - SIPWs, PASDS, Budget.
  - Competing service system priorities; staffing stability.
  - Amount of training initiated and given.
  - Exemplary case practice studies; Team Leader and CP worker reports.
  - Embedded HRI guidelines; child protection worker reports.

- **SIPWs & PASDS Models and Implementation.**
  - SIPWs, PASDS, Budget.
  - Performance Indicators.

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The evaluation has been enriched by multiple data sources and types, a wide basis of consultation, continuous dialogue, and the opportunity for continuing dialogue with the Head Office program advisory staff and reference group members, and the participation of the Regional HRI and other child protection staff members has kept it connected to the realities of the field.

Inevitably, the evaluation has limitations. Most importantly, the picture painted in this report lacks the views of the parents whose family lives have been touched by these initiatives. This will be in part redressed in the next phase of the PASDS evaluation. The evaluation team’s late entry to the PASDS component of the research means that section 3 is still primarily descriptive and may not provide an exhaustive account of model variations. In addition, Regional arrangements of HRI team structures and activities (section 2) are shifting sands, and as soon as an account is committed to paper it tends to become inaccurate. Attempts have been made to cover as many variants of SIPW arrangements as possible. Consultations within Regions have attempted to be strategic but there has been an element of the opportunistic. Child protection workers have many competing demands and have to give case issues priority, and they have not always been able to meet as agreed. This means that there has been non-consistent flow through statistics, court results and orders, and reinvestigations within six months.

1.3 Organisation of the Report

This report is in three parts, reflecting the brief to the evaluation team:

Part One: Program Description

Part One comprises this Introduction (section 1), Implementation Findings, an analysis of implementation issues in relation to the SIPW positions (section 2), the PASDS (section 3), and the HRI Flexible Budget (section 4).

Part Two: Impact Findings

Part Two comprises an introduction to the baseline information against which impact has been measured and the methods for gathering impact information (section 5). It presents the findings with respect to program impact on risk and need assessment and case planning and decision making, with some comments on issues of direct practice with families (section 6). Section 7 examines court issues and the apparent impact of the HRI initiatives on court outcomes for infants while Section 8 explores other inter-disciplinary and inter-agency relationships. Section 9 presents information arising over the course of the evaluation relating to indigenous infants.
2. Implementation Findings: the Regional High Risk Infant Teams

2.1 Introduction: Core SIPW Roles

The core roles envisaged for the SIPW positions at the commencement of the program were:

- Consultation to child protection staff, focused on assessment and case management of high risk infants.
- Assistance with obtaining specialist assessments and relevant services.
- Participation in case conferences as required.
- Liaison with community agencies to enhance communication and coordination.
- Participation in conferences as required.
- Assistance with the preparation of reports and evidence for court, or by assuming case management as required.
- Monitoring practice (see Appendix 10 for sample duty statement).

The SIPW initiative was, however, an ‘experiment’, conceived as action research given that there was uncertainty about the place of specialists within child protection services. Over the course of the program, it has become clear that SIPWs attempt to cover a full range of case consultation functions, picking up cases at any stage from the earliest point of contact with Child Protection Services, through to vetting closure decisions, and reversing these case closure plans if necessary. While these internal consultations with child protection workers are the mainstay of their work, they occur in the context of wider case-related and programmatic consultations and joint work with other professionals within and outside Child Protection Services. This wide range of activities has been a result of SIPWs’ experimentation with the role.

Key outcomes for SIPWs required at the implementation and consolidation phases of the program were:

- SIPWs appointed supported:-
  - Effective models of use of SIPW.
  - SIPWs are skilled and confident in role.
  - SIPWs actively influence the field.
  - Key workers are confident and skilled in cautious practice.

The SIPWs’ influence on the field and their impact on the practice of other child protection workers will be discussed later in this report with respect to the core goals of the program (for example, enhanced risk management and better court outcomes). In this section, we explore how the roles were structured and linked into child protection services, how they have been enacted, and issues in their development.

2.2 Implementation of the SIPW Positions and Roles

2.2.1 Appointments

As previous reports have indicated, there were, in most instances, appointments made of appropriately qualified and experienced people to both the CAFW 4 and CAFW 5 level SIPW positions across the Regions and the After Hours Service (Appendix 11). Most had social work, psychology or welfare studies qualifications, and all had substantial experience as Department of Human Services child protection workers and team leaders or managers, or as workers in relevant settings locally or interstate. Despite some debate in some Regions initially, with some senior staff suggesting that appointment of SIPWs at CAFW 4 and 5 (the equivalent of team leader and unit manager levels respectively) might be excessively high, the level of appointment appears to have been appropriate. For CAFW 4 level positions, for example, the Department of Human Services Labour Market Analysis (Hay Group, 1998: 54-56) nominated the following key job outcomes.

Examples from the routine SIPW job performances (derived from Regional consultations and SIPW activity data sheets) demonstrate their applicability:

- Managing conflict of opinion-challenging information put forward by workers or other sources.
  - SIPWs conduct file audits and initiate resolution of case scenarios that have been poorly handled, bringing in new information to challenge poor practice (for example, cases allowed to drift in care without action to resolve permanency planning).
- Managing priorities—juggling degree of risk to clients (resource management).
  - SIPWs assist workers to take appropriate risks to test parenting capacity at home while building in safeguards and monitoring observations of effects (for example, combining use of PASDS, experts via flexible budget, and child protection worker contact plan for graduated and tailored supervisory regime).
• Implementing creative solutions and decisions, where there is no precedent. SIPWs devise innovative packages of care and intervention to maximise both the opportunity for parents to demonstrate their capacity, and the information for future planning should these opportunities not be realised (for example, for parents with multiple risk factors, including intellectual disability).

• Ensuring time critical action. SIPWs act on the developmental imperatives of infants, ensuring the best service response to neonates at risk (for example, outreach discharge planning to local maternity hospitals for high-risk cases).

• Caring for the worker—emotional and physical wellbeing. SIPWs provide case-specific supervision about the impact of infant work, and undertake joint visits where necessary to assist workers to defuse explosive situations.

• Keeper of the continuity from the client perspective. SIPWs manage the transition of infant cases across phases, teams and dispositions, ensuring the flow of developmentally appropriate information (for example, tracking a case through multiple court appearances and securing consistent legal representation).

• Ensuring quality involvement with the family—matching intervention to need. SIPWs educate workers in infants’ developmental needs and rehearse (or model on joint home visits) ways of interpreting these needs to parents and securing their cooperation in a case plan to have those needs met.

• Contributing to and maintaining a body of professional knowledge. SIPWs compile, maintain and update resource materials (hard and electronic), assist workers to apply concepts from the body of knowledge to specific cases, undertake their own professional development (both through the Department and independently) and present material in training and conferences.

• Formulating independent client assessments and identification of client needs. SIPWs review workers’ assessments and direct additional work to strengthen and validate those assessments, sometimes engaging with the family and the worker to jointly complete these tasks.

• Consistently and accurately recording information. SIPWs routinely record the results of consultations on CASIS, or review and endorse the records made by consultees.

• Using an appreciation of organisational dynamics to affect change or create opportunities for self and others. SIPWs identify training needs and contribute to planning to meet these; devise a range of strategies to overcome structural, relational or personal impediments to use of the HRI program; use information strategically to compensate for blockages to improved HRI practice.

SIPWs devise innovative packages of care and intervention to maximise both the opportunity for parents to demonstrate their capacity, and the information for future planning should these opportunities not be realised (for example, for parents with multiple risk factors, including intellectual disability).

Most Regions appointed their SIPWs in March–April 1998. Southern Metropolitan Region had begun to prepare for the initiatives in late 1997, and the latest initial Regional appointment to come on stream was in Gippsland in June 1998. Barwon South West’s SIPW manager, while appointed in April 1998 to the then Youth and Family Services Division to begin the HRI implementation, did not move into the Child Protection Services structure until December 1998. For this reason, evidence of program impact on protective practices might be expected to appear a little later for both Gippsland and Barwon South West.

2.2.2 Structural and Operational Arrangements

Each Region was allocated funds on the basis of one full-time SIPW augmented according to the Protection and Placement Equity formula, with some notional agreements with the Child Protection and Juvenile Justice Branch at Head Office about how these funds would be deployed. The need for CAPW 5 and 4 appointments was stressed, and expectations set about the nature of the roles. A prototype job description was made available. Nevertheless, Regional managers were free to modify these proposed arrangements as necessary to fit with Regional characteristics and needs, provided that the key case consultation and monitoring functions were implemented. Some ‘topped up’ the monies to ensure whole positions could be created or wider coverage ensured; others linked the SIPWs to existing or emergent Regional structures (such as the Infant Unit in the western suburbs, or the court support position in the north).

Rural Regions with small additional amounts that could not sustain whole positions or a reasonable fractional position (0.5) (Hume, Gippsland) appear to have used this money to supplement existing roles (intake in Gippsland, project support in Hume) with the intention of focusing this supplementary work on infants. It has proven difficult to retain this infant focus in such part-time mainstreamed arrangements.

The basic initial structural arrangements are outlined in Figures 3 and 4 below:

**Figure 3: Rural Initial Arrangements**

<table>
<thead>
<tr>
<th>Region/Site</th>
<th>Initial HRI SIPW Allocation</th>
<th>Regional HRI SIPW Establishment at Inception</th>
<th>SIPW Manager Accountable to</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South-West</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>YFS Manager</td>
<td>Geelong</td>
</tr>
<tr>
<td></td>
<td>0.5 CAPW4</td>
<td>0.5 CAPW4</td>
<td>Than Child Protection</td>
<td>Warrnambool</td>
</tr>
<tr>
<td>Gippsland</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>CPS Manager</td>
<td>Bairnsdale base—sessions</td>
</tr>
<tr>
<td></td>
<td>0.3 CAPW4</td>
<td>0.3 CAPW4 (augmenting intake – non-specialist)</td>
<td></td>
<td>0.3 at Morwell—intake</td>
</tr>
<tr>
<td>Gippsland</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>Child Protection Manager</td>
<td>Ballarat base—sessions</td>
</tr>
<tr>
<td>Hume</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>Child Protection Manager</td>
<td>Warrangatta base—sessions</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>Child Protection Services Manager</td>
<td>Wodonga— Mildura and Swan Hill sessions</td>
</tr>
<tr>
<td></td>
<td>0.4 CAPW4</td>
<td>0.4 CAPW4 (duties backfilled FT CAPW 4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 4: Metropolitan Initial Arrangements**

<table>
<thead>
<tr>
<th>Region/Site</th>
<th>Initial HRI SIPW Allocation</th>
<th>Regional HRI SIPW Establishment at Inception</th>
<th>SIPW Manager Accountable to</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours</td>
<td>FT CAPW5</td>
<td>G.5 CAPW5</td>
<td>AHS Manager</td>
<td>AHS—undisclosed</td>
</tr>
<tr>
<td>Eastern Metropolitan Region (EMR)</td>
<td>FT CAPW5</td>
<td>G.6 CAPW5</td>
<td>Child Protection Manager</td>
<td>Box Hill</td>
</tr>
<tr>
<td></td>
<td>CAPW4 x 1.5</td>
<td>G.6 CAPW4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FT CAPW4 x 2</td>
<td>Access worker</td>
<td></td>
</tr>
<tr>
<td>Northern Metropolitan Region (NMR)</td>
<td>FT CAPW5</td>
<td>FT CAPW5</td>
<td>Senior Projects Manager</td>
<td>Preston</td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>G.6 CAPW4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FT CAPW4 (assistance Court officer 0.3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Over time there were other structural modifications to this, chief among these being:

- **Western Metropolitan Region—WMR**—integration of the Unit manager and HRI manager roles into one CAFW 5 position, in charge of the Infant and Sibling Unit, and the addition of a CAFW 4 position. Later, the Unit manager and HRI manager roles were disaggregated when the incumbent moved on to another post in the Region.

- **Northern Metropolitan Region SMR, Barwon-South West, Grampians—supplementation of the HRI teams with CAFW 3 positions (Advanced Infant Caseworkers, carrying small high risk infant caseloads and assisting with SIPW duties, such as being a mentor for other workers).**

- **Northern Metropolitan Region NMR, Loddon Mallee, Grampians, SMR, Gippsland—allocation of additional duties to the CAFW 5 on a continuing or temporary basis, for example, management of intake and response, sub-office management, court unit management.**

Most HRI managers were then, and remained, directly accountable to their Child Protection Services manager, and thus were part of the Regional child protection management team. At times, however, the larger metropolitan Regions have had the HRI manager reporting to a Projects manager, in view of the Child Protection Services managers’ wide span of control. HRI managers are of equal rank to unit managers with case planning responsibility (for example, in Response or Long term teams), and they carry the brief to influence practice according to some clear goals. Nevertheless, some found that the lack of clear delegation of responsibility for a designated caseload restricted full connections with the external professional community, building a community base for the later benefit of the child protection teams.

Similarly, the SIPWs at CAFW 4 level found themselves to be equal to the team leaders in rank but not in day-to-day influence, and this was at the heart of many of their early struggles with the role, discussed below. Partly in response to this tension, one structural modification that has waxed and waned in different Regions at different times has been to allocate infant cases for a short or long period to the HRI teams. This gives supervisory responsibility to the SIPWs and case planning responsibility to the HRI managers. The protective casework may be provided by child protection workers either ‘on loan’ from other teams for those cases only, or assigned to the HRI teams as advanced infant caseworkers.

Such structural arrangements reflect the deeply hierarchical nature of the host organisation and the delegation of case and supervisory responsibilities as the main currency of exchange for status and recognition. These arrangements signal that the HRI teams are ‘real’ units, and they may (occasionally to a significant degree) divert workload from other overburdened teams at times of resource scarcity. This usage was not intended under the initial program guidelines. The limited budget information available to the HRI evaluation team does not allow it to determine whether the line had been crossed between legitimate integration of HRI resources with operational structures and using designated HRI resources to compensate for other shortfalls.

### 2.2.3 Evolution of the Core Attributes of the SIPW Component across Regions

The program has been fluid in its development, with structural arrangements, staff members and functional emphases shifting from time to time. Figures 5 and 6 summarise some of the major features that have evolved over the two years to June 2000.
2.2.4 Managerial and Peer Support for the HRI Initiatives

The support given to these roles has varied across sites and times. Some Regional management groups embraced the program—they appointed workers with instantly recognised credibility and gave clear direction to staff that this was a valued area. They ensured that the budget was protected, added resources if necessary, and quickly assisted with the definition of initial priorities. HRI managers were given a significant role in the development of PASDS arrangements. Some Regions, especially rural, were ambivalent about the introduction of specialist high level positions. Others (fewer) appear to have been less clear as to the best use and pitch of the service, and gave the program staff less systematic public endorsement and credibility, leaving the staff to make good the policy and managerial gaps in a ‘sink or swim’ manner. Subsequently, SIPWs have engaged the interest of higher level managers when opportunities have arisen, such as a contentious case or policy matter that taps the wider boundary-spanning responsibilities of more senior managers. Despite these Regional differences, which meant that some HRI teams had smoother implementation processes than others, all SIPWs have had to create a role for nothing, to a very large degree winning the respect, credibility and support of peers and more junior staff by their own efforts.

It was clear in the course of the evaluation that scepticism about the SIPWs was initially quite common, and that at first SIPWs were often seen by their peers as ‘overnight experts’, and resented a little for the ‘luxury’ of time to focus on particular issues. Other team leaders and unit managers felt their own need was for more time and team members, not another external watchdog. Some Regional senior staff members were worried that their own ability to coordinate, manage and plan for the cases and workers in their units would be compromised by demands from the SIPWs. In several Regions, there was a strong belief that there were core protective skills that did not require specialisation by age, given adequate time for workers to do the appropriate research and networking. There was also concern that over-specialisation would limit career options for workers.

In the implementation phase of the program, SIPWs sought to overcome scepticism and establish the role in a variety of ways, such as:

- Establishing protocols for referring cases for consultation through the existing team leaders.
- Consulting jointly with the worker and their team leader.
- Recording the outcomes of consultations on CASIS.
- Privately communicating worker or practice-related concerns to the team leader or unit manager in person or via email, rather than through the client record.
- In larger teams, devising rosters to ensure availability or allocating SIPWs to particular units.
- Accepting both formal and informal consultation requests.
- In the early stages, ‘pitching in’ to help at times of overload with tasks outside their roles to help dispel the image of ‘preciousness’.
- ‘Working around’ pockets of resistance, by concentrating first on building good working relationships with receptive colleagues.
- Monitoring/auditing infant cases and using the issues thrown up in these audits to open dialogue with unit managers and team leaders.
- Getting on with a variety of consultation, education and resourcing strategies (discussed below.)
- Adding value to simple requests for brokerage by linking these with educational material and the larger case plan.
- Facilitating community referrals and access to limited external resources.
- Assisting workers with their felt needs—often preparation for difficult court cases involving likelihood arguments, or home visits to resistant and potentially aggressive parents.
- Modifying structures, processes and strategies in response to requests and difficulties.
- At critical times, involving Regional management to lend power to efforts to renegotiate structural and procedural links with other units.

After two years of the program the scepticism at operational level has largely dissipated. While some structural and communication problems recur from time to time, and the search for a good fit continues, there appears to be widespread acceptance of the SIPW role. Their ability to focus on the needs of infants, their capacity to gain access to critical information and resources, and their exposure to a wide range of infants give them great value as advisors to workers and other senior staff. Somewhat paradoxically, as this ground level acceptance has grown Regional management has been more likely to deplete or borrow staff time (especially the HRI manager positions) for other duties.

2.2.5 Consolidation and Worker Turnover

At June 2000, over two years from establishment of the initiatives, four rural Regions (Barwon SW, Loddon Mallee, Gippsland and Hume) and the After Hours Service still had their initial HRI managers, despite some incursions into their time in some instances. Of the others, two had SIPWs succeed to the HRI manager role after the loss of the CAFW5 (WMR and EMR), and three (NMR, Grampians and SMR) appointed new HRI managers from outside the SIPW pool after approximately two years. Since WMR, at an early stage, had two SIPWs at CAFW 5 (one part-time) splitting the HRI manager duties, they effectively moved on to a third HRI (short term manager) in the metropolitan Regions the turnover seems to be a function of time in the job and the attraction of more mainstream career challenges elsewhere, although there were also reports of exhaustion from the challenges of program implementation in volatile and sometimes challenging settings.

At CAFW 4 level there have been a number of staff changes, including:

- Early departures of SIPWs who did not fully engage with the role (two metropolitan Regions).
- Later departures of staff in part through disenchantment with the role (one rural and one metropolitan Region).
- Normal staff movement for personal and career reasons (four metropolitan Regions).
- Promotion to HRI manager (two Regions).
- Incoming staff because of the creation of new program positions or partial assignment to the program, including some at CAFW 3 level (AHS and two rural and one metropolitan Region).

Where movement has been a result of structural movements in Regional arrangements (Grampians, WMR, After Hours) in efforts to achieve greater coverage, it is a little difficult to distinguish ‘turnover’ from diffusion of roles and responsibilities. (The evaluation team has not systematically interviewed SIPWs who have left the program.)

While the situation has been fluid and occasionally appointments have been so fleeting as to barely warrant counting, in all, over two and a half years there appear to have been 13 departures from the HRI project out of 34 appointments. This appears to be a higher rate of turnover than is usually recorded for staff at this level (reputedly 4-5 years), but this is probably misleading in that, as far as the evaluation team is aware, only two of the departing staff have left child protection services.

The particular meaning and implications of turnover need to be addressed on a Region by Region basis. It is clear, however, that the SIPW role, while rewarding, is a complex and challenging role requiring considerable initiative and assertiveness, because of its recent invention, its location outside the main hierarchy, its ‘high risk’ focus, and the breadth of the functions. When asked ‘What is a SIPW?’ after almost two years of program operation, the group replied:

Lead, accountant, knowledge fount/disseminator, pragmatist, mediator, visionary, motivator, self-regulator, monitor, accountable, administrator, number-cruncher, consultant, trouble-shooter, reviewer, sounding board, educator, facilitator, balance worker/team leader, community contact for program, ‘meetings bloody meetings’, exhausting.

The tensions were well captured by the following comments:

‘The project is practice enhancement: it has no beginning, no end’
‘If there is no end, there is no end to the potential, there is no end to the boundaries’.

Inevitably it takes time for new appointees to build their own confidence and facility as SIPWs. The SIPWs at both levels who have been present for most of the program (16 people) have a firm command of the role, while experimenting with different ideas. The blend of
confidence, experience and accumulated infant knowledge is reflected in the positive evaluations they tend to receive from staff. Among the newer appointees are some SIPWs with excellent training and experience who are poised to also develop this credibility and who are well placed to assist with the next stage of program development.

At first glance it might seem that the major factor in rural continuities is the relative lack of alternative attractive job opportunities, which may be true, in part. Nevertheless, SIPWs in the rural Regions also discuss the relative dearth of community services and the greater sense of legitimacy for the service and community development roles of rural SIPWs. These factors appear to give these positions some more sustainable intrinsic attractions. The great threat to the rural positions is the sheer problem of distance, leading to heavy but dispersed workloads, extensive travel demands, and the difficulty of personally relating to several very self-contained work sites with very different issues, demands, staffing patterns and cultures (see below).

### 2.3 The Role Enacted: SIPW Activity and Liaison

#### 2.3.1 Whole HRI Teams

One way of considering how SIPWs are used within the Regions is to examine how they spend their time and whether the patterns of activity differ from Region to Region. More specific aspects of the SIPW inputs will also be presented later in relation to the core program goals, however, a broad overview is given here.

As noted in the Method section above, SIPWs returned detailed data sheets accounting for their activities and the persons with whom they consulted (organised into categories) over three ‘snapshot’ periods of two weeks in each of May 1999, August 1999 and February 2000. Below we consider these patterns of data for the HRI teams as a whole, then the distinctions between CAFW 5 and between rural and urban programs.

Since a higher proportion of metropolitan than rural workers returned the August data, that period is more skewed toward a metropolitan profile, making the May 1999 and February 2000 figures the most useful comparison for statewide trend data. Even so, these can only be treated as indicative given the problems of reliability and interpretation. For example, staff turnover means that, even within Regions, the forms may not have been completed with the same mental sets informing how activities were coded.

Table 1 below suggests slightly greater discrepancies between the May-August figures than between the August-February figures on most items. This is partly attributable to the metropolitan distortion arising in August, partly suggestive of program maturaition, and partly attributable to the wide variance within items between Regions in the first data collection period, when staff of two Regions tended to concentrate their data in fewer categories.

This profile suggests that case consultation was, in each period, the most time consuming of these activities for the teams in each site (with both CAFW 5 and CAFW 4 data included), followed by case monitoring/auditing. As case file audits are a major tool of the After Hours SIPWs, their results on this item may skew the statewide picture a little in this direction. Slight rises in ‘other Regional duties’ and ‘case conferencing/planning’ are also indicated.

These seem relatively firm trends despite the evident substantial variations between Regions as indicated in the ‘State highest’ figures, and this view is supported by the feedback from Regional staff throughout the evaluation period. Consultation was a clear priority for all CAFW 4 SIPWs, the core of their role, and a major commitment of lone SIPW managers. For HRI managers with other SIPWs in their team, case consultation was an important but more fluctuating activity. When time allocation to consultation is compared with the instances or episodes of consultation, there appears to be a trend toward fewer but longer consultations (see Appendix 12, tables 1 and 2). This is consistent with the reported tendency for SIPWs to focus their work on more complex cases and sometimes on less experienced workers. The former is particularly true of the HRI managers.

The growing tendency to give the SIPW managers other roles and portfolios is reflected in the rise in ‘other Regional duties’ and probably accounts for a proportion of the increasing use of case conferences/case planning as a vehicle for HRI influence. Some of the extreme ‘State highest’ figures reflect particular phases or tasks. For example, February’s State highest for program development (39%) indicates a Region undertaking a substantial review and redevelopment of its work to date.

Other interesting features of this table include the small gains in family contact time, a finding that concurs with SIPWs’ reports of acceding to workers’ requests in 1999 for more SIPW/child protection worker joint visits to model appropriate engagement, assessment and intervention strategies. Previously, more time had been spent entering case notes on the file as a record of SIPW advice to the workers. The relative emphasis on SIPWs’ own professional development in May 1999 reflects some specific statewide training inputs. Receiving and giving training, like many program development activities and some forms of networking, tend to occur in blocks of time over longer time cycles than a data collection period of a fortnight can detect.

The scope of the SIPWs’ external relationships will be discussed below in relation to the program goal of improved inter-agency communication and collaboration. Region by Region, the data are so variable as make inference risky. There is, though, some evidence that there are rises over time in the overall numbers of people with whom the SIPWs interact, both within and outside Child Protection Services, with a proportionate drop in internal consultations (which still predominate) and a proportionate rise in external liaison.

#### 2.3.2 SIPWs and SIPW/HR Managers

Table 1 is a snapshot of the overall work of the program staff across the Regions, but it blurs some important distinctions.

The distinctions between the CAFW 4 and 5 roles, with the single worker rural positions more of a hybrid, were clear from the early months of the program. When we aggregate the data for case related functions, program development and management functions, and other functions, and then separate the SIPWs at CAFW 4 level from the HRI managers (CAFW 5) there are some clear distinctions (see charts 1A and 1B in Appendix 12). The CAFW 4s have maintained a strong and steady, though not exclusive,
focus on enhancing casework. Further analysis suggests that within this case focus CAFW 4’s early investment in case monitoring has given way to more active case consultation. The HRI managers’ work is more evenly spread, with a slight decline in case level activity and rise in program level activity. The increase in ‘other’ activities reflects, in part, the regional resource management decisions discussed previously.

2.3.3 Rural/Metropolitan Distinctions

It is difficult to distinguish rural issues from small team issues, since the one leads to the other, and both aspects make these rural teams vulnerable to vicissitudes. Although most rural Regions had, on paper, funds for some staff time in addition to the HRI manager, Loddon Mallee was effectively the only Region with a clear team (of two people), the others functioning as sole SIPWs for most of the time. In Barwon South West this was because of the departure of the CAFW 4 and the failure to refill that position. In Grampians, the program was augmented by the partial assignment of a team leader to the program, but further re-structures created periods of instability and discontinuity in staffing, although with the intention of expanding the reach of HRI information. Even in Loddon Mallee, a combination of staff illness and the lateral assignment of both workers in succession to unit management in a sub-office meant that there have been substantial periods of under-resourcing.

The SIPW activity data provide some glimpses of the rural/small team issues. While no one data collection period achieved complete returns of data sets, inhibiting meaningful comparison, there are interesting issues raised by such rural/metropolitan comparisons.

Table 2 suggests that, on the whole, there are many similarities between rural and metropolitan Regions within each of the data periods, even though both groups show changes in their patterns of activities over time. Some of the more salient differences seem to be:

- More substantial rises in the proportion of time spent on case recording, family contact, court related activities and other case management tasks in metropolitan Regions than in rural.

This picture is consistent with verbal reports from metropolitan SIPWs about their efforts to meet staff members’ requests for more ‘hands on’ casework guidance, and with the frustration about the constraints upon this expressed by rural SIPWs and caseworkers. While this is in part a distinctively rural issue, in that it relates to dispersed offices and families and the associated travel time, it is also a function of the small size of rural HRI programs.

- More substantial rise in the proportion of time spent by metropolitan SIPWs in their own professional development than by rural SIPWs. Professional development may be more accessible in the city, but a contributory factor in this finding appears to be the relative newness of several of the metropolitan SIPWs completing the returns in February.

- A disproportionate jump in the recorded time spent in rural program development in February. This is largely accounted for by one program under review. Were it not for this occurring during the data collection period, we might have expected a more even spread of time to other activities in rural Regions in February.

Table 2: Mean Proportions of Time Spent on Activities for the State, for February 2000 and May 1999: Metropolitan Regions Compared with Rural

<table>
<thead>
<tr>
<th>Activity</th>
<th>Metro Regions Mean % - February 2000</th>
<th>Rural Regions Mean % - February 2000</th>
<th>Metro Regions Mean % - May 1999</th>
<th>Rural Regions Mean % - May 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at case conference/PMC</td>
<td>8.3</td>
<td>10.8</td>
<td>2.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Case consultation</td>
<td>13.3</td>
<td>14.2</td>
<td>12.7</td>
<td>15.2</td>
</tr>
<tr>
<td>Case management—case records</td>
<td>7.8</td>
<td>6.6</td>
<td>13.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Case management—family contact</td>
<td>8.4</td>
<td>2.1</td>
<td>3.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Case management—other tasks</td>
<td>6.4</td>
<td>1.4</td>
<td>3.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Case monitor/audit</td>
<td>7.5</td>
<td>5.8</td>
<td>3.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Court related activities</td>
<td>7.6</td>
<td>2.9</td>
<td>1.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Flexible budget allocation</td>
<td>1.3</td>
<td>2.2</td>
<td>0.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>1.9</td>
<td>4.3</td>
<td>0.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Other Regional duties</td>
<td>8.0</td>
<td>8.9</td>
<td>1.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Own professional development</td>
<td>4.4</td>
<td>1.0</td>
<td>2.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Program document, and develop.</td>
<td>5.6</td>
<td>15.7</td>
<td>1.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Providing training</td>
<td>2.8</td>
<td>1.8</td>
<td>0.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Service system networking</td>
<td>5.3</td>
<td>5.8</td>
<td>1.1</td>
<td>1.8</td>
</tr>
<tr>
<td>Supervision given</td>
<td>5.0</td>
<td>3.2</td>
<td>1.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Supervision received</td>
<td>1.3</td>
<td>1.6</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Travel</td>
<td>5.3</td>
<td>12.0</td>
<td>0.6</td>
<td>1.4</td>
</tr>
</tbody>
</table>

In the data for February, four rural offices and four metropolitan are represented.

In the data for May, three metropolitan offices and five rural offices are represented. Since only one rural Region has had a CAFW 4, in addition to the CAFW 5, for most of the operational history of the HRI initiative, there are too many Region-specific factors to make a rural/metropolitan CAFW 4 comparison very illuminating. There is some evidence, however, to suggest that where there has been an active CAFW 4 (Loddon Mallee) the demands of case consultation (27.5% time in February), case recording (31.4% time in February) and travel (15% in February) have been so high (74.4% in total) as to minimise the time given to other functions. Metropolitan CAFW 4 data returns suggested that they spent only 31.8% of their time on these three activities in the same period. Differences in the rural and metropolitan CAFW 5 positions are reflected in the following snapshot from February 2000:
process; and the SIPW appeared to have direct contact with the families in 32.5% cases. In the CFR 2000, SIPW consultations were noted for 64.4% of the cases, and there had been direct contact with 32.4% of the families in the review period.

That is, SIPWs seem to be consulted on approximately two-thirds of the infant cases, and actually see the families in about half of these, sometimes actively 'co-working' the case. The consultation occurs depends, in part, on the processes and working relationships established between the SIPWs and the child protection teams.

### Table 3: Mean Proportions of Time Spent on Activities: Metropolitan and Rural CAFW 5, February 2000

<table>
<thead>
<tr>
<th>Activity</th>
<th>Metro Regions</th>
<th>Rural Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at case conf/cpm/fgc</td>
<td>6.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Case consultation</td>
<td>9.1%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Case management—case recording</td>
<td>1.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Case management—family contact</td>
<td>2.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Case management—other tasks</td>
<td>2.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Case monitor/audit</td>
<td>6.1%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Court related activities</td>
<td>2.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Flexible budget allocation</td>
<td>3.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other Regional duties</td>
<td>1.76%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Own professional development</td>
<td>6.2%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Program document, and develop.</td>
<td>12.4%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Providing training</td>
<td>4.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Service system/networking</td>
<td>8.5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Supervision given</td>
<td>9.9%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Supervision received</td>
<td>1.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Travel</td>
<td>4.0%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

Aggregates for the State, for February, are based on data returned by nine Regions. The data set returned covered a two-week period.

The rural profile in that fortnight was rather more case-focused than the metropolitan profile. This suggests that rural HRI managers include in their work more of the case consultation work undertaken by the CAFW 4s in the metropolitan Regions, but with less scope for 'hands on' casework. While rural HRI managers are vulnerable to being assigned either to higher duties or laterally into other Unit manager vacancies (which does not appear to have been the case during the February data management period reported above), the blend of CAFW 4/5 functions appears to leave them relatively little time to be diverted into other Regional projects or duties on a day-to-day basis.

The difficulty of achieving widespread coverage of all cases has been reported by rural and metropolitan Regions alike. This was also evident in the CFRs, which showed consistent frequency of SIPW input across the two reviews. In the mid-1999 review, when most Regions had had at least a year of SIPW time, 66% of the case files reviewed showed evidence of SIPW advice; for 46% it was noted that the SIPW had been consistently consulted at critical points in the case process; and the SIPW appeared to have direct contact with the families in 32.5% cases. In the CFR 2000, SIPW consultations were noted for 64.4% of the cases, and there had been direct contact with 32.4% of the families in the review period.

That is, SIPWs seem to be consulted on approximately two-thirds of the infant cases, and actually see the families in about half of these, sometimes actively 'co-working' the case. The consultation occurs depends, in part, on the processes and working relationships established between the SIPWs and the child protection teams.

### 2.4 SIPW Interactions with Child Protection Teams

The content of SIPW input to Regions follows the training given about the needs of infants, and SIPWs have delivered and/or facilitated formal and informal training in the following areas:

- Ages and stages
- Sudden Infant Death Syndrome
- Emotional abuse
- Attachment and transfer of attachment
- Postnatal depression
- Parenting with an intellectual disability
- Domestic violence
- Work with Koori agencies
- Neglect
- Infant observation/behaviour assessment
- Non-accidental injury
- Using psychological assessments
- Shaking babies
- Foetal alcohol exposure
- Cautious practice

These are also themes in the consultation process, which also reflect the generic skills and knowledge needed in protective work. Along with training and case consultation, vehicles of knowledge diffusion have included:

- Team and unit meetings
- Books and videos
- Scanning articles and e-mailing these as part of the Regional YAFS newsletter for discussion
- Collecting articles for loan from HRI library
- Portable library of articles for use during consultations
- Use of flexible budget for saturation of agencies with particular articles—ensuring that relevant service network shares information on common issues
- Community-based workshops
- Development of criteria for child protection workers seeking input from specialists—to help them ask good questions
- Prompt/trigger lists, cards and posters in strategic locations

The content areas and strategies used depended on local issues and events, needs and preferences of child protection workers and SIPWs, logistics, stage of program development and resource availability.

Just as content of the SIPW-child protection team interaction varies, so does its form, especially in the management of the consultation function. While there are clear arrangements in place for how SIPWs are to relate to the other teams, it should be noted that there are many sources of variation. SIPWs attempt to be responsive to particular needs of clients or workers, and the HRI teams try to retain a degree of flexibility in their work patterns in order to respond quickly and, if necessary, intensively. In addition, some workers have particular interests and skills, and pick up more of some kinds of tasks than others. For example, a comparison of returns from the SIPWs over all three activity data collection periods showed that some recorded no court-related activities, while there were two SIPWs who each recorded several court-related activities in each period, averaging between two and six hours per episode. That some of these activities might be very time-consuming suggests SIPW responsiveness; that some SIPWs have more court events than other workers do across all three periods speaks to idiosyncratic work patterns. Similar variations arise in relation to the data recording family contact.

Despite such variations, the following general types of working relationships and processes have occurred:

- **Consultation by request:**
  - In all sites, SIPWs have made themselves available for formal and informal consultations by request. While most have protocols that call for formal requests to come via the team leader or unit manager, they are also available for ad hoc minor consultations. While many child protection workers value informality and ready accessibility, SIPWs generally report that consultation is more effective when planned, with the SIPW reading the case file in advance if possible, researching relevant issues and reporting back to both worker and team leader.

The major advantages of consultation by request have been reported to be better utilisation rates by staff already sensitised to infant issues than by staff who may be unwittingly practising poorly. When consultations can occur jointly with worker and team leader, the potential for knowledge diffusion is enhanced. Consultation without day-to-day case responsibility frees the SIPW to bring a ‘clear head’ to the case, and is very valued by staff for those times when worker and team leader have become ‘stuck’ and need an injection of new perspectives and ideas from someone who can ‘think outside the box’.
• **Assertive consultation:**
  Regions have in place some monitoring and case-finding systems by which SIPWs are notified of all infant cases opened in the Region, and they can scrutinise the case by entering CASIS (the computerised case record system) or by sampling the cases at random. On the basis of these reviews, consultation can be offered to workers (via the team leader) when the SIPW identifies concerns in the case management. While this is potentially a more threatening form of consultation, it is a useful quality assurance tool that has been particularly helpful in allowing the SIPWs to identify systemic problems, such as general minimisation of the impact of domestic violence on infants.

• **Co-working the case:**
  In some Regions (WMR, EMR, NMR) SIPWs have effectively co-worked cases. This is a good tool for mentors/modelling (and has been increasingly seen as an appropriate function for trained CAFWs 3s). It is, however, very time-consuming (leaving other cases unattended) and there are some ambiguities in the status of the SIPW as the more senior partner: a co-worker? a case aide? a supervisor? accountable to the team leader?

In the context of close team relationships and high acceptance, these ambiguities can be worked through. However, the HRI teams have identified the need for vigilance to... infant observation and developmental assessment, attachment assessment, and assisting with parent-child interaction issues.

• **HRI case planning and management:**
  In an extension of supervisory case management, some Regions (BSW, WMR, SMR) have transferred the allocation of selected cases for example, those on the HRI register) to the HRI unit on a temporary basis, either to a CAFW 3 dedicated to the HRI unit, or by ‘lending’ the worker for that case, and the case planning functions are undertaken by the HRI manager. This is an excellent strategy for integrating risk assessment, inter-agency collaboration and long term case planning. It can, however, ‘ bog down’ the HRI teams and the HRI manager in particular, and deflect from other program developmental work or wider reach for consultation.

• **Monitoring critical decision points:**
  Most HRI managers have instituted regular case monitoring at critical points, such as intake and closure. This has been consolidated by practice enhancement instructions from the program branch in 2000, reinforcing the SIPW role in case conferences and case closure decisions relating to infant cases involving serious parental mental illness, significant parental intellectual disability, family violence and/or substance abuse or gross parenting deficits.

Such case monitoring provides critical program development intelligence about the nature of cases coming through and the issues in service delivery requiring troubleshooting. At intake, the experience of, for example, the Hume and EMR SIPWs has shown that it gives shape to the critical early... keeping decisions, and sets up expectations for subsequent work. At closure, it ensures a ‘last chance’ to detect service failures. On its own, however, such monitoring is not an adequate service to child protection staff and clients, since it allows the whole middle band of crucial case activity to go unattended.

2.5.1 Balancing Functions: Internal and External, Case and Program

All SIPWs report their role to be very demanding, and other workers who want more time with the SIPWs also mention the wide range of duties calling their attention elsewhere. Each re-arrangement of Regional models represents attempts to find an optimal balance between activities. In seeking this balance, they experience the following tensions.

**Demand:**
For most child protection units handling infant cases, the requests for consultation are more than can be handled. Even SIPWs in large HRI teams report a constant demand for attention. Strategies to manage the demands include making consultation a planned and prepared event, targeting teams of categories of workers, setting time limits, and using HRI registers as a limiting device.

• **Good beginnings:**
With a constant stream of notifications coming in, SIPWs are unclear whether intake is the best place to focus effort. Those Regions that have invested heavily in screening at intake report good benefits in sound diversion and community-based early case planning, fewer inappropriate ‘no further action’ cases, and accelerated access to critical resources in serious cases. Those that have chosen not to invest in the intake phase, or have moved away from it, have done so in the grounds that intake teams tend to be staffed by senior and experienced staff anyway, and that they are able to flag cases for later attention. At a minimum, advice to the HRI team about infant intakes allows the SIPWs to monitor patterns of cases and to detect re-notifications or previously known high risk infants.

• **Maintaining a HRI register:**
Most Regions carry some form of HRI register, like the High Risk Adolescent registers, and these serve as a monitoring device. Where, however, the HRI register effectively becomes a SIPW caseload, resources are drawn away from other functions, including some of the important diversionary work.

• **Case monitoring through CASIS:**
In the early days of the program, this was seen as a good device for detecting lapses in standards and finding cases needing attention. It can still serve those functions, and has been experienced by workers as ‘yet another senior looking over your shoulder’ and is necessarily a good vehicle for inducing practice changes.

• **Case conferences:**
Most Regions have found that assigning SIPWs to chair or assist with protective planning meetings and other case conferences is time well spent. Less routinely, the use of the HRI manager as case planning meeting chair can be a powerful tool in implementing a case plan underpinned by HRI knowledge and resources. This function may, however, cut across unit managers’ case planning delegations, and can be crippling in its time demands.

• **Approving closure:**
Most Regions had not been able to ensure full coverage of infant case closures prior to the Practice Enhancement Instructions requiring this in cases...
have been able to be seized when there is clear management support and resource allocation (such as, After Hours Infant Case Data analyses, Southern Region’s analysis of the results of expert reports) and/or strong community support, such as the Barwon antenatal screening program.

• Working on PASDS/managing the HRI resources base:
For most HRI managers, helping in the development of the PASDS and managing (and experimenting with) the brokerage budget have been very satisfying, if demanding, aspects of the role, made complex by the tendering arrangements, involving key risk factors. This was because of a mix of factors: sheer numbers, the logistics of ensuring the SIPW is notified of impeding closure, and the clash with unit managers’ responsibilities. This use of SIPW time can also be seen as ‘too little too late’. The close of the evaluation data collection period was too soon to see if they had been able to sustain adherence to the new Instructions.

• Communicating infant sensitive practices:
Given the demands on the role, SIPWs experiment with different ways of communicating with child protection workers, with no single formula emerging. Whether face-to-face, by telephone or e-mail, they employ a mix of suggestion, direction, ‘asking the difficult questions’, theoretical discussion, case examination in the light of specific research, and demonstration. To discriminate between these options they need to juggle their knowledge of the worker and his/her usual supervisory arrangements, the type of case, the urgency of the decisions to be made, the availability of the requisite information, and the time available.

2.5.2 SIPWs Working Together
In the HRI Evaluation Interim Report 2C, the evaluation team identified a number of program issues worth the combined attention of the SIPWs as a group, along with the Head Office Child Protection and Juvenile Justice Branch and other relevant players. These issues included:

• Case recording protocols.
• Routine documentation of crisis management plans for vulnerable infants.
• Reviewing the balance between case monitoring and active consultation in the SIPW role.
• Mutual learning about the creative possibilities of the flexible budget, and reviewing on a Region by Region and statewide basis, the flexible budget expenditure from the perspectives of cost effectiveness, social justice, quality control.
• Reviewing the standards for purchasing in-home support and supervision.
• Developing a shared database for lodging HRI protocols between child protection services and other agencies, and consolidating or updating these protocols collaboratively in the light of diverse Regional experiences in implementing them.
• Developing a set of priorities for refining HRI policies and guidelines.

These and other suggestions that will emerge from the impact findings below call for a strong collaborative HRI working group, shared ideas and resources, and joint projects. To date, Regions have shared a range of strategies and products in an ad hoc, but often productive, manner. There has been clear movement toward some common standards expected in Head Office documentation to the Regions, such as Practice Enhancement Instructions around such issues as the use of SIPWs, pre-birth notifications and Sudden Infant Death prevention education for families. Even so, the internal Regional implementation and consolidation demands, in a context of Regional difference, independence and sometimes competition, have meant that this statewide program development has been neither systematic nor sustained. This has led several SIPWs and other stakeholders to express frustration about inconsistencies of approach and the lack of guidance, and the evaluation team has been aware of multiple separate efforts on similar issues. These are in part justified and necessary because of the very different Regional conditions and sets of actors, but some rationalisation of effort could be more productive (see Recommendation 13).

2.5.3 Rural/Metropolitan and Small/Large Team Issues
In reporting SIPW activity patterns, rural/metropolitan and small/large team issues were noted (2.3.3). Regional consultations fleshed out some of these differences.

• Rural client issues of isolation are less easily addressed in more sparse service systems and populations. For example, supervision of the infant at home becomes difficult, especially because the association of poverty and the housing shortage tends to lead to remote low cost housing options being taken up by vulnerable families.

• The flip side of this rural picture has been reported as ‘too much visibility’. Families are notified on family surname alone or seen as having nothing wrong because they are ‘too ... protective workers as an anxiety producing and emotionally and politically loaded caseload, and this has a sharper edge when the workers live in the same communities as the families. In some Regions, we have been told of ‘endemic violence’, and that it is reasonable to expect staff to be experiencing norms of violent behaviour in their own networks and communities.

Rural poverty is widespread. Substance abuse among client families appears to have accelerated more markedly in the provincial centres in recent years, and there is a less well developed service system and body of practice wisdom for responding. When staffing vacancies occur they may be difficult to fill; rural child protection workers reported caseloads of up to 20 children; and often they have to maintain long term relationships with clients in the absence of adequate family support services in the community.

This combination of location, rural networking and workload can lead to practices that the HRI staff identify as dangerous, such as under-developed risk assessments or under-intervention. Sometimes these practices are perceived as matters of local or sub-office culture, but they may equally be artefacts of these organisational and rural development issues.

These rural issues shape the SIPW role in particular ways. The use of a SIPW can introduce some helpful distance into the process when local relationships and alliances are fraught with difficulty, but they need to invest in relationships with the staff to achieve this, which can be difficult when travelling between offices. To offer this buffer, the rural SIPWs, with large areas and several sub-offices to cover, have periods of intense travel and then periods on phone and email consultation. With limits to the Regional car pools and travel budgets, they are faced with high use of personal vehicles, heavy dipping into the brokerage money for travel expenses and/or working by quite restrictive schedules and appointments. They cannot so easily grant the informal consultations that tend to be available from the city SIPWs, and the ratio of notifications to SIPW positions does not offset this difficulty. Since travel times to clients may be even more further afield, child protection workers have less capacity to use SIPWs on joint visits and less flexibility in responding to SIPW advice, for example, for more assessment information via more home visits. This has been particularly driving respect to the expectations of CAHCPS workers (for example, requests to fax through information when the worker...
is at a remote home visit). Rural workers also appear to bear a heavier burden than metropolitan workers when high levels of access or service are specified by the court, especially if local placements are unavailable. While some of these difficulties might be solved with larger and stronger HRI representation in sub-offices, as is beginning to occur, the link to a wider system of resources and to an external ‘clear head’ would seem to be worth retaining.

In contrast, metropolitan Regions tend to be characterised by high turnover of clients, a fast pace, complex and often conflicting service system relationships, multi-need/disability parents attracted by these services, and high levels of base-grade staff turnover.

As larger teams in smaller locales, the HRI staff have the potential to allocate SIPWs to particular units (functional or sub-Regional). While this is often what is requested by front-line child protection staff, clear co-location within units poses more direct threats to the established order and requires considerable investment in process and protocols. Until their roles and credibility were firmly established, some SIPWs also experienced a pressure to define themselves as ‘luxurious appendages’ to the unit, making it hard to resist calls to ‘pitch in’ in less than appropriate ways. Despite these differences, child protection worker feedback (see sections 6 and 8) reflects considerable similarity in how the SIPWs are seen and used after at least two years of the program.

2.5.4 Program Integrity and Competing Regional Priorities

Reference was made in the discussion of SIPW appointments and continuity above to the vulnerability of these senior staff to lateral or hierarchical assignment to other duties, and to the possibility of special program funds being used to supplement for other deficits. Despite the most positive affirmations of the value of the program from colleagues and management, such occurrences testify to the many competing demands on Regional resources. For example, managing a sub-office, or managing the Intake and Response Units, while attempting to implement and develop the HRI initiatives, may in theory and practice build excellent links between the HRI ethos and the core practices of the service. Yet, the operational imperatives of the line management roles inevitably overshadow the more deliberative and planned work required of the HRI manager role. It is these competing demands that have made the struggle for program integrity a major theme for the SIPWs in most Regions. The struggle is made more compelling by the rise in notifications of infants to child protection services over the period under review (see Appendix 13 CASIS Data Analysis). All SIPWs are aware of gaps in coverage and the many areas for program and practice development identified in the case file review results and discussed in sections 6, 7 and 8.

2.6 Conclusion: SIPW Implementation

The core roles set down for the SIPWs (see 2.1) have remained fundamental since the inception of the initiatives, with variation from worker to worker in how they are implemented. By the end of the second year of the program, the roles of CAFW 4 and CAFW 5 SIPWs, where there was an HRI team, had become more differentiated into consultation emphasis and programmatic emphasis, respectively, with (or effectively lone) rural SIPWs continuing to blend all roles. In mid-1999, whether at an individual level or when speaking on behalf of whole teams, SIPWs as a group voiced their concern that the role cluster was essentially boundary-less, with SIPWs ‘spreading themselves thin’ trying to be all things to all people with respect to infant matters. Bowers, Esmond and Canales (1999) discuss this dilemma with respect to case management supervisors in long term care, noting their struggle to resolve: ‘Do we try and serve more people with less, or do we serve less people with more?’ For SIPWs this question has two prongs: ought they serve more (or less) infants, or more (or less) workers?

For SIPWs this is a real tension. They are aware that most team leaders (fellow CAFW 4s) are so overwhelmed by the volume and pace of case monitoring and supervision that they cannot be as specific in their attention to infant matters as the HRI program requires. SIPWs, therefore, see there is at least the potential for any child protection worker with any infant case to need their attention; on the other hand, they are aware that not all infant cases continue to be regarded as ‘high risk’. There are also problems in the SIPWs, outside routine line management, determining which cases are high risk and require their intervention. For this reason, they have continued to advocate the need for a more refined definition of a ‘high risk infant’ and they have used random case auditing, referral systems and ‘high risk registers’ as tools in case finding and workload regulation. In addition, they are aware that there will be some workers who potentially contribute to the high risk cocktail for infants by virtue of their inexperience or work practices, however, to target them without reference to the unit managers/team leaders is to step into others’ supervisory territory. This potential area for workload regulation and priority setting has not received as much formal attention as case targeting, although it is a factor taken into account when workers or team leaders contact the SIPW or when the SIPWs reach out to particular workers or teams.

For rural SIPWs, these dilemmas are compounded by difficulties associated with rural issues faced by families, service provision to outlying offices, sheer geographical logistics, more fragile and slender external service systems, and the low SIPW establishment (low both in absolute numbers and in proportion to infant notifications compared with metropolitan Regions). In metropolitan Regions, the pace and complexity of the work are major features. All have struggled with, and to a large extent overcome, pockets of resistance from colleagues. Less easily overcome are the frustrations of staff turnover, in their own ranks and among the front-line workers with whom they are attempting to build an increasingly well-informed and sophisticated culture of awareness of, and responsiveness to, the special needs of infants. This is a major factor in the continual adjustments of Regional models.

In this context, the major casualties of the SIPW role set have been community and service system developmental activities, formal training and practice-based research for program development. These require more separation from the ‘coal face’ activities, more time and more cross-Regional work than has usually been available to date. Rather ironically, some of these functions can be better performed in the least resourced HRI teams, where the sheer incapacity to do everything is obvious, and priority setting therefore more legitimated. The implications of these issues will be further discussed in the conclusions and recommendations of this report.
3. Implementation Findings: The Parenting Assessment and Skill Development Services (PASDS)

From the inception of the HRI Service Quality Improvement Initiatives, it was envisaged that the PASDS would be a key component. The PASDS were established with the following aim:

To improve Child Protection Services' risk assessment and management plans for high risk infants through improved access to timely, comprehensive, research-based assessment of parenting capacity and ongoing skill development and support. (Department of Human Services 1999: 15).

The intended key features of PASDS service delivery were that they would provide:
- Timely, comprehensive, evidence-based assessment.
- Individually tailored skill development and support.
- Flexible delivery modes.
- Priority access for child protection services clients.

PASDS would provide either residential, day-stay and/or in-home skills development and support for clients. While there were already, in the broader service system, other mother/parent-baby residential or day-stay services and other intensive in-home family preservation services, there were no services specifically designed to provide specialist infant-parent assessments and interventions tailored for child protection services clients. This gap had been clearly identified in the consultations leading up to the establishment of the initiatives.

The material presented in this section is derived from consultations with HRI staff, child protection workers, and PASDS providers over the period June to July 2000. This picture will be enlarged by the Phase 2 PASDS evaluation process over the latter half of 2000.

3.1 Establishment of PASDS

The timing of the establishment of PASDS has varied between Department of Human Services Regions. At mid-2000, all Regions described the status of the service agreements with PASDS as ‘interim’. A number of factors have influenced this, most notably a change of government in Victoria in 1999. This change has resulted in a hold being placed on the existing and developing funding arrangements between the Regional child protection services and PASDS. Some Regions are waiting for the completion of the PASDS evaluation to ensure they are developing ‘best practice’ frameworks for service delivery.

Notwithstanding the ‘interim’ nature these arrangements, all Regions except one have been operating some form of PASDS service since 1999. A number of Regions have developed a service delivery system that they are confident of and wish to continue, others are in the process of redeveloping appropriate service delivery systems and one Region is in the establishment phase.

3.2 PASDS Purchasing Models

During 1999-2000, the first full year of service operation for most PASDS, the Department of Human Services established a number of targets and funding levels for the provision of PASDS. These targets provide a basic framework for the establishment and implementation of PASDS in each Region. The funding agreements with PASDS providers define a number of key output measures. These are to provide:
- A PASDS to a nominated number of families across a year.
- An assessment report on all families commencing the service within 21 days.
- A skill development service and an individual skill development plan for a nominated number of families.

From these basic parameters a few key service delivery frameworks emerged. These being:
- Lead agency delivering all aspects of PASDS, residential and in-home. (NMR, Gippsland, Grampians).
- Lead agency providing residential service and heading a consortium of services to deliver Regionally based in-home support. (SMR).
- Lead agency delivering all Regionally based in-home PASDS and provides residential services in conjunction with another sub-contracted agency (EMR).
- Department purchasing individual service packages from Regionally-based services (WMR, Hume, Barwon South-West). These rural Regions geographically divide into two with a different service delivering the PASDS in each part.
The day-stay program provided at QEC is available for SMR clients only. It is sometimes used by residential PASDS clients if they require some additional skills development following discharge. For home-based clients it provides an intensive period of skills development during the program.

between 5-10 days. The QEC, Tweddle and the City of Greater Geelong also provide a day-stay facility for families.

### 3.3 Service Delivery Funding and Targets

#### Figure 7: Funding Levels and Placement Targets for PASDS between July 1999 and June 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Funding Level ($)</th>
<th>Residential Places</th>
<th>Annual Target*</th>
<th>In-Home Support</th>
<th>Agencies Used to Deliver PASDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR</td>
<td>352,700</td>
<td>30</td>
<td>50</td>
<td>20</td>
<td>Canterbury Family Centre, O'Connell Family Services</td>
</tr>
<tr>
<td>NMR</td>
<td>522,500</td>
<td>30</td>
<td>74</td>
<td>54</td>
<td>Queen Elizabeth Centre, Canterbury Family Centre (until Sept '99)</td>
</tr>
<tr>
<td>SMR</td>
<td>632,000</td>
<td>60</td>
<td>130</td>
<td>70</td>
<td>Queen Elizabeth Centre (QEC), Anglicare, Southern Family Life, City of Port Phillip, Windermere Child &amp; Family Services</td>
</tr>
<tr>
<td>WMR</td>
<td>492,200</td>
<td>35</td>
<td>64</td>
<td>29</td>
<td>Tweddle, Westadd, QEC, O'Connell, Anglicare, Abercare, Child &amp; Family Service, Contacare, Mackillop</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>234,200</td>
<td>10</td>
<td>30</td>
<td>20</td>
<td>City of Greater Geelong Waurnpoo Town Council</td>
</tr>
<tr>
<td>Hume</td>
<td>325,000</td>
<td>12</td>
<td>32</td>
<td>20</td>
<td>QEC Wangaratta, Goulburn Valley Family Care</td>
</tr>
<tr>
<td>Gippsland</td>
<td>204,900</td>
<td>12</td>
<td>44</td>
<td>32</td>
<td>QEC</td>
</tr>
<tr>
<td>Grampians</td>
<td>193,300</td>
<td>NA</td>
<td>40</td>
<td>NA</td>
<td>Ballarat Child &amp; Family Service, QEC</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>Fully funded for 2000-2001</td>
<td></td>
<td></td>
<td></td>
<td>QEC, Child Protection Services, CFC, Ballarat Ch</td>
</tr>
</tbody>
</table>

Some families receive more than one unit of service. *NA = Not Available

### Additional Brokerage Funding

Brokerage money is used by all Regions and services to augment the PASDS by purchasing assessments and services not available from existing services, notably specialist psychological testing and assessment and anger management classes.

Some Regions have used brokerage money to purchase emergency residential places for families if there is not space available in services with existing agreements.

### 3.4 Service Delivery Models for Residential PASDS

Existing agencies providing services for families experiencing difficulties with parenting have taken up the establishment of residential PASDS. There are three agencies that provide residential PASDS in the metropolitan area: the Queen Elizabeth Centre (QEC), O’Connell Family Services, and Tweddle Child and Family Health Service. A specialist residential drug and alcohol service planned for WMR is yet to commence operation.

The ten-day program run by QEC breaks down into:

• Three days initial assessment, care planning and intensive one-to-one teaching.
• Five days participation in group parenting skill programs with other families.
• Three days reassessment of progress in applying and consolidating learning and future planning.

A discharge conference is held between QEC staff, Child Protection Services staff and the family to provide a forum for exchange on progress and development of plans for follow-up.

The day-stay program provided at QEC is available for SMR clients only. It is sometimes used by residential PASDS clients if they require some additional skills development following discharge. For home-based clients it provides an intensive period of skills development during the program.

### 3.4.1 Queen Elizabeth Centre (QEC)

Regions using QEC include SMR, Hume, NMR and Gippsland. WMR and EMR have used QEC to absorb any overflow of referrals within the region. Brokerage funds are used to purchase these additional places, usually once the Regional provider’s own targets have been met.

The QEC residential model includes 24-hour stay with a minimum of five days and maximum of ten days. Each family is provided with a comprehensive assessment report within 21 days of referral. The format used to provide this report is The Queen Elizabeth Centre Parenting Competencies Assessment Instrument (QECPCAI). Assessments developed using this instrument explore parenting competence across four dimensions: physical health and wellbeing, emotional development, cognitive or intellectual development, social development and environmental awareness.

QEC applies eligibility criteria that include a written undertaking of willingness to participate in the program and, if drug and alcohol issues are present, a written undertaking by parents to remain drug-free during their stay.

All referrals are brokered by the HRI manager and a standard referral form is completed. Notification of the suitability of the client for the program is confirmed by QEC within four hours of the referral being made accompanied by an invitation to a pre-admission interview. QEC aims to conduct the pre-admission interview within five days of receiving the referral.

### 3.4.2 Canterbury Family Centre (CFC)

Canterbury Family Centre (this agency has now become part of Uniting Care Connections, but it is referred to as Canterbury Family Centre in this report since this was its identity through much of the period under review) provides two types of residential services. The first is provided using the service delivered by O’Connell Family Centre. O’Connell can offer families a five-day residential assessment program. CFC provides a residential service with 24-hour supervision that families can be placed in if necessary. Because of the limited nature of the residential program offered at O’Connell decisions regarding the placement of an infant during the weekend are made at a case conference meeting held every Thursday between O’Connell staff and the Child Protection Services case manager, Canterbury Family Centre staff and the family.

Families can receive up to 15 days of residential assessment and support at O’Connell. The service offered by O’Connell is primarily assessment although skills development does occur through the process of identifying parenting capacities and deficits. The strength of the O’Connell model, and one of the reasons the service is used by CFC, is consistency of staffing where a family gets to work with the same staff member across the five-day period. A maternal and child health nurse and mothercraft nurse are assigned to a family and work individually with the family half a day each across the week.

Eligibility criteria to be accepted into the program are similar to other services. The client has to agree not to use drugs or alcohol, to respect staff and other clients, to be willing to participate and to be well physically and mentally. They are not able to accept women with serious psychiatric conditions.

During the period a family is at O’Connell, CFC staff are assessing and monitoring the progress of the family in order to provide ongoing assessment and organisation of appropriate support services for the family. If a family already has a number of services...
involved that can provide the skills development for the child, this option is preferred to involving an additional service in the family’s life. Decisions regarding who should work with a family and where they should be placed are made on a case by case basis.

When the program was first established all referrals from child protection services came into the program via liaison between the SIPW and CFC, with families then being connected to O’Connell. More recently an increasing number of referrals are being made to O’Connell directly from the SIPW and the SIPW informs O’Connell if CFC is involved.

O’Connell uses a framework for assessment developed by the service manager and based on the QEC assessment form, existing internal documents and the Riverstone Centre tool from Queensland. The assessment report produced by O’Connell is used by Child Protection Services in case planning and assessment. If families are referred to O’Connell from CFC, staff from the CFC make additional assessment of parenting capacity during the family’s stay. Assessment tools used by the service are the Victorian Risk Assessment Framework and the Canterbury Family Services assessment format developed by Dr. Gaye Mitchell specifically for the service.

At the end of a family’s stay a case conference will be held where decisions regarding the ongoing needs of the family and arrangements for the weekend can be made. These meetings involve O’Connell staff, child protection workers, CFC staff, if involved, and the family. The ongoing skills development needs of families who have been referred to the residential program are assessed and organised for on a case by case basis. The preferred approach is to have the skills development work provided by the services that are currently involved in the family’s life.

3.4.3 Tweddle Child and Family Health Services

Tweddle has only recently been able to offer residential PASDS to the Department of Human Services. During 1999-2000, Tweddle worked primarily with the WMR Child Protection Services office. Parenting assessment occurs over a ten-day period with 24-hour support every day of the week.

Service users are referred to the PASDS manager at Tweddle. A formal referral form is provided and all referrals are approved by the HRI manager. The eligibility of the client is assessed using Tweddle guidelines. Essentially they are: children have to be between 0-3 years, the parent has to agree to participate in the program willingly and fully, the parent has to refrain from using any chemical of dependence during their stay and from exhibiting any aggressive or threatening behaviour during their stay. Clients considered eligible then attend a pre-admission interview organised by the child protection worker and Tweddle. The aim of the pre-admission interview is to:

- Establish what parenting skills the family want to enhance and the expectation of the family during their stay.
- Establish the current protective concerns and any court orders applicable.
- Explain the program and the assessment provided for the Department on completion of the program.
- Read the service contract and explain conditions of stay.
- Agree on the admission date, length of stay and date for discharge planning.
- Show the family the premises.

Families are then admitted to the residential program. The aim of the assessment process is to assess parenting competencies. A baseline assessment is taken during the first three to four days, where parenting deficits are identified and a skills development plan developed in consultation with parents. Skills development opportunities and support are offered to parents through individual and group learning experiences. A final assessment is undertaken during the eighth to ninth day of the program and recommendations for ongoing care or support are established. The involvement of Tweddle in post-assessment work with the family is established case by case on an ‘as needs’ basis.

On completion of the program a report is prepared for the Department of Human Services using a format developed by Tweddle staff. The assessment of parenting competency is based on this format and uses a range of indicators:

These parenting indicators demonstrate the parent’s knowledge, understanding and interest in the child’s health and developmental progress and requirements and their ability to incorporate and apply learnings consistently to a level that an ‘average’ parent practices (Tweddle Service Description Document).

3.4.4 City of Greater Geelong

Residential and day-stay services are available to families in the Barwon South West Region (chiefly Geelong and environs) through the PASDS provided by the City of Greater Geelong. The Maternal and Child Health Centre was successful in its tender to provide PASDS. It has facilities to provide day-stay assessment and skills development with families. This approach is usually taken when a child is out of the parents’ care, where the home is dangerous or where the home environment is too distracting to be conducive to parental learning. The day-stay program is structured in the same way as the in-home skills development program.

The service has developed a comprehensive protocol for referrals coming into the program. The residential program is usually offered when there is a need for fully supervised access between parents and their child. Every child aged 0-3 years in these situations is also referred to be under the care of a paediatrician. These families are referred to the Geelong Hospital Child Care by Parent Unit, and the PASDS coordinator assesses them across a week. The level of supervision required by a PASDS worker is determined case by case. A formal report is presented to Child Protection Services early in the assessment period with the skills development plan attached. The assessment tools used to assess parenting capacity were been developed by the co-ordinator of the service and are based on a parenting competency table used in maternal and child health nursing and other indicators identified as important by literature on the field.

All referrals are approved by the HRI manager. A meeting will be held with the HRI manager and the case manager within one day of receiving the referral. Often families are referred to residential PASDS more than once for additional service (repeat referrals will be considered in the PASDS evaluation Phase 2).

3.4.5 Grampians

Limited information has been received from Grampians to date, and the following model description is drawn from program documentation. The intent of the model was for both assessment and skills development to be delivered to specific groups within the population, these being parents with a history of family violence, intellectual disability, mental illness or substance abuse problems, or young parents from disrupted backgrounds.

The out-of-home or residential parenting assessments to be undertaken within the Region would be based on a formula of 24-hour support including monitoring, support for children (both high risk infants and siblings), formal reporting and staff appearance at court if necessary. These stays were to be provided for up to 21 days.

The day-stay centre-based program provides professional assessment and support at an intensity of monitoring two to four times a day, three days a week across two weeks.

The program aimed to have all assessments completed and reported on within two weeks of referral into a PASDS. This work would result in the preparation of an individual family skills development plan for each family.

3.5 In-Home Assessment and Skills Development Models

In-home assessment and skills development is provided by a range of agencies across the State. The Department of Human Services has primarily used existing Regionally-based family support services to deliver home-based PASDS. Therefore, while there are differences between service delivery systems, most use a similar model, that is, providing in-home skills development for a period of hours across a number of weeks. The actual formula used at the various service delivery points will be provided in more detail in the following section.

3.5.1 Eastern Metropolitan Region

PASDS providing in-home assessment and skills development in the EMR are run through CFC. During the first 18 months of operation, CFC primarily provided in-home assessment.

The package of assessment and skills development is appropriate for families is established on a case by case basis. Meetings are held weekly with a member of the HRI team within Child Protection Services and plans are developed according to the families’ needs and resources available to them. Work with families is primarily one-to-one with the same worker being used
to deliver the service to the family across that time. If intensive support and skills development is needed, family support workers from other more appropriate programs will be used to assist families and the Canterbury staff will act as case workers looking after the more therapeutic needs of the client. Canterbury has a maternal and child health nurse attached to the organisation who is involved in the weekly monitoring of the child.

CFC can provide up to 30 days of skills development and families can access this up to three times, thus potentially a family can have up to 90 days intervention. This is the equivalent of 20 hours per week across 6-2 weeks. The assessment frameworks used in the in-home PASDS programs are the Victorian Risk Assessment Framework and CFC’s internal assessment format. If skills development can be provided by an agency already working with the client, then this is preferred, as the work can build on an existing client-worker relationship.

3.5.7 Grampians

The City of Greater Geelong Maternal and Child Health Service provides in-home parenting assessment and skills development across three months with at least 8-10 hours contact each week. The program provided to families follows the skills development plan established with each client through the early assessment process. The plan is based on the deficits identified during the assessment conducted with each client. This assessment is based on a format developed at the service around the areas of nutrition and hygiene, cognitive and intellectual development, social and environmental adaptation, safety in the home and parental health.

3.5.6 Gippsland

The in-home assessment and skills development services for Gippsland are managed by QEC. The model developed to deliver the service involves in-home assessment of parenting competency, followed by a period of skills development. An initial report is provided to the Child Protection Services after assessment is undertaken using the QEC assessment format and a final report is provided after a period of skills development and final assessment has been undertaken.

The program is delivered by two QEC teams, one based in Warragul servicing the south and west of the Region, and one based in Morwell, servicing the east of the Region. These bases are strategically located to optimise access to the entire Region and effective liaison with Department of Human Services staff and other service providers.

The service model is based on 69 hours of service per family. This comprises 42 hours of direct service and 26.8 hours of service coordination. The service was delivered over 810 weeks with a program target of 44 families for the initial nine month period.

3.5.5 Barwon South West Region

The City of Greater Geelong and the Warrnambool City Council provide the in-home parenting assessment and skills development service for Barwon South West Region. The Warrnambool PASDS has only been in operation since October 1999.

The original plan for PASDS skills development and support services was to provide a service, the intensity of which would vary according to the needs of the family and the issues involved. The standard formula used in the establishment plans was the delivery of a medium term service. In practice this meant monitoring families in their home twice a week for four hours per week and this work would take place across three to six months. For referrals involving parents with an intellectual disability or in reunification situations, the intensity shifted to four hours per day, two days per week across an average of three weeks. Then the transfer of these skills to home would occur across eight hours per week for two weeks and this would be supported by an additional therapeutic work of two hours a week across twelve weeks. The extent to which these formulae have been adjusted during the implementation process is yet to be confirmed.

3.5.4 Western Metropolitan Region

3.5.3 Southern Metropolitan Region

3.5.2 Northern Metropolitan Region

3.5.1 Eastern Metropolitan Region

3.5.6 Loddon Mallee

3.5.5 Barwon South West Region

3.5.4 Western Metropolitan Region

Until the suspension of interim arrangements, pending resolution of changes to tendering policy, WMR used Abercare, Anglicare Choices, CentaCare, and Mackillop Family Services to deliver their in-home assessment and skills development component of the PASDS program. Only three of the listed agencies provide in-home assessments: Abercare, Anglicare Choices and CentaCare. On the whole, the assessment frameworks used shape the structure of the assessment program. Abercare uses the Keys to Caregiving tool and NCAST feeding and teaching scales when undertaking in-home assessment. The Anglicare Choices program uses the Monash Mother-Infant Interaction Scale (MMIIS) as the basis of their in-home assessment. CentaCare provides in-home assessment using a number of assessment tools, most notably the MMIIS, the Parenting Scale, the Parenting Sense of Competence Scale and the Home Observation for Measurement of the Environment.

The in-home skills development component of the PASDS was provided by all the services listed. Originally the Department negotiated to purchase 20 hours of intensive work per week, for a 6-8 week program from most of the services. In reviewing the implementation phase, the Department adjusted this service delivery formula to occur with the same intensity but across a 12-week period, with planned review at weeks four and eight to check progress against objectives. In all programs, the Department of Human Services child protection worker (in conjunction with SIPW) specifies the areas they feel require skills development with any given referral. Some services used external consultants to assist in the planning and implementation of skills development plans for families.

The service model is based on 69 hours of service per family. This comprises 42 hours of direct service and 26.8 hours of service coordination. The service was delivered over 810 weeks with a program target of 44 families for the initial nine month period.

Since the implementation of the PASDS, it has become apparent that the initial formula for service provision needs adjustment. After nine months of operation the length of service identified as optimal is 13.5 weeks with the 107 hours of service required per family.

3.5.8 Hume

Hume Region is divided into Eastern Hume and Western Hume with a different PASDS provided within each of these areas. The PASDS for Eastern Hume is a relatively recent service development provided by a local QEC run at the Yarrunga Child Care Centre in Wangaratta. The in-home assessment and skills development provided here works within the same framework as the other QEC centres. The PASDS provided in Western Hume is delivered from Goulburn Valley Family Care Centre, and builds on the prior work of its Early Parenting and Intensive Family Preservation Services (Families First).

3.5.9 Loddon Mallee

The Loddon Mallee has not yet established a PASDS in-home service although an implementation plan for the service has been developed.

3.5.7 Grampians

The City of Greater Geelong, Maternal and Child Health Service provides in-home parenting assessment and skills development across three months with at least 8-10 hours contact each week. The program provided to families follows the skills development plan established with each client through the early assessment process. The plan is based on the deficits identified during the assessment conducted with each client. This assessment is based on a format developed at the service around the areas of nutrition and hygiene, cognitive and intellectual development, social and environmental adaptation, safety in the home and parental health.

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The program is delivered by two QEC teams, one based in Warragul servicing the south and west of the Region, and one based in Morwell, servicing the east of the Region. These bases are strategically located to optimise access to the entire Region and effective liaison with Department of Human Services staff and other service providers.

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3.5.8 Hume

3.5.9 Loddon Mallee

The Loddon Mallee has not yet established a PASDS in-home service although an implementation plan for the service has been developed.
### 3.6 Profile of PASDS Service Delivery across the First Year of Operation

#### Figure 8: Details of Regional Residential and In-Home PASDS Delivered Across the First Year of Operation

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<tr>
<th>Region</th>
<th>Date of First Commencement</th>
<th>Date of Final Commencement</th>
<th>Number of Resi.</th>
<th>Number of In-Home</th>
<th>Number of Total</th>
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<td>12</td>
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<tr>
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<td>3</td>
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</tbody>
</table>

### 3.7 PASDS and the Protective Process

It was intended that PASDS places be dedicated to infants classified as high need/risk by Child Protection Services, and through clear gate-keeping mechanisms between the HRI managers and the PASDS coordinators, this focus has been held. Referrals into the PASDS program occur in a reasonably standard way across the State. In most programs referrals come either from the HRI manager or SIPW directly to the PASDS program coordinator, or the HRI manager has approved the case worker to contact the PASDS program coordinator. With varying degrees of formality, the Regional HRI managers have developed referral protocols and written information to guide child protection staff.

The relatively small numbers of infants referred to PASDS (less than 10% of the infants notified annually to Child Protection Services) suggest they are being used sparingly, as is appropriate given the highly intrusive nature of such services. This first descriptive phase of PASDS evaluation has yielded a number of observations of the way the PASDS fit within the protective process and the other HRI initiatives.

#### 3.7.1 Legal Status, Case Phase and Protective Queries

PASDS have been employed at a range of critical points along the protective intervention process:
- After substantiation and in the protective investigation period where capacity to care is untested.
- Between Protection Application and final order, often on an Interim Accommodation Order, to guide disposition recommendations.
- During an Order to clarify the potential for reunification or as a first stage of reunification.

#### 3.7.2 PASDS Communication with Child Protection Services

While families are involved with a PASDS, there are frequent communications between the PASDS staff and Child Protection Services. The largest provider, the QEC, has a clear process for both residential and in-home PASDS.
• PASDS residential reporting process:
  – Pre-admission interview
  – Alternate day contact with the child protection worker
  – Discharge planning meeting
  – Presentation of the parenting competencies assessment report
• PASDS in-home assessment and skills development reporting process:
  – Pre-intake interview
  – Regular phone contact between child protection workers and staff
  – Case closure planning meeting
  – Production of the parenting competencies assessment report

Given the services QEC provides across regions SMR, Gippsland, NMR, and Eastern Hume, it can be assumed these processes are in place across these Regions.

In the EMR, with CFC as the primary PASDS provider, communication occurs through verbal and written reports to Child Protection Services. The Region has developed a common assessment form and a standard case closure process. Reports are provided within the guidelines of the funding agreement. CFC provides assessment reports based on the assessment framework they had designed for specific application within their program.

Within the WMR, where PASDS are delivered by a range of services, there is regular, at least weekly, contact between agencies and Child Protection Services case managers. There is also formal reporting requirements built into funding contracts. Both residential and in-home PASDS use their own assessment tools to provide the basis of these reports. A review meeting has also been established for in-home support to ensure a program is developed with clearly articulated and achievable objectives.

In the Barwon South West Region, there is regular contact between the HRI manager and service providers. Warrnambool only provides in-home support to families; Geelong has the facility to also provide residential support. Formal reporting requirements apply in the Region as in others. The assessment tools used to provide the basis of reporting on families are described in more detail below. The two PASDS are in regular contact with one another and have pooled administrative procedures and pro formas.

In general, for cases involving assessment only, whether it is undertaken in a residential or in-home environment, one report is provided to the Department by the PASDS. For cases where assessment and skills development have been undertaken by the PASDS provider, the Department would receive an initial assessment report and a second report at the completion of the skills development program. The different assessment and reporting frameworks used to structure these reports are listed in detail below.

3.7.3 Assessment Tools
As indicated in the Regional profiles above, the assessment tools selected by different PASDS providers vary according to the existing practice within services and the needs of the particular families with whom they are working. Some services have spent some time and research dollars in developing a tool appropriate for application in their particular service setting.

The QEC uses an assessment tool they developed on site, the QEC Parenting Competencies Assessment Instrument. This tool forms the basis from which parenting competency reports are made. The tool has been described in detail elsewhere (Littelfield et al., 1999). The tool explores parenting competency across four sub-scales: physical health and wellbeing, emotional development, cognitive or intellectual development, and social development and environmental awareness. Parenting competencies are assessed on an adequacy continuum.

Within the WMR, where there are a number of services delivering PASDS, a number of assessment tools are being used. Tweddle, the primary service provider of residential assessment, has developed their own version of the QEC tool and bases their formal reporting to Child Protection Services on this tool.

Three services within the WMR provide in-home assessment. These services use a mix of: NCAST Feeding and Teaching scales, Keys to Care Giving Tool, Monash Mother and Baby Interaction Scale, Edinburgh Post Natal Depression Scale, the Parenting Scale and Parenting Sense of Competency Scale.

Within the EMR, where CFC (now Uniting Care Connections) is the major PASDS provider of in-home assessment and skill development, a tool developed specifically for CFC’s needs is used in conjunction with the Victorian Risk Assessment Framework.

3.7.4 Child Protection Worker Feedback on the PASDS
Owing to the constraints upon the evaluation to date with respect to PASDS, only incidental information about PASDS usage has been collected from child protection staff, but a number of observations and themes have emerged:
• PASDS have been widely acclaimed within Child Protection Services as a constructive new service option for infants and their families in high risk situations.
• Workers report the relatively high credibility to parents of PASDS staff, in view of their demonstrated skills and knowledge in infant care, and their time and ability to join with the parents in the interests of the infant.
• Workers report the information they receive from PASDS, and their own direct interaction with PASDS staff, as assisting their own learning about child development, infant care and infant/parent observation.
• Both the residential and in-home components have been well-received by child protection staff members-residential, because it offers security, intensive assessment, and saturated learning; in-home, because it offers the opportunity to assess in situ and to assist families to consolidate gains and face new challenges and developments over time.

General limitations to the PASDS program reported in the Regional consultations to date are chiefly:
• The time limits to in-home work, and the dilemma of disabled parents who need permanent support to care at the level possible while the services are involved, but for whom there may be no alternative community service available to follow on.
• The need for even more specialised facilities in some cases of substance abuse, serious parental behavioural disturbance and potential violence.

From the perspective of Child Protection Services workers, the existence of the PASDS has created some dilemmas:
• Magistrates have sometimes chosen to nominate PASDS interventions, with little reference to availability, Regional priorities or other case planning considerations (see Court Issues below), leading to program operation and case plan implementation difficulties.
• Some parents have been able to demonstrate marginally adequate care in the time frame and with the intensive support of the PASDS (and other HRI resources), resulting in court decisions to leave the infant at home, but this marginal parenting cannot be sustained over time in the community, exposing the child to further harm and delays in achieving viable permanent care.

3.8 PASDS Implementation Issues
As part of the evaluation process, PASDS providers and Departmental HRI liaison staff members were asked to identify the following features of the implementation process:
• Program strengths, achievements and weaknesses.
• Program design and operational issues.
• Policy issues arising from the implementation process.

The following discussion is a summary of their responses.

3.8.1 PASDS Program Strengths
The program strengths identified by PASDS stakeholders are:
• The development of agency assessment tools based on existing research and practice wisdom. While staff differ on the issue of whether a single statewide assessment tool should be used, there is widespread support for further research into the benefits and limitations of such an option.
• That the delivery of PASDS is informed by practical and manageable learning frameworks.
• The professionals interviewed believe that PASDS are seen by families as supporting their efforts and, as such, there is a high level of client participation, completion and satisfaction with the service they receive.
In most cases, the presentation of expert assessment by PASDS staff is received well by the Children’s Court. This is assisting the improvement of the relationship between Child Protection Services and the Children’s Court in cases involving high risk infants.

All established programs provide assessment and the development of parenting capacity through this process. On the whole families benefit from receiving a PASDS.

The ability to tailor individual packages for families.

The work done by PASDS strengthens the knowledge base from which long term case plans are developed within the Child Protection Services, enriching the decision making process.

The PASDS initiative has strengthened the relationship between the Department of Human Services and community-based family support agencies.

The ability for universally accessible early parenting services (such as QEC and Tweedle) to work with this high needs population alongside other service users.

3.8.2 PASDS Program Weaknesses

The program weaknesses identified by PASDS stakeholders are:

• The interim nature of the funding has inhibited the development of new frameworks for the delivery of services. On the whole, service delivery has been integrated into existing programs.

• The lack of cross-Regional planning and development in terms of design and delivery of PASDS.

• The lack of family support available to families receiving PASDS alongside their need for parenting skills development.

• Some families receiving PASDS are extremely deprived. These families need sustained longer term skills development and support if they are to successfully keep a child at home in their care. Currently this need is not met by PASDS or existing family support agencies.

• A framework for dealing with case failures is under-developed within the program.

• The ability of PASDS to successfully deliver services to families with drug and alcohol issues or mental health issues is limited due to lack of appropriate infrastructure, lack of suitably trained staff and lack of strong linkages between PASDS providers and drug and alcohol and mental health agencies.

• The difficulties created as the result of working for Child Protection Services, particularly when conflicts arise regarding the ethics of information sharing and client involvement in decision making. Community-based PASDS require voluntary involvement by clients but staff often question whether this is realistic when the Child Protection Services is referring a case and often this is the family’s only chance of keeping the child at home.

3.8.3 Funding and Program Design Issues

A number of funding and program design matters arose through the process of implementing the PASDS. Some of these issues were resolved during the period of implementation Others are still present for services involved in the delivery of PASDS.

• Most PASDS providers and the Department had difficulty developing and costing models of service delivery. The level of service use and appropriate service intensity was difficult to predict from the outset. The implementation process has produced a much clearer idea of the appropriate level of service delivery to families and the cost of this.

• The interim nature of much of the implementation funding has worked against the development of fully operational specialised service delivery systems. It requires the employment of staff on short term contracts, inhibiting staff recruitment and retention, and thus diminishing the stability of the programs and the opportunity to mature. This in turn acts as a disincentive to depart substantially from existing models of service. In addition, the strong link between funding and targets in a situation of fluctuating demand makes it difficult for PASDS to cope with ‘down time’ while limiting their freedom to experiment with service innovations.

• The fixed nature of the budget will mean a reduction in the number of units offered to deal with increases in service provision costs (such as salary rises).

• The targets established for funding have been somewhat arbitrarily set. Sensible targets need to be established, based on the first year of service operation and knowledge gained regarding the frequency and intensity of service provision to PASDS families (this aspect will be considered through Phase 2 of the evaluation).

• It has become apparent that there is a conflict between the wish for flexible funding (that is, purchased places) and the need for a high quality predictable service response for HRI families. The latter requires stability of funding and targets negotiated with the PASDS provider to ensure the availability of appropriately staffed services and places. The former requires short term planning, is reactive to need and relies on the goodwill of existing services to maintain the program when it is not being used.

• There is an established need for a number of families with high risk infants to receive both a residential PASDS and in-home skills development. This should be factored into future funding frameworks.

• The worker contact hours needed to successfully implement both PASDS residential and home-based skills development are higher than initially expected.

• Continuity of case worker through the process of assessment and skills development is beneficial to clients.

3.8.4 Referral Networks

A number of PASDS providers and Child Protection Services staff identified several referral issues relevant to the implementation of PASDS. These comments highlight the inherent tensions in primary care services contracting to provide work for a statutory service.

Referral in:

As previously discussed, PASDS assessments can be very informative for child protection workers at several different decision making points. PASDS providers, however, whose primary mission tends to be skill development, reported that the point of referral into a PASDS program needs development. They suggested that this timing should be informed by research into the point in the process that interventions will be most effective for clients.

In one agency, referrals made during the investigation stage have received better outcomes. This is consistent with literature on the impact of early intervention. Families need to feel they have a real chance to demonstrate their parenting capacity if the voluntary nature of the program is to be maintained. From the perspective of PASDS providers, it is important to avoid using PASDS to strengthen a Child Protection Services case on its way to court. Yet this was one of the key reasons for Child Protection Services funding the PASDS initiative and, from the child protection worker point of view, an expert opinion is invaluable in court.

• Adequate and consistent referral protocols between Child Protection Services and PASDS are essential to quality service provision.

Referred out:

There is a clear need for program links with family support agencies and some form of cross-referral. The competitive tendering process has, in some Regions, damaged these relationships in a way that has created obstacles to effective post-PASDS planning.

• There is a need for case monitoring and crisis support to be available to these families on an ongoing basis.

• There is an established need across Regions to strengthen the linkages between PASDS and drug and alcohol and mental health agencies. This network and program development work in the community is essential to the implementation of an integrated service delivery system.

• There is a strong need in rural areas to inform and train workers in using PASDS and to train local services to be able to deliver PASDS.

Phase 2 of the PASDS evaluation will examine referrals made for families post-PASDS. Efforts will be made to analyse and compare service networks developed by the maternal and child health-based PASDS and the child and family services-based PASDS.
• There is a need to monitor parenting capacity and performance as intense services are reduced with a view to determining whether safe and effective parenting can be sustained. Existing PASDS arrangements have a finite period of service, and the child protection worker and the PASDS need to look ahead to needs beyond the PASDS phase.

• All PASDS providers expressed concern about the lack of feedback from the families they work with. They see this information as essential to the ongoing development of the program.

• There was also a need in some instances for debriefing to occur with child protection staff. This was not always made possible.

• Sometimes due to the different expectations of PASDS from the Child Protection Services and the family, conflict can arise over matters such as providing families with information about their progress and work within the program. This creates some ethical tensions for PASDS providers. This situation can become extreme in contested court cases. Secrecy and judging a person’s parenting capacity is not a good basis for the establishment of a strong working relationship with the family, which is essential to achieving positive outcomes for clients.

• Good communication between Child Protection Services and PASDS is dependent on the HRI manager being available to attend to program needs as they arise. This often cannot occur and the strength of the specialist program gets diluted when specialist staff are used within the Department of Human Services for other purposes.

3.9 Summary of Findings

The information provided in this descriptive report on the implementation of PASDS in Victoria clearly highlights a number of important issues. The following summary is an attempt to identify the most critical of these.

On the basis of the data provided by PASDS providers, it is clear that PASDS are achieving the aim they were established to meet and the program frameworks demonstrate the key features intended. All PASDS providers deliver services that provide:

• Timely, comprehensive, evidence-based assessment.
• Individually tailored skills development and support.
• Flexible delivery modes.
• Priority access for Child Protection Services clients.

The PASDS providers and the Regional Child Protection Services HRI teams are to be commended for the current success of the program in achieving these aims.

Notwithstanding the success of implementing PASDS, the process has highlighted a number of operational issues that need some attention in order to further refine and develop the delivery of PASDS.

• A number of issues are raised by trying to implement services aimed at a specialist population through a mainstream open access service, notably, issues around timing of referrals, work with semi-voluntary clients, the court processes, and the status of information.

• The process of implementation has presented a number of ways in which the general funding formulae and frameworks needed to be revised on the basis of client needs. Most Regions have adjusted the intensity and frequency with which PASDS are delivered to clients, providing for more intense and longer service than the original funding contract specified. This now needs to be reflected in the next funding agreements with PASDS providers.

• There is an important need for strong linkages between PASDS and specialist drug and alcohol and mental health agencies. This is critical if PASDS are to successfully work with these populations. This has implications for PASDS staff training.

• There is a need for better consultation between Regions regarding the establishment of models for PASDS. Although there is a need for Regional variation in delivery modes, very little information and ‘know how’ is shared between Regions. Some areas of service delivery could be enhanced by a common approach across Regions, such as assessments used and various operational protocols.

• The quality and type of reporting used within agencies varies, and PASDS are keen to explore whether a uniform framework for both assessment and skill development can be found, and the training implications of establishing such a framework. To this end, they encourage the implementation of the planned PASDS research.

• Problems are caused by the irregularity and unpredictability of referrals coming through the system and there are implications for developing funding and staffing models for programs. This needs some attention as there is a clear conflict between funding on a case by case basis and providing stable and well-structured programs.

• Within rural Regions there is a lack of locally-based services and appropriate professional staff. The issue of how best to deliver PASDS to rural Regions needs development.

• Resources need to be made available to ensure that the HRI teams within the Department are able to fulfil a community role, which would contribute significantly to the successful linkage of PASDS with other community-based family support agencies.

3.8.6 Other Issues

• There can be a problem working with other agencies, as they are involved in advocacy for the parent/s rather than the child, which is the PASDS responsibility.

• The skills development aspect of the PASDS program appears to be applicable to a wider client group of families who are not in the Child Protection Services system but have high risk indicators.

• The assessment component developed for intellectually disabled parents is suitable for use with that population but outside the umbrella of Child Protection Services.

• The process of implementation has presented a number of ways in which the general funding formulae and frameworks needed to be revised on the basis of client needs. Most Regions have adjusted the intensity and frequency with which PASDS are delivered to clients, providing for more intense and longer service than the original funding contract specified. This now needs to be reflected in the next funding agreements with PASDS providers.

• There is an important need for strong linkages between PASDS and specialist drug and alcohol and mental health agencies. This is critical if PASDS are to successfully work with these populations. This has implications for PASDS staff training.
The flexible budget is a tool managed by the Regional HRI managers who vary in the degree of authority they can exercise over it, just as they vary in their conception of the Budget's possibilities and limitations. HRI managers have managed that portion of the Flexible Budget ear-marked in the Region for caseworkers to augment support to, and supervise of, parents and their infants (such as during parent-child contact visits), either through staff appointment or fee-for-service arrangements.

4.2 Budget Expenditure

The flexible budget has been used in several major ways:

- Operational expenses, such as travel, equipment and, in some cases, pro-rata contribution to infrastructure, such as rent of the building.
- Salary top up, to increase the staff allocation to the HRI team, whether by increasing fractional hours of SIPWs or subsidising the assignment of other staff (for example, to CAFW 3 advanced caseworker functions).
- Augmenting support to, and supervision of, parents and their infants (such as during parent-child contact visits), either through staff appointment or fee-for-service arrangements.
- Purchase of specialist reports to aid in assessment, case planning and court action.
- Purchase of additional legal representation from selected barristers.
- Training and educational expenses, including fees and materials.
- Direct assistance to families.
- Special projects (such as the Geelong Hospital antenatal screening project).
The evaluation team examined program materials and various forms of financial reports from most Regions for the first year of the program, and an incomplete and variable data set, with no common form of categorisation and lack of clarity about what was included and excluded from the records perused. The team found the variation in actual expenditures on categories was wide.

This appears to have been in part a reflection of Regional size and caseloads, and possibly also a result of variations in classification of items. While some Regions appear to have spent approximately a third of the budget on external assessments, distributing the residue evenly across a range of other categories, other Regions have accorded this level of priority to training or to the employment of support staff. Where there is sufficient data to discriminate the kinds of assessments bought, it appears (not surprisingly) that assessments of parents vastly outweigh specialist assessments of infants. From $708–$73535 was spent on assessments and reports (the largest figure reflecting SMR’s use of a panel of experts); from $400–$9320 on therapy and counselling; from $303–almost $31,477 on support staff; from $250–$15,710 on child care; from $102–$14,822 for training. Other commonly used categories, such as rent assistance, essential services for families, house-cleaning and medical screening, were reported to be low expenditure categories.

A more comparable reporting method is desirable if budget use is to be effectively tracked. Even so, it does appear that a very large proportion of the budget has been spent augmenting the assessment and reporting functions of child protection services. The second largest usage appears to be for a variety of support staff (often contracted from human services personnel agencies) undertaking in-home supervision and parent support, among other functions.

**4.3 Innovation in the Use of the Budget**

A major goal of the HRI initiatives was that they would encourage new ways of working with infants and their families. The SIPW manager is pivotal in opening up options for use of the budget and as a group they have done so, but, child protection workers must also think broadly. In some circumstances the SIPWs may have insufficient line authority, influence, time and case contact to stimulate workers to draw on the budget in innovative ways. One Regional SIPW manager noted that a poor service infra-structure in parts of the Region, and the lack of a history of creative use of brokerage, meant that a year into the HRI program child protection workers were only just beginning to draw on the budget to realise creative case plans. As a result, there was under-spend of the allowance in the first year, and a priority for the second year was to stimulate thinking about new ways of meeting needs.

Some programmatic uses of the flexible budget testify to the HRI teams’ strategic use of funds to prepare for and augment other aspects of the initiatives, such as the SIPW role, the diffusion of knowledge to child protection workers, or the PASDS, for example:

- The panel of experts, which meets to provide program advice and is funded from the flexible budget to provide expert consultancy and reports (one-third of the SMR flexible budget, that is, $70,000 from $219,396). There are eight experts (selected by tender), people of different disciplines, willing to go to court, and trained for court work via the brokerage fund.
- Pilot Geelong Hospital antenatal screening project ($35,000 from first budget).
- Pre-purchase of an allocation of hours of a rural municipal child health worker (pre-PASDS) for use as necessary with families.
- A collaborative project with disability workers using a ‘think about it’ baby doll for women with intellectual disabilities contemplating having babies.
- The ‘infant kits’, developed by CAHCPS and other sites, to ensure child protection workers’ routine and emergency access to safety equipment and baby goods (base description of kit and form to ensure tracking of use of items provided in CAHCPS documents).
- ‘A mobile library’ and scanner to assist with disseminating articles and program materials to remote workers.
- Education expenses for HRI staff to upgrade their training in infant health and mental health.
- Regional training initiatives relating to infant development, attachment issues, domestic violence.
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- Regional training initiatives relating to infant development, attachment issues, domestic violence.
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Some case-specific uses of the budget testify to the strategic use of monies within the context of a case plan:

- Paternity testing to resolve the family status of an infant to clarify the direction for permanency planning.
- A funeral for a half term foetus—assisting an adolescent client to move on from loss of her baby and to facilitate her development and decision making about further pregnancies.
- A specialised chair for a disabled infant for whom prolonged lying was endangering health and who was not receiving sufficient attention to his physical development from an overburdened mother. Money was also made available for the time of a support worker to assist the mother to use the chair and associated activities appropriately. The result has been fewer hospital admissions for pneumonia.
- Extended counselling (six months instead of the usual 10 weeks) was funded for anger management for a young father, a Juvenile Justice client, at his request and to cover an important developmental phase in his parenting and the infant’s life.
- After-hours employment of a local social worker to work closely with a family to sustain reunification.

Child protection workers also noted the contribution of the budget to quality of life measures for families. Workers described how, when general funds are limited, the HRI material help, given in the context of an infant focus, raises the sense of importance of the infant and the self-esteem of parent as provider for the baby. It improves social presentation of the family, assisting social acceptance, and the parent’s ability to pass as adequate (especially important for parents with an intellectual disability). Money appears also to be an important tool in generating a sense of reciprocity. One SIPW noted, ‘We’re asking a lot of poor families’. Giving as well is a gesture of good faith. Material provision can also be educative. Examples of these links included providing nappies along with nappy rash education; feeding formula with dietary information; bedding with advice on sleeping patterns; refrigerator with hygiene/food handling advice; housing arranges with re-housing and network building. This use of strategic use of resources to meet routine problems with individualised responses is a hallmark of mature protective practice.

The reverse side of innovation and creativity can be the relative lack of systems and standards. For example, the mix of support and surveillance that is put in place to prevent removal of an infant while the assessment phase proceeds is particularly intrusive and requires a high level of integrity and competence of the workers.

The ability to purchase such services, outside the usual framework of program standards and service agreements, raises quality control issues. There is considerable variation in the kinds of workers and the auspices under which they work. Some such services are obtained by funding additional time from established home care or family support agencies; some are provided through private personnel agencies; some (in remote areas especially) may be provided casually by individuals known as credible through the service system. Purchasing these services requires clarity about security clearance (police checks), preparation of these workers for risk assessment and management, monitoring quality of work, and clear reporting back arrangements.

The next stage of development might be to discern from the budget expenditure patterns those aspects of spending that might be made routine and subject to reliable accountability mechanisms. There also appears to be merit in distinguishing genuine flexibility and creativity from those expenditures that reflect policy gaps in other areas such as after-hours family support, consistent trained legal representation, or the widespread problem of housing unavailability).

**4.4 Purchased Assessments/Reports**

A noteworthy product of the HRI budget has been the purchase of case reports from external consultants with particular expertise. These have consumed a large proportion of the budget and have been well-received by child protection staff, and often appear to have influenced court deliberations. Reports may serve one or more of several purposes for example:

- To inform judgments about the level of risk.
- To differentiate areas of adequate and inadequate functioning, to predict their capacity to change their parenting practices.
- On the basis of assessment of parents’ personal functioning, to predict their capacity to change their parenting practices.
• To give guidance about case planning—what kinds of services, delivered in what way, might be most effective to safeguard the infant and ensure its development; what are the attachment and developmental implications of placement changes and reunification plans.

• Specialist reports may be used in conjunction with PASDS to reframe the approach taken to parenting skill development. While using external experts is not a new practice, its extensive use in the HRI program allows consideration of some of the contractual and practice issues that arise.

4.4.3 Range of Experts Used

SMR has the most formalised arrangements for requesting expert assessment, advice and court testimony, through the panel of experts. This panel comprises a mix of consultant paediatricians and psychologists, a child and adolescent psychologist, and child and family psychotherapists. Other Regions make use of similar specialists, with particular attention to generalist and forensic psychologists who assess the intellectual and cognitive functioning, violence potential and personalities of parents; and developmental psychologists who assess the attachment issues between parents and infants, and the development of infants.

There appears to be an emphasis on those who will provide both testing and clinical interviews, and who are willing to attend court to defend their assessments and testify for Child Protection Services. Parenting assessments may be purchased in addition to those available through PASDS arrangements, from agencies such as QEC or other intensive parenting programs (for example, by topping up Families First programs to provide an additional assessment). Less frequent use appears to be made of psychiatric, drug and alcohol, and medical assessments. It may be that these health assessments are available through publicly funded programs.

There are surprisingly few reports requested from paediatricians. There appear to be several reasons for this; including active use of maternal and child health nurses’ reports for general developmental information, use of public hospitals if the child’s condition is serious, and a general emphasis in protective practice on resolving the parental conditions and situations that place an infant at risk, rather than on the health and wellbeing of the infant, as will become evident throughout this report.

The prevalence of reports from clinical and forensic psychologists reflects the high proportion of emotional harm cases and the child protection workers’ predictive difficulties in assessing and arguing likely harm for this age group and may also reflect the lack of capacity to undertake psychological testing within Child Protection Services.

4.4.4 Costs

There appears to be considerable variability in prices paid for such assessments (from $800 to $4000), variations partly attributable to the complexity and duration of the assessment process in each case.

The data supplied to the evaluators were not readily comparable, since some practitioners appear to have billed and been paid separately for components of the process (for example, assessment, testing, meeting attendance, court testimony), while others have consolidated these accounts. Because of the potential sources of error in making comparisons, it does appear that some services purchased from public/quasi-public agencies (for example, hospital-based clinics) may cost significantly less (even half) than comparable work from a private psychologist.

4.4.3 Using Expert Reports

While many of the consultants’ reports have been found to be valuable, the question arises: is it because of their technical skills, the quality of their observation and framework for analysis, or simply their ‘independence’ from the Child Protection Services, even if their expertise is being ‘bought’? All of these aspects are valued by Child Protection Services and appear to be equally valued by the court.

Through trial and error over the first two years of the program, several themes have emerged about the use of specialist reports by the HRI teams and child protection workers:

• The importance of primary (rather than secondary) consultation. Even acknowledged experts will have more influence if this expertise is combined with actual contact with the child and family, producing a report based on both theory and evidence.

• The need to build a working relationship with the consultant, and a mutually respectful basis for negotiating process and product expectations (see provider feedback in sections 4 and 8).

• The need to give child protection staff clear guidelines and training about when to request a specialist assessment, of whom, how to ask clear questions of the expert, and what questions to ask. In referring to psychologists, there has been a gradual move away from asking for global psychological and parenting assessments. Requests are for more specific assessments of such areas as intelligence and learning capacity and styles, or personality and psychopathology and their implications for parenting, with particular attention to depressed affect, violence, memory and rigidity of cognitions.

• Expert reports have greater value when they contribute to a multidimensional, biopsychosocial risk and protective assessment, which can contextualise the findings of the specialist. These reports need to be integrated into the child protection workers’ risk assessment guided by the JRF.

• Use of expert reports at court needs to be integrated into the case worked out with the legal representative. Since experts will be asked at court to make recommendations, which may or may not agree with the child protection worker’s recommendations, the worker must anticipate these and explore and prepare corroborative and conflicting evidence.

• It can be helpful to have agency-specific forms and a clear process for child protection workers to refer to specialists and to give feedback to the HRI manager about their satisfaction with, and the outcomes of, referrals to external consultants for report. Such documentation serves the dual purpose of collecting quality and planning data, enabling collated results to be fed back to the providers, and sensitising workers to the need for clarity about expectations and the working brief given the consultant.

Several ethical and political issues have emerged with respect to the use of external consultants that may be worth closer programmatic attention. These include:

• The complex information chains constructed as a result of purchasing arrangements (for example, where a portion of the budget has been assigned to the PASDS which uses this as brokerage to purchase third party assessments) raises some concern. The usual processes of consent to gather and release information may need modification in such circumstances. There also appear to be issues of ownership of purchased reports, and questions about the relative rights and obligations of the Department as purchaser, the writer as provider, the parent or child as client, and other agencies who then assume case management. If, for example, a consultant determines that there is a high probability of violence from a parent, to whom and how is that conveyed?

• These complexities are compounded by the incidence of parents whose capacity to consent to information exchange may be impaired by intellectual disability, mental illness and the effects of substance abuse and trauma. The best interests of the child may well override these considerations, but nevertheless the right issues involved appear to require closer attention.

• How expectations of help are met once an assessment is concluded can be problematic. Several SIPWs noted that in commissioning a clinical assessment report, Child Protection Services builds an expectation of treatment. This is exacerbated when, in the course of the assessment, the practitioner engages well with the parents, when the case planning implications coming from some of the reports are clear, and when the consultant has the capacity to provide the sorts of interventions the family needs. Both parent and consultant may wish to move into the next step of intervention, yet the funding may not be a priority for the case and agencies used for assessment work will be seen to have vested interests in relation to the treatment plans they suggest.

• The use of large sums of money on assessment, by a government agency that is itself primarily in the business of assessment, raises an important issue about cost-effectiveness and the justice of resource distribution. Does money spent on assessment result in better decision making by Child Protection Services? Does it enhance intervention? Do these interventions lead to better outcomes?

Consultations from this evaluation suggest that the answer is in the affirmative for the first two questions. In addition, reports from SMR’s analysis of reports provided by the panel of experts, and limited outcome data from the HRI case file.
reviews, suggest that flexible budget money does facilitate both positive parenting interventions and accelerated permanency planning for infants most at risk unless placed in substitute families. Even so, monitoring the tangible benefits of budget expenditure for infants and families would seem to be an important continuing goal for SIPWs managers if goal displacement is to be avoided.

4.4 Provider Feedback

Regions were asked to nominate external professionals who had worked closely with the HRI program and who would be in a position to comment on its impact. Most were professionals who had supplied services through the HRI brokerage, but seven also had connections with PASDS. Twenty-six nominees were interviewed, usually by telephone but seven in person. A thematic summary of their responses follows, emphasising the feedback from professionals whose services had been purchased through the flexible budget. (Further comments from these providers will be reported in the section on project impact on service networks below.) Among the issues raised by providers were several that echoed the themes mentioned in Section 4.4.3 above.

6) Exposure and Experience

A mix of functions is performed by these services and professionals. The professionals, who are mainly clinical psychologists, are used primarily to produce clinical assessments of parental capacity and skill. One in particular ran anger management classes for parents. Assessment includes areas such as cognitive capacity, attachment, post-natal depression and more general parenting skills. These assessments were used to assist in case planning and in achieving positive outcomes at court. Interviewees believed that their work was too dependent on the qualities of the worker with whom they had contact.

The use of the flexible budget to gain access to professionals other than psychologists has been limited and one such professional, an experienced child psychotherapist who was used regularly by Child Protection Services prior to the tendering of HRI services, has not received any referrals from Child Protection Services since the tender process. It would appear from the feedback received in the evaluation that paediatricians are also under-utilised by the HRI program. Some of the professionals have also been used in induction training programs by the Department of Human Services. A number of the professionals interviewed considered the Department’s need regarding the Children’s Court process was too influential in determining who is selected to undertake assessments. The professionals and services that work across Regions usually experience a stronger relationship with one of the Regions. This was usually the Region with which they had first started working and had developed a strong working relationship. Most referrals were received from SIPWs or the HRI manager; referrals received from other case managers had usually always been cleared through the HRI program.

Those professionals interviewed who were part of a panel of experts developed in the SMR were, on the whole, satisfied with this model, yet they felt it was under-utilised in terms of developing combined case planning and used more for a basic information exchange function. Consultants often found that their work would be conducted in association with the use of a PASDS.

Needs identified in relation to use of consultants:

• To more clearly identify the type of professional expertise required by Child Protection Services and to use this information to improve the targeting of appropriate professionals.
• To review the process of selection of professionals in order to reduce any personality-driven selection and to ensure all appropriate providers available are used in a fair and equitable manner.
• To develop processes whereby any problems regarding a private provider’s work can be discussed, reviewed and resolved between the Department and the provider.
• To review the concept of the panel of experts and develop its involvement in case planning and development (such a review is in process in SMR).
• To explore more fully the relationship between the use of PASDS for assessment and reports and the use of private providers, focusing particularly on who can provide what for what purpose.

(ii) The Working Relationship

The service providers interviewed gave mixed responses to questions regarding their working relationship with the HRI program. Most respondents claimed that the relationship had improved and developed the longer the program had been in existence, and most felt any problems experienced early in the program’s life were smoothed out through discussion and negotiation with SIPWs. On the whole, respondents felt they were used appropriately by SIPWs. The information exchange between SIPWs and providers was also good with any problems or inadequacies worked through by the provider and the appropriate worker. Criticisms regarding the relationship arose chiefly in relation to a damaging tendering process. Among these respondents, private professional providers and PASDS seemed considerably clearer about the HRI program and its function than the few other community-based service providers.

A number of providers felt that the working relationship with Child Protection Services was much improved as the result of the implementation of the HRI program. The strengthening of this relationship was thought, by these professionals, to be of considerable benefit to families. They were not confident that other child protection workers shared the SIPWs’ knowledge of the roles of PASDS, private providers and other non-government services available to assist families in the community. Private providers felt referrals worked best when they came via SIPWs and not directly from other workers. A number of respondents did generally feel that the SIPWs were approachable, flexible, contactable and open but felt their contact with other workers produced mixed results and, on the whole, their experience was too dependent on the qualities of the worker with whom they had contact.

Respondents talked of the relationship between SIPWs and private providers as an exchange, with each player contributing to the other’s understanding of the issues at hand. This relationship is supported, in some Regions, by formal assessment frameworks and protocols. Some providers involved across Regions felt there was considerable variation in the quality of the working relationship.

There were some infrequent comments of interest to the program, such as concerns about the short time lines provided to conduct assessments and prepare high quality reports. A few providers considered the payment system too slow but the majority did not find it a concern. One respondent expressed concern about what she considered to be a gatekeeping process, seriously restricting the number of referrals being given to outside providers and focusing these on providing material for court cases. This stopped Child Protection Services from using external professionals and the panel of experts in a creative way to assist seriously in case planning and development.

Some providers were concerned that participating in the evaluation could damage their relationship with the Department of Human Services and were reluctant to provide a lot of information regarding how things were going. It is hoped that this reluctance does not conceal problems in the development of the program that would be better addressed.

There seemed little formal feedback, communication or support from SIPWs to providers when a difficult or litigious experience arose. There appears to be a need to develop frameworks or protocols for dealing with private providers’ negative experiences such as these.

4.5 Conclusion

The HRI flexible budget is a valued component of the HRI initiatives, and its introduction has been welcomed and relatively smooth. At this early stage the staff are still in an active learning phase about the most productive and efficient ways of using the resource, but each Region has much learning to share with the others. There is no clear picture emerging of the optimal balance between using the budget for salary enhancement, program infrastructure, training initiatives, expert reports and family assistance.

Comments are made throughout this report on the need for strengthening the strategic programming role of the HRI managers, and the use of the flexible budget is one issue clearly calling for their combined attention. In its crudest form, there is an argument that, aside from paying for the basic support of the program staff (such as travel), the Budget needs to clearly serve three ends:

• Enhancing risk and need assessment and decision making (for use internally or in court).

• Reviewing the process of selection of professionals in order to reduce any personality-driven selection and to ensure all appropriate providers available are used in a fair and equitable manner.

• To explore more fully the relationship between the use of PASDS for assessment and reports and the use of private providers, focussing particularly on who can provide what for what purpose.

• To develop processes whereby any problems regarding a private provider’s work can be discussed, reviewed and resolved between the Department and the provider.

• To review the concept of the panel of experts and develop its involvement in case planning and development (such a review is in process in SMR).

• To explore more fully the relationship between the use of PASDS for assessment and reports and the use of private providers, focusing particularly on who can provide what for what purpose.

• Enhancing risk and need assessment and decision making (for use internally or in court).

• To more clearly identify the type of professional expertise required by Child Protection Services and to use this information to improve the targeting of appropriate professionals.
• Implementing case plans through creative services to infants and families.
• Diffusing knowledge about infant development and infant protective practice through the Child Protection Services staff body.

The HRI budget, while welcomed in the Regions, is a source of tension as it exposes the relative lack of such resourcing for older children. Ear-marking such resources for infants can, however, be justified.

The first form of expenditure (chiefly via expert assessments and reports) is defensible as a special contribution to infant safety and wellbeing, particularly because of the high prevalence of ‘likelihood cases’ and the difficulties of prediction and advocacy.

The second form of expenditure is most like that needed by all families, comparable to the use of existing Family Support Grants, but can be justified for infants by their high level of physical and developmental vulnerability and by the arguments for facilitating a ‘good start’. It will be important, however, to ensure that this service provision money is soundly based theoretically and guided by an infant-sensitive case plan, if it is not to be used to ‘prop up’ unviable living circumstances and waste precious developmental time.

The third form of expenditure (largely through training and other information dissemination practices) is justifiable through the special needs of infants. It also has ramifications, however, for other age groups when the issues shared (such as the relationship between domestic violence and child development, assessing attachment behaviour, or the use of specialist opinion in constructing a court case) have more generic application.

It is suggested that in the absence of clear evidence that any one form of expenditure yields more results than any other, it might be reasonable to seek an equitable distribution to these three ends of risk assessment, family intervention and knowledge diffusion. To achieve this, the HRI managers need a clear delegation of authority to develop the budget as a strategic aspect of the program in the interests of high quality service to infant clients. In each of these three areas, there appears to be a need for HRI managers and SIPWs to draw together their acquired knowledge of appropriate resources, procedures and safeguards.
This section establishes baselines for measuring progress toward the HRI service quality improvement goals, and outlines the stages in the analysis of impact. Interim measures of program impact reported in previous internal reports to the Department of Human Services are also summarised in this section, as a prelude to the following sections which will be organised according to program goals.

5.1 Using Existing Data

The HRI program was instituted in part in response to findings of both the Victorian Auditor-General and the Victorian Child Death Review Committee (VCDRC) that infants in particular were ill-served by failures in risk assessment and risk management, court applications and inter-professional and inter-agency collaboration. These practices are extremely complex and there can be no simple measures of change in practices or the extent to which changed practices lead to new outcomes. While there are no unequivocal baselines for judging improvement in child protection practice on behalf of infants, those findings of the VCDRC (1997) and the results relating to infant cases in a case file audit in 1998, provide a starting point (as documented in the HRI Evaluation: Interim Report 1).

The 1997 VCDRC report, published just prior to the main implementation of the HRI project, considered 34 deaths of children known to the Victorian Child Protection Services in the previous year, 15 of whom were infants under two years of age. The VCDRC noted the high incidence of Sudden Infant Death Syndrome, and made a number of observations about child protection practice with, and on behalf of, infants. Among those observations were some that the HRI project set out to address. Those observations particularly concerning infants included:
- Lack of data regarding the growth and development of infants listed as SIDS cases.
- Inadequate hospital discharge plans for mothers who, by virtue of their lifestyle, fall into a high risk SIDS category.
- A lack of appreciation of maternal intravenous use of drugs risk factors.
- A concern in regard to the level of awareness by protective workers about risk factors for SIDS.
- Problems with specific inter-agency collaboration regarding:
  - Acute hospital services
  - Royal District Nursing Service
  - General practitioners
  - Maternal and child health services.
- Failure to conduct effective risk assessment.
- A culture of optimism [noted in relation to parents with intellectual disabilities].
- Lack of adequate family and social assessment [including males/de factos].
- Premature case closure.
- The impact of drugs on the parent’s ability to manage and cope with their child.

(VCDRC, 1997, 32-40)

In addition to these findings, the HRI evaluation team used data that the Child Protection and Juvenile Justice Branch had at its disposal. This data was obtained from an internal case file audit conducted in 1998 by a program advisor from Head Office and senior Regional staff (reviewing Regions other than their own). It covered a wide range of service standards, grouped under four ‘domains’:

- Domain 1: Risk assessment and risk management
- Domain 2: Case practice and decision making
- Domain 3: Engagement and direct practice
- Domain 4: Inter-agency communication and collaboration

While that exercise was not infant-specific, it provided a tool that was already familiar to the Child Protection Services staff group, was grounded in the practice standards documents guiding their work, and had obtained results for some infants. The HRI evaluation was able to examine the results for the 78 infant cases within that 1998 sample, and drew from these relevant quantitative baseline measures of performance and qualitative issues commented upon by the reviewers. Since the audit sample was not selected on the basis of age, Regions varied more than was desirable in representation of their infant cases, but this was at least some basis from which to draw comparisons over time.

In that 1998 audit, only one-third of the 78 infant cases scored well in relation to risk assessment. There was better performance with respect to case planning and
decision making, but there were problems in meeting relevant standards relating to engagement and direct practice with the family and infant. This last was in part a feature of the bias of the instrument toward the verbal child. The qualitative comments noted the following major shortcomings:

- Poorly formulated risk assessment statements.
- Information gaps relating to men in families.
- Information gaps about the extended family and their interest in the child.
- Lack of use of specialist expertise (for example, drug and alcohol).
- Inattention to infants when notified as part of a sibling group.
- Minimisation of the impact of domestic violence on infants.
- Confused and inaccurate accounting for factual information.

That audit, like the CFRs conducted as part of the HRI evaluation, was limited in that it treated the case record as the window onto case practice (see 1.2.4), but in a field marked by high formal accountability, this is a legitimate though incomplete form of appraisal. Nevertheless, together these sources give some idea of the areas of practice on which the HRI project was intended to have an impact.

## 5.2 Estimating Progress: The First HRI Case File Review 1999

Section 1.2 presented briefly the method of this evaluation. The approach to evaluating impact is presented a little more fully here as a prelude to the presentation of the impact findings. The CFR conducted in 1999 as part of the HRI Evaluation (documented in HRI Evaluation: Interim Report 2B), used a slightly modified and more infant-specific form of the previous Department of Human Services audit tool (see Appendix 3 for list of questions). The standards for practice were organised according to the same four domains: risk assessment and risk management; case practice and decision making; engagement and direct practice; and inter-agency communication and collaboration.

The tool was augmented by a checklist of risk factors for infant cases used by the HRI project. The reviewers checked whether these factors were present in the case and whether they viewed them as serious issues in the working of the case. In the evaluation team’s use of these risk factors, it was decided to use the former checklist (‘present in the case’) as these were more reliably completed.

A 5% sample of infant notifications in the preceding year from each Region was drawn from those infants whose case was open at the time of selection and who had been notified to the Department of Human Services since the commencement of 1998. Infants were defined as being under two years of age at the time of notification. They were all, then, cases known to the Region since the inception of the HRI program, which in most Regions was more than a full year after commencement. The final sample statewide consisted of 158 cases that were rated in relation to 93 questions concerning the evidence in the CASIS record about standards of practice and recording. The reviewers examined CASIS case records for the six months preceding the review date (or less if the case had been opened more recently).

The evaluation team sought to draw a sample that represented the distribution of cases across the phases of intervention in the Region at the time of selection. Since there are many cases in the Child Protection Services that do not go to a Court Order before closure, the sample was weighted toward these early ‘protective intervention’ cases.

Since the evaluation team was not allowed direct access to case records, the 1999 HRI case file reviews were undertaken by the HRI program advisor from the Child Protection and Juvenile Justice Branch of the Department and the HRI manager from the Region concerned, each reviewing half the chosen cases. These staff members were chosen as those most knowledgeable about the required standards of protective practice for infants and those in the best position to act on the findings of the CFR to improve Regional practices. This was in the spirit of the formative goals of the program evaluation.

This process is open to the charge that those conducting the review might be biased in favour of finding positive results from the introduction of the HRI project. On the other hand, the review was conducted at a time when the Regions were still consolidating their work, and these staff proved as keen to find evidence of poor practices to be corrected, as they were to find evidence of positive achievements with respect to infant protection.

While the qualitative comments entered by the reviewers showed little difference between the Head Office reviewer and the Regional reviewer, there were some Regional reviewers whose mean scores were lower than the mean of the scores given by the Head Office reviewer. The lower Regional means appear to be largely a result of the lower scoring by the two reviewers mentioned above. It appeared that these mean scores might be related in part to Regional conditions, and might reflect tenuous connections between the HRI program and protective teams in those Regions in the earlier stages of SIFP employment. On the other hand, both the low number of cases concerned and the range of scores entered by these reviewers, suggests that this may be a matter of a few cases with poor case management distorting the picture.

Overall, however, when the differences between the Head Office reviewer’s results and those of the Regional reviewers, as a group, were tested for significance, the following results were found:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>0.70</td>
</tr>
<tr>
<td>D2</td>
<td>0.68</td>
</tr>
<tr>
<td>D3</td>
<td>0.54</td>
</tr>
<tr>
<td>D4</td>
<td>0.70</td>
</tr>
</tbody>
</table>

These results are not significant, lending support to the view that the Head Office reviewer and the Regional reviewers, as a group, were applying similar criteria.
5.3 Interim Impact Results Measured by CFR 1999

5.3.1 Standards Compliance

When the scores for standards compliance on comparable questions were compared in the 1998 case file audit (infant cases only) and the HRI CFR 1999, a trend toward improved scores was found across each of the four practice domains of: risk assessment and risk management; case practice and decision making; engagement and direct practice; and inter-agency communication and collaboration.

On every comparable question, a higher proportion of cases ‘clearly met’ the relevant standard in 1999 compared with 1998, and fewer cases were judged as falling into the ‘not met’ and ‘barely met’ response categories.

While these results were consistent with progress toward the quality improvement goals for infant protection practice, some areas still appeared to require attention, notably:

• Recording of the infant’s specific vulnerability and wellbeing.
• Use of infant-specific resources, knowledge and skills, both within and outside Child Protection Services.
• Attention to longer term case processes and outcomes, driven by the developmental imperatives of infants.
• Engaging families in clearly specified change activities.
• Effective strategies for overcoming blockages to engagement with parents (which may be linked with family difficulties/needs).
• Adherence to the Children and Young Persons Act 1989, s.119 Case Planning Principles with respect to permanency planning goals, and inclusion of ethnic and indigenous community representatives.
• Minimisation of placement changes for infants.

Overall, the CFR 1999 results were more positive than negative. There was strong adherence to formal procedural requirements relating to case intake, case planning, communicating concerns and procedures to parents, court action, and some aspects of supervision. There was reasonably strong performance in relation to collecting risk and needs data, with room for closer attention to infant specific variables and information about the social context of the family, including extended family issues. These results were consistent with the staged implementation of the HRI program, in the early stages of which most SIPWs focused on consultation at key procedural points in the case. There was also evidence that where SIPWs were involved, standards compliance was significantly higher than in those cases where they were not involved (see Appendix 20). While there may be many variables affecting this positive association between SIPW involvement and mean scores on the audit questions, the statistical significance of these differences lent some support to the hypothesis that the HRI program had made a difference to protective practice quality approximately 12 months into the life of the project.

The positive predisposition of the reviewers cannot be discounted, but their judgments were frequently supported by qualitative examples of data from the files.

On the basis of these judgments of file quality made by the DHS internal reviewers in the CFR 1999, the evaluation team cautiously argued that the HRI program appeared to have an initial impact, but identified the following major priority areas for the HRI program:

• Skill development in infant assessment and its documentation for child protection workers.
• Documentation in CASB of the links between parental risk factors and actual or predicted harm for the infant, that is, evidence about the process by which parental problems result in specific harm to the child.
• Overcoming barriers to engagement with parents, especially where domestic violence or substance abuse are evident.
• Examination of impediments to culturally inclusive procedures.
• Closer attention to planning for, and achieving, long term outcomes for infants in care.
• Stronger transmission of the SIPW service system contacts to other child protection workers.

5.3.2 Links between Key Practice Standards and Risk Indicators

The CFR1999 results generated several additional questions:

• Is standards-compliance affected by the kinds of families worked with?
  Again, common sense suggests that some family characteristics (suggested by the risk factors noted on the audit sheets) will be harder for workers to manage than others, with resulting differences in quality of work and its documentation.

With so many variables to be cross-tabulated, and little prospect of statistical significance given the methodological constraints, the evaluation team opted for a modest exploration of these questions, focusing on five performance criteria selected for their programmatic importance, and upon the five most commonly recorded family risk indicators.

The standards chosen were not simple procedural standards that readily attracted a ‘clearly met’ rating, but could reasonably be seen as complex standards calling for a relatively high level of well-documented practice. They were:

• The case record of the response and decision making regarding the risk issues contains specific references to, and analysis of, information regarding the parents and their critical risk indicators. (66% of the CFR 1999 cases clearly met this criterion.)
• The case record of the response and decision making regarding the risk issues contains specific references to, and analysis of, the infant’s vulnerability. (50% of the CFR 1999 cases clearly met this criterion.)
• Critical decisions were made within a permanency planning framework. (37% of CFR 1999 cases clearly met this criterion.)
• The plan is realistic and practical, focused on the infant’s needs and the risk issues and achievable solutions to the protective concerns. (24% of CFR 1999 cases clearly met this criterion. This low figure may relate to the several components of the standard to be satisfied.)
• The frequency and quality of the contact by the protective worker with the family has been appropriate to the case. (44% of the CFR 1999 cases clearly met this standard.)

For each of these criteria, cross-tabulations were made to explore how many of the cases that ‘clearly met’ that criterion also ‘clearly met’ the others. Similarly, for each of the chosen risk factors, cross-tabulations were made to explore how many of the cases with that factor ‘clearly met’ each of the chosen standards. (See Appendix 14 for the relevant tables.)

The risk factors chosen were:

• Family violence (63.3% cases).
• ‘Chaotic families’ (56%).
• Parental substance abuse (53%).
• Protective services history (44%).
• Child seen as problematic by parent (20%).

Cross-tabulating risk indicators with performance measures leads to sizeable amounts of missing data and hence small cell sizes. These and the margin for variability in secondary analysis of case record data collected by a number of assessors, demand caution in interpreting the results. The results are, however, suggestive of some findings that echo the narrative data obtained during Regional consultations, and they may be useful in generating ideas for further exploration. Provided that they are treated with caution, they help us begin to explore how clusters of variables might hang together.

From the cross-tabulations, several tentative connections might be made:

a. Parent risk X infant vulnerability

Of those cases where infant vulnerability was clearly documented on the case file, it was highly likely (83.5%) that parent risk factors were similarly well-documented. However, the reverse was not true. That is, in those cases where the reviewer was clearly satisfied with the documentation of parent risks, only 63.5% also clearly documented the infant’s vulnerability.

b. realistic and practical infant-focused plans X parental risk and infant vulnerability

Of the 38 cases judged to have realistic, feasible, infant-focused plans, 28 (73.7%) were also judged to be very clear in their documentation of both parental risk and infant vulnerability.

c. Permanency planning orientation X parental risk and infant vulnerability

Of the 58 cases that clearly met the permanency planning criterion, 70.7% also met the standard in relation to parental risk assessment, but only 48.3% met the infant vulnerability assessment standard.
These patterns together may suggest a stronger orientation to parental risk factors than to the impact of these on the child, and a link between the clarity of understanding parental risks and the plans developed. These connections are not absolute and reflect the lower general level of recording of infant variables.

In themselves these linkages are not of great significance, but they raise the possibility that when families present as ‘chaotic’, their histories marked by prior Child Protection involvement, substance abuse and/or violence, the child protection worker’s attention may be deflected from observation of the infant. Levels of contact sufficient to enable good case planning may suffer.

Contrasting with this impression is the cluster of results relating to the risk factor ‘child seen as problematic by parent’. While this category contains many different kinds of case situations, it appears that a common element is that the parent draws the worker’s attention to the child. In these cases, it was more likely that the worker would have adequately documented both the child’s vulnerability (78.1%) and parental risks (81.3%); would have had an appropriate level of contact with the family (62.5%); and would have produced a feasible and child-centred plan (43.8% compared with 25-30% for cases with other risk factors).

This pattern suggests, perhaps, that where a parent draws attention to the child, the worker may follow, but that it is otherwise possible that the parents’ own issues will become the dominant features of a case.

The major findings of the CFR 1999 were that, compared with baseline date from 1998, there was evidence in the case records of improved risk assessment, case planning and decision making, engagement and direct practice and inter-agency and inter-disciplinary collaboration in infant cases. These improvements appeared to follow the introduction of the HRI program and were most marked in cases where there was evidence of SIPW involvement in the case. While parents’ problems received considerable attention in these cases, there was room for sharper analysis of how these factors interact with the actual wellbeing of, or harm to, the infant. The analysis of the data suggests the proposition that since infant wellbeing is so contingent upon parent and family factors, if workers focus on the needs of the infant they are unlikely to neglect parental risks.

The subsequent HRI CFR 2000 built upon these findings by examining those cases that remained open for at least six months from the previous review, and exploring whether such an infant focus became more evident over time.

The major findings of the CFR 1999 were: that, compared with baseline data from 1998, there was evidence in the case records of improved risk assessment, case planning and decision making, engagement and direct practice and inter-agency and inter-disciplinary collaboration in infant cases. These improvements appeared to follow the introduction of the HRI program and were most marked in cases where there was evidence of SIPW involvement in the case. While parents’ problems received considerable attention in these cases, there was room for sharper analysis of how these factors interact with the actual wellbeing of, or harm to, the infant. The analysis of the data suggests the proposition that since infant wellbeing is so contingent upon parent and family factors, if workers focus on the needs of the infant they are unlikely to neglect parental risks.

This method of case selection removes from the second CFR the group of cases that had been criticised in the CFR 1999 for premature closure.

The data collection for the CFR 2000 was conducted by an experienced child protection worker and SIPW, seconded from the CAHCPS. Three cases were audited twice, once by this reviewer and once by the program advisor who had conducted many of the 1999 reviews. (The three reviews by the previous reviewer were discarded from the CFR 2000 analysis.) This process showed this new reviewer to be slightly more stringent in her scoring than the other, more akin to the Regional reviewers of the previous period.

In addition, the CFR 2000 asked for qualitative examples to substantiate the conclusions drawn for each section, and the reviewers made detailed entries. The instrument ended with a series of ‘outcome’ questions, relating to the progress of the case toward safe family care or alternative permanent care (see Appendix 4a).
6.1 Improved Assessment and Management of Risk

6.1.1 Key HRI Inputs to Risk and Need Assessment

When asked on each occasion of SIPW data collection to estimate what proportion of their time was spent pursuing the program goal of enhanced risk assessment, the mean estimated time proportion was 37.2% in May 1999, 41.9% in August 1999, and 40.7% in February 2000. Across Regions, the range was from 25% to 75%. From the more detailed activity data recorded by SIPWs, we can see that this focus on assessment and management of risk was located largely within those SIPW activities relating to particular cases (see the shaded areas in the table below). The CFR 4s, more than the CFR 5s, contributed in various ways to protective casework. The means indicated below represent the combined data from each of the teams of SIPWs who returned data. The ranges indicate highest and lowest Regional means for the period.

Table 7: Overview of the Mean Proportions (with Regional Ranges) of Time Spent on Activities, for the State

<table>
<thead>
<tr>
<th>Activity</th>
<th>State Mean % - Feb 2000</th>
<th>State Mean % - Aug 1999</th>
<th>State Mean % - May 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at case conf/cpm/fgc</td>
<td>8.5 (20.7)</td>
<td>7.4 (11.1)</td>
<td>3.7 (11.2)</td>
</tr>
<tr>
<td>Case consultation</td>
<td>16.2 (46.3)</td>
<td>17.3 (28.2)</td>
<td>21.0 (61.5)</td>
</tr>
<tr>
<td>Case management-case record</td>
<td>7.1 (12.1-16.3)</td>
<td>8.1 (3.4-24.1)</td>
<td>9.5 (0.9)</td>
</tr>
<tr>
<td>Case management-family contact</td>
<td>5.7 (0-11.8)</td>
<td>5.0 (1.4-8.6)</td>
<td>4.3 (0.1)</td>
</tr>
<tr>
<td>Case management-other tasks</td>
<td>4.1 (0-10.8)</td>
<td>6.4 (1.3-14.0)</td>
<td>4.4 (0.7)</td>
</tr>
<tr>
<td>Case monitor/audit</td>
<td>8.1 (0.7-20.9)</td>
<td>9.9 (3.3-23.8)</td>
<td>16.3 (1.3-46.7)</td>
</tr>
<tr>
<td>Court related activities</td>
<td>4.6 (0.12.8)</td>
<td>7.4 (0-23.3)</td>
<td>5.3 (0.17.4)</td>
</tr>
<tr>
<td>Flexible budget allocation</td>
<td>1.6 (0.3-3.4)</td>
<td>0.9 (0.3-2.2)</td>
<td>0.5 (0.2)</td>
</tr>
<tr>
<td>Other</td>
<td>3.1 (0.1-11.3)</td>
<td>5.0 (0-13.1)</td>
<td>2.1 (0.5)</td>
</tr>
<tr>
<td>Other Regional duties</td>
<td>7.8 (0-12.7)</td>
<td>8.4 (0-10.5)</td>
<td>5.6 (0.14.0)</td>
</tr>
<tr>
<td>Own professional development</td>
<td>2.9 (0.5-5.8)</td>
<td>4.9 (0-10.5)</td>
<td>9.5 (0.08.21.9)</td>
</tr>
<tr>
<td>Program documentation and development</td>
<td>9.5 (0-38.0)</td>
<td>3.4 (0-6.8)</td>
<td>4.2 (0.14.4)</td>
</tr>
<tr>
<td>Providing training</td>
<td>2.1 (0-4.4)</td>
<td>0.7 (0-7.4)</td>
<td>2.8 (0.7)</td>
</tr>
<tr>
<td>Service system networking</td>
<td>5.2 (0-11.7)</td>
<td>5.3 (0-8.8)</td>
<td>2.9 (0.7)</td>
</tr>
<tr>
<td>Supervision given</td>
<td>4.0 (0.1-8.3)</td>
<td>4.5 (0-31.7)</td>
<td>2.2 (0.4)</td>
</tr>
<tr>
<td>Supervision received</td>
<td>1.8 (0-5.2)</td>
<td>1.4 (0-5.2)</td>
<td>1.2 (0.4)</td>
</tr>
<tr>
<td>Travel</td>
<td>7.7 (0.3-30.9)</td>
<td>0.0 (0.7)</td>
<td>4.6 (0.15.8)</td>
</tr>
</tbody>
</table>

Aggregates for the State, for February, are based on data returned by nine Regions. Aggregates for August are based on data returned by seven Regions and, for May, on data returned by nine Regions. Each data set returned covered a two-week period.
The major tools of the HRI project in pursuit of the goal of enhanced risk assessment have been:

- The training in infant, family and service system assessment given to the SIPWs who in turn consult with other child protection workers at critical phases in the case, sometimes offering joint family visits and interviews. This consultation is clearly a very large part of their working week.
- The residential and in-home PASDS that provide ‘real life’ assessment opportunities through closely monitored parenting and analysis of the effects of corrective intervention.
- The specialist assessments (both home and office based) provided by other professionals and funded chiefly through HRI brokerage, focusing on the infant, the parents and, sometimes, the caregivers, and on the interactions between these parties. These have been most commonly provided by clinical psychologists with forensic, neuro-psychology or developmental specialties.

One must also bear in mind, however, that the Child Protection and Juvenile Justice Branch also embarked on widespread implementation of risk assessment training over this period, using the Victorian Risk Assessment Framework. It is, then, difficult to say definitively that the HRI project itself accounts for all the changes seen.

6.1.2 CFR 2000-Domain 1: Risk Assessment and Risk Management

The CFR 2000 was organised according to the same ‘domains’ as CFR 1999, with some modification of the previous instrument (see Appendix 4a). This section concerns the findings within domain 1: Risk assessment and risk management.

The risk assessment section of the Case File Review 2000 held fewer questions than the previous review format, largely because it focused on issues of longer term casework and case resolution and on longer term cases. It might be assumed that within these cases a risk assessment had been made prior to the period of the case record under review, but that continued monitoring and risk management might be necessary. Of the questions asked in CFR 2000 relating to risk assessment, the following ‘clearly meet’ the relevant standards most frequently.

- The case record of the response and decision making regarding the risk issues contains specific reference and analysis of information regarding the parents and their critical risk indicators (63.8% cases met).
- Overall, reasonable attempts were made to collect all critical information required to make a decision about what action is required at this stage (71.8% cases met).
- The case record outlines the decisions made about what action to take (76.1% cases met).
- A rationale for all decisions is recorded and is focused on the infant’s safety (70.4% cases met).
- Overall, available information was considered in terms of its meaning for the safety needs of the infant (75.4% cases met).

See Appendix 15 for full frequency tables for Statewide results on the CFR 2000.

On those questions that were consistent across the two review periods, almost all showed a rise in the proportion of cases clearly meeting each standard in the reviewer’s estimation, with generally two-thirds to three-quarters being rated as satisfactory. The corollary, of course, is that approximately 25% of cases were routinely not seen as satisfactory (or only partially so), and it is a matter for the Child Protection Service to determine acceptable levels. When the results are compared for only those cases that are consistent across the two review periods (see charts in Appendix 16a), it appears that the recording of parental risk indicators remained consistent, and attention to the severity of risk declined (perhaps because the threats had become less immediate after intervention). Incidents of risk tended to have lower profile in these cases, probably because less than 40% were still living with their parents for much of the period under review.

On the other hand, the cases were rated more highly than they had been previously on those risk assessment measures that directly concern the infant and documentation of knowledge about the infant. This improvement suggests that the previous recommendations to improve attentiveness to the infant as a person had been heard, and also dispels the concern that infants may become or remain invisible once a case has progressed beyond the initial investigation stage. Comparing results when cases are directly matched, however (see Appendix 16b), shows that while half to two-thirds of the cases show little change, there is a band of a quarter to one-third of cases that vary in terms of their levels of standards compliance.

Qualitative comments made by the case file reviewers about matters of risk assessment and risk management illustrate some of the improvements over previous reviews as well as areas still requiring attention. Problems in the recorded assessment of, and accountability for, managing risk attracted more comments than any other sections in those cases generally rated lowest overall. In the poorly rated cases these comments tended to refer to the lack of specific information about the infant, such as observations made on home visits, for example:

**Older sibling on order, new injury to face. No information regarding likelihood/risk to infant.**
**Assessment regarding older sibling very poor. Assessment re infant-nil.**

In the worst scenarios, the reviewer noted serious failures to follow-up major risk indicators.

In those cases as ‘partially’ meeting risk assessment criteria, comments were made indicating patchy performance, such as:

- *Partially met* was a judgment that might also reflect systemic factors, such as worker turnover.

In the cases rated highest overall, the reviewer’s comments about risk were less fulsome, but included summaries such as:

- *Generally good documentation, including monthly summaries, CARAs (the recording tool of the Victorian Risk Framework). However, several incidents placed the infant at risk during access, and these should have been addressed more promptly.*

In relation to infant risk assessment, there were clear improvements noted, but some lapses still occurred in adequate documentation of the condition of the infant and the impact of parental risk factors on the infant. It is possible that temporary or long term removal of the child, in its reduction of immediate harm, masks longer term risk factors. Although it is possible that the workers were very aware of the infant but failed to document this in specific terms, there is some reason to believe that the issue was more than one of recording, since these lapses in the reviewed files appear to occur when one or more of the following issues applied:

- The infant is part of a sibling group where older children’s issues claim official attention.
- There was no recent active involvement of a SIPW or other HRI inputs, and no HRI endorsement of case closure decisions.
- The case ‘slipped’ in a transfer between workers, teams or Regions.
- The case assumed a low priority because of apparent parental absence (missing, jail) or status of the order (especially Supervision Orders).

6.1.3 Reviewer and Child Protection Worker Perspectives Compared

A comparison was made of the reviewer’s comments on the seven lowest scoring cases with the child protection workers’ survey responses on the same cases (five were returned). The comparison suggests that, in contrast to the reviewer’s concern, the workers believed the risks to be understood and managed. In three cases, the cursory statements to this effect do not substantiate this view. In one case the worker was clearly aware of the vulnerability of the infant and subsequently took action appropriately and had requested a SIPW consultation, but the cost of delay was a period of several months of high risk while change efforts were attempted. In one case the worker provided sufficient detail to suggest that there were levels of service input, monitoring of the children, parental behaviour change, and HRI involvement, that were more substantial than the reviewer could detect from the written record.

In the five highest scoring cases, four infants were in long term placement (on Custody or Guardianship to Secretary Orders) and one was successfully reunified with the parents. In the five cases that varied in terms of their levels of standards compliance.

In relation to infant risk assessment, there were clear improvements noted, but some lapses still occurred in adequate documentation of the condition of the infant and the impact of parental risk factors on the infant. It is possible that temporary or long term removal of the child, in its reduction of immediate harm, masks longer term risk factors. Although it is possible that the workers were very aware of the infant but failed to

6.1.4 Reports from SIPWs Regarding Changes in Risk and Needs Assessment

SIPWs report great variability in the degree to which other child protection staff have improved their
assessment practices, and suggest a range of factors underlying the variability. These include:

- Personality and role confidence: anxious workers often still ask for direction rather than taking initiative in the assessment process.
- Use of the VRF: workers who work through the VRF, including the sections calling for worker judgment, are likely to incorporate their HRI knowledge.
- Team leader and unit manager confidence in, and acceptance of, the HRI program: some workers have been deterred from using the HRI resources and their assessments do not include relevant material.
- Worker turnover means that not all workers have had the opportunity for visits accompanied by their mentor and case consultations.
- Incidence of infants on worker caseloads: those located in infant units or recognised as having skills with, or interests in, infants tend to use knowledge to improve their assessments.
- Bright workers with a strong interest in continuing professional education and upgrading their professional qualifications tend to avail themselves of the material and learn to incorporate it more quickly.
- Outlying offices in some rural Regions have had less exposure to HRI input.

6.1.5 Reports from Child Protection Workers Regarding Changes in Risk and Need Assessment

Team leaders and unit managers have, perhaps, less pressure to see major behavioural change in their workers than do the SIPWs, and consequently their threshold for noting improvements may be lower. They tend to report significant gains in risk assessment standards and attribute these mostly to the active involvement of the SIPWs or the benefits accrued from expert external assessments and PASDS inputs. Several expressed the view that while risk assessment is improving all the time, to the point where they see major differences between their own understanding of risk and that of workers in the non-government sector, needs assessment based on strong developmental theory is less well developed as yet.

However, those front-line and advanced child protection workers consulted (possibly those workers with a stronger appreciation of the program and a desire to feed in their positive views to the evaluation) had a stronger appreciation of their own changed assessment capacity. This was especially so if they had worked on multiple occasions with a SIPW, had undertaken joint visits with a SIPW, or had experienced close supervisory case management by a SIPW. They reported such changes as:

- Being more vigilant about seeing the infant regularly.
- Watching the interaction of the infant and parent.
- Using body checks if there was reason to believe there might be an injury.
- Exploring issues such as feeding patterns.
- Assessing the child according to developmental milestones.

They tended to emphasise attachment and bonding issues as a focus of inquiry. (HRI managers have noted that the approach to the complex and contentious issues of attachment assessment is still quite superficial.) Generally, child protection workers saw SIPWs as contributing to their assessment practices through enhancing awareness of the infant as a person with distinct needs, helping the worker assess the risk levels and supporting the worker through the implementation of the plan. External consultants were seen as contributing to protective assessment through enhancing the workers’ awareness of parental personality variables, cognitive abilities, learning patterns and change potential. It was in the context of this enhanced input to the infant cases that a child protection worker reported, with support from her peers, that: ‘It makes us braver about keeping a baby in the family’.

6.1.6 Feedback from External Service Providers about the Impact on Protective Assessment

From the respondents who felt able to comment on change in this area, there was a general belief that practice had improved through enhanced sensitivity to infant needs and ability to use specialist information.

What is less clear is the degree to which they see this as generalised to the wider body of child protection workers or base their observations on their dealings with HRI team members. While four external professionals explicitly mentioned improvement in the work of child protection workers other than SIPWs, these improvements were not about assessment exclusively. Other respondents cited events and themes relating to the HRI teams themselves when discussing improvements in assessment.

6.2 Better Informed Case Decision Making

6.2.1 Key HRI Inputs to Case Planning and Decision Making

This section reviews data relating to the procedural aspects of decision making and the processes and working relationships with the families that fuel these decision making procedures and facilitate the two-way flow of information. Key HRI contributions designed to enhance this goal were:

- Trained HRI managers at a level (CAFW4) that allowed them to accept case planning delegations, if necessary, and to negotiate on equal terms with other decision makers.
- Trained SIPWs at a level (CAFW4) that allowed them to chair case conferences and provide direct supervision to workers, if necessary, and to negotiate on equal terms with team leaders.
- Brokerage to commission expert input to guide the process of engagement with parents, the provision of information about change potential would be available to case planners.
- Training focused on critical decision points, such as decisions to separate or reunite infants with their parents.
- PASDS to allow monitoring of the consequences of decisions prior to the finalisation of case plans and Departmental withdrawal.

It is clear from the snapshots of activity data provided by the SIPWs that, throughout the program, their efforts have been focused internally on Child Protection Services. Time spent by the CAFW 4 SIPWs on case-related duties, and case consultation in particular, clearly outstripped all other functions (see SIPW activity data Table 3, Appendix 12). Even the HRI managers had an internal focus, though reducing over time, and made substantial contributions to protective case practice through case planning meetings, consultation and monitoring. Over each of the three data collection periods, CAFW 4 SIPWs spent approximately 60% of their time with other child protection staff members (usually caseworkers). The HRI managers (some of whom are also sole SIPWs) spent at least 80% of their time with child protection staff, divided evenly between base-grade and senior staff members.

When asked on each occasion of SIPW data collection to estimate what proportion of their time was spent pursuing the program goal of enhanced case decision making (and court outcomes), on average the SIPWs estimated this as about one-third of their time. Across the State and the three data collection periods these estimates varied from 17.6% to 48.6%.

6.2.2 CFR 2000—Domain 2 Case Practice and Decision Making and Domain 3 Engagement and Direct Practice

Risk assessment activities are meant to feed directly into case decision making and case planning activities. The baselines established for the project (see section 5) suggested that while formal case planning procedures were adhered to, there was room for improvement in analysing case information and translating it into well-reasoned case plans. There was also room for improvement in the level and quality of the face-to-face contacts with immediate and wider family as a basis for that planning. This section examines the areas of planning and direct contact together (domains 2 and 3 of the CFR instruments).

To what degree did the cases continuing to the CFR 2000 meet the standards in relation to case planning? In domain 2, the questions that achieved the best level of compliance with standards in the highest proportion of cases were those relating to:

- Aboriginal involvement in decision making (100% of the 10 relevant cases).
- Aboriginal involvement in care planning (88.9%).
- Adherence to the principles of case planning in s.119 of the Children and Young Persons Act (1989) (80.3%) (see Appendix 17).
- Case conference/protective plan held (81.7% relevant cases).
- Review held or planned (85.5% relevant cases).

Improvements were seen on most questions in domain 2 between the two audits, taking the total sample each time as the basis for comparison, when only those cases that continued across the two reviews are considered, and when the results across both periods are matched to see whether individual cases improved or declined. (see appendices 15 and 16a and 16b). This
is further support for the conclusion that for these infant cases, at least, time ‘in the system’ did not result in decline in case planning attention.

There were, however, some reductions in the percentage of cases clearly meeting the criteria in relation to:

- Working within a permanency planning framework—clearly met in only about one-third of cases in the second review.
- Appropriate response to incidents of risk (‘not apparent’ that standard was met in approximately one-quarter of relevant cases).
- Documentation of the case plan (almost a quarter judged inadequate).
- Clear definition of roles.
- Regular contact with parties to the case plan (about a third only ‘partially’).

Of these, the most concerning and puzzling, given that the focus of the second review was upon longer stay cases, is the suggestion that decision making occurred within a permanency framework clearly in only 22 of the 74 cases (29.7%).

This appears to relate to an ambiguity in the wording of the question in that it implied that question was relevant only if it was apparent that long term care by the family was unlikely. A previous question (see Table 13, Appendix 15), which also looked at whether the longer term implications for the child were considered, scored much better. Closer examination of the review returns suggests that many of the 31 cases for which ‘not apparent’ (the lowest score) on the ‘permanency framework’ question was entered would have attracted a ‘not applicable’ response if that had been offered. Cross-checking against the supplementary questions about whether these cases had moved closer to permanent care or reunification reveals that of these 31, eight moved closer to reunification, one moved closer to permanent care, and for only seven was the answer ‘no’ to both these questions. The rest were marked ‘not applicable’, usually because the children had not been removed from home.

For the full sample from the second CFR, the pattern of response to these questions was:

<table>
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<tr>
<th>Table 8: Permanent Plans CFR 2000 Sample</th>
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<tbody>
<tr>
<td>Permanency Orientation</td>
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<td></td>
</tr>
<tr>
<td>Has the case moved closer to reunification?</td>
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<tr>
<td></td>
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<tr>
<td>Has the case moved closer to permanent care?</td>
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This suggests some idiosyncrasies in the case histories, for if all the 24 or 25 ‘not applicable’ were those cases of children who had consistently remained at home and for whom neither reunification nor permanent care was appropriate, we might expect the ‘yes’ and ‘no’ responses to the two questions to be mirror images. The clear preponderance of ‘yes’ responses to the permanent care question over the ‘yes’ responses to the reunification question suggests permanent care might be the more common case direction for infant cases open for more than nine months. However, this would be misleading if the remaining 25 have been able to stay at home, as appears to be the case.

The few qualitative comments by the reviewer about an inadequate permanency planning orientation focus on the slowness of progress toward resolution, given the age of the infant (in part a consequence of the Act), and occasionally on the tendency to fail to confront the realities of an unlikely reunification plan.

In most cases, the reviewer noted the placement and case plan at the end of the period under review, and the following pattern emerged (Figure 10 below).

The numbers in Figure 10 suggest a substantial reliance on kin for both permanent and temporary care but, if the ‘other care’ figures accurately suggest that these are not kith and kin placements, there is an even greater reliance on non-relative foster parents to provide permanent care for infants. Although 10 cases were named as having achieved permanent care, these had not yet (in most cases) resulted in a Permanent Care Order, mostly because the infant had not yet been out of parental care for two years. Together, these results suggest an active pursuit of secure placement for infants, in some cases in advance of the legislated timelines and in response to the developmental imperatives of the infants. It might be desirable to institute a tracking system to develop further data on how soon after notification infants have a Permanent Care plan made, and how long after that planning decision a Permanent Care Order results, with attention to the factors influencing this timing.

This sample was only half the size of the previous CFR sample and excluded many cases that had been closed after protective intervention. (Approximately one-quarter of the earlier sample were believed to result in children safely returned home. One cannot, of course, be sure of the continued safety of these children.) Yet, even so, almost half of the infants in the CFR 2000 group were at home with one or both parents and several more were destined for home. While, there was a substantial group of infants who appeared destined for permanent care, the clear majority of infants sampled for the HRI evaluation were permanently removed from home by the Child Protection Services.

In four of these 31 cases of children at home (12.9%) the reviewer explicitly stated a belief that this situation was unsafe. This was a much lower proportion than noted in the earlier audit, where the safety of 36 of 158 (22.8%) infants was questioned. Most of these 36 were at home and were cases where the reviewer judged that the case had been closed for ‘no further action’ prematurely or where the case was in an initial intervention phase at the time of the review and the reviewer judged that the investigation was not sufficiently timely or incisive. Some of these cases were subsequently resolved more satisfactorily as the investigation proceeded, more information became available and interventions were tried. A closer examination of the limited case specific detail available to the evaluation team shows that many of the infants who were at home arrived there via a period in foster care or with kin. It appears that often it is the separation of the parents that provides them with the opportunity to return home. This in turn is related to the high incidence of domestic violence in these cases— at least half. Those infants who were in, or destined for permanent care were more likely to come from families with multiple risk factors. While, for example, substance use and misuse was also very pervasive, it tended to be the combination of this with other multiple complex issues, such as mental illness,
Desirable levels of contact with infants in a range of situations seems worthy of further program attention. Whether or not these levels of contact are appropriate will hinge to some extent on who else is involved with the infant or family. With a drop in scores on inter-agency collaboration (see section 8) the child protection worker’s role may well remain central.

On the other hand, there were clear increases in the approval of documentation about the infant’s wellbeing and interactions with parents, although at approximately 50% ‘clearly met’ this could be improved. HRI project input, usually in the form of SIPW consultations, as well as SIPW face-to-face

- There were only 18 cases where it appeared that the child protection worker had been refused access to the child. It remains of some concern that, of these, in only three cases was the reviewer satisfied that a decision had been clearly made on how to ensure that the infant was seen.
- There were clear improvements noted with respect to the clarity of the changes required in the child’s condition or situation, and the clarity of the child protection worker role. The requirements of parties to the case plan were clear in 74.6% of relevant cases.
- Infants were seen by the child protection worker at least once a fortnight in 23.2% of cases, and at least monthly in 62.3% of cases. Only in 48.6% (34) of cases was the frequency of child protection worker contact with the infant judged to be clearly appropriate to the case; all but six of the rest of the cases scoring a ‘partially met’ response. This is a level similar to the previous review, with no increase in the proportion of contact by a suitable alternative monitor. For most of the period under review, 39.4% (28) of the infants had been with one or both parents, 32.4% (23) had been with relatives, and 19.7% (14) had been in foster care. Permanent care accounted for 8.5% (six children). The reviewer was less likely to be satisfied with quality and frequency of recorded contact between the child protection worker and the infant when the infant was in the care of relatives, foster carers or permanent carers.
- In one-third of cases where there was evidence of resistance or hostility, there were clearly planned engagement strategies, but the proportion of cases where this was an issue had reduced (perhaps in line with the later stage of the cases.) The lack of strategies to overcome such problems in two-thirds of the relevant cases, leaves room for further attention to this issue.

Reported contact frequencies were as follows:
- 31 cases (34%) were clearly met
- 26 (28%) were partially met
- 13 (14%) were not apparent

• Related to this, there were improved scores registered with respect to the infant’s needs being met by the care arrangements, and placement changes were less frequent. No cases failed the criterion that placement changes must be defended as appropriate to the case.

- ‘Overall, make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would’ was a standard ‘clearly met’ in almost 90% of the cases for which it was judged appropriate (39/46). This might be regarded as generous given some of the less positive scores accorded other items within this domain.

6.2.3 CFR Qualitative Data—Domains 2 and 3

Over the period of the HRI program, which also coincides with the further embedding of Family Group Conferencing and the introduction of the VRF, it is clear that a key feature of the case decision making process is that extended family members are contacted more routinely than had previously been reputed to be

contact with the family. They are involved in the assessment and intervention processes, not only in order to provide a home for the child. In relation to the highest scoring cases, the reviewer noted the careful planning, attention to detail and thorough documentation. For example:

Excellent, well managed case. Intensive activity with the aim of strengthening the family’s capacity to care and provide safe, stimulating environment, acknowledging all of the infant’s needs in terms of emotional, physical development, etc. Although prospect of success appeared poor (mother’s attachment was very poor), DHS worked intensively on the reunification plan. The careful plan and monitoring along with the appropriate use of services such as PASDS, psychiatric services, enabled an adequate attachment to develop between parents and infant. Parenting skills and confidence also a focus. It is assessed that the infant is safe at present in parents’ care, however without very intensive supports, counselling, etc., the reunification plan may well still fail.

<table>
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<tr>
<th>Table 9: HRI Input and SIPW-Family Contact x Infant Sensitive Documentation</th>
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<tr>
<td>Documentation of Infant’s</td>
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<tr>
<td>Wellbeing Indicators</td>
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<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>HRI input</td>
</tr>
<tr>
<td>HRI input</td>
</tr>
<tr>
<td>No HRI input</td>
</tr>
<tr>
<td>Total</td>
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</table>

Desirable levels of contact with infants in a range of situations seems worthy of further program attention. Whether or not these levels of contact are appropriate will hinge to some extent on who else is involved with the infant or family. With a drop in scores on inter-agency collaboration (see section 8) the child protection worker’s role may well remain central. While it was possible for cases to be rated as clearly or partially meeting these standards without HRI project input, this was less likely. These findings are suggestive of a program impact, but show that the diffusion of desirable practices is still incomplete (presumably for many reasons).
Evidence noted in the direct involvement by SIPW in assessment/case planning/decision making, and action plan. Also, SIPW expertise was useful in engagement of family, critical but collaborative and timely decision making, Knowledge of impact, long term, on infant in temporary care.

In the lowest ranked cases, the comments related to the lack of evidence of case planning and review meetings, unrealistic planning, drift in cases as they transferred between Regions or teams, and lack of monitoring and review in situations of continuing risk. This example shows the significance of organisational conditions in interpreting these findings:

Case was reopened ...when a professional dealing with mother notified. Immediate follow up should have occurred to establish current care arrangements of infant to ensure immediate safety then a planned investigation etc. occurring. This appears not to have occurred, due to illness of staff in Intake. Case was not transferred to Response for action. This may raise the question of communication and role clarification between Intake team and Response team and where the SIPW fits into has occurred. It noted that SIPW was not advised or consulted and case waited until Intake team became available.

A reading of the qualitative comments across all the Regions suggests the following regional summaries, each numbered point representing, for one Region, the main issues raised by the reviewer:

a) Some poor practices without SIPW involvement, and good practices with SIPW involvement. Poor tracking to a new Region. Good work on permanency planning.

b) Generally systematic SIPW advice and good use of other HRI resources to resolve permanency. Some vagueness and limited impact in one Supervision Order case and one Guardianship case. Awareness of domestic violence.

c) Much more direction and clarity when there was SIPW involvement. Drifting Custody cases.

d) Excellent cases where there is HRI involvement in providing both resources and complex case management, and some extremely poor cases without HRI involvement. Gaps between teams and between offices.

e) Regular SIPW input appeared to be related to good casework and recording, and especially planning and collaboration. An understanding of domestic violence was evident. There was room for improvement in recording infant-parent interactions. Closure and Regional transfer was not handled well in one case.

f) Good outcomes where HRI was heavily involved, often early in case. Later work with infants on Supervision Orders and in sibling groups needed more attention. One Koori case very badly handled.

g) Cases generally received more positive comments when there was SIPW consultation and other HRI input, and in these there was evidence of cautious practice, a clear permanency planning orientation in these, and attention to the infant. Two cases were criticised for leaving the child at risk.

h) While there were good cases with SIPW involvement, other poor cases lacked this or deteriorated some time after early SIPW consultation. Two cases were seen as having continued to have a very high level of risk. Drug and alcohol analysis and interventions were not strong. Supervision Orders tended to be more neglected. Collaboration was generally good.

i) Three cases were doing well with HRI input and several others were drifting, usually without SIPW involvement or, in one, with the SIPW advice not followed. There was evident difficulty resolving cases of parental substance abuse, but otherwise good use of consultants.

Each Region had a mix of cases viewed very positively, and cases seen as poorly served. Well-regarded case records were marked by tight planning, good collaboration, attention to risk and infant-specific information. Where performance was seen to be poor, drift over time as the case wore on was of some concern, and both inter-Regional and sectional transfers, and parental substance abuse, were seen as associated with poor performance.

From these summaries it can be seen that the reviewer made clear links between HRI input and SIPW consultation in particular, and the quality of case decision making and practices as recorded in the CASIS files. While it might be argued that the reviewer was sympathetic to the HRI program, the review format asked for evidence of HRI input and for specific examples of good and poor practices. Many were provided.

6.2.4 Caseworker Questionnaires: CFR 2000

Of the worker questionnaires relating to the 71 cases in the CFR 2000, 40 were returned (56%), from a mix of Regions and teams, including some from teams overseeing contracted cases. There is nothing in the responses to indicate a systemic bias in these returns other than, perhaps, the diligence and time of the individual worker sent the questionnaire.

Workers were asked a number of questions about the cases reviewed, including their goals for the case and whether they were confident that the infant’s safety had improved and, if so, why. One might expect few answers in the negative, as workers tend to have a high sense of personal responsibility for their cases. This was so—only in one case did the worker express concern that the child had received injuries and that parental care was unsafe, and in three there was uncertainty.

The pattern of reasons for seeing the child as safe is interesting, both because the reasons relate to the placement outcome data above, and because they give a small glimpse of the degree to which HRI concepts are articulated by workers.

Workers reported that, of the 40 cases, 20 were safe because the baby was placed, 11 were safe because the placement had changed in some way, five because the department had separated and five because of other factors (for example, social support or re-housing.) While the answers were usually in this brief form, a number of workers elaborated, some showing sensitivity to infant wellbeing. For example, with respect to children in placement, several noted details of observed access and safety plans for access arrangements. Two workers justified their conclusion that the infants were safe at home in the following terms:

...there are clear signs of the parents providing for the needs of (the child) and a strong bond is occurring. (The child) is meeting her developmental milestones.

The situation has become safe due to mother’s increasing understanding of the needs of her child and her own needs. Increased understanding by mother of how her behaviour impacts on her child.

Workers views were also sought about what factors facilitated or impeded progress toward the case goals in these 40 cases, and the replies were grouped into clusters as indicated below. (The number in brackets after each point represents the number of cases for which this factor was mentioned.)

Facilitating factors:
- Parents accept service support (13).
- Support from extended family (9).
- Parent/s committed to addressing protective concerns (9).
- Good work/engagement by child protection workers (8).
- Child is very much wanted by parents/carers (7).
- HRI involvement (5).
- Suitable permanent carers found (4).
- Good case plans (3).
- Better housing has been accessed (2).
- Parents are educated re: risk (2).
- External assessment of parent/s was undertaken (2).
- Problematic parent not currently involved/living with child (1).

Impeding factors:
- Parents not committed to addressing protective concerns (9).
- Ongoing parental drug use (7).
- Problems with work overload (Department/other) (6).
- Parent/s not willing/able to comply with order/plan (5).
- Lack of available resources (5).
- Parent’s/s’ relationship patterns (5).
- Parent’s/s’ problems with anger management (3).
- Parent’s/s’ low IQ (2).
- Parent’s/s’ ambivalence or lack of attachment to child (2).
6.2.5. SIPW Report of Changes to Engagement and Decision Making

Through the field visits and meetings, several SIPWs shared their observations of whether workers had changed in their engagement and case planning practices. Generally, all acknowledged that some workers were very skilled in this area, and others still learning but enthusiastic. From different Regions, however, came observations about significant worker deficits, particularly in the area of engagement. These included poor basic interviewing and especially listening skills; muddling the legitimate and judicious use of authority with authoritarian instruction; and superficial use of notions of attachment, without discriminating types of attachment or attending to how the child responds to the mother. These difficulties were attributed to various causes:

- Limitations in pre-service education and recruitment of unskilled staff.
- Workload pressures and too rapid assumption of caseload responsibilities, restricting workers’ access to induction training.
- The pressures on team leaders that prevented them from live supervision and mentoring.
- Poor modelling and an authoritarian culture in some teams.
- Flow-down effects of disrespectful practices toward workers at court.

SIPWs stressed the importance of the consultation process for assisting workers to refine the logic of their case planning recommendations. They did not see this as a diminishing need.

6.2.6. Child Protection Worker Report of Changes to Engagement and Decision Making

The focus groups of child protection staff reported gains in confidence in working with parents toward better case plans and outcomes. The case planning process itself was not usually described as greatly affected by the HRI program, unless the HRI manager assumed the case planning delegation for the case. Senior staff were divided over the advisability of this, some expressing relief at having some of their onerous workload shared with the HRI Unit, others expressing concern that it is unit managers who must retain case planning delegations for all cases allocated to their workers. Front-line child protection workers tended to focus on the benefits of HRI consultation and joint work. They noted that joint visits and consultations with SIPWs increased their awareness of how to make pertinent observations and enquires to inform their decision making, and reported that they believed their case planning to be greatly improved by inputs from external experts and PASDS staff. Many of the examples they gave related to their changed understanding of, and confidence in, the process of engagement with parents on the common ground of their infants’ needs. Such examples included:

- Using the advice about personality disorder given by a forensic psychologist to help focus the work with a volatile young couple, and work with them to contain their anger in the interests of the children.
- Encouraging the parents to join with them in deferring to the specialist infant workers (SIPWs or PASDS) to clarify parenting issues about which the parents were unclear.

Parents relate differently because we are talking about their baby… They talk better if there is a SIPW and me…listen to the ‘special infant worker’.

Directly using knowledge gained from the program to shape goals with the parent, for example, a feeding routine or access management plan.

6.2.7. Return of Problematic Parent to Child’s Home/Life (1)

- Return of problematic parent to child’s home/life (1).
- Previous long history with Department of Human Services (1).
- Poor housing situation (1).

These comments suggest that, for the caseworkers, it is largely the engagement of adult family members, including parents, in the case planning and management that facilitates the attainment of case goals. Parental intrusiveness, for a variety of reasons, is seen as the core impediment to case resolution.

While the HRI project essentially asks the child protection workers to be more infant-focused, it seems that to the worker this will be contingent upon resolving the working arrangements with the parents. This indicates the importance of HRI training and consultation attending to helping workers develop a wider repertoire of ways of engaging parents in making protective decisions about their infants.

6.3 Conclusion: Impact on Assessment and Case Decision Making

These central goals for the HRI initiatives were both basic and ambitious. From a wide research review, Gough (1993:12) suggested that:

- Child protection cases have relatively high rates of re-referral. There is little evidence that child protection services improve outcomes for children or reduce re-referral rates (except when children are permanently removed).

While the statistical data about the Victorian population of infant clients of Child Protection Services over the past three years suggests that it is possible to reduce re-investigation rates (see section 10), this difficulty of prediction in child protection is a constant challenge. Macdonald and Macdonald draw attention to the field’s generally poor understanding of probability, and note the danger of decision making on the basis of low frequency events. ‘Preventing homicides’ is thus not a rational goal, although while intervening to prevent detectable suffering we might incidentally prevent some deaths’ (1999:31). They focus on the need to test hypotheses and beliefs against information about the case, and to ask: what is the probability of these data arising if the hypothesis (for example, that the child will be harmed) were true? This exercise requires good population and outcome information that is usually not available in the child protection system. When, therefore, we draw conclusions about changes to risk assessment practices through the HRI initiatives, we do so within the parameters allowed by the current state of local knowledge.

The data from the multiple sources feeding this evaluation suggest that there have been clear gains in risk assessment and decision making for infants over the course of the program. These include:

- Closer attention to the emerging consequences to the child at risk of harm (notably such factors as domestic violence, untreated and symptomatic mental illness, unmanaged substance use).
- More active efforts to intervene to moderate those risk factors which safeguard the infant’s wellbeing and development.
- A much more sophisticated approach to the assessment of parental capacity and motivation through the use of direct, informed observation and analysis of the effects of parenting interventions.
- A stronger orientation toward case resolution by keeping infants at home with multiple services or seeking to stabilise them in permanent alternative placements with kin or permanent caregivers.

These gains are, however, far from universal across the whole of the infant client population, and even in the sample considered in this evaluation there remained some cases that appear to have been poorly served. The matched data (Appendix 16b) suggests that there is a considerable group of cases (50-70%) that continue as they began in terms of standards compliance. From outside this process, it is difficult to determine whether this means that if one starts well, then it is easier to continue well, and if one starts poorly that will continue to haunt the planning. If so, this would suggest HRI input in the early stages would be well-placed. It may, however, suggest that there are pockets of volatility relating to local, team, worker and case issues that make standards compliance a patchy affair. This would be more indicative of a need for highly flexible support that could meet needs where and when they arise, perhaps targeting ‘hot spots’.

I’m your baby and these are the things I need… What do you think about whether you can give me these things just now, and how…?
7 Program Impact: Infant Protection and the Children’s Court

7.1 Introduction—The Context

One of the goals of the HRI program was to improve the performance of child protection workers at court, in the interests of securing improved court outcomes for infants. The evaluation team was, therefore, asked to look into how infant cases fare at the Children’s Court, the involvement of the SIPWs in the pursuit of court outcomes, and what strategies appear to be linked with what child protection workers define as successful protective interventions and acceptable settlements at court. The evaluation gathered material about recent court issues for infant Child Protection Services clients in Victoria from:

- Individual and group consultations with SIPWs.
- Regional consultations with other child protection workers and some community lawyers.
- Head Office (Child Protection and Juvenile Justice Branch) consultations.
- A consultation with the Court Advocacy Unit (CAU) management.
- Child protection worker interviews about a sample of selected infant court cases with HRI involvement.

Since the major part of the data presented in this section comes from child protection workers, and illustrates their observations about the Children’s Court compared with Regional courts, and the representation and support provided by the Department’s own CAU to the metropolitan Regions.

The Children’s Court is administered by the Department of Justice, and magistrates, while drawn from the general population of magistrates, specialise in children’s matters. In these cases, they are the investigators and prosecutors of the cases, they instruct legal counsel to represent them at court.

The CAU, staffed chiefly by lawyers, is located in close proximity to the MCC and is responsible for the legal representation for the Child Protection Services. CAU staff members are also, however, responsible for legal advice to child protection workers. The CAU has one legal officer (trained lawyer) or court officer (child protection worker with experience in court matters) on duty daily to provide legal advice over the telephone to child protection workers. The CAU staff have a close involvement with the MCC, representing child protection workers directly on every Family Division matter before the MCC each day, as well as briefing barristers for contested hearings at court. Legal staff are responsible to court by virtue of their role and ethics, but are employed (or briefed and paid) by the Department to prosecute cases and represent the Child Protection Service in the metropolitan area. As both representatives and advisors, CAU employed and funded lawyers often negotiate with other parties over conditions and other matters of contention, sometimes asking child protection workers to modify their requests to the court.

The CAU management reports a number of constraints upon their service. These include a limited budget for briefing barristers. The set daily payment rate exceeds that paid by the Legal Aid service to other parties at court (usually parents and older children who are able to give separate instruction); however, barristers finishing early on a given day check with the CAU staff and provide assistance with other cases listed for the day. The CAU also faces the constraints of a high throughput of cases, with little preparation time for urgent cases. Under the present system for organising the throughput of cases, they report a restricted capacity to arrange for the same lawyer to handle a case across several appearances. In addition to the CAU arrangements, several Regions have their own court advisory officers who assist child protection workers to prepare cases for court. In rural areas, child protection workers tend to work regularly with designated local lawyers, sometimes briefing Melbourne barristers for difficult contests, or occasionally arranging to have a case heard in Melbourne.

It was reported by child protection workers and lawyers that, increasingly, much of the work of the court is conducted outside the courtroom, in the negotiations between the legal representatives for the
various parties. Workers must be on hand at court to work with their legal representatives on these matters under negotiation. They are, therefore, called upon to be skilled and confident in presenting a case to court, clear about their recommendations, but also free to negotiate and confident in working with the legal representative in the negotiation process. From the Regional consultations, it was evident that team leaders and unit managers, as well as SIPWs, also often assist child protection workers to prepare a case for court, reviewing the court report, discussing the evidence, and planning how to present this. It was reported that team leaders and unit managers may also have strong views on what outcome is desirable and, therefore, help shape the recommendations made to court. The evaluation team formed the view that in a formal hierarchy such as the Child Protection Service, these instructions are often experienced as compelling by the allocated child protection worker. The allocated worker, however, must bear a personal responsibility for preparing a court case, for it is the worker concerned who can testify to what she or he has seen, heard and done. It is the worker who may have to respond to the lawyer’s advice and negotiation efforts at the time of the court case. The mix of the accountability and flexibility required of the child protection worker is a feature of current court practice.

In interpreting the experiences of child protection workers, it is important to bear in mind that, while these workers have police-like roles in investigating cases and taking Protection Applications to court, the Child Protection Services workforce is welfare-oriented. Under the terms of the Children and Young Persons Act 1989 its workers are expected to assist families to resolve child protection issues, not merely to investigate cases and instigate court action. The workforce is also diverse. A mix of social workers, welfare workers, psychologists or psychology-trained workers and other human service professionals, few have much explicit legal training. While there is some channelling of complex and serious new cases to ‘urgent’ or ‘forensic’ response teams, whose staff members build some expertise in investigatory and court matters, court issues arise throughout the life of a case, and any worker must expect to go to court. The CAU staff contribute to the induction and subsequent training of child protection workers, but report that many workers do not receive this for many months into their period of employment, because high

Regional workloads make it difficult to release staff for training. They also claim that for these and other reasons few senior Child Protection Services staff attend training, and this may be problematic given changes in the court process and environment.

7.2 HRI Involvement in the Court Process

HRI initiative contributions to the court process have included:

- Use of the SIPWs in joint visits to gather evidence and testify on the basis of first-hand family contact.
- SIPW consultation/assistance with court report writing, witness preparation, case analysis, and theoretical and empirical material to support the argument.
- Brokerage to commission special assessments or services that clarify points in contention and help put the case, or brokerage to brief selected legal counsel.
- PASDS to test the viability of parenting and to clarify whether a residential order is needed for the child or whether a lesser disposition will suffice.

These contributions vary from Region to Region and from case to case. Over the three collection periods for SIPW activity data, ‘court related activities’ did not feature as a large proportion of the SIPWs’ work. As a proportion of SIPW time, the State mean for court related activity was 5.3% in May 1999, 7.4% in August 1999, and 4.6% in February 2000. Court work was, however, plainly episodic, with the Regional means for the proportion of time spent on court activity within these data periods ranging from nil to 23.3%.

SIPWs vary in the degree to which they work directly on court reports, cases and attendance, according to their own working styles and the model of the Region. If, for example, they have jointly visited the family (for example, in WMR when integrated with the infant and sibling teams), they may well be called to testify. If not, their role may focus on advice to the worker about experts to use, theory to incorporate, assembly of facts and instruction to legal counsel, and they may offer support through the process. If the Region has a court officer (for example, SMR, NMR) some of these roles may belong to them, and the SIPW will focus less on the court case than on the assessment that leads to it. Some SIPWs (for example, Barwon SW) have made decisions to get involved in cases personally in order to be able to present first-hand evidence in court and influence the process of having the infant’s voice more effectively and actively represented.

7.3 Court Issues Reported in Previous Reports

In the first round of evaluation visits, while rural workers raised fewer concerns about the court process than metropolitan workers, there was quite widespread concern expressed by child protection workers about the workings of the Children’s Court.

At that stage, all SIPWs had begun directly and indirectly intervening in contentious infant cases to try to strengthen the performance of workers at court. There was some concern expressed about the unintended consequences of some strategies, including raising magistrates’ expectations that resources, such as beds at QEC, would be freely available, or finding child protection workers using expert reports instead of, rather than integrated with, their own protective assessments. Regions had begun to use the HRI flexible budget to fund legal advice and representation to supplement the limited support routinely available. In one Region, the court environment was described as ‘hugely pathological’, a reference to reputedly unsafe home returns ordered by court, and the denigration of workers by opposing counsel.

Collectively, SIPWs nominated court problems as a major difficulty confronting the program and a major impediment to quality improvement, especially in the metropolitan Regions. While they did not argue that these difficulties were universal, areas of dissatisfaction revolved around:

- Procedural matters, such as inefficiency and lack of continuity in legal personnel working on court cases.
- Court use of HRI resources (such as ordering specific assessments to be funded via PASDS or the flexible budget) while dismissing SIPW advice about the case. (This was interpreted as inappropriately drawing on single elements of the integrated package of HRI service.)
- Confusion around standards of proof, especially for cases based on the likelihood of harm, as infant cases must often be. For example, is it necessary to demonstrate imminent harm in order to argue the need for immediate protection?

- The perception that magistrates were parent-focused and allowed infants to stay in high risk situations.
- A belief that Departmental legal representatives may not advocate strongly enough the Department’s position when cases are heard by submission, a procedure that has become the norm unless a contest is booked in.

Senior Departmental representatives, including those responsible for court advice, made a number of pertinent qualifications to these claims, noting that:

- The Children and Young Person’s Act 1989 is a critical source of the tensions, since it sets the expectation that child protection workers will have tried everything before arguing for separation of children from their parents, and magistrates must be satisfied of this (ss. 86 and 87).
- The Victorian system puts pressure on court to reach decisions by consensus, with implications for how child protection workers prepare for court. They need to recognise that the vast percentage of cases will not proceed to full contested hearings. Workers may not be as well prepared for this out-of-court work as they are for court contested hearings. This is an important training and mentoring issue.
- Infant cases may be no more difficult to present than others, and the critical issue is how to present good evidence, including how, when, where, how and why. Magistrates also expect to see a balanced report, noting family strengths where these exist.

- SIPWs do not have the kind of expert qualifications that will be accepted as ‘expert status’, and they must have seen the family if they wish to testify.
- Child protection workers do not always understand that the Department pays lawyers for both advice and representation, so workers prepare for a contest by pointing out the negative aspects of a case, alerting the worker to what the opposition...
might say and do, and asking them to circumvent these challenges or marshal their arguments in reply. This can be experienced by workers as lack of support or lack of commitment to the case. Lawyers may expect child protection workers to run a case autonomously, and find confusing those changes of position that come when a SIPW or unit manager suggests new directions.

- Team leaders play a critical role in supporting workers for court, but they may not be free to attend such training as is given.
- Brokerage and the expanding range of service options has created new dilemmas, in terms of enabling a child to stay with the parent, but in some cases leaving unresolved the longer term developmental risks.

The concerns voiced in these earlier consultations appeared to relate to salient incidents that appear to be low in frequency but high in their importance to workers as they seek to resolve the infant’s situation. It was apparent from those consultations that no quantitative data were routinely collected by Regions about such matters. Many of these court issues relate to protecting the infant from harm to the infant, and they have been pursued by the Child Protection and Juvenile Justice Branch in a number of other ways alongside and independent of this HRI evaluation.

### 7.4 Court Issues Reported in Regional Consultation in 2000

By the time of these later consultations, the body of HRI-influenced court cases had grown considerably. In addition, rural Regions were reporting more difficulties with the court system, due in part to new magistrates entering the court and more activity by Melbourne-based lawyers in some Regions, upsetting what had been experienced previously as a relatively smooth working relationship. The use of Melbourne-based services, such as residential PASDS, also takes some court cases to the MCC, for convenience of witnesses.

Across the State, child protection workers did refer to ‘good magistrates’, helpful lawyers, and positive court outcomes for infants. The CAU manager also reported that child protection staff members frequently thank the CAU staff and legal counsel for their assistance in the many cases that proceed smoothly. Child protection workers were inclined, however, to use the consultations to air their concerns about the legal process, most of which echoed the points raised previously, in the hope of influencing change efforts. It was clear that for many child protection workers, the court is experienced as a very stressful arena of practice. Since they discussed issues in general terms, their comments did not always differentiate between different professionals in the court process, and this creates some difficulties for interpretation and response. While efforts were made to keep the consultations focused on infant cases, workers appeared to have difficulty separating these from wider court experiences. Issues stressed by SIPWs and other child protection staff in these later consultations included the following. (Interpretive or qualifying comments by the evaluation team are indicated by brackets.)

- The need for a voice for the infant, especially in matters of court-ordered access, and the hard-to-argue effects of exposure to domestic violence and neglect in the absence of observable injury. A worker asserted: ‘There is no lawyer for the baby. Lawyers want to get involved in a case and compromise—want the truth of least resistance.’ This comment refers to the lack of independent representation for a pre-verbal child, unable to give instruction. While workers did not call for separate legal representation of infants, it was evident that they saw their own role as this ‘voice for the infant’. This adds to the sense of responsibility and stress if the worker compromises with parents or fails to ‘win the case’, this may be equated with a sense of having failed to make the baby’s voice heard.)

- Wasteful court procedures—excessive waiting at the court and repeated adjournments. While the Child Protection Service may request and use adjournments, these tend to be major frustrations because they tend to arise on the day at court, and result in the worker ‘hanging around’ at court and spending time for little return. This is a major problem for long term workers, whose caseloads become immobilised at these times.

- Excessive and unfeasible access arrangements, whether ordered by magistrates or determined as a result of negotiation between the Department’s and parents’ legal counsel. (Some child protection workers perceived these bilateral negotiations between lawyers as their own lawyer arguing against instructions.) From the perspective of the child protection worker, too much access was described as both too expensive and destructive for the baby, for example, up to 10 adults handling the baby in a week. Rural workers reported that placements must often be made in outlying areas, necessitating a lot of travelling time. For an access arrangement of two hours, three times a week, a worker might be committed for 18 hours per week altogether. Another example given was four hours access five days per week. It was suggested that this fails to take into account the developmental stage and needs of infants, and that in cases where there is a permanent care case plan it can set up bonding by the parent that will be devastated.

- Increasing reliance by magistrates on expensive ‘one-off’ expert and/or Children’s Court Clinic (CCC) assessments. From the perspective of child protection workers, these assessments may be based on a single contact that is more limited in scope and validity than a child protection worker’s assessment made over many more times and places.

- Confusion over the path to permanent care. Staff members from different Regions reported different interpretations coming from the bench about which Order allows for permanent care planning. For example, one Region reported finding magistrates reluctant to use the Guardianship to Secretary disposition, wanting to keep open the reunification plan ‘at all costs’, or to leave guardianship with parents even while agreeing that the child will be reared in another family. Another Region believed the court is not accepting Custody to Secretary Orders as the basis for a permanent plan, because this Order is seen as built on a presumption of the parents as competent guardians. Yet others reported strong cases being quickly advanced to Guardianship with a permanent care case plan. (It was apparent to the evaluation team that there were examples given of parents who appeared willing to permanently relinquish their infants, but that as these were protective cases in the Children’s Court domain, workers did not consider adoption as a possibility, despite the existence of this legal option.)

- The general culture in the court environment was again reported to be one of contempt for Child Protection Services, where lawyers for the parents are seen as vitriolic and passionate, while the lawyers for the Department are seen as passionate and appearing to lack conviction about the value of their role. (A response to this claim from the perspective of the CAU is that the prosecuting lawyer is required to be balanced and fair in the presentation of clear evidence, leaving ‘passion’ to the defence lawyers seeking to discredit that evidence. Yet the subjective experience of many child protection workers appears to be that the process of contested hearings undermines their credibility as professionals concerned for the wellbeing of the infant, making continued work with the family very difficult. They appear to experience this as also eroding the message that the infant has independent rights.)

Despite questions put to child protection staff, there were very few comments made about the role of the pre-hearing conferences, most respondents appearing vague about such events, which had become just one or two of many transitory legal/quasi-legal encounters in the cases discussed.

Along with these concerns, suggestions were made by child protection workers and SIPWs about strategies for practising more constructively in the court setting and process, suggestions often based on what they perceived to be constructive experience to date.

- More Regions were making overtures to meet with magistrates to discuss issues, and through face to face contact were taking notice of the requests made by magistrates for clearer presentation of case data and carefully argued analysis.
- Use of HRI brokerage to fund lawyers of choice was becoming more common. It appears that SIPWs choose to use barristers with whom they are familiar from their training, who demonstrate an understanding of the Child Protection Services role and constraints, who are able to support and encourage the workers in their preparation and conduct of a case, and who have been known to successfully argue complex infant protection matters. They believe that brokerage also allows
them to purchase more time from these lawyers than would be possible through the usual CAU allocation process, or that the additional money can allow them to ‘top up’ the normal time allocation.

- Some staff called for supplementary workshops for child protection workers, SIPWs, team leaders and court support workers on inter-personal processes at court, for example, strategies for dealing with bullying at court.
- Where PASDS have been used before a Protection Application is proven, there have been cases where parents saw an immediate result, issues were addressed, and by the time of the hearing the Department was able to walk away with an undertaking—seen as a success and in the spirit of the Children and Young Persons Act.
- Lawyers who work frequently with the Department have expressed appreciation of the consistency and added clarity offered by a SIPW.

### 7.5 Analysis of Sample of Children’s Court Cases

#### 7.5.1 Method
In order to develop a more detailed understanding of the experiences of child protection workers at court with infant cases, the evaluation process included closer examination of 25 specific purposefully sampled cases. Regional HRI managers were asked to nominate cases that had received HRI input and that had either satisfactory or unsatisfactory outcomes at court from a Child Protection Services perspective (in the case of metropolitan Regions, two satisfactory and two unsatisfactory; in the case of rural Regions, one of each category). In the event, 25 cases were nominated and included. The allocated caseworker for each was interviewed using a structured interview format, and it was found that workers did not adhere so neatly to this either/or categorisation. When they were asked to verify the categorisation of cases, the following profile resulted.

**Table 10: Court Case Sample**

<table>
<thead>
<tr>
<th>Region</th>
<th>Satisfactory</th>
<th>Mixed Satisfaction*</th>
<th>Unsatisfactory</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EMR</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>NMR</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>SMR</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>WMR</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Barwon S-W</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Gippsland</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hume</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Grampians</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>7</td>
<td>11</td>
<td>25</td>
</tr>
</tbody>
</table>

* ‘Mixed satisfaction’ cases tended to be described as cases with poor process but acceptable outcomes.

This deviation from the planned approach means that the picture presented below is not as balanced as it might be, because even several of the otherwise ‘satisfactory’ cases have ‘unsatisfactory’ overtones. We cannot know, however, whether this distribution reflects the overall pattern of experiences at court. It is possible that despite the evaluation team’s efforts to achieve a mix of cases that would include both lessons for what to do and what not to do at court, the human tendency in nominating cases is to select those that are salient in the memory, and problems may be easier to remember than smooth processes. In addition, the case seen as successful from the HRI manager perspective, in terms of results, might still have been experienced as very difficult by the allocated child protection worker. It is also likely, however, that the aim was misplaced, in that complex socio-legal processes are unlikely to be experienced as uniformly ‘good’ or ‘bad’.

Therefore, the weaknesses of this research strategy are that it may have yielded atypical cases and that it rests upon the presumption that the child protection workers’ definitions of ‘satisfactory’ or ‘unsatisfactory’ cases are not problematic. Different interpretations might well be made by a magistrate or lawyer. (In the two cases where a written magistrate’s judgment was also supplied, however, the child protection workers and magistrates’ views appeared not dissimilar.) On the other hand, the strength of the method is that it has drawn out how child protection workers often experience the court process and in this it offers some guide for program development and training with respect to problematic or contentious areas of court practice.

#### 7.5.2 Patterns of Results

Of the seven ‘satisfactory’ cases, one has allowed the child to be referred to a permanent care agency by five months of age. In four of these satisfaction cases, there was a high level of issues raised at court, including drug and alcohol use, domestic violence, previous placement of the infant in question and evidence of unexplained injury. These could reasonably be presumed to be among the cases about which workers were most anxious. One might hypothesise that the issues for the ‘mixed satisfaction’ group suggest marginally more ambiguity and room for debate over matters of fact and interpretation. It is perhaps notable that in choosing court related cases, HRI teams found those involving parental mental illness and intellectual disability to be salient.

### Table 11: Distribution of Major Family Risk Factors in Court Sample

<table>
<thead>
<tr>
<th>Category (n)</th>
<th>Drug/Alcohol Violence</th>
<th>Domestic Disability</th>
<th>Parents Intellectual Disability</th>
<th>Parents Perinatal or Dead</th>
<th>Previous Child Risk Factors</th>
<th>Total Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not satisfactory (12)</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Mixed satisfaction (7)</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Satisfactory (7)</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Total cases (26)</td>
<td>6</td>
<td>11</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>38</td>
</tr>
</tbody>
</table>

Figure 12 illustrates how these risk factors blended in the cases-each numbered point representing one case.
A number of specific themes arise from this sample of court cases. In addition to substantive concerns about the nature of the problems shared by many of these families, there were themes relevant to the interface between the Child Protection Services and the court. These included: court as case planner, magistrates’ use of attachment concepts, delays in finalisation of Protection Applications, purposeful and linked use of HRI inputs, quality of legal representation, family inputs and events, and parental intellectual disability as a contested matter.

(i) Court as Case Planner

While, under the Children’s and Young Persons Act 1989, case planning is clearly the province of the Child Protection Service, some magistrates appear to be making decisions that determine the shape of subsequent case planning, beyond the influence of the making of an Order. Evidence from the evaluation included explicit statements in judgments about the desirability of the magistrate following the case over time and reviewing the case management; the use of many and increasingly lengthy Interim Accommodation Orders; and the proliferation of conditions imposed on judgments, some of which bind the Department and other agencies to committing specified resources. (Child protection workers tended to highlight cases with many conditions—24 in one extreme case.)

From the rare written judgments, it is also clear that magistrates have a strong sense of personal responsibility to the child and parents for the decisions made. This retention of quasi-case planning/management at court may be because magistrates distrust the Department’s case planning; in some cases they are concerned that long orders allow workers to delay implementing reunification plans put to court, and some workers have suggested that workload pressures mean that in some cases this might be a realistic fear. Nevertheless, the major difficulties associated with the court holding onto the case planning function in these cases were:

- Cumbersome timetables of returns to court and repeated temporary orders.
- Developmentally inappropriate care and access regimes.

• Unclear messages to parents about decisions (for example, long term placement decisions softened by generous access).
• Costly and unfeasible resourcing implications.

Court as case planner, Example 1:

This case concerned a mother’s significant physical abuse of her infant. The Child Protection Service faced a complex assessment task, confounded by questions about mental illness, cultural issues and domestic violence. While several months elapsed with the child on Interim Accommodation Orders, this time was used to obtain specialist assessments of the mother (forensic) and mother and baby, to clarify the mental health, cultural and religious issues involved, and to prepare addendum information for the court in the form of tables of significant relationships and chronologies of events. (These were praised by the magistrate as ‘of great assistance to me in the hearing of this case’.)

The case was managed by the HRI team, which reports ‘brilliant’ preparation and support at court by their legal representatives, and close attention from the magistrates involved (a 56 page written judgment being given). A range of witnesses was called, including a MCHN described by the magistrate as ‘an excellent witness, a beacon of common sense’. The MCHN had referred to her meticulous documentation of her work, and was guided by the MCHN Standards of Practice, supporting her professionalism. The protective worker applied for a Custody to Secretary order, but was granted a part-heard Interim Protection Order with 10 conditions, on the grounds that the mother would have more confidence in the reality of a reunification case plan if the Court ‘retains overall control of the case for the time being’. The protective worker/SIPW understood that the magistrate wished to ensure timely action on the part of the Child Protection Service if reunification was to occur. A PAS65 has been arranged to facilitate this. The MCHN has remained in supportive contact with the family. Staff in the Department have been divided over whether this is a good or poor outcome. (Metro case—mixed protective worker satisfaction)

It was evident that in most cases in all three categories there were complex issues calling for some argument about likely harm if the case was to proceed to court.

<table>
<thead>
<tr>
<th>Level of Satisfaction</th>
<th>Case No.</th>
<th>Protective Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>19</td>
<td>Extremely domestic violence, infant part of large sibling group.</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Newborn, mother mentally ill with psychosis and personality disorder; possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>maternal intellectual disability; mother aggressive, with mood swings.</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Adolescent parents, mother personality disorder; lack of supervision of infant/lack</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of skills; cycle of crises; domestic violence.</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>Domestic violence; mother young with psychosis.</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>Neglect of high needs baby.</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>Premature baby, maternal mental illness.</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>Maternal intellectual disability, 6 previous children removed.</td>
</tr>
</tbody>
</table>

| Mixed satisfaction   | 12      | Serious injuries to infant.                                                      |
|                      | 13      | Serious physical abuse of infant; mental illness, cultural issues; domestic       |
|                      |         | violence, alcohol.                                                               |
|                      | 14      | Multiple risks; hygiene, feeding, safety.                                        |
|                      | 15      | Neglect, supervision; hygiene; 5 children out of mother’s care; domestic violence.|
|                      | 16      | Neglect, both parents’ intellectual disability.                                  |
|                      | 17      | Drug affected mother and baby; dangerous birth.                                  |
|                      | 18      | Physical injury by unknown perpetrator; minimized in significance by parents;     |
|                      |         | substance abuse.                                                                 |

| Not satisfied        | 1       | Neonatal neglect, paternal domestic violence, maternal intellectual disability; |
|                      |         | 4 children previously removed.                                                   |
|                      | 2       | Paternal domestic violence, likely injury.                                       |
|                      | 3       | Inconsistent explanation of bruising; substance use.                             |
|                      | 4       | Maternal mental illness, domestic violence, substance abuse, 2 children in care. |
|                      | 5       | Unexplained fracture, crime; domestic violence, substance abuse.                 |
|                      | 6       | Maternal degenerative illness, infant’s weight loss.                             |
|                      | 7       | Newborn whose infant sibling had died of exposure.                               |
|                      | 8       | Both parents’ intellectual disability and doubtful capacity to care; health issues; |
|                      |         | cruelty to animals.                                                              |
|                      | 9       | Maternal borderline intellectual disability; 3 other children in permcare.       |
|                      | 10      | Mother un-medicated bipolar disorder; father violent.                            |
|                      | 11      | Both parents intellectual disability, domestic violence, sexual abuse, child     |
|                      |         | physically disabled.                                                             |

| Case Scenarios—Court Case Sample |

Figure 12: Case Scenarios—Court Case Sample

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<td></td>
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<tr>
<td></td>
<td>21</td>
<td>Adolescent parents, mother personality disorder; lack of supervision of infant/lack</td>
</tr>
<tr>
<td></td>
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| Mixed satisfaction   | 12      | Serious injuries to infant.                                                      |
|                      | 13      | Serious physical abuse of infant; mental illness, cultural issues; domestic       |
|                      |         | violence, alcohol.                                                               |
|                      | 14      | Multiple risks; hygiene, feeding, safety.                                        |
|                      | 15      | Neglect, supervision; hygiene; 5 children out of mother’s care; domestic violence.|
|                      | 16      | Neglect, both parents’ intellectual disability.                                  |
|                      | 17      | Drug affected mother and baby; dangerous birth.                                  |
|                      | 18      | Physical injury by unknown perpetrator; minimized in significance by parents;     |
|                      |         | substance abuse.                                                                 |

| Not satisfied        | 1       | Neonatal neglect, paternal domestic violence, maternal intellectual disability; |
|                      |         | 4 children previously removed.                                                   |
|                      | 2       | Paternal domestic violence, likely injury.                                       |
|                      | 3       | Inconsistent explanation of bruising; substance use.                             |
|                      | 4       | Maternal mental illness, domestic violence, substance abuse, 2 children in care. |
|                      | 5       | Unexplained fracture, crime; domestic violence, substance abuse.                 |
|                      | 6       | Maternal degenerative illness, infant’s weight loss.                             |
|                      | 7       | Newborn whose infant sibling had died of exposure.                               |
|                      | 8       | Both parents’ intellectual disability and doubtful capacity to care; health issues; |
|                      |         | cruelty to animals.                                                              |
|                      | 9       | Maternal borderline intellectual disability; 3 other children in permcare.       |
|                      | 10      | Mother un-medicated bipolar disorder; father violent.                            |
|                      | 11      | Both parents intellectual disability, domestic violence, sexual abuse, child     |
|                      |         | physically disabled.                                                             |
Protection Services key performance indicator that cases should be taken to court or closed within 90 days. Workers accept some delay as an opportunity, and are devising strategies to make use of those times to either build the case or resolve the case. From the perspective of parents’ rights, there is something of a paradox in this, in that while these delays may be intended to offer assistance to the family and minimise the longer term consequences of Final Orders, if these can be averted, they pose new risks to the family. An issue for consideration in the repeated and extended use of Interim Accommodation Orders and adjourments, is the increasing latitude this gives for very intensive and intrusive interventions (for example, residential assessment, neuro-psychological assessment) by Child Protection Services in the absence of a proven Protection Application. These intrusive interventions may be with parents who have limited knowledge and impaired consent capacity.

From the perspective of the protection of the infant, lack of finalisation leaves the worker without a strong mandate to protect the child, and starts the clock ticking in terms of the passage of time. The protection of the infant is an urgent matter and for child protection workers, where there is evidence of child abuse or neglect, they may be required to act immediately to secure the child’s future care.

For example, a psychologist’s assessment is used to tailor a PASDS intervention and offer the parent a ‘good faith’ positive experience and real chance to prove parenting capacity. This was a finding noted by the Protectiveworker to use assessment findings to shape their own approach to the working relationship with the parent.

Some of the most effective uses of HRI resources relate to basic court preparation tasks that have become unworkable in the everyday context of heavy workloads, limited funding and resources. In this way, there may be the potential for HRI resources to act as a bridge, setting up expectations in the court that cases can be conducted with such thoroughness for children of all ages.

This child was notified to Child Protection Services as a result of weight loss and concerns about inadequate feeding. The workers’ attempts to engage the mother in planning and involving her in the child’s situation were met with a lack of response. The CCC continues to be involved, and the case has remained open since April 1999. The child, while in care, has no effective guardian. While the HRI staff have been involved with extensive consultation and joint work with the child protection worker, the flexible budget has been used, the fundamental problem is how the Department can act to secure the child’s future care and identity in the absence of court resolution. (Metro case—PW not satisfied)

(ii) Purposeful and Linked Use of HRI Inputs

Since the HRI teams were instrumental in identifying cases for this sample, using the criterion of substantial HRI input, all cases used a variety of resources from the HRI program, from each of the three main components—SIPW, PASDS, flexible budget. Those nominated as most satisfactory from the protective service perspective were those with the highest amount and range of HRI inputs. This might be interpreted as an inevitable result from the selection process, in that the HRI teams would have nominated precisely those cases where they felt their inputs had generated positive returns. On the other hand, the link between the inputs and the outcomes may be no less real despite the sampling process.

These inputs appear most effective in at least influencing court process if they are linked together in a purposeful way and are employed in the context of good relationship building with the parent, assisted by SIPW advice. For example, a psychologist’s assessment is used to tailor a PASDS intervention and offer the parent a ‘good faith’ positive experience and real chance to prove parenting capacity. (One must note, however, that these residential services are very time limited). Psychological assessments may be used to assist the goals of counselling; SIPWs may help the protective worker to use assessment findings to shape their own approach to the working relationship with the parent...

Some of the most effective uses of HRI resources relate to basic court preparation tasks that have become unworkable in the everyday context of heavy workloads, limited funding for legal assistance and thinly spread supervision resources. For instance, HRI has been able to fill these gaps with practical assistance such as preparation of chronologies, securing expert witnesses, court report advice and editing, bruting counsel, top-up funding to secure counsel of choice, and retrieval of inexperienced staff and witnesses. There is a ‘Catch 22’ in this, in that the use of HRI funding in this way may set up expectations in the court that cases can be conducted with such thoroughness for children of all ages.

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Quality of legal representation, example 1:
The SIPW assumed the responsibility for running a court case in relation to a mother who had an intellectual disability and had previously had another infant removed after she had been found unable to care for it. Child Protection Services was anxious not to expose the new baby to prolonged risk. A Melbourne-based psychologist was used as an expert witness in relation to the mother’s intellectual functioning and parenting capacity. The HRI budget covered the expenses of a ‘good barrister from Melbourne’. In 3-4 days of contest, the SIPW, barrister and a local solicitor noted that the courtroom atmosphere had become very emotive, and feared that the case might be dominated by whatever was the last salient courtroom event. Noting their intent to appeal if the decision was unfavourable to the Department’s case, the prosecution team requested that final evidence be given by written submissions, and the magistrate agreed. At the end of the verbal evidence, the defence was given one week to respond in writing, and then the prosecution was given a further week to respond in writing. The magistrate withdrew for one month’s deliberation and made a 10 page written judgment (finding the case proven). (Rural case—protective worker satisfied.)

(vi) Family Inputs and Events
While the emphasis of this survey was on child protection worker perspectives on professionals and their working relationships, the primacy of family inputs to the court process cannot be forgotten. Several cases rose or fell on the actions and experiences of family members throughout the sequence of court events: extended family interventions, mothers deciding to separate from fathers, limited access to social supports, restrictions on rights to visitation, and ultimately on the parents’ capacity to learn. It is in this context that their assumption of quasi-case planning tasks might be partially understood.

Family inputs and events, example 1:
In this case, the outcome has been satisfactory from the Child Protection Services perspective, but the process has been protracted and problematic for reasons relating to family life. This infant was notified as a result of physical injury, of unknown origin. Substance misuse was noted. The worker reported that the Child Protection Services legal representatives was generally good, and representatives for the parents were good advocates for them. Resolution was delayed by repeated adjournments and ‘rollover’ Interim Accommodation Orders owing to parental separation, allegations and access disputes. An unintended benefit of these delays was that the mother and child were linked to a PASDS, which the mother enjoyed and where she related well to the staff. This allowed for a favourable re-assessment of her capacity to care, and more confident recommendation of a Supervision Order with additional assistance. While the court process was slow, it had the advantage of flexibility and responsiveness to a changing family situation. (Rural case—protective worker mixed satisfaction.)

(vii) Parental Intellectual Disability as Contested Matter
In seven of the 25 cases it was noted that one or both parents had, or appeared to have, an intellectual disability. In three of these, previous children had been removed from the parents’ care, a factor shaping the workers’ predictions of likely harm to these infants. In two of these cases of parental disability the infant was placed to a CCC worker, who reported that there were genuine attempts to give the parent a real opportunity to demonstrate their capacity to learn, given assistance. The other five cases were drifting unresolved with high levels of court inputs and service inputs. Sticking points in these cases appeared to have been genuine attempts to give the parent a real opportunity to demonstrate their capacity to learn, given assistance. The other five cases were drifting unresolved with high levels of court activity and service inputs.

Purposeful and linked HRI inputs, example 1:
From early days of this case, the Child Protection Service sought a Guardianship Order with a view to planning permanent care, because of threats to the baby’s safety from the mother’s severe cognitive and behavioural impairments as a result of multiple disabilities. Over a period of several months, the case had included SIPW consultation and case planning, and was assisted by a psychologist’s assessment funded through HRI brokerage. This assessment was taken into account by the PASDS, which attempted to tailor a program (though only of 10 days duration) that would maximise the opportunity to parent despite her learning problems, but in the PASDS the infant regressed in the mother’s inadequate care. Together these two assessments appear to have been persuasive in the outcome. (Metropolitan case—protective worker satisfied.)

Purposeful and linked HRI inputs, example 2:
This premature baby was notified as a result of symptoms of maternal mental ill-health that were directly endangering the child. Over an eight-month period, the child has been successfully reunited with the parents on a Custody to Secretary Order by consent, as a result of clarification of the mother’s diagnosis and implementation of an effective medication regimen, and through a series of linked services. These included: SIPW consultation and case conference; SIPW advice to medical staff resulting in immediate cessation of troubling incidents; PASDS day-stays and in-home assessment and assistance (twice); inter-disciplinary liaison; mother/baby psychiatric admission; and use of HRI brokerage. The worker reported the magistrate (MCC) as praising all parties for working together to produce a feasible reunification plan in the best interests of the child. Settlement (on the first of a projected five day contest) was aided by clear advice to the Department’s legal representation through the compilation of a folder of relevant evidence, and by worker responsiveness to parental worries and abilities, illustrated by her ‘on-the-spot’ production of a visual calendar to assist them to understand the case plan. (Rural case—protective worker satisfied.)

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failed to take account of the parent’s intellectual disability when rating the parent’s level of care. Workers reported that magistrates appear to be moved by the ‘no fault’ aspect of intellectual disability, and to seek solutions that respect the parent’s good intentions and positive emotions towards their children, and their expressed desires to parent like others in the community.

Parenting by people with intellectual disabilities is clearly an area fraught with debate and emotion. In these cases that went to court, the disability also tended to be accompanied by other risk factors such as mental illness, domestic violence, housing problems, social isolation, and usually (it appears) the less frequently named issue of poverty. The results of the earlier C9F 1993 risk factor listing showed that in the 22 cases where a maternal intellectual disability was recorded, it was never the sole risk factor recorded. For 10 or more of those 22 cases, the file also recorded at least one of the following: child seen as problematic by parent; mother under 20 at first child; mother’s current or past history of domestic violence; mother’s past history of abuse; father’s poor caring capacity; father’s history of assaulting behaviour; father’s poor impulse control; father’s intellectual disability; or chaotic family.

The HRI program has made efforts to advance the consideration of the issues for this population of parents in the courts through the provision of expert evidence about intellectual capacity and learning patterns, supported and observed parenting opportunities, and flexible placement and access options. While sometimes this has clarified the situation, at other times it has muddied the waters by disguising parenting limitations or creating the impression that resources are available to assist parenting in perpetuity; a state of affairs that is far from reality in budget terms. The short term nature of the HRI parenting services to date have been shown to have diagnostic power and to enable some tailored intervention, but they can meet only a fraction of the need over time. These are early days with respect to resolving these matters, and further in-depth policy attention is required.

7.6A Legal Perspective

The child protection perspective on the Children’s Court presented here comes from a particular set of roles and experiences. The workers interviewed were usually discussing complex cases, fraught with ambiguities of fact and interpretation, involving vulnerable infants for whom the workers felt very responsible. From this perspective, both lawyers and the court itself were sometimes experienced as impediments to achieving the goals of the Child Protection Service. This is not the only perspective. From the evaluation consultations, it has become apparent that there are very different perceptions of the court process co-existing, contributing to the reported conflicts and tensions. Illustrations of some of these competing perceptions follow.

As noted in 7.3 of this report, senior Departmental staff and legal advisors are very aware that many child protection workers have been criticised by magistrates and lawyers for performing poorly at court. These criticisms include:

- Court reports that fail to clearly marshal the facts of the case, with appropriate statements about events, people, times and places.
- Lack of presentation of family strengths and resources, resulting in at least an appearance of bias, which is unacceptable in a prosecution case.
- Lack of clarity in briefing counsel, fraught with ambiguities of fact and interpretation, involving vulnerable infants for whom the workers felt very responsible.
- Difficulty with the negotiation process at court and the flexibility this requires.
- Procedural errors relating to the meticulous paperwork required.

The Department has recognised these problems and is attempting to meet them through training, new procedures (such as the development of the VRF and the development of new Court Report format) and, for infant cases, the assistance of the SIPWs. It is evident that these criticisms stem from a model of the Children’s Court that derives, at least in part, from the criminal justice system, with its language of investigation, prosecution and adversarial parties.

The view has also been put by CAU management to the evaluation team that child protection workers sometimes fail to fully appreciate the function of the court and the roles within it of magistrates and lawyers. It is contended that it is this failure to grasp the role differences that leads to much of the distress and frustration expressed by child protection workers. For example, workers sometimes see magistrates as uninformed about child development and as failing to understand the workers’ concerns for infant development, yet keen to use developmental concepts in various ways. The legal perspective suggests it is more fruitful to see magistrates’ expertise as lying in the evaluation of evidence, the application of law and the scrutiny of legal process. Such an understanding would prompt child protection workers to focus on providing clear evidence within a fair process. From this perspective, the court cannot be regarded as the place to secure formal approval of child protection plans and actions, precisely because it is designed to be a check on the power of the bureaucracy.

Similarly, instead of evaluating lawyers’ performance as ‘passionate’ or ‘weak’, their roles can be understood from a legal frame of reference. From this perspective, the legal representatives of the Child Protection service has the role of dispassionate, fair and meticulous prosecutor, presenting facts and advising the worker about the presentation of those facts and about the imperative to seek resolution of Children’s Court cases by consensus, where possible. The role of the parents’ legal representative is necessarily to challenge those facts and to debate the assessments that arise from them. From the legal perspective, the in-court contest is not intended to be a process of personal denigration, as experienced by child protection workers, nor should the outside-court negotiation be experienced as a process of capitulation.

The different functions lead not only to different discourses and modes operandi but also to different administrative challenges. For the court itself, there is the challenge of processing many cases efficiently, yet being flexible enough to tolerate losing time when justice demands that an adjournment be granted when parents fail to attend. Just as child protection workers have to juggle competing demands and limited resources, so too does the CAU. An emerging frustration for the CAU is an unintended consequence of the HRI brokerage budget. In their quest for more supportive barristers with more time to prepare cases, SIPWs have turned to a small group of barristers known to them through the training program, or with a reputation for good handling of infant cases, and have engaged these directly using HRI monies. The CAU has found that this has introduced an element of the market into what has previously been a more regulated system for engaging counsel. It appears that privately engaged barristers are able to set higher fees (commensurate with those commended for appearance at higher courts) and to escape the additional duties required of CAU-briefed barristers working for the unit on a daily basis. There is a fear that this will adversely affect the capacity of the CAU to secure legal counsel at reasonable (already higher than Legal Aid) rates.

From a legal perspective, it is crucial that child protection workers understand these different roles, responsibilities and resource imperatives. For this reason, pre-service, induction and in-service training needs are emphasised. From the perspective of the CAU, for the child protection perspective to prevail unchallenged perpetuates dissatisfaction and distress, and does not assist in the conduct of court work.

7.7 Conclusion—HRI and the Court

While the evidence of the impact of the HRI project on Children’s Court outcomes is tenuous at best, there are clearly ways in which elements of the HRI initiatives enhance court processes and open up options to resolve the future care of highly vulnerable infants. Brokerage appears to make available representation from more fully briefed and available legal counsel, and enables the presentation of expert evidence based on direct family contact, not secondary consultation. PASDS inform assessments for court and provide options to Court. SIPWs help to shape reports, prepare and support witnesses as well as applicants, and may appear administratively in court if they have co-worked an assessment and seen the family. There have been some clear achievements in moving infants more quickly through unviable home circumstances to a permanent alternative, and some excellent results using the combined strengths of a short term court order and an infant-specific set of interventions to support and educate troubled parents in their infant care.

These types of inputs go some way to addressing what Sheehan (1999) reported to be MCC magistrates’ reservations (expressed in a study conducted between 1993-95) about the quality of the evidence put before them and the wisdom of the relatively young and inexperienced child protection workers presenting it.
Even so, the apparently slight discrepancies between court outcomes for infants and older children (as witnessed in the CASIS charts 42-63, Appendix 19) and the frustrations expressed by child protection workers, suggest that issues relating to the court process are not specific to infants.

Not all difficulties experienced at court by the child protection workers were attributed to the court and legal personnel. SIPWs see some problems located within the Child Protection Service itself, and the evaluation team queries whether these may contribute to the magistrates’ close attention to conditions and case plans, and to the extensive out-of-court negotiations that occur. Such problems include the delays in executing case plans that become ‘bogged down’ in the accumulating caseloads of the long term teams. SIPWs also note that there is room for much more improvement in risk and need assessment and in predicting and planning the gains to be made by parents through service interventions. The case file reviewers over both the HRI CFRs shared some of these observations. Some staff mentioned the negative impact of a strictly hierarchical way of working, which leaves workers’ positioning in court as instructed by a senior staff member, but neither committed to the position nor well-prepared to argue and defend it. They also suggested that team leaders, whose job it is to support applicants to the court, may be among those least able to update their own court training because of time and workload pressures. In relation to infant cases, SIPWs filled some of this gap. Through their efforts to prepare and support staff for court (for example, preparing chronologies, ensuring witnesses were clear about their evidence, documenting observations, attending to family strengths as well as performance deficits), SIPWs demonstrated their awareness of the evidentiary needs of the court.

The clash of perspectives and reported level of discomfort is a serious impediment to, and distraction from, practices that will secure good outcomes for infants and their families at court. How are we to understand the claims and counter-claims made about unsatisfactory court experiences? One possibility is that the problems are not as bad as has been suggested, and this view has been put by CAU management, who note the gratitude frequently expressed by workers when things go well. Macdonald and Macdonald (1999) note vividness as a source of error in risk assessment, the power of concrete examples with emotional undertow. Similarly, in the inquiries into court issues, the evaluation team has been struck by the power of the vivid case, the ‘war stories’. Child protection workers sometimes believe that magistrates build case lore as law on the basis of cases that have struck an emotional chord or where a particular informant or type of evidence has been very powerful. The apparently sharp rise in copious access conditions, linked with the use of attachment theory, is an example. Workers themselves use the vivid cases to argue about the failings of the court system. Indeed, our method of inquiry capitalised on this tendency. Certainly practice wisdom (both social and legal) grows from the accumulation of vivid cases, hopefully tested against other sources of data, but it is necessary to find ways to bring to collective consciousness the unremarkable stories of competent and dignified performance at court.

Another possibility is that, in the absence of reliable feedback loops about inputs and outcomes in the Child Protection Services and at court, there are few checks on the praxeology of these ‘war stories’. Magistrates follow particular cases only accidentally or when particularly anxious to do so for case-specific reasons. Child protection workers may leave or pass the case on to the next team. Data systems linking inputs and outcomes are not in use. Child protection workers do not appear to receive widespread and systematic feedback about magistrates’ judgments and the reasons for these, so that they remain relatively uninformed as a workforce about legal reasoning. Magistrates and lawyers have little or no exposure to the many Child Protection Services notifications that do not go to Court, so they are less able to understand the passion and concern underlying those Protection Applications, breaches and disposition requests that child protection staff finally bring to court. There would appear to be a real need for the Justice and Human Services departments to collaborate on data systems and case tracking exercises to better round out the knowledge base of all players.

Another major factor underlying the tension about infant matters at court appears to be the problem of prediction. This is perhaps the single most perplexing issue in infant cases in the child protection courts (see section 11). Although the training and expert resources enabled by the HRI monies have assisted with this, there is still limited predictive capacity in the many ‘likelihood’ cases that arise when there is a potent mix of risk factors and infant vulnerability, but no demonstrable harm. Theories of attachment, for example, are indeed theories and as such are a contested discourse, and even those professionals used as experts (let alone less qualified child protection staff) acknowledge the complexities and questions that are thrown up in efforts to make ‘attachment assessments’. The extent to which intensive parenting skills input can tip the delicate and dynamic balance of skill, knowledge, motivation and context toward competency in different types of infant/family situations, is yet to be clarified in the Victorian service system. This will be pursued further in the PASDS phase of the evaluation, but the variability of intervention models, complementary services and families themselves holds little hope for definitive models of prediction. Much of the relevant risk and even permanency planning literature is similarly equivocal. Under these conditions, it is not surprising that workers are anxious about taking cases to court, or that legal personnel become frustrated with the ratio of fact to opinion.

A fourth interpretation of the reported difficulties is that the court is necessarily a meeting place of opposing interests and contrasting roles, and that these tensions are to be expected and must be accommodated. This tension is evident in the apparent rise of the term ‘prosecutor’ even while the Children and Young Persons Act refers rather to ‘protective intervenor’. Under the current legal framework, it is neither possible nor desirable for child protection workers to adopt a wholly legal perspective nor for lawyers or magistrates to adopt a wholly welfare perspective. For Victorian child protection workers, the juxtaposition of investigatory and helping functions has been a constant dilemma since assuming the protective role in the mid-1980s. Channelling cases into ‘forensic response’ and ‘long term’ or ‘case planning’ provides only a partial resolution, because court appearances may be necessary at many different stages of a case, and because the Act requires workers to problem solve in a spirit of consensus and collaboration, without recourse to legal action where at all possible. The introduction of the Strengthening Families diversionary program in Victoria may yet prove to have reduced the number of cases in which legal functions have intruded unnecessarily into welfare functions. In infant cases, however, there are several factors that heighten this endemic legal/welfare tension. These include:

- The mix of high infant vulnerability, parental risk factors and ambiguous or tenuous evidence of harm.
- The developmental imperatives and the resulting pressure of time.
- The acute learning curve for new parents and the opportunity this presents to use authority constructively to assist families to make a ‘good start’.

The tension is exacerbated by child protection workers’ perception that they alone represent the interests of the voiceless infant. It is also heightened by the public perception that to prosecute a case that a child is in need of protection is tantamount to blaming and prosecuting parents when, both conceptually and in terms of the face-to-face conduct of the child protection worker-parent relationship, these should be distinguished.

A fifth interpretation of the claims and counter-claims is that both sets are right, and that the failure to grasp the perspectives and roles of the other players is so widespread, and the resource base within each camp is so constraining, that there is a systemic bias against addressing the complaints of the other parties. Through the course of this evaluation, several workers have discussed the need for, and difficulties of, ‘thinking outside the square’, just as the SIPWs have testified the difficulties of trying to change existing patterns of practice. Change cannot simply be willed or prescribed.

From the information gleaned during this HRI evaluation process, it appears that each of these interpretations has an element of truth. There are no doubt many other potential analyses to be made, but this study provides only one small window on the larger vista of the meeting point of the child protection and legal systems. If these interpretations have merit, they suggest several broad directions for further action, requiring collaboration between the Child Protection and Juvenile Justice Branch and the CAU, and dialogue with magistrates and appropriate representatives of the Department of Justice.
different roles and perspectives, constructive response to challenge and contest, and negotiation skills. Both sets of professionals need to be able to state what they require of the other, in terms of achieving a desirable court outcome and the kind of working relationships which facilitate their own practice quality. This two-way, face-to-face educational work about roles, perspectives and relationships is in addition to formal training about the many legal requirements and procedures of protective work and court action.

**Justified Mutual Criticisms**

This interpretation suggests the need to develop a strategy plan to address the specific complaints, noting where such efforts are already in train and seeking feedback on their implementation. Priority areas might be:

- More continuity in legal representation for cases, and resolution of whether market or regulatory principles are to apply in briefing barristers.
- Formal trial of an improved Court Report format.
- Development of a clearer system for handling feedback and complaints between child protection workers and legal representatives.
- At Regional level, attention to early release of new staff for induction; formal mentoring of new staff through court work; adequate preparation of workers for the negotiation processes that is likely to arise within or outside the courtroom.

**Absence of Feedback Loops**

This interpretation suggests the need to collaborate on a database on agreed performance criteria and indicators of prompt and just case settlement, and a mutually determined research agenda.

Specific projects might include:

- An examination of the reasons for repeated adjournments of cases both before and after a Protection Application is granted, with the aim of differentiating between avoidable inefficiencies and productive interjections in the process.
- Analysis of the legal pathways to permanency planning for infants, compatible with the scope of the Act, natural justice, and the developmental imperatives of infants.
- Tracking the consequences of contentious court outcomes for infants, families, workers and the service system and developing appropriate dialogue about these and policy responses.
- A review of copious parent-child access by the court, and attention to the research base for making access decisions.

**The Problem of Prediction**

This interpretation suggests the need to ensure access to further research into the bases of prediction of likely harm, and the appropriate interventions to avert such likely harm, to strengthen the evidence base.

**Inherent Role and Perspective Tensions**

This interpretation suggests the need to strengthen pre-service education and training for both child protection workers and legal practitioners. There appears to be a need for joint training, planned collaboratively, with lawyers used by the Department’s legal service, with an emphasis on the mutual understanding of the high-risk infants service network, much higher for the HRI manager than for the CAFW 4 SIPWs, averaging approximately 5% of the SIPWs time overall in the more recent data collection periods. If the recording were accurate and the activity categories mutually exclusive and exhaustive, this might indicate that the SIPWs think more about the service network than about these thoughts. However, from extensive discussions in the field it is likely that their consciousness of the service network permeates other activities recorded separately, such as case conferencing, consultation and program development.

### Table 12: Overview of the Mean Proportions (with Regional Ranges) of Time Spent on Activities, for the State

<table>
<thead>
<tr>
<th>Activity</th>
<th>State Mean % - Feb 2000 (0-20.3)</th>
<th>State Mean % - Aug 2009 (0-11.1)</th>
<th>State Mean % - May 2009 (0-13.2)</th>
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<tbody>
<tr>
<td>Attendance at case confer/perm/fgc</td>
<td>8.5 (0-20.7)</td>
<td>7.4 (0-11.3)</td>
<td>3.7 (0-13.2)</td>
</tr>
<tr>
<td>Case consultation</td>
<td>16.2 (4.6-36.2)</td>
<td>17.3 (8.7-28.2)</td>
<td>21.0 (8.1-57.2)</td>
</tr>
<tr>
<td>Case Mangement—case record. recording</td>
<td>7.1 (1.2-16.3)</td>
<td>8.3 (1.4-24.1)</td>
<td>9.5 (0.9-19.5)</td>
</tr>
<tr>
<td>Case management-family contact</td>
<td>5.7 (0-11.8)</td>
<td>5.0 (1.0-8.6)</td>
<td>4.3 (0-11.1)</td>
</tr>
<tr>
<td>Case management-other tasks</td>
<td>4.1 (0-10.8)</td>
<td>4.4 (1.3-14.0)</td>
<td>4.6 (0-7.9)</td>
</tr>
<tr>
<td>Case monitor/audit</td>
<td>8.1 (0.7-20.8)</td>
<td>9.0 (3.3-22.8)</td>
<td>16.3 (1.3-46.7)</td>
</tr>
<tr>
<td>Court related activities</td>
<td>4.6 (0-12.8)</td>
<td>7.4 (0-23.3)</td>
<td>5.3 (0-12.4)</td>
</tr>
<tr>
<td>Flexible budget allocation</td>
<td>1.6 (0-3.4)</td>
<td>0.9 (0.3-2.2)</td>
<td>0.5 (0-2.3)</td>
</tr>
<tr>
<td>Other</td>
<td>3.1 (1.0-11.3)</td>
<td>5.0 (0-13.1)</td>
<td>2.1 (0-5.3)</td>
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<tr>
<td>Other Regional duties</td>
<td>7.8 (0-12.7)</td>
<td>8.4 (0.10.9)</td>
<td>5.6 (0.14.0)</td>
</tr>
<tr>
<td>Own professional development</td>
<td>2.9 (0-5.1)</td>
<td>4.9 (0.10.9)</td>
<td>9.5 (0.8-21.9)</td>
</tr>
<tr>
<td>Program documentation and development</td>
<td>9.5 (0-30.0)</td>
<td>3.4 (0.6-14.8)</td>
<td>4.2 (0.14.4)</td>
</tr>
<tr>
<td>Providing training</td>
<td>2.1 (0-4.1)</td>
<td>0.7 (0.7-4.1)</td>
<td>2.8 (0.7-5.9)</td>
</tr>
<tr>
<td>Service system networking</td>
<td>5.2 (0-11.7)</td>
<td>5.3 (0.8-9.9)</td>
<td>2.9 (0.7-8.9)</td>
</tr>
<tr>
<td>Supervision given</td>
<td>4.0 (0-8.3)</td>
<td>4.5 (0.11.7)</td>
<td>2.2 (0-4.7)</td>
</tr>
<tr>
<td>Supervision received</td>
<td>1.8 (0-5.2)</td>
<td>1.4 (0.5-2.5)</td>
<td>1.2 (0-4.5)</td>
</tr>
<tr>
<td>Travel</td>
<td>7.7 (0-16.0)</td>
<td>0.0 (0.7-5.9)</td>
<td>4.6 (0.15.6)</td>
</tr>
</tbody>
</table>

Aggregates for the State, for February, are based on data returned by nine Regions. Aggregates for August are based on data returned by seven Regions and, for May, on data returned by nine Regions. Each data set returned covered a two-week period.
Especially when compared with case consultation, service networking as such occupies a tiny fraction of the SIPWs’ time, and we have no comparative estimate for other child protection workers. Despite these limits to interpretation, the evaluation has found that in the course of this formal networking and of the many case related activities, the SIPWs collaborated with many different workers. The proportions of liaison with workers internal and external to Child Protection Services varied across periods and Regions. The absolute number of persons contacted in each data collection period spanned a wide range, with the largest number being 147 in one of the larger HRI teams in the August 1999 data fortnight.

The more dramatic variations within Regions across data collection periods may be explained chiefly by major events that fell within the period (such as inter-agency workshops), with some apparent effect from recording style variations and some from staffing movements.

Nevertheless, the impression of a general shift in the balance from substantially inward directed consultations to a wider base of collaboration external to Child Protection Services does accord with information gathered on the Regional visits. It appears to reflect the relative freedom of the HRI teams to deal with the outside world when more solidly established with their peers in Child Protection Services. This mix is valuable to the child protection workers who will consult with the SIPWs, as it brings new information, resources and perspectives into the protective work. Both the CAFW 4 SIPWs and the HRI managers engage in this external liaison (see table 9 SIPW data) with the managers being the major link with the PASDS. When their time spent in liaison is taken into account, it is clearer that the HRI managers carry the slightly heavier load of external service relationships (see figures 13 and 14).

Table 13: Overview of the Proportion Internal and External Liaisons, for the State, Aggregated by Regions

<table>
<thead>
<tr>
<th>Region</th>
<th>% of Internal Liaisons - Feb 2000</th>
<th>% of Internal Liaisons - August 1999</th>
<th>% of Internal Liaisons - May 1999</th>
<th>% of External Liaisons - Feb 2000</th>
<th>% of External Liaisons - May 1999</th>
<th>% of External Liaisons - August 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours</td>
<td>46.8</td>
<td>82.5</td>
<td>82.5</td>
<td>44.2</td>
<td>17.5</td>
<td>17.5</td>
</tr>
<tr>
<td>Barwon South West</td>
<td>30.0</td>
<td>64.2</td>
<td>60.5</td>
<td>70</td>
<td>35.7</td>
<td>30.5</td>
</tr>
<tr>
<td>EMR</td>
<td>48.9</td>
<td>74.5</td>
<td>64.3</td>
<td>51.1</td>
<td>25.6</td>
<td>36.1</td>
</tr>
<tr>
<td>Gippsland</td>
<td>24.5</td>
<td>0.0</td>
<td>96.1</td>
<td>75.5</td>
<td>0.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Grampians</td>
<td>0.0</td>
<td>0.0</td>
<td>78.8</td>
<td>0</td>
<td>0.0</td>
<td>21.2</td>
</tr>
<tr>
<td>Hume</td>
<td>50.0</td>
<td>0.0</td>
<td>89.8</td>
<td>50.0</td>
<td>0.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Lockdown Mallee</td>
<td>52.4</td>
<td>86.0</td>
<td>96.8</td>
<td>47.6</td>
<td>20.0</td>
<td>3.2</td>
</tr>
<tr>
<td>NMR</td>
<td>27.8</td>
<td>90.7</td>
<td>66.0</td>
<td>72.2</td>
<td>9.3</td>
<td>34.0</td>
</tr>
<tr>
<td>SMR</td>
<td>62.1</td>
<td>73.7</td>
<td>0.0</td>
<td>37.9</td>
<td>26.3</td>
<td>0.0</td>
</tr>
<tr>
<td>WMR</td>
<td>50.7</td>
<td>87.4</td>
<td>81.8</td>
<td>49.3</td>
<td>12.6</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Aggregates for the State, for February, are based on data returned by nine Regions. Aggregates for August are based on data returned by seven Regions and, for May, on data returned by nine Regions. Each data set returned covered a two-week period. Note: Where data for a given Region appears in italics, this refers to the fact that no data was submitted by the Region for the period under whose heading the italicised data falls.

The distribution of the SIPWs’ time among the various categories of external liaison raises some interesting questions (see Table 14). Only the PASDS appeared to receive significant proportions of time from the HRI managers. It is notable that the two major family issues identified from the family risk factor analysis and from Regional consultations—substance abuse and domestic violence—are not reflected proportionately in the service liaison times of either the CAFW 4 or CAFW 5 SIPWs. While it may be that it is the allocated caseworkers who do most of the agency to agency contact, one might expect more substantial network and policy development or training activity at SIPW level. Since it is known from the Regional consultations that these services are in the forefront of SIPW awareness, it may be that the work done is too episodic to have been captured well by this activity recording method.
Inter-Agency Communication and Collaboration

One of the baseline concerns noted earlier was that there has been a view that cases are more poorly served the longer they stay in the Child Protection Services system. It was assumed that one of the contributions of the HRI program would be facilitating case resolution by making more effective service links for infants.

CFR 1999 suggested an improvement in inter-agency collaboration over the results of the prior audit, an improvement not quite sustained at the second CFR in 2000. The CFR 2000 leaves some doubt about the achievement of this aim with respect to this later sample of longer term cases. Ratings on the domain 4 questions did not improve on the 1999 returns, and there was a slight decline in three of the four continued items, but still with very few cases receiving the lowest score on the relevant questions (see Appendix 16, tables 59-64). Those cases that had proceeded to a permanent care plan often did so as a result of considerable inter-agency effort. In three of the highest scoring cases, the reviewer noted good use of the QEC and other PASDS services, good collaboration with psychiatric services (to monitor the mother’s mental health in one case, and to assist with the mother-child bonding in another), and in one case very clear case contracting to a permanent care agency.

For some children at home and in care, however, the reviewer commented on inadequate consultation. In the poorest scoring cases, such deficits were an inevitable outcome of the case drift identified in earlier sections of the review tool. Relatively few comments were made by the reviewer on these issues, and the main areas for attention identified were closer work with drug and alcohol services and better use of services to enhance the health and wellbeing of infants in placement or at home.

There may be several reasons for the relatively low profile of inter-agency collaboration in this sample. Because there were the cases still open from the earlier review, some were in the late stages of a Supervision Order and were seen to have settled. Many of the children in the care of kin or prospective permanent carers were regarded by workers as doing well and having their needs met by the carers, as noted in the worker survey. The infants were now older, some having turned three, and could be seen to attract less attention than new infants entering the service. Even so, these cases were still seen as justifying statutory involvement and the family issues were complex. From the reviewer’s notes on the 71 families in the CFR 2000, seven infants had one or both parents with an intellectual disability, 18 had a parent with a mental illness, while 42 families were troubled by domestic violence and 40 by drug and/or alcohol abuse. The latter two variables were closely tied in many cases. Even with some case stability, one might expect to see more evidence of active inter-agency work.

8.3 Reports from SIPWs on Inter-Agency Collaboration

SIPWs have clearly invested in expanding child protection workers’ access to other professionals and services skilled in infant matters. All have increased their liaison with local maternity hospitals and maternal and child health nurses. Building the Regional PASDS constellation has been a major preoccupation of the HRI program would be facilitating case resolution by making more effective service links for infants. The CFR suggested an improvement in inter-agency collaboration over the results of the prior audit, an improvement not quite sustained at the second CFR in 2000. The CFR 2000 leaves some doubt about the achievement of this aim with respect to this later sample of longer term cases. Ratings on the domain 4 questions did not improve on the 1999 returns, and there was a slight decline in three of the four continued items, but still with very few cases receiving the lowest score on the relevant questions (see Appendix 16, tables 59-64). Those cases that had proceeded to a permanent care plan often did so as a result of considerable inter-agency effort. In three of the highest scoring cases, the reviewer noted good use of the QEC and other PASDS services, good collaboration with psychiatric services (to monitor the mother’s mental health in one case, and to assist with the mother-child bonding in another), and in one case very clear case contracting to a permanent care agency.

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Some examples of the important particular connections strengthened or forged, in addition to the PASDS arrangements, have been:

- After Hours Child Protection Service: The Maternal and Child Health After Hours Service.
- Barwon South West: Geelong Hospital, where a pilot risk-screening program was funded and undertaken.
- EMR: Use of the Regional Child Protection Services Forum to raise infant issues.
- Gippsland: Particular dependence on Maternal and Child Health Outreach and Community Health Centres in this dispersed, elongated Region.
- Latrobe Mallee: Discharge planning work with the Bendigo hospital.
- NMR: Development of access to the Cairnmillar Institute’s services relating to violence and anger, especially for men.
- SMR: The development of a ‘panel of experts’, comprising psychologists, child psychotherapists and paediatricians, to provide expert consultancy; developing work with Odyssey House substance abuse service.
- WMR: Developing options with a range of drug and alcohol programs.

Such initiatives are by no means exhaustive or exclusive to the Regions mentioned. While most build on existing contacts, they have focused on building closer and more reciprocal relationships with a strong emphasis on infant safety and development. Each
Region has developed a list of private providers to whom they refer for specialist family assessments and interventions—at least one paediatrician and at least one clinical psychologist with an interest in infant development and attachment issues per Region. Several of these are used by more than one Region, and some have also been invited to provide training for child protection workers. In one rural Region, a respected trainer on attachment and bonding is being invited to train interested local psychologists who lack this specialised knowledge.

Major remaining problems in the service networks reported by SIPWs were:

- Continued adult-focused practices in most adult mental health, disability, substance abuse and adolescent services. For example, less experienced psychiatric registrars might miss those detusions that are inclusive of the child, or may fail to communicate about sedation. Reports may be weeks late, which stalls the court process, since the court will not rely on Child Protection Services assessment alone. While the different foci and advocacy commitments of these services are recognised as valid, SIPWs are still struggling with how to achieve an appropriate balance of infant and parent interests during high risk periods.

- Limited places for parent/mother-infant placement that can accommodate and respond to drug and alcohol misuse.

- Rare availability of mother-infant foster care, largely dependent on the flexibility of particular agencies and the special qualities of particular caregivers. While not in large demand, this form of care has been found appropriate for some adolescent mothers and some mothers with an intellectual disability.

- The sheer insufficiency of longer term family support and parenting-focused services in rural Regions generally, and accessible to more remote families in particular.

- Similar but lesser difficulties of access to longer term services in metropolitan Regions: ‘There are a few gems out there.’

- Under-use by protection staff of specialist paediatricians, and queues for paediatricians in some rural areas.

- Too few permanent care placements.

8.4 Reports from Child Protection Workers on Inter-Agency Collaboration

Generally, workers commented on the improved range of services for infants and their own improved awareness of these. When asked about service network issues, child protection workers tended to echo the comments of SIPWs about needs in their locality (as above), with rural workers focusing on the lack of services to pick up where Child Protection Services leaves off.

In these areas, the ‘family support service’ might consist of a single worker, not necessarily full-time, serving a wide geographic area and focused on lesser risk cases. In East Gippsland, for example, it was noted that if there was to be long term family support offered after a PASDS intervention or to sustain a family reunification, it was likely to be the child protection worker who would do this. This situation is out of killer with the policy emphasis on time-limited statutory involvement in families. In one provincial city, the workers noted that while services for infants had expanded markedly, services for toddlers had remained the same. In an outlying rural area with an influx of young mothers, the need for adolescent/infant foster care (‘rent a mother’) was noted. Rural workers also noted the lack of depth and availability of the more specialised services, such as treatment and rehabilitation for violence or substance abuse.

The major contribution of the HRI program to the wider service system in the eyes of the child protection workers was clearly the PASDS component. Here workers were glowing about what this had offered the infants, their families and themselves as case managers. Attributes of PASDS appreciated by child protection staff included:

- A safe environment to keep the infant with the mother during assessment.
- The opportunity to blend residential assessment (with its comparative intensity and safety) with home-based assessment and skills development (with its real-life tests and application of learning).
- The specificity of the assessments and the assistance these provide with case planning.
- The blend of support and skills teaching with assessment.
- The opportunity for child protection staff to learn more about the minutiae of parenting infants from specialised staff, through observation, their reports and case discussion.

8.5 Reports from External Service Providers on Inter-Agency Collaboration

8.5.1 Maternal and Child Health Nurses Survey

The HRI Evaluation: Interim Report 2C reported on a survey of maternal and child health nurses conducted in November 1999. Briefly re-stated, the results from 46 nurses from seven Regions (four metropolitan, three rural) attending a Saturday MCHN conference were as follows:

- Approximately two-thirds (34) indicated that they were aware of the SIPW positions, while only 14 said that they had had contact with a SIPW. A slightly smaller proportion (27/46) was aware of the PASDS services, with 11/46 having had contact. Relatively few were aware of the HRI brokerage (a less public component of the program).

- A small number responded to the request to comment on helpful aspects of their contacts with the HRI components, and on suggestions for improvement. They noted as helpful discussion/information, risk sharing and links to services, and suggested that more information, contact and services were needed.

- When asked what infants and families they would see as warranting the term ‘high risk’, they responded with the major descriptors of concern to child protection workers. More than half named parental drug and alcohol abuse and approximately one-quarter named domestic violence, parental psychiatric illness and parental social isolation.

These responses need to be understood in the context of maternal and child health nurses providing a universal service. While they are very important to the infant workers in Child Protection Services, child protection issues for most nurses are a very small proportion of their workload. For nurses in high need areas, however, the relationship with Child Protection Services can be very important, and one such nurse was interviewed in relation to the court sample.

8.5.2 Provider Interviews

As discussed in relation to the HRI flexible budget (section 4.4.4), Regions were asked to nominate external professionals who had worked closely with the HRI program and who would be in a position to comment on its impact. Twenty-six nominees were interviewed, 19 by telephone and seven in person. Most were professionals who had supplied services through the HRI brokerage, but there were seven who were PASDS staff members, lawyers, family support providers, and a foster care provider. In addition to what they had to say about the brokerage arrangements, they also commented on issues and relationships in the service system more generally and the impact of the HRI program on these. Service system issues will also be explored more fully in the forthcoming PASDS Evaluation Phase 2.
6) Perceptions of Change

Not all respondents felt qualified to address this area of questioning as they had had little contact with the Department prior to the development of the HRI program. Unequivocally, respondents who had previously worked with the Department considered the implementation of the HRI initiative had improved the Department’s practice with this client group. Comments made included references to workers now having better knowledge and information regarding the needs of infants. This had improved their skills in assessment and observation of infants and their needs and had provided the infant with more of a voice within the Department, which is important. As the workers have become more knowledgeable their confidence has increased in dealing with cases involving such young children.

Interviewees reported that the program has made the Department more open to outsiders and this has been an important development in terms of providing a forum for exchange with experts in the field. They expressed the view that this has led to better case work practices and better outcomes for families, and infants are safer as a result. Even so, it is important to note that families still experience added stress by often having to be involved with so many different services and this has not changed as the result of the implementation of the HRI program.

Private providers said that because workers are now better informed they tend to be more specific and concise about what they need from private providers. At the same time, they are also better able to deal with complex cases and manage the often conflicting aspects within a case. A number of respondents were unable to state categorically that this was the product of the HRI program, although the differences they felt emerged with the implementation of the program.

6(i) Gaps in Service Provision to Infants

The following comments are a list of all the ideas generated by respondents. They fall naturally into the following groupings:

- Coordination and liaison.
- Service consistency.
- Service funding and resources.

Coordination and Liaison

- A number of respondents felt that there needed to be a more coordinated approach when there were multiple services and professionals involved in a case. Currently no one performs a clear case management function once the Department is no longer involved.
- A number of private providers felt they would like to have more follow through with cases and have child protection workers inform them of the outcomes of the cases they were involved with and contributed to.
- One private provider felt the legal team needed to become more familiar with the case earlier and that the tendency to receive short notice to attend court made the work difficult in the context of a private practice.
- A few private providers felt that case managers needed more information and training on how to use the outside ‘experts’.

From these comments it appears that there is a need to continue to work towards limiting the stress on families arising from the involvement of multiple service providers and work towards the development of a case management model that buffers families from some of this stress.

Service Consistency

- There is a need for a more formalised statewide assessment process for PASDS.
- There needs to be a well-developed database of information on services available to families once they leave residential settings.
- A number of services noted Regional differences in the way the program was administered and felt these differences needed to be minimised.

Service Funding and Resources

- A number of services identified the lack of services available after hours as a serious gap in the provision of care to at-risk infants.
- There needs to more funding available for ongoing support of high risk families.
- In relation to the PASDS and PASDS-like service, there needs to be pay parity between SIPW and the specialist family support workers employed by voluntary agencies, to reflect the specialist nature of the work undertaken by these agencies.
- Some families need the possibility of longer stays and more intensive work. Sometimes the work is trying to fill gaps in parenting that have existed for generations.
- One service considered there needed to be more services available for the two to five year age group—some form of developmental day care.

6(vii) Training

A number of services noted the difference between working with specialist workers and other general child protection workers. They identified the need to enhance the skills and knowledge of the generalist workers by providing more training. The areas identified for further training were:

- Infant observation and assessment.
- Infant developmental needs.
- Parental drug and alcohol issues covering both the impact and the process of change for the user.
- Writing court reports that are not formulaic.

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- Writing court reports that are not formulaic.

(ii) What Would Be Lost if the HRI Program No Longer Existed

Only one interviewee felt unsure about the value of the HRI program for infants. This was a foster care worker who queried the degree to which there was a clear policy about an infant’s risk status once on placement. All other respondents felt that to lose the program would mean a significant loss to the families and infants. Most respondents identified the specialist nature of the program to be of great value as it ensured that the special needs of infants were being attended to and that this resulted in the infants having a voice.

A number of respondents felt the model should be extended to other age groups. Adolescents and preschoolers aged two to five years were mentioned in particular.

Another loss, identified by one community-based service, would be the unique relationship that is now developing between statutory, voluntary and professional services. One service identified the focus on parenting skills as very important and this would be lost. It is one way of breaking the cycle of deficient parenting that can exist across generations. The more collaborative approach that has developed with parents would be lost, because if outsiders or third parties were not involved, this would revert back to a ‘them versus us’ style fight between parents and the Department.

One respondent identified the way that having specialist workers expedites the process and having specialist assessment means quicker outcomes in terms of court contested placements, thus making the whole process much more efficient. The ability for resolutions to be developed in a timely fashion has been a major contribution of the program. Also, the ability to intervene or start working with a family early, sometimes even prior to the birth of a child, would be lost and this is really valuable work.

6(iii) Outcomes of Change: Infant Protection in the Service Network

Drawing these observations together, it is apparent that the links between the HRI initiatives and the wider service network have broadened the practice and service repertoire of child protection workers. These workers were very appreciative of the external professionals on whom they can draw more freely than in the past, and the more substantial services offered through the PASDS. Most of the less experienced workers consulted reported both better service to infants and families because of this, and improvements in their own skills and confidence from this additional input from external professionals.

On the whole, the external providers who have worked closely with the SIPWs appear to understand the SIPW role and value the HRI contribution. They have found that when a SIPW or PASDS is involved the needs of infants appear to be better understood and responded to than they believed had previously been the case. They generally also believe their own role is both valued and useful to Child Protection Services and to the infants and families. In general, they are confident that they are used appropriately. The support for the program from these respondents, both within and outside Child Protection Services, was very strong and it was often suggested that the model should be applied to other age groups.
The HRI program, being at an early stage of development, has not yet set out to develop specific services to indigenous families. The planned Koori HRI demonstration projects have not yet been implemented.

The limited information on Koori infants gleaned for this evaluation comes mostly from the qualitative comments made by the reviewers in the CFR 1999 and CFR 2000, for those cases in which there was evidence on CASIS that the family was indigenous. We cannot be sure that this sub-sample is complete, and we have no systematic and reliable information about the extent to which the families concerned are identified with the Koori community or involved with Koori services.

During consultations, Regional staff shared their concern about the many forms of disadvantage suffered in their local Koori communities, while expressing the view that the HRI program represents an important initiative that needs to be supported to ensure that it can make an impact. The Regional staff also expressed concern about how difficult it is to identify and refer families to the HRI program.

These findings echo some in other studies. The High Risk Infants Literature Review, for example, referred to Appleton’s findings (1994, 1996) that the health visitors (a parallel for our MCHN role) experience tension between the support role with ‘grey area’ families, and the monitoring role on behalf of Child Protection Services. The review noted (p. 30): ‘It is essential to ensure that health visitors’ work with vulnerable families in relation to Child Protection Services is understood and valued.’ Similarly, the Review cited (p. 35) Birchall and Hallett’s finding that collaboration over investigation is more accepted than joint working, and attribution of this in part, to the differences of perception arising in the different agencies. The HRI program appears to have made headway on the issues of respect and consultation, and there are signs of this work now extending into more thorough-going joint work. A worker from Disability Services described the benefits of moving from consultation to more reciprocal joint work:

...made an enormous difference to my work with a disabled mother, by working together. I consult all the time with the SIPWs ...and the joint work)...educates the protective worker about the disability, but also frees them to focus on the baby, not on the parent.

This need for collaboration to be more truly two-way is a sub-text to many of the other more concrete observations and proposals made by participants in this evaluation, and it is an important message to take into any extensions to the service networking, protocol development and inter-agency training programs.

Running alongside this concern with the process, is a concern about content. The HRI program has opened up Child Protection Services to specialised infant services and professionals in a most positive way, and has strengthened the use of psychological tools as part of the assessment repertoire. There remains a need for more thorough attention to the infant ramifications of specialised adult services, in fields such as drug and alcohol, domestic violence and homelessness. It appears that more work has begun on infant issues with adult mental health and disability services. As well as process and content, the service network issues relate to context. While the HRI initiatives are valued highly, they are seen to be one part of a service system that still has many gaps, notably in the areas of flexible and open-ended and multi-faceted support to vulnerable families after protective intervention and intensive service.

9 Infants from Indigenous Families

The CFR 1999 included 18 infants (or 11.4% of the CFR sample) identified in the CASIS record as coming from indigenous families. By the second CFR in 2000, there were 10 indigenous cases included (14.1% of 71 cases), suggesting the possibility that cases of Aboriginal infants may be more likely to stay open than cases of non-Aboriginal infants. (With low numbers in these samples and some small room for discretion in allocating cases to the second review, this is not a definitive conclusion, but may be worth further exploration.) The reviewers’ reports on those 18 cases have been analysed for patterns of variables and pathways through Child Protection Services. The following picture emerges.

The indigenous families were spread across most Regions, much as might be expected demographically, except that the outer Eastern Region Aboriginal community was not...
## 9.2 Risk Factors in the Indigenous Families

The qualitative data entries by the case file reviewers emphasised the prominence of substance abuse (13 cases), domestic violence (9 cases), and homelessness (5 cases) as key issues impeding case resolution. While these factors were salient, they take their place in a more complex picture, as is evidenced by the reviewers’ accounts of risk factors apparent in the case records. The profile of risk factors is more extensive than for the CFR sample overall.

Whereas 53.2% of all the CFR 1999 cases had 10 risk factors or more, for the indigenous families 94.4% had 10 risk factors or more, with half of the families having 18 or more risk factors recorded (mean = 15.7). It should be noted that the items are not mutually exclusive, and that several may be checked in relation to the same cluster of experience (especially those relating to violence). This is a design problem applying to all cases in the sample, not just the indigenous cases, but to the extent that they are more likely to experience domestic violence, their risk profile will be weighted accordingly.

### Table 16: Risk Factors in Case File Review Sample: Indigenous Compared with Non-Indigenous

<table>
<thead>
<tr>
<th>Risk Factors Recorded on File</th>
<th>All Cases N=158</th>
<th>% Non-Indigenous</th>
<th>% Indigenous</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current/past domestic violence (M)</td>
<td>88</td>
<td>56</td>
<td>66</td>
<td>47.1</td>
</tr>
<tr>
<td>Chaotic family (F)</td>
<td>88</td>
<td>56</td>
<td>64</td>
<td>46.7</td>
</tr>
<tr>
<td>Current/past substance abuse (M)</td>
<td>79</td>
<td>50</td>
<td>64</td>
<td>46.4</td>
</tr>
<tr>
<td>Isolated family (F)</td>
<td>74</td>
<td>47</td>
<td>64</td>
<td>46.7</td>
</tr>
<tr>
<td>Poor impulse control (Fa)</td>
<td>71</td>
<td>45</td>
<td>60</td>
<td>42.8</td>
</tr>
<tr>
<td>Child Protection Services history (F)</td>
<td>70</td>
<td>44</td>
<td>56</td>
<td>38.5</td>
</tr>
<tr>
<td>Under 20 at first child (M)</td>
<td>68</td>
<td>43</td>
<td>55</td>
<td>39.2</td>
</tr>
<tr>
<td>Mother’s past hist. of abuse (M)</td>
<td>67</td>
<td>42</td>
<td>56</td>
<td>40.0</td>
</tr>
<tr>
<td>Current/past substance abuse (Fa)</td>
<td>64</td>
<td>41</td>
<td>54</td>
<td>38.5</td>
</tr>
<tr>
<td>Single parent (M)</td>
<td>63</td>
<td>40</td>
<td>54</td>
<td>38.5</td>
</tr>
<tr>
<td>Frequent moves and homelessness (F)</td>
<td>61</td>
<td>39</td>
<td>49</td>
<td>35.0</td>
</tr>
<tr>
<td>Maternal mental illness (M)</td>
<td>56</td>
<td>35</td>
<td>47</td>
<td>33.5</td>
</tr>
<tr>
<td>Poverty and material crises (F)</td>
<td>53</td>
<td>34</td>
<td>46</td>
<td>32.8</td>
</tr>
<tr>
<td>Poor capacity in caring (Fa)</td>
<td>51</td>
<td>32</td>
<td>44</td>
<td>31.4</td>
</tr>
<tr>
<td>Disrupted family structure (F)</td>
<td>51</td>
<td>32</td>
<td>42</td>
<td>30.0</td>
</tr>
<tr>
<td>Substance abuse during pregnancy (M)</td>
<td>50</td>
<td>32</td>
<td>38</td>
<td>27.1</td>
</tr>
<tr>
<td>History of assaulting behaviour (Fa)</td>
<td>50</td>
<td>32</td>
<td>22</td>
<td>15.7</td>
</tr>
<tr>
<td>Other children removed from home (M)</td>
<td>46</td>
<td>29</td>
<td>20</td>
<td>14.2</td>
</tr>
<tr>
<td>Premature or underweight (C)</td>
<td>36</td>
<td>23</td>
<td>19</td>
<td>13.5</td>
</tr>
<tr>
<td>Severe as problem (M)</td>
<td>32</td>
<td>20</td>
<td>28</td>
<td>20.0</td>
</tr>
<tr>
<td>Poor antenatal care (M)</td>
<td>30</td>
<td>19</td>
<td>23</td>
<td>16.4</td>
</tr>
<tr>
<td>History of abusing (Fa)</td>
<td>29</td>
<td>18</td>
<td>22</td>
<td>15.7</td>
</tr>
<tr>
<td>Pregnancy and birth complications (M)</td>
<td>26</td>
<td>16</td>
<td>19</td>
<td>13.5</td>
</tr>
<tr>
<td>History of abuse (Fa)</td>
<td>25</td>
<td>16</td>
<td>10</td>
<td>12.1</td>
</tr>
<tr>
<td>Special meaning to mother (C)</td>
<td>24</td>
<td>15</td>
<td>22</td>
<td>15.7</td>
</tr>
<tr>
<td>Mother’s intellectual disability (M)</td>
<td>22</td>
<td>14</td>
<td>15</td>
<td>10.7</td>
</tr>
<tr>
<td>Feeding/sleeping difficulties (C)</td>
<td>21</td>
<td>13</td>
<td>15</td>
<td>10.7</td>
</tr>
<tr>
<td>Intolerance of children (F)</td>
<td>18</td>
<td>11</td>
<td>17</td>
<td>12.1</td>
</tr>
<tr>
<td>Currently underweight (C)</td>
<td>17</td>
<td>11</td>
<td>11</td>
<td>7.8</td>
</tr>
<tr>
<td>Prolonged and frequent crying (C)</td>
<td>17</td>
<td>11</td>
<td>15</td>
<td>10.7</td>
</tr>
<tr>
<td>Drug dependent (C)</td>
<td>16</td>
<td>10</td>
<td>12</td>
<td>8.5</td>
</tr>
<tr>
<td>Current/past mental illness (Fa)</td>
<td>16</td>
<td>10</td>
<td>14</td>
<td>10.0</td>
</tr>
<tr>
<td>Intellectual disability (Fa)</td>
<td>14</td>
<td>9</td>
<td>14</td>
<td>10.0</td>
</tr>
</tbody>
</table>

RF = risk Factors  (M) = Mother RF’s  (Fa) = Father RF’s  (C) = Child RF’s  (F) = Family RF’s

When the risk factors for the indigenous and non-indigenous families are compared (see Table 16), the relative disadvantage of the Koori clients is clear. While one should use caution expressing the data in percentage terms when there were only 18 families identified as indigenous, this does allow for comparison of the patterns of risk in the two sub-samples. The table below is arranged in descending order of frequency for the sample as a whole, juxtaposed with the indigenous and non-indigenous frequencies and the % difference between the sub-samples. It is apparent that while there was no item scored as a risk factor for more than 50% of the non-indigenous families, there were 18 items noted as risks for 50% or more of the indigenous families. There were only three items on which Aboriginal families were relatively less represented than non-indigenous families.
The major parent and family risk factors are consistent across both groups, but the data suggest that indigenous families with infants coming to the attention of Child Protection Services were considerably more likely than non-indigenous families to be described as experiencing:

- Mother’s current or past substance abuse and substance abuse during pregnancy.
- Mother under 20 at first child.
- Family’s prior involvement in Child Protection Services and prior removal of children from mother.
- Frequent moves and homelessness.
- Father’s history of assaultive behaviour.
- Mother’s intellectual disability.

Another distinctive cluster of relative disadvantage for indigenous infants is most important for the HRI program, if the CFR sample is to be taken as a guide. Compared with the non-indigenous infants, the indigenous infants were much more frequently described in terms of:

1. Premature or underweight at birth.
2. Currently underweight.
4. Feeding and sleeping difficulties.
5. Mother’s poor antenatal care.

Appendix 18 shows a risk matrix for each indigenous case, and a comparison of the age at notification of indigenous infants and the CFR sample as a whole. There appears to be a strong association between early motherhood, family violence, and mother’s current or past substance abuse. There also appears to be an association between infants who are born premature or underweight and families with several other characteristics: have a history of Child Protection Services involvement; present as ‘chaotic’ or experienced frequent moves and homelessness; the mother was under 20 at the birth of the first child; mother has a history of substance use (including during pregnancy); and the father has poor impulse control. We need to exercise some caution in typing families in this way, in case there is a greater tendency for child protection workers to record such factors for Aboriginal than for non-Aboriginal clients, and because the sample is so small. This picture is, however, consistent with the literature on the health and wellbeing of many vulnerable members of Aboriginal communities.

### 9.3 Indigenous Infants in the Service System

These risk factors testify to core unmet survival needs. Despite the Aboriginal infants being disproportionately represented in this sample of the protective population, Regional consultations and other sources of information, such as the Aboriginal Family Preservation Pilot Program Evaluation (Atkinson, Abser and Campbell, 2000), suggest that there are many young indigenous families with high needs who do not reach the Child Protection Services system.

The risk profile presented here may reflect a higher threshold for Child Protection Services intake applying to Koori infants. Whether or not these are the ‘hardest’ or most needy infant cases in the Koori community, the risk profile points to the need for programs like the HRI initiatives to be embedded in a range of community-based health and welfare services. Such services appear to need to be focused on antenatal care and substance abuse treatment for young Koori women, and to attend to family violence early in relationships and family formation. Housing stability in supportive communities will be crucial. The CFR yielded insufficient contextual detail to know how much access these families had to such services, whether, for example, they had been involved with maternal and child health outreach initiatives.

Once in the Child Protection Services process, services employed appears to have included domestic violence services, counselling, general practitioners, family support, mental health, material aid, drug and alcohol services, church-based volunteers, specialist children’s services, day care and respite care. (In four cases the reviewer noted that the families had refused services.) Despite this range of services, the reviewers named each of these services in just two or three cases. It is not clear whether the families gained access to few services relative to their needs, or whether their access to services was mediated chiefly by indigenous agencies, with details omitted from the Child Protection Services case record and/or the reviewer’s HRI qualitative data records. In 11 of the 18 Koori cases in the CFR 1999 the reviewer found the workers had involved a Koori representative in the planning process, and in ten cases there was a Koori agency recorded as actively involved in making care arrangements. The omission of reference in the case record to involvement by an Aboriginal agency may have been a recording error in some cases, but might also have been a matter of timing. By the time of the CFR 2000, which examined the ten Koori cases still open and often involving child placement, nine cases had Aboriginal agency involvement.

SIPW consultation was noted as consistent in eight of the 18 indigenous cases in the 1999 review and in four of the ten cases in 2000. The reviewers commented on the use of PASDS in three families.

### 9.4 Outcomes for Indigenous Infants

There were several different patterns of case progress through the audit period noted for these 18 children, roughly half involving the child remaining in, or returning to, parental care and half going to substitute care (see Appendix 19 for some abbreviated examples).

- Parental care sustained without recourse to formal placement (excluding brief respite)—six cases. In one of these the reviewer noted that this was achieved because of parental separation. In another, the brief incident of domestic violence appears not to have been repeated, and the case was closed ‘No further action’.
- Placement followed by successful reunification—two cases (both involving parental separation, one after several attempts).
- Parental care not sustained, leading to placement—two cases.
- Placement and failed reunification efforts leading to further placement—three cases, at least one of these being placed with kin.
- Placed with kin, pending resolution—two cases.
- Permanent care case plan or order achieved—two cases, one of which involved a continuous foster placement from four weeks of age, the other a kinship placement from birth.
- One case not known (unclear from CFR record—an initial investigation case).

There appear to be no clear simple links evident between the range and type of risk factors and the progress of the cases. Because so many of the families had so many risk factors recorded, each risk factor seems to be as likely to be found in the cases where the child remained with or returned to the parents as in those cases where the child was placed. Neither does a simple count of risk factors appear to relate to the outcomes—whether placed or not, the infants come from families with relatively many risk factors. Both the placed infants and the infants at home were evenly divided in terms of whether or not there had been a SIPW consultation and other HRI input. PASDS were rare for this indigenous group.

There does appear to be some evidence that if the infants are notified very early in life and placed immediately, they are likely to remain in long term care, sometimes by default when parents refuse services. Service refusal may, however, also lead to infants remaining at home, as families retreat from the formal system and cases are closed. There appeared to be only five Koori cases where there were successful active efforts to work with the parents to resolve the question of their capacity to care, and only three cases where the reviewer recorded the use of a PASDS. In the PASDS episodes, one appears to have supported the mother to care, and in the others, the parents’ inability to care was clarified and a kin placement ensued. With the growth of rural in-home PASDS options, and further research into the use of residual PASDS, it may be possible to explore further the suitability of the PASDS models for indigenous families, and where the PASDS sit in relation to more Koori oriented family services.

### 9.5 Implications for Indigenous Infant Protection

Unless there is a bias among child protection workers toward more detailed problem specification for indigenous families than for other families, we can draw some conclusions. Whilst the indigenous families covered by the HRI CFRs in this evaluation share the same risk characteristics as other families, on the available tool, they appear to experience many more compounding problems and to have more obvious socioeconomic difficulties.

Koori infant health appears to be a major concern and to require further policy attention and possibly some priority in the HRI liaison with primary health care and the maternal and child health systems. Young pregnant women with a protective history and problems with substance use appear to be an important target group for preventive services.
Part Three: Contribution to Child Protection
Results and Learning

10. Key Infant Client Statistics
11. Discussion—Key Program Issues
12. Conclusions
13. Recommendations

The Koori families appear to receive fewer mainstream services and may not have been as well integrated into the HRI program efforts in the early stages of the program. This picture may have changed with the maturation of the program since the first CFR was conducted, as we are limited in that the second CFR stayed with the same core sample. It is known, for example, that the Goulburn Valley Family Care PASDS has begun to experiment with using its assessment capacity assist the local Aboriginal Cooperative in its family preservation work, while SIPWs in other Regions are building working relationships with local Koori family support and health agencies.

This snapshot of Koori infant issues indicates the need and the potential for more systematic attention to HRI liaison with Koori agencies in relevant communities, and consideration of how the growing knowledge base of the HRI program can be used to assist indigenous workers in their community development and family support work.
10. Key Infant Client Statistics

10.1 Infant Deaths in the Child Protection Service

As discussed in section 5, the deaths of infants known to Child Protection Services in the years leading up to the HRI project drew attention to several issues of concern: the relatively high incidence of SIDS in this client population; the incidence of drug effects in babies and their mothers; poor hospital discharge arrangements for newborns; gaps in inter-agency collaboration; inadequate risk assessments; and low attention to fathers and other household residents.

While the incidence of infant deaths while under the attention of Child Protection Services is always of deep concern, there are (fortunately) so few deaths that it is difficult to use information about these definitively either for program evaluation or for policy development. With this reservation in mind, data supplied by the Department of Human Services have been considered for any relevance they might have for this evaluation and for the development of the HRI project.

Between 1996 and 1998 there were 12 deaths of infants reported by the Victorian Child Death Review Committee. This rate of approximately six infant deaths per year seems quite constant at this time. The shaded area of Table 17 represents the years the HRI project has been in operation.

Table 17: Cause of Infant Death

<table>
<thead>
<tr>
<th>Year</th>
<th>1996</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDS</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Query SIDS</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Accident</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Neglect/Supervision</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Medical</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>NAI/Abuse</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>32</td>
</tr>
</tbody>
</table>

a. Data to September only.

b. Query SIDS involve maternal and infant substance effects and usually co-sleeping. 1996-under 2

c. Neglect of supervision relate to two drownings unattended in the bath (one 9 months old, one 11 months old) and one dog mauling (infant almost 2 years of age).

d. Medical includes acquired illnesses and congenital conditions.

e. NAI/abuse includes non-accidental injuries resulting in homicide charges or as yet undetermined injuries consistent with physical abuse. Two of these children were already 2 years of age.

f. These two cases occurred at the start of 1998 when the HRI project was just being established.

Not all of these infants who had died were under the direct supervision of the Child Protection Services at the time of death. Over the period of the HRI project the protective status of these cases can be described as follows.

Table 18: Protective Status of Reported Infant Death

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2000</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified at time of incident</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Closed</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Initial investigation</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Investigation-siblings known</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Protective intervention</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Supervision order</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>17</td>
</tr>
</tbody>
</table>
10.2 CASIS Data Trends

The evaluation brief asked the team to examine whether the HRI program could be seen to make a discernible impact on the overall infant protection results with respect to key criteria, distinct from changes applying to all ages groups in child protection:

- Did notification patterns change, either in source of notification or how abuse or neglect was recognised or named?
- Was there any change in the pathway from notification to investigation to substantiation to court action and results?
- Did the courts change with respect to the types of court orders granted?
- Were cases that were closed less likely to require another investigation within six months?

While some of these results have been touched upon in the preceding sections, the results of a review of case flow data generated from the Department of Human Services Child Protection Services case database, CASIS, are summarised in this section. (Relevant charts and tables are attached as Appendix. 13 and all chart and table references in this section refer to that Appendix.) Data provided were organised according to birth date, so that there were two sets provided: infants, those children under two years of age at notification (up to the eve of the second birthday), and those who were two years of age or older. These are referred to as under 2s and over 2s in this section. The data presented in these analyses are population data, that is, the figures are a census of the total study population not a sample. For this reason, inferential statistics have not been used in the presentation of the data, as they are not appropriate. There is no need to estimate what the population values may be from a sample, as we have the full population values available to us.

A second issue in the analysis is the extent to which the introduction of the HRI initiative in the Child Protection Services system has ‘caused’ any observed changes. Although we have the benefit of pre- and post-intervention data, this type of design does not permit definitive causal statements to be made. In the terminology of Campbell and Stanley, many extraneous factors and their influences are over-lain upon the systemic changes that are being studied. These include history effects for example, changes in society that occur separate from the intervention targeted for study, maturation effects, or naturally occurring changes over time as well as many other factors. Thus, in the interpretation of the data presented, one must exercise appropriate caution. A range of relevant changes to the Victorian Child Protection Services setting has been documented in section 12.1, and it is clear that the HRI program has by no means been the only Child Protection Services system change designed to enhance assessments and outcomes over this period, though it has been the only one targeting infants. This might lead us to expect weak program effects, if any, in such a large database, bearing in mind that there are over 30,000 notifications per year, over 4000 per year of these being two years and under.

It is suggested that in reading the attached charts, the reader bear in mind the two idealised templates presented at the commencement of the charts, showing the pattern one might expect when the intervention at year 2 has had an initial impact that has then not been consolidated or sustained.
3.2.1 Did Notification Patterns Change, Either in Source of Notification or How Abuse or Neglect Was Recognised or Named?

Over the three year period, the kinds of alleged abuse and neglect notified to the Department (charts 3 and 4, tables 1 and 2, Appendix 19) have shown similar profiles for the under and over two year olds across the three years. Physical and sexual abuse notifications for infants rose in the first program year (March 1998-February 1999) and fell again in the following year to just under the 1997-98 baseline. This profile was similar for the over 2s, but there was a slight overall increase in the three year period. It is interesting (and disturbing) to note that CASIS Chart 5 shows sexual abuse hovering at about 5% for infants, or approximately 200 notifications per year. While some of these may relate to malicious or emotive custody disputes, they might be worth a closer examination, since alleged sexual abuse of infants was rarely mentioned during the evaluation process. It is also likely that some of these concern infant siblings of older children notified with alleged sexual abuse.

Neglect allegations grew by approximately 6% in 1998-1999 and again in 1999-2000 for the over 2s, with a similar but more marked growth for infants in the 1999-2000 period. As a proportion of total infant notifications (see Table 5, Appendix 19), neglect fell a little, from being the most frequent type of allegation to taking second place to emotional abuse. This may possibly relate to some re-framing of situations as emotional abuse rather than neglect, but is also likely to be an artefact of the rise in emotional abuse notifications overall.

The rise in emotional abuse notifications was dramatic over the three year period. In 1998-1999 emotional abuse notifications rose by 16.2% for infants and 12.9% for over 2s; in 1999-2000 the rise for infants was 23.3% and for over 2s 17.7%. This is believed to relate primarily to the clear rise in notifications received from the police. It is understood that this largely reflects the implementation of a new police protocol with respect to reporting children affected by domestic violence, notifications usually recorded as emotional abuse unless the children are reported to be injured. While this policy change affected all age groups, these proportionate differences for under and over 2s, while small, are suggestive of a slight HRI program effect, possibly related to the higher profile of infants as a result of SIPW training and liaison activities in rural Regions, which account for much of the discrepancy. This change in notification has important program ramifications, because of the difficulty in proving likely harm from emotional abuse, especially for a pre-verbal child who is unable to give instruction or testify. The rise in emotional abuse notifications was not accompanied by a similarly steep rise in substantiated emotional abuse cases (Charts 34 and 35), and indeed the percentage of substantiated emotional abuse cases fell for both age groups.

In addition to the sharp rise in police notifications, there were also some small changes in other sources of notification. Maternal and child health nurses’ total notifications of infants jumped in the first program year, steadying to a slighter rise in the following year. While the initial increase in neglect and physical abuse notifications from the MCH nurses has been sustained (see Chart 7), emotional abuse notifications rose then fell. A similar pattern is evident for notifications from hospitals (Chart 8), from which only neglect notifications have had a sustained rise.

Internal Department of Human Services notifications for neglect and emotional abuse of infants showed a surge in the first program year, with the neglect notifications remaining at a similar level in the second program year. It is hypothesised that the 1998-99 internal notifications of emotional abuse might relate to SIPW’s early emphases on infant development, attachment and domestic violence in their Regional training and consultation. Child protection workers have also reported that the HRI program has raised their awareness of infants’ needs to the point that they are now more likely to notify a new infant in an existing neglected client family, where previously they might have simply “kept an eye on the situation”. Such notifications facilitate access to resources on behalf of the infant as an individual.

Overall changes in notification rates tend to be at the mercy of many factors, including demographic, outside the control of Child Protection Services, but they raise some interesting program issues. From a baseline in March 1997-February 1998, infant notifications across the State increased by 2% in 1998-99 and another 7.8% in 1999-2000 (see tables 1-10, Appendix 19). The corresponding rates for over 2s were 7.2% and 6.2%. Barwon South West, Gippsland and Loddon Mallee appear to account for a large part of these rises in infant notifications in both years, with Hume, Grampians and EMR each having a marked rise in one year. While some rural Regions also had large increases in the notification of older children, the figures do indicate a disproportionate increase in infant notifications suggestive of a raised public profile of infant risk, commensurate with the attention to service system networking efforts of the HRI staff (especially salient in rural Regions) and perhaps the greater belief that there are now services available to infants should they be notified to the Department. In terms of absolute numbers of infant notifications (tables 11-30, Appendix 19), the gap between the metropolitan and rural Regions appears to have narrowed considerably, with Loddon Mallee’s infant notifications surpassing both Northern and Western Regions in March 1999-February 2000. Infants tend to make up from 11%-13% of the Regional notifications (13% in most rural Regions in 1999-2000). This changing rural profile has implications for program resourcing (see section 11).

3.2.2 Was There Any Change in the Pathway from Notification to Investigation to Substantiation to Court Action and Results?

At each stage in the flow through the child protection process, infant cases are more likely to proceed than are the cases of older children. Infant cases notified are more likely to be investigated than cases of older children (charts 44-63), a similar rate of decline to that for the older children who were, however, less likely to be investigated (a drop from 44% to 34%). Despite this fall in investigations, most Regions show a steady rise in the percentage of substantiations to investigations for infant cases from a statewide average of approximately 55% in the baseline year to 58% in the second program year. While infants were slightly more likely to have their investigated cases substantiated than older children, this gap narrowed slightly over the three years (chart 15). It is possible that this slight overall rise in substantiation is attributable to the introduction of the VRF, used by a wide variety of child protection workers. Rural Regions tended to fall below the statewide trend line and metropolitan above. Grampians and Eastern Region show atypical patterns, the cause of which is unknown to the HRI evaluation team (charts 13 and 14). There is possibly a slightly sharper decline in substantiated infant cases going to court that for older children (charts 44-63), but this is less clear (see below). If this is so, there might be a slight program effect from the PASDI and the use of brokerage creating alternatives to court action.

In summary, all Regions appear to be more interventionist at each stage for infants than for older children, but they do not appear to have become increasingly more so. This might be read as evidence that practice with infants was already more cautious than with older children, and that it has not become any more so. There are, however, different pathways for expressing caution. The implication drawn by the evaluation team is that while the HRI program has raised the probability that infant child protection cases will be confirmed as worthy of intervention, that intervention will not necessarily involve court action, but will call on a variety of resources to make and implement protective plans.

3.2.3 Did the Courts Change with Respect to the Types of Court Orders Granted?

On the CASIS data available, as a proportion of substantiations, court action ‘proven’ for infant cases has declined from approximately 37% in 1997-1998 to just under 20% in 1999-2000 (see Charts 44-63). While this might suggest program failure, the close correspondence of the ‘substantiation—court action’ proven and the ‘substantiation—court action’ trends, and their similarities for under and over 2s, along with
the Protection Application outcome data (see charts 42 and 43) suggest that impression is more likely to arise from a combination of methodological and organisational factors.

First, there will have been a delay in cases reaching finalisation in the data collection period. In addition, there appears to have been a rise in cases withdrawn, possibly because of improved risk assessment and diversion, but perhaps also related to the reported disenchantment with the legal system. Proportionately more infants than older children have their cases investigated, substantiated and taken to court. Once at court, however, there is no discernible difference in the rates of Protection Applications dismissed, proven and withdrawn (see charts 42 and 43).

In terms of trends with respect to Orders granted, once again there was a cohort flow through delay creating an incomplete data set for 1999-2000. Between 1997-98 and 1998-99, however, total orders tended to rise for infants, while they fell for older children, the differential accounted for largely by the very high rises for infants in both Interim Protection Orders and Custody to Secretary Orders (to some extent replacing Supervision Orders) and a less sharp decline in Guardianship to Secretory Orders than was the case for older children (see charts 64-65). It is not clear from the data whether this differential was sustained, and it is possible that for the Custody Orders in particular there may have been a short term program implementation effect, as SIPWs moved quickly to identify infants drifting without progress toward a permanent plan. Given, however, that the final year of the three will have an incomplete count of final orders (tables 31-30), it is noteworthy that the rural Regions, and to a lesser extent WMR, were close to the previous amount of Custody Orders for infants, suggesting that these are holding their place as a main option for infants. Permanent care orders remain negligible. The other major ways in which ‘cautious practice’ is reflected through the courts are unavailable through these CASIS reports, that is, the use of Intermem Accommodation Orders and multiple conditions associated with these (see section 7).

3.10.2.4 Were Cases That Were Closed Less Likely To Require Another Investigation within Six Months?

Analysis of CASIS data with respect to re-investigations of cases within six months of closure shows a small but clear decline in the percentage of re-investigations of infants, compared with children over three years of age (see charts 37-41). This difference is clearer when the three point moving average is used to smooth the seasonal variations. The decline in re-investigations is even more marked for 2-3 year olds, which has relevance for the HRI program both because several Regions include children past the second birthday in their HRI purview, and because of those children who were under two during the previous investigation period. While infants and especially 2-3 year olds were previously more likely to be re-investigated, by the final period of data collection, re-investigations occurred at approximately the same rate for all three groups. This is indicative of a slight program effect, very tentatively supporting reports from Regions and the CFRs of improved risk assessment, case planning and service provision, and service system responsiveness to infants.

3.10.2.5 Did Regions Differ Greatly with Respect to These Measures, and Are There Indications That Any Change Might Relate to Program Models?

It has not been possible to discern Region by Region program effects that might be related to HRI program design, except in the most tentative way. Rural service system issues may be as much a consideration as the HRI program itself. We have noted the rise in rural cases, and for some Regions the disproportionate rise in infant cases, and have cautiously hypothesised that the closer affiliations developed by SIPWs with rural and provincial hospitals and other key agencies might have made a difference to notification rates of very young infants. In addition, the service networking efforts of rural workers raise the significance for infants of otherwise ‘taken for granted’ issues like domestic violence. From the Regional consultations, it seems that it is also possible that the impact of police notifications might have ‘hit harder’ in the rural areas, where there are fewer services to tackle the serious issues raised by domestic violence, and where it may fall to child protection workers to handle those cases themselves. Workers in most rural Regions have also spoken of the impact of rural unemployment and housing movements, and of the rise in substance abuse that appears to have both arrived with transitory populations and to have been actively marketed in some rural communities in recent years. Thus the face of young parenthood is changing rapidly. In terms of court orders, most Regions had very similar infant and older child trends, suggesting that Regional variations were more significant than HRI/non-HRI or age variation.

3.10.2.6 Conclusion—CASIS Results

There are many reservations about the accuracy of data entered into, and the information generated from, CASIS, and these must be borne in mind when considering these results. In addition, the parallel introduction of other programs and procedures in Child Protection Services practice makes it difficult to make clear assertions about the contribution of the HRI program to the overall Child Protection Services results in Victoria. The Regions varied with respect to program implementation and hence broad population effects might show up in different ways and times. For example, Loddon Mallee has not had access to a PASDS, Gippsland did not have an operational SIPW position until mid-1998, Barwon South West had an external rather than internal focus for almost the first year, other Regions have experienced periods of staffing turnover. Within these constraints, this analysis of CASIS-generated Child Protection Services statistics has led to the following tentative conclusions, indicative of very modest possible program effects at the broad client population level.

• Notifications of infant neglect appear to have shown a small steady increase.
• Emotional abuse notifications have strongly increased (believed to be a result of more police notifications following domestic violence incidents) but the increase is not reflected in stronger rates of substantiation.
• Overall, infant notification numbers have risen disproportionately for rural Regions. It is possible that this may be related in part to the particular additional professional recognition received by the HRI program in relatively under-resourced rural service systems.
• Maternal and child health nurses and hospitals showed an initial rise in infant notifications, now steadied by still increasing with respect to alleged neglect.

• Infants have retained their lower thresholds for intervention at each stage of the protective process.
• There is some evidence of a rise in the use of Custody to Secretary and Interim Protection Orders for infants, replacing Supervision Orders to a more marked extent than is true for older children.
• Court outcomes for both under 2s and over 2s appear similar.
• For both infants and 2-3 year olds (those just beyond the HRI target group in most Regions) there appears to be a small but clear decline in the re-investigation within six months of case closure.

It is suggested that, in combination with the preceding sections of this report, these data suggest that much of the HRI program impact remains concentrated on subgroups of the overall infant client population, and that broad program effects are therefore both hard to see and debatable. There is, in any case, some ambiguity about what effects might signal ‘improvement’ at this level of analysis. For example, high levels of re-investigation might be taken as a sign of poor planning in the earlier investigation, or as a sign of appropriate extra caution at a re-notification. Higher uses of ‘heavier’ orders, such as Custody to Secretary Orders, might be taken as over-intervention or a step toward appropriate permanency planning for young infants at severe risk. The data do, however, give some tentative support to the other sources of information that suggest that HRI service system networking is affecting the willingness of external professionals to notify cases of infant neglect and emotional abuse, and that infants do receive added care and caution when compared with older children in the protective process. The CASIS data cannot show what is occurring inside the ‘black box’ of the time periods between notifications and court orders (see sections 6-9).

Major issues for further attention arising from this picture include:
• The impact of raised levels of notification of emotional abuse, given the difficulties of proving this alleged or likely harm for infant clients.
• How ‘real’ are the sexual abuse allegations with respect to infants?
• The apparent changes in the flow of infant cases to rural Regions, and the implications for program resourcing.
• What is a reasonable differential between Regions in rates of substantiated investigations of infant cases?
Noting Gough’s (1993) call for attention to specifying and theorising interventions in routine child protection, in this section we discuss five main issues arising from the experience of the program, and represented in many of the comments made in the foregoing sections. They are:

a) Understanding and arguing high risk in infancy, in the context of Child Protection Services.
b) Some features of good infant protective practice.
c) Using specialist child protection consultants (SIPWs) within Child Protection Services teams.
d) Consolidating and diffusing the benefits of innovation within the Child Protection Services workforce.
e) Program infrastructure.

The program is also accumulating learning about ways of building safety and enhancing parenting for infants at risk of imminent harm and longer term developmental troubles. Since much of this work is located in the PASDS and along the pathways to and from PASDS, this learning will be discussed in the PASDS Evaluation Phase 2 Report.

11.1 Understanding and Arguing High Risk in Infancy, in the Context of Child Protection Services

11.1.1 High Risk Infants

While ‘high risk infants’ were seen to be defined chiefly by having ‘high risk parents’ there were several child specific factors that tended to elevate babies to HRI status, but even these are largely reactive to parent factors:

- In utero exposure to violence, drugs and/or other health risks.
- Illness, developmental delay and/or somatic problems (for example, weight loss, infections, infestations).
- High need for medical attention.
- Born premature or addicted.
- Lacking a strong attachment to a nurturing and reliable adult.

In their own right these infant-specific factors would often normally be dealt with in mainstream health and community services, augmented by mother-baby units accessible to the ‘non-protective’ families. They become psycho-social risk factors when compounded by social and family variables in families excluded from, or wary of, mainstream services. The HRI program has given to protective practice a stronger focus on infant variables. Even so, the evaluation has seen little evidence to date (perhaps because the team has not been close enough to the casework, the PASDS evaluation should reveal more) of awareness of the infant as an actor helping to shape parenting. For example, of the 158 infants in the first CFR, in only 17 records was prolonged and frequent crying noted as a risk factor, and in only 21 cases were sleeping-feeding difficulties noted. This may be the way it was, but given the potency of these issues in many families with infants, it seems surprising, especially when there were so many other risk factors and 88 families were described as ‘chaotic’. While these baby issues may have been construed as normal or simply reactive to other higher priority stress factors, if they were present and unattended to, then an important strategy for initiating a sequence of change might have been missed.

11.1.2 High Risk Parents

From the data provided to this evaluation, there are several features that stand out as markers of parents regarded as posing high risks to their infants:

- Parents who have already had children removed.
- Parents with intellectual disability or unstable/unmedicated mental illness who lack a competent partner and effective and intensive monitoring and supplementary parenting from the kith and kin network.
- Parents and partners with a known history of violence.
- Parents who refuse worker access to the child.
- Parents whose substance use has a direct impact on quality of child care, often combined with parents’ own protective history (some are current adolescent clients in their own right) and/or history of domestic violence.

Combinations of these heighten the perception of risk and are more likely to lead to placement of the child (often with kith or kin) or to intensive use of PASDS and other resources if only to confirm the perception of parental incapacity at this time and infant risk. For example, while in the first CFR there were 22 mothers (out of 158) noted to have an intellectual disability, the more concerning cases were those where the father
also has an intellectual disability and/or a history of violence in or outside the home. Nine of the mothers with intellectual disability also had a mental illness. Thirteen of the families headed by a mother with an intellectual disability were described as ‘chaotic’. The others, where supported socially, stand just outside the borders of diagnosed mental illness, intellectual disability or known organic disorders. These parents evoked some of the most heart-felt expressions of worker frustration, as they described volatile emotional expression, explosiveness, unpredictable attitudes and behaviour, litigiousness, self-absorption and evidence of unrealised and/or unsustainable parenting competence. It is likely that these are among the characteristics linked to those families classified as ‘chaotic’ on the list of risk indicators attached to the CFR 1999.

During this evaluation process, workers have stressed that because infants may be presented to Child Protection Services without a personal Child Protection Services history and... of harm occurring, then arguing a case for ‘likely harm’, especially in the court context, becomes fraught with difficulty. Some workers have argued that their focus should be upon arguing the child’s need for protection, rather than trying to predict the probability of harm. Practically, a major... that distinguish the processes of reactivity to crises, family development and purposeful and planned change in families.

(i) New Parents

The question of likelihood of harm and concomitant parental protection is fundamentally different for first time parents and for those with older children. With a new parent, ... substance abuse in pregnancy, diagnosed psychiatric disorder, intellectual disability, and high risk lifestyle. Usually, it is only some time after birth that other risk factors tend to become evident, such as domestic violence, postnatal depression, personality disorder, and homelessness. It is after birth that the worker is able to... neglect, abuse, poor frustration management, rejection, abandonment and failure to provide for the child. For new parents, then, an assessment of high risk is largely a prospective exercise and rests on an analysis of parenting capacity—a mix of personality, knowledge and environmental variables. Data on these factors are available through interview, psychological testing, specialist reports relating to psychiatric conditions, disabilities, and substance use patterns and consequences, reports of others involved with the parent and social and environmental mapping. Synthesising the full range of inputs throughout this evaluation, the evaluation team suggests that prospective criteria for determining that it is unlikely that a first time parent will adequately safeguard a new infant tend to include:

- Demonstrated incapacity to provide and care for self routinely.
- Demonstrated incapacity to provide and care for self sporadically as a result of unmedicated mental illness or substance abuse.
- Frequent outbursts of uncontrolled anger or violence.
- Inability to learn new behaviour and attitudes at a speed commensurate with the infant’s development.
- History of inability to understand and respond to the needs of others.
- In association with the above, lack of reliable and consistently present supplementary caregivers, and the lack of adequate financial and material resources, and loneliness-lack of positive and sustained friendships.

These and similar criteria essentially involve a search for analogues to the components of sound parenting: provision for... in the light of subsequent events. A few of the CFR 1999 cases received positive ratings with respect to standards of practice, including risk assessment and decision making, in the first review, but were still open and re-reviewed in CFR 2000 and received much lower appraisals. In one case this was because of the reviewer’s judgment that the case was drifting with insufficient planning, but the others had been seen as resolved previously and had ‘bounced back’. Many others from the CFR 1999 had also been concerning but had closed apparently successfully, without re-notification. SIPWs and child protection workers carrying HRI caseloads grapple with this constantly, knowing that placement on, or removal from, a high risk register may be transitory because these decisions tend to be linked to changing parental and environmental conditions even while the infant’s vulnerability remains constant. Yet despite these uncertainties, they often must act as though they have the power of prediction.

During this evaluation process, workers have stressed that because infants may be... 1999. The research literature on which such predictive arguments must be built is often itself flawed or open to various interpretations. Macdonald and Macdonald (1999) suggest distinguishing ‘risk’ - (you don’t know for sure what will happen but you know the odds’) from ‘ambiguity’ (‘not knowing the odds’). The multi-factorial nature of both harm and safety in child rearing means that, in these terms, child protection workers are more likely to be working with ambiguity than risk. No two cases have all of the above, and few families follow patterns so clear as to guarantee certain outcomes. If one cannot ‘know the odds’ of harm occurring, then arguing a case for ‘likely harm’, especially in the court context, becomes fraught with difficulty. Some workers have argued that their focus should be upon arguing the child’s need for protection, rather than trying to predict the probability of harm. Practically, a major part of the protective argument rests on the assessment of whether the ‘parents have not protected and are unlikely to protect’ from the relevant type of harm. These ‘likelihood of protection’ assessments challenge the worker to distinguish between volatility and change in working with families at risk, and call for a conceptual map that distinguishes the processes of reactivity to crises, family development and purposeful and planned change in families.

6) New Parents

The question of likelihood of harm and concomitant parental protection is fundamentally different for first time parents and for those with older children. With a new parent, there is a gradual revelation of risk factors, with only some becoming obvious before birth: substance abuse in pregnancy, diagnosed psychiatric disorder, intellectual disability, and high risk lifestyle.
this case, and the coherence and defence of the argument that they are generalisable to prospective parenting. Commissioned assessments from external psychologists help validate or refute child protection workers’ judgments about these variables and their generalisations from these analogues to parenting. The assessment functions of the PASDS have provided a vehicle for testing the conclusions in real life parent-child interactions in heavily supervised settings (residential or at home).

These cases generate emotionally-charged communication in the professional network when the different bodies of expertise give rise to different assessments of personal functioning from which the professionals draw different inferences about parenting capacity. Inter-disciplinary collaboration in the assessment phase on an even playing field is critical in these cases, both in order to build a consensus case at court where possible and to produce a viable case plan. The major difficulty appears to be developing a collaborative process that can accommodate different bodies of knowledge within the mandated role of the Child Protection Services. Those cases that have been settled without that it helps if the parents and extended family, too, can see the connections between personal functioning and parenting capacity and can participate actively in the assessment and planning processes.

There appears to be a need for closer examination of the theoretical and empirical basis for establishing the parenting capacity of high risk new parents, and a need for wider training of child protection staff in how to manage this delicate process. Further inter-disciplinary practice and policy work in relation to assessing and working with parental disability, substance abuse and personality disorder is also indicated. The prospects for a common assessment framework across the PASDS; widely accepted, are yet to be tested.

(ii) Parents Who Have Had Children Previously

For the parent who already has children, there is a greater tendency to treat assessment of high risk as a retrospective exercise, drawing on evidence of past parenting behaviour, good or poor, and drawing attention to the continuities of personality, knowledge and environmental variables since that past experience. Data on these factors are available through interview, observation of parenting practices with existing children, review of the Child Protection Services history and information from kin and kin and other service providers. These parents, and especially those who have already been investigated by Child Protection Services, may have had older children removed and placed in care. There may already be information ‘in the system’ about those factors that only emerge after birth for new parents (for example, domestic violence, personality variables). Given the legislative preference for all children to be at home if possible, there has been a tendency for both workers and courts to treat a new baby as a new chance to parent. The focus on the extreme vulnerability of infants since the introduction of the HRI program has put more pressure on workers to argue previous parental failure as evidence of likely harm and likely inability to protect, creating tension both within the service and within the courts.

For parents who have previous children, the criteria for determining that they are unlikely to protect tend to include:

- Previous child was harmed while in parental care.
- Demonstrated failure of parent to protect previous child from harm.
- Previous children removed and placed (especially in permanent alternate care).
- Continued presence of same risk factors in parent/s and environment.
- Lack of new compensating protective factors in parent/s and environment.

These and similar criteria essentially involve an argument that past parenting behaviour is indicative of parenting capacity. This assumption may be problematic on a number of counts:

- Poor practices or mistaken judgments in earlier interventions.
- Improvements or deterioration in the parent’s condition, beliefs or knowledge.
- Changed family and social circumstances (among which re-partnering is common).
- Differences in the characteristics or meaning of the new child compared with previous children.

To counter these concerns, any argument about parenting capacity linked to past parenting behaviour must be based on an analysis of change. Some of the contentious cases drawn to the attention of the evaluators have involved SIPWs investing heavily in building a case that there has been insufficient change to be confident that this child will be safer than a previous child. There have been other cases in which HRI resources were used to inject new information and support and to provide an opportunity for parents to successfully demonstrate that their care of this child was better than in the past. In either scenario, the availability of follow-up support and monitoring appears critical.

To argue a likelihood case based on presence or absence of change, it appears that it is helpful to use chronologies of, and testimony about, past events, interventions, and results of interventions. This is a major time-consuming orchestration task for the child protection worker. Since change is not uniform, the court will be likely to want to hear of both positive developments and significant deterioration. Assessments from external psychologists may be used to help explore the capacity and motivation of parents to change and, in the absence of baseline evidence, when a new parent-figure has been added to the family, they can be used in a similar way to assessments of new parents. Where there is good evidence of the child’s condition in the parent’s care, this can serve as a baseline for observations using PASDS and other closely supervised parental care episodes.

It appears that there is room for more detailed exploration of theories of change and SIPW training focusing on how to operationalise change concepts in the assessment and planning with repeat presentation parents.

(iii) Pre-Birth Notifications

SIPWs’ involvement with community professionals, especially hospitals, prior to the birth of infants, has varied. They have assisted hospitals with their own screening practices, have consulted them on discharge planning prior to birth, and have worked with child protection workers and community agencies on formal pre-birth notifications. The little formal data we have on these formal pre-birth notifications through the HRI Evaluation CFRs suggests that such notifications are often of very troubled families who subsequently have their children placed. Of the nine cases in the CFR 1999 notified before birth, only three had exited the system by the second CFR 2000, one through intensive services that had apparently assisted the mother to parent and remain drug free, one because the child had an apparent SIDS death while receiving intensive services, and the other because the infant had joined its siblings in a foster placement. Of the five that remained open and were examined for the CFR 2000, two infants, each from a family with a young, drug using mother and a violent partner, were in foster care with permanent care case plans. Another infant was in foster care pending reunification, after support services had been unable to sustain a mother-child placement with a family friend. Another had remained since birth with the maternal grandmother, pending resolution of parents’ treatment for mental illness and the stabilisation of their lifestyle, and permanent care was under consideration. The last infant was in permanent care with extended family after intensive service, including PASDS, had confirmed the two intellectually disabled parents’ inability to cope. Pre-birth notification can, then, be a potent tool in advancing either parental caregiving or substitute parenting. There will, however, need to be awareness of the limits to prediction and a commitment of resources to prevention, such as the HRI program has allowed. Without these qualifiers, pre-birth interventions risk distorting the processes of natural justice.

Some pre-birth inter-agency work appears to involve the SIPWs in a consultancy role, and it may be that their protective input can occur without formal notification and registration as a Child Protection Services case. This might occur through good antenatal screening and access to well-informed diversionary programs, like Strengthening Families, as community referrals, provided such programs have the training and resources to provide infant-sensitive practice. Over the next few months, before the thorough institutionalisation of pre-birth notifications, it would be timely for the SIPWs as a group to review the pathways and outcomes of these pre-birth notifications and like consultations. This might further clarify the optimal relationships between the SIPW roles of community education and network development on the one hand, and pre-birth consultation and management on the other. It could also help refine the function of Child Protection Services in assisting child maltreatment prevention efforts in the community.
11.2 Some Features of Good Infant Protective Practice

There is evidence of an evolving infant protective practice model that is not yet clearly articulated. Some aspects of that model are outlined below in a minimal way that does not capture the depth of the material embodied in SIPW consultations. Further development requires attention from the HRI teams and elaboration through the PASDS Evaluation Phase 2. While the safety and development of the infant at risk of harm is always at the forefront of inquiry and action, the family is the key to case resolution. The processes below are variants on, or additions to, general protective practice. The emerging conceptual framework for defining the situation for work is essentially cognitive-behavioural, within an ecological frame. The emerging framework for action builds on this and is also driven by competency-based child and family developmental imperatives. The core principles appear to be:

- The baby is physically and developmentally vulnerable—harm will last.
- Time to prevent harm is short.
- Most parents desire the good of the baby.
- Caring is a physical, cognitive and affective cluster of activities with increasing parent-infant mutuality over time.
- Parenting is a social construct, embedded in webs of family, community and societal influences. It cannot be done alone. Social learning is an appropriate theoretical approach to the development of parenting competence.
- Parenting competence is a product of intrinsic individual factors, learning and demonstration opportunities and enabling social expectations and conditions. It is not static.
- The State has an investment in parenting and child development, justifying the respectful use of legitimate authority to give babies a good start in life.

11.2.1 Assessment and Planning

(i) Ajust Process

To ensure due care and justice within the spirit and letter of the Children and Young Persons Act 1989, it appears that several attributes of the working relationship between Child Protection Services and the family might help make this process of early protective intervention both more comprehensible and less adversarial:

- Honesty about the process:
  - Clear explanation about how the issues in contention affect infant safety, development and wellbeing.
  - Clear explanation of procedures and rights, tailored to the cognitive and affective status of the parent.
- Advocacy and support for the parent, alongside HRI advocacy for the infant.

(ii) Active Engagement with Parents and Extended Family

To clarify the Objectives of Protective Intervention and Develop a clear Response

- Use of trusted others to build bridges.
- Focus on the baby and baby’s development.
- Validating and dignifying parenthood.
- Joining with the parent’s desire for a well baby.
- Inviting the mother/father to hear the child’s voice and to see the infant’s world from an infant perspective and see risks of the parent’s situations to the baby’s development.
- Inviting the parent/s to explore options to counteract the risks.
- Establishing goals and timelines appropriate to the developmental imperatives of infancy.
- Inviting the help of family and friends.
- Judicious and timely use of family group conferences to explore ways of keeping the baby safe at key phases.

(iii) Infant Wellbeing Assessment

- During the assessment process, ensuring that the infant is in the care of a responsible adult at all times. Is a vulnerable parent linked with another competent and nurturing adult with access to the child on a daily basis (or more frequently and continuously for a neonate)?
- Considering the material provisions for the child. Are food, clothing, living space and equipment safe and adequate to needs?
- Assuring the infant’s feeding, sleeping and awake routines, and patterns of behaviour. Is feeding adequate? Is behaviour disturbing to the parent? Are there safe sleeping arrangements?
- Assenting parental knowledge of, and attitudes to, age appropriate care.
- Observing the infant awake and in interaction with parents and other key caregivers, gauging mutual attentiveness and responsiveness as appropriate to age level. Do the parents express joy and pride in, and hope for, the child? If there appears to be parental ambivalence, what is the nature of the opposing negative and positive affects?
- Timely bodily examination (by the child protection worker or by an appropriate health professional) of the child if neglect or physical abuse are alleged and in situations of current physical domestic violence. Look/feel for bruising, severe rashes, bite marks, touch-sensitive areas, infections, fever and extreme lassitude.
- Providing an opportunity for the parents to join the assessment process, with support, to experience and reflect upon the impact on themselves and the baby of their parenting behaviour, in the home or through a PASDS.
- Exploring the living circumstances, parental health and wellbeing issues, and relationship factors that intervene between necessary, intended and actual care, and establishing the precise ways in which they impede the child’s development and safety. Look at routines, behaviour patterns, attitudes, ideation about the child, accessible harmful substances, and number of caregivers.

(iv) Assessment of Change

- What have been the duration and frequency of the infant’s and parents’ troubles?
- Exploring the living circumstances, parental health and wellbeing issues, and relationship factors that intervene between necessary, intended and actual care, and exploring their susceptibility to positive change or deterioration.
- Consider the development of previous children (if any) and the ways in which this infant and his/her relationships and circumstances are similar or dissimilar from those.
- Search for indicators of other difficult changes that have been achieved with positive results.
- Who or what in the environment works for and against parenting, for and against positive sustained change in parent role.

(v) Multidisciplinary Input

- Is the child in regular contact with a maternal and child health nurse, physician and/or qualified child care worker? If so, how do they see the condition of the infant?
- Gathering clear developmental data from maternal and child health nurse records or requested assessment, then, if so indicated, from a medical/paediatric assessment. Is the child within an acceptable range for age on key development criteria? If there is a historical record of the infant’s development, is it stable, deteriorating or improving?

11.2.2 Intervention and Outcomes

(i) Urgent Attention to Core Need

- Establishing how violence is, and will be, kept in check. Contract for immediate safety. Secure longer term services to maintain personal and family safety and prevent recurring violence that will undermine other parenting efforts.
- Secure safe and continuous feeding, housing, physical care, provisioning. Safety nets for the infant will require that the child is known in a caring and protective community, which will not be possible if transience and family survival struggles ensue.
- Secure needed health/medical attention for the infant and caregivers.
- Ensure the daily availability of warm, attentive interaction between the infant and a very small number (consistent with infant’s needs and stage) of consistent adults.

(ii) Developmental Provision

- Link infant to maternal and child health system, with a monitoring system to respond if the infant fails to develop appropriately.
- Link infant to a general practitioner the parent is happy to use.
- Link infant to competent real or fictive kin.
- Ensure back-up care for primary caregiver.
- Provide parents with developmental and child care information and skills through different approaches—verbal, written, modelled and practised.
- Problem solve with respect to stress-inducing infant behaviour.
- Offer parenting skills development through action learning and a supportive and educative relationship, reinforced informally in the home by respected others. Parenting intervention may be residential, day-stay, centre-based or in-home, but must be tailored to the specific infant needs and parental conditions and capacities.
 Such risk-taking chiefly involves building a strong fabric of supervision and support for parents who are believed to be at high risk of parenting incompetence, but giving them scope to succeed or fail. Workers and the courts seek to run this risk that parents may not be able to care for the infant safely, while ensuring that there is a caring and competent adult available to modify the risk of actual harm to the infant. PASDS, especially in-home PASDS, have made this much more possible for families with young infants.

These kinds of interventions draw the HRI program attention to preventive opportunities with families who might or might not fall into the high risk basket. Cautious experimentation has been aided by the ability to purchase expert assessments via the brokerage monies, enabling finer case planning and guiding the way the workers relate to families. More policy, program and practice development is needed not just to refine the emergent practice model but also with respect to appropriate levels of risk-taking.

While infant-sensitive practice appears to be growing, the comparison of the case file data from the three data collection periods suggest that, despite the gains in most areas, there is still work to be done on workers’ analysis of the why and how questions relating to parenting failures. This is critical to the problem of prediction and more particularly to planning to prevent relapses and planning to accommodate new developmental phases and challenges. It appears that constraints upon effective protective intervention ‘across the board’ for all infant clients include:

• Workload and especially work flow management issues for child protection workers and their supervisors.
• Insufficient access to SIPWs and other specialist supports for workers not co-located with a SIPW.
• Confusion and frustration with the Child Protection Services/drug services policy and service interface, leading to insufficient combined intervention options.
• Efficacy and substance use in some communities, overwhelming the case-by-case strategies available to Child Protection Services. Despite these constraints, the HRI teams are working toward a greater awareness among Child Protection Services staff of their critical role in infant wellbeing.

11.3 Using Specialist Consultants with Child Protection Services Teams

11.3.1 ‘Specialisation’ and ‘Expertise’

In the preceding sections on the implementation and impact of the SIPW positions, the primacy of the case consultation role was noted. This has provided an opportunity to consider both the notion of ‘specialisation’ within an already highly specialised workforce, and the place of ‘consultation’ in an already highly supervised workforce. We have noted that in the early stages of the program there was considerable suspicion among child protection workers about their colleagues who saw as becoming ‘overnight experts’. Then and later those SIPWs who came from outside Child Protection Services and brought other infant-relevant knowledge and experience experienced less of this suspicion, but this was offset by their lack of credibility as child protection workers. These reservations for the most part waned as SIPWs demonstrated their utility and, through continued study and frequent exposure to infant cases, built their own case lore or practice wisdom.

Specialisation (devoting oneself to a particular branch of one’s profession or occupation) and expertise (being steeped in the knowledge of a particular discipline/aspect and practising it skillfully) are distinct concepts, clearly held to be so in the courts. Yet in practice, especially in the rural Regions where there is a dearth of relevant ‘experts’, SIPWs have sometimes had to bridge the two. Within the specialisation of child protection, they have further specialised in understanding the implications of infant development, risk and early parenting in child protection work, and those who remain become increasingly expert in infant protection. The major expertise of SIPWs is as brokers of infant specific knowledge and resources, and it is on this base that their credibility has grown.

As a group, they have quite diverse additional strengths to bring to the bear on the initiatives, some indicative of direct practice expertise, and some of managerial or programmatic expert skill. For example, the Loddon Mallee SIPWs appear to have expertise in facilitating linkages between formal services and community processes, and then harnessing these to protect children. Among the SIPWs in NMR is expertise in connecting adult forensic practice with infant needs assessment. In SMR and Barwon, there are workers who appear particularly skilled in engaging with families toward change goals. Other Regions have evidenced a variety of areas of expertise in program development and data management and analysis. In all Regions, SIPWs have used their specialist training and roles to help child protection workers understand which external experts are needed to help resolve particular questions or dilemmas. There is a history of Child Protection Services teams drawing on such external experts (especially psychiatrists and psychologists) for secondary consultation. The imperative of court credibility and the opportunities created by the HRI flexible budget have driven a change toward using them more as primary consultants, undertaking face to face assessment work with families, as the basis for advice to Child Protection Services.

11.3.2 Consultation

With the added HRI training, and access to HRI information resources, the SIPWs have bridged the gap between external expert consultants and internal supervisors through the process of case consultation. External expert consultation is not only expensive (some cases have consumed several thousand dollars of expert input) but is also often scarce and unavailable at the time it is needed. Child Protection Services and consultancy work to different timetables (see provider feedback in section 4). As a vehicle for attending to infant issues, internal supervision is hampered not only by the lack of infant-specific training, such as the SIPWs receive, but also by the heavy workloads of team leaders and (in most Regions) their mixed caseloads, lacking the saturation in infant issues experienced by SIPWs.

As discussed in section 2, this consultation function has often been blended with supervisory responsibilities. This blend of authoritative and advisory stances in the supervisory/consultative function of the SIPWs appears to be inevitable, and requires continual attention if the complex goals of the program are to be borne in mind. The figure below presents a simplified model (because in practice the connections are less discrete and linear) showing the different pathways that consultation/supervision process can take according to the emphasis of the model, the style of the SIPW, and the receptivity of the staff group or individual.
Most SIPWs support the need for both the instructional and exploratory approaches to consultation. They have found, for example, that some workers may need a series of reminders and instructive prompts before they are ready to engage in more free flowing exploration, advancing their own hypotheses and responding non-defensively to challenges. Local politics may make it either necessary or unacceptable for SIPWs to work in a clearly instructional way. The representation below also serves as a reminder that both streams are needed if the twin HRI program outcomes of caution and innovation are to be promoted. In further program development within and across Regions, SIPWs could fruitfully focus on sharing and documenting strategies for internal specialist consultation within each of these two streams.

Everett Rogers (1983) refined this analysis, expanding the notion of peer support to include patterns of relationships among roles, norms, opinion leadership and change agents within the social system receiving the innovation. He also drew attention to the issues of the timeliness and duration of the innovation diffusion process.

In similar vein, Davenport, De Long and Beers (1998) shift the focus from innovation to the broader concept of knowledge, and its centrality in large organisations. They define ‘knowledge’ (1998: 43) as ‘information combined with experience, context, interpretation, and reflection. It is a high-value form of information that is ready to apply to decisions and actions.’ They add to this earlier literature a focus on electronic technologies and the part they play in building and disseminating knowledge. They propose (from a study of 31 projects in 24 companies) likely success factors for an organisation wishing to build an effective knowledge management process (1998: 50-55):

- Link to economic performance or industry value (for example, reduced time expenditure, re-usable knowledge).
- Technical and organisational infrastructure (electronic technology and coaching in its use-ready document exchange, video conferencing, net searching).
- Standard, flexible accessible knowledge structure (how structured and accessible is existing information and knowledge—tied up in one person or a database that is hard to modify?).
- Knowledge-friendly culture (intellectual curiosity, free knowledge sharing, fit with existing culture, respect for both the original and the replicated).
- Clear purpose and language (added value for the data exchanged, for example, context, interpretation, analysis): Normal business language gives the impression of being fact based, often drawing on military and natural science metaphors. But knowledge management deals with things like complexity, uncertainty, and organic growth. That calls for a new vocabulary...more probing, it invites debate, and it exposes the uncertainty we all have.(1998:53)
- Change in motivational practices, developing knowledge sharing as part of the culture rather than a management direction.

Whether workers want and need a particular emphasis does not appear to be related to their level of experience, although less experienced workers can derive particular benefit from having their consultation linked with a joint home visit or interview, allowing them to observe as well as discuss the SIPW’s perspective. SIPWs have also found it helpful to formally focus on conceptual or research material in some consultation sessions, inviting the worker to engage with the relevant literature by applying specific materials to the case at hand, offering précis versions if necessary. Workers’ personal needs and issues are sometimes an important part of the process. Childless workers without supplementary child care experience have been particularly vocal in their appreciation not just of the information SIPWs can give them, but also of the example provided for how to overcome the engagement hurdles, and their own anxieties.

The supervisory components of the role might appear to warrant locating the SIPWs as part of the service units. Yet because SIPWs are ‘specialists’ rather than ‘experts’, this blend of consultation/supervision has been quite problematic at times when the SIPWs have been placed in teams that already specialise in infants (such as WMR)—it can be hard to differentiate their role from that of the line team leaders.

While most workers want SIPWs readily accessible, it appears that a measure of separateness and independence strengthens the consultation role, by adding a ‘clear head’, free of the existing mind-set about the case, team culture and emotional investment. This combination of information/knowledge, saturation in infant issues, process skill, and a degree of separation from the case and team seems productive, and is especially useful because it is located with, and drawn on, the other resources of the HRI initiatives—PASDS and the flexible budget.

11.4 Consolidating and Diffusing the Benefits of Innovation within the Child Protection Services Workforce

Acceptance of internal specialists is ephemeral in such a challenged and challenging service environment as Child Protection Services. The ‘specialist’ is viewed as such only as long as the specialty is deemed useful and accorded priority given the practice and policy demands of the day. Crittenden (cited in Gough, 1993: 216) noted how an innovation designed to improve routine child protection practice was thwarted in part by staff resistance and threats to the inter-disciplinary status quo, and in the face of larger political problems. He concluded that it is necessary to change the macro system or else to attempt modest changes that do not disrupt the inter-locking micro and meso systems. The HRI initiative has some parallels in the experiences of SIPWs, who also encountered resistance and found they had to expend high energy to earn credibility and their place in the established order to be able to introduce a modest base for change and development.

11.4.1 Innovation Diffusion

This issue of fitting the innovation into the social order is one of the key themes of the diffusion of innovation literature, which was prominent in the 1970s and 1980s. Rothman (1980), for example, noted that the rate of innovation adoption was high when:

- The diffusion process was compatible with values of the target system.
- Information about the innovation is passed through appropriate communication channels.
- There is strong peer support in favour of the initiative.

- It is promoted by opinion leaders.

Everett Rogers (1983) refined this analysis, expanding the notion of peer support to include patterns of relationships among roles, norms, opinion leadership and change agents within the social system receiving the innovation. He also drew attention to the issues of the timeliness and duration of the innovation diffusion process.

In similar vein, Davenport, De Long and Beers (1998) shift the focus from innovation to the broader concept of knowledge, and its centrality in large organisations. They define ‘knowledge’ (1998: 43) as ‘information combined with experience, context, interpretation, and reflection. It is a high-value form of information that is ready to apply to decisions and actions.’ They add to this earlier literature a focus on electronic technologies and the part they play in building and disseminating knowledge. They propose (from a study of 31 projects in 24 companies) likely success factors for an organisation wishing to build an effective knowledge management process (1998: 50-55):

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- Change in motivational practices, developing knowledge sharing as part of the culture rather than a management direction.
Multiple channels for knowledge transfer (synergy between electronic and face to face communication, importance of co-location).

Senior management support (validation messages, funding, resources, clarifying knowledge priorities).

In essence they found successful knowledge-based organisational change drew on both technological and human resources.

Unlike data, knowledge is created invisibly in the human brain, and only the right organizational climate can persuade people to create, reveal, share, and use it. Because of the human element in knowledge, a flexible, evolving structure is desirable, and motivational factors for creating, sharing, and using knowledge are very important. Data and information are constantly transferred electronically, but knowledge seems to travel most felicitously through the human network. (Davenport, De Long and Beers, 1998: 56.)

The emerging drive toward evidence-based practice in health and welfare services, and more recently in child protection systems, echoes this focus on the significance of knowledge for practice. These changes demand a focus on the mechanisms of organisational learning and, particularly in government bureaucracies, a shift from instructional to exploratory modes of communication and knowledge diffusion. Following these researchers, the organisation’s intellectual capital must be seen as inextricably part of its human capital. This way of thinking about organisational learning helps throw light on the characteristics, strengths and struggles of the HRI project to date, and gives some direction to thinking about its future development. The following section discusses the HRI project in the light of these elements of innovation diffusion; the examples given are not exhaustive but represent a large section of the range of issues encountered.

11.4.2 Knowledge Diffusion and the HRI Project

(i) The Innovation

The defining characteristic of the HRI innovation within the Child Protection Services has been its complexity of form, the multiple roles and components brought together under the one innovation, held together by the SIPWs. A major strength has been the flexibility this gives rise to, in tailoring an HRI response to different infants and different Regions, just as a major struggle has been the mirror image of this, the lack of clear prescription for what needs to be done. Zooming in on the detail, one can see that the other key characteristic of the innovation has been the complexity of the knowledge base, and the challenge of absorbing a large and rapidly changing knowledge base about infant development and risk management, alongside a diffuse and less ‘validated’ knowledge base about the dynamics of infant protection and family change.

The innovation was timely as a response to needs widely publicised, and it was compatible with the existing functions of the main host organisation, the Child Protection Services. How timely and compatible it has been for the PASDS hosts is not yet clear. Part of the struggle of the HRI staff relates to the issue of the timeliness of innovation: a timely beginning may not lead to sustained commitment when other demands of more pressing concern leap to the fore. The timing issues were complicated by uneven progress of tendering arrangements across the Regions and a volatile staffing establishment.

(ii) The Site

The social systems into which the HRI project was introduced were deeply segmented. The SIPWs and other HRI program components were designed to serve whole Regions but were introduced into settings organised around multiple units, teams and sub-Regions. Not only did this substantially complicate the webs of relationships to be formed by the new players, but it created specific challenges:

- The innovations were introduced into multiple sub-cultures with different ways of learning and different orientations to change.
- Norms about core substantive issues like thresholds for intervention, responses to family violence, or the rights of parents with disabilities showed some variations from site to site.
- The innovation and its resources had different meaning and utility for these different sites, so that HRI implementation practices had to vary.
- The peers from whom one might seek support and legitimacy in introducing new ways of thinking and acting sometimes, in the first instance, experienced the incoming workers as competitors or threats to their own roles.

Complex and multiple social systems also yielded some advantages for the HRI project. These included many options for choosing a receptive starting point and developing from there; enlisting the advocacy of sympathetic peers; meeting the needs of the most ‘hungry’ members, such as young new workers eager for input on infancy, or stressed team leaders keen to share the supervisory load. As the project proceeded into its second year, many SIPWs found that joint family visits with staff were a major tool in transmitting new ideas and ways of working. The cross-Regional network of SIPWs and PASDS meant that the HRI personnel could also tap into wider networks of influence and information, to advance their understanding and action (such as through inter-agency protocol development).

Management support and legitimation is described in the literature as essential to implementing, consolidating and diffusing new programs. For the HRI project, top level management support from the central department was clear from the start, but local level advocacy was more variable and equivocal. While some SIPWs appear to have been opinion leaders with ‘the ear of management’ prior to the program, others received this support through the implementation process and still others have had to battle and strategise to attain and retain it. One of the strengths of the program has been the use of the influence of the central program branch to help shape management imperatives and make links between better infant protection practice and the core performance measures of the Child Protection Services. A source of vulnerability that threatens the further development of the HRI project is the shifting sand of resource fluctuation and redefined political imperatives that drive management to shift its support and legitimation from one program to another.

(iii) The Process

To reshape knowledge of infant needs and the culture of intervention into high risk families with infants, and to keep this process moving, has been the core task of the HRI project and the SIPWs in particular. Much of this report has discussed their many strategies for transmitting information and, as Davenport and colleagues (1998) suggest is necessary, assisting the conversion of this information into knowledge and still further into behaviour. These many strategies do not need restating here. The major methods have included shaping language, creating a discourse, modelling behaviour, and sharing information. The major media of communication have been face to face consultations and training, distribution of materials in hard copy and electronically monitoring performance through the case record. Some keys to successful knowledge building have been using a mix of immediate and planned responses, and a judicious blend of help from the trusted insider (the SIPW) and relative mystique of external experts (through the PASDS, brokerage and training).

(iv) Remaining Challenges

These examples and the worker feedback illustrate the developmental process of embedding a new initiative, and help explain why two years is a short period in the implementation of a new approach. The experience of introducing SIPWs to the Regions has confirmed the significance of the social structure and opinion leaders in diffusion of innovation, along with the critical role of management support. It is these elements that have shaped the models, as SIPWs and their colleagues have worked around and through implementation difficulties.

The need for a culture of inquiry has also been seen, both where it is present and where it had to be stimulated. Child protection workers have been keen to assimilate new knowledge and skills, but they, and more particularly some of their senior colleagues, have often been hampered by the sheer workload pressure. More particularly they have faced the difficulty of controlling the work flow and pacing their reflection in action, and have sometimes had difficulty accommodating consultation approaches that depart from the institutional and directive modus operandi embedded in protective procedures. The Child Protection and Juvenile Justice Branch is attempting to shift this toward a culture of more professional judgment and responsibility, and the consultative/exploratory practices of SIPWs are assisting with this shift. Since the ‘bottom line’ of child protective practice is highly accountable legally, these tensions between procedure and process must be continually managed.

Culture building, and the transmission and consolidation of knowledge, need influence to be continually exerted over time, so worker turnover is a
significant constraint. In the SIPW initiative, turnover of front-line child protection workers often meant that basic issues needed to be covered over and over again, rather than transmitted to a stable cohort who would then be in a position to build on the core concepts and join a new discourse. In addition, movement in the SIPW ranks because of management and career issues undermines this process of culture change. Drucker (2000:11) addresses the problem of ‘skyrocketing turnover’ of knowledge workers who ‘take the human capital with them’. He suggests:

Employers need to find out what work their ablest people want to do and do best; place them where they can make the greatest contribution; pour responsibility on them rather than chores; encourage subititals and rotation; and use knowledge employees as teachers.

These approaches to innovation consolidation and knowledge diffusion suggest some principles to consider if Regions review program arrangements for SIPWs, while holding to the objective of providing good mentoring of infant protective practice:

(c) Structure and Resources

• No deflection of resources to other age groups at the expense of vulnerable infants.
• Staff with time dedicated to continued learning about the age group, through training and professional development.
• Such staff to be accessible to any team encountering infant issues (including adolescent teams, case management/contracting teams).
• A dedicated senior staff person with responsibility for HRI liaison with other professionals and organisations in the community, building relationships, policies and shared standards.
• Links between such senior staff across Regions to ensure cross-Regional program development and issues resolution.

(d) Opportunities for Influence

• Mixed strategies for influencing other staff, blending consultation with formal and informal training.
• Minimal commitments to continuing caseload management, to allow room for independent consultation-a ‘clear head’.
• Early contribution to the socialisation of new staff: participation in Regional and central induction; active ‘hands on’ mentoring of new staff or staff newly given infant cases.

Region and the smaller metropolitan Regions, especially NMR and WMR. Taking both SMR and Lodden Mallee out of the calculation, given their particular profiles, then the gap in notifications between the largest metropolitan Region and the smallest rural Region shrank from 282 to 144 over the three years, while the gap between the smallest rural Region and the largest metropolitan Region shrank from 111 to 38 infant notifications (see tables 11-30 in Appendix 13).

Figure 7: Rank Ordering of Regions on Various Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>BSW</th>
<th>EMR</th>
<th>Gipps</th>
<th>Hume</th>
<th>LM</th>
<th>NMR</th>
<th>SMR</th>
<th>WMR</th>
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</thead>
<tbody>
<tr>
<td>CP Base Budget 1997-98</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>9</td>
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<td>CP Base Budget 1998-99</td>
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<td>CP Base Budget 1999-2000</td>
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<tr>
<td>HRI Budget Yr 1*</td>
<td>5</td>
<td>4</td>
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<td>9</td>
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<td>6</td>
<td>2</td>
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<td>HRI Budget Yr 2</td>
<td>6</td>
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<tr>
<td>Infant Notification 1997-98</td>
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<td>Infant Notification 1999-2000</td>
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* excluding PASDS. PASDS funds distribution follows the same pattern.

Something of this shift is recognised in the incremental changes to the distribution of base Child Protection Services funds, particularly in the form of increases to Lodden Mallee. Even with such adjustments, the experiences of the rural HRI staff must be taken into account. The SIPWs try to maintain oversight of the protective process for all infants entering the service in order to maximise early intervention, detect high risk and implement intensive safety and change plans as necessary. On the basis of comparable notifications, rural Regions have approximately half the specialist staff capacity of metropolitan Regions to meet the need, in less well-developed specialist service systems, and with great pressures from Regional management to share the resources of the HRI staffing establishment. No rural Region over the course of the evaluation could demonstrate that its full HRI salary allocation had been continuously devoted to the HRI project, usually because of changes in the deployment of HRI staff time.

Even if the SIPW funding is fully deployed, rural Regions appear to have between $164 and $205 SIPW salary dollars per annual notification, compared with approximately $200 for SMR but $275-$392 per notification for the smaller metropolitan Regions. Over the same period, rural Regions report a rise in the public and professional recognition, and probably the actual incidence, of serious substance abuse among the young, along with a raised profile for serious domestic violence. To compound the difficulties, they attempt to cover sub-Offices many miles apart, with their own discrete cultures, staffing needs and community characteristics. They also try to compensate for the gaps in the relatively sparse external specialist professional network. Most rural SIPWs are conscious of significant unmet infant needs among the local indigenous communities, and are aware of the need to approach such issues with delicacy and in a programmatic and collaborative way. The SMR, in its size and complexity, mirrors some of these difficulties. Recent experiments in the rural Regions and in SMR, with further devolution of HRI responsibilities to selected experienced staff, are a reflection of some awareness of these strains among Regional management teams.

While these differences have imposed severe strains on the rural SIPWs, perhaps paradoxically, they have also stimulated some important learning, from both achievements and limitations. Lessons from these Regions include:

• The value of investing in raising the infant assessment skills of the Intake teams, as a first port of call for making viable community linkages for young families, and for screening for high risk
infants who may require more intensive case planning. Where this has been done, HRI managers are now more confident to let the intake phase take care of itself, a reasonable position provided there is sufficient staff continuity, periodic monitoring, and feedback from the HRI team about those cases that proceed.

• The value of identifying interested CAFW 3s and 4s who have potential for assuming HRI responsibilities in sub-offices, and linking them with relevant training. (Several Regions have introduced arrangements to encourage such diffusion of knowledge and responsibility.) This option costs time and money with respect to training, and may call for a level of specialised supervision that has been difficult to sustain even among the more limited pool of SIPWs.

• The need to work programmatically, moving beyond internal information dissemination and case level procedures to build strong and flexible service linkages outside the Department.

• The need to build strong early intervention systems for lower risk infants whose high need families are new to the protective system, and for infants whose families’ prior protective difficulties have been compounded by service system failures and gaps.

• The need to view the flexible budget as a strategic resource and to manage it accordingly, whether this be at the level of case planning, with well-reasoned ‘rural inventiveness’, or at the program level, where more system issues can be tackled.

• The critical role of the PASDS as an example of a new program that can enrich the existing service constellation, providing a tangible specialised service that allows Child Protection Services matters to be worked with in new ways without recourse to child removal. Through close involvement with PASDS providers, HRI managers can help a service system open up to new ways of thinking and relating.

• The critical importance of the SIPW making face to face contact with targeted professionals if there is to be new learning within and outside Child Protection Services.

This is not to suggest that metropolitan Regions have not done these things, nor that metropolitan SIPWs have used their positions and themselves with less sensitivity and inventiveness. It is, however, clear that a very small or single person team is unlikely to be able to sustain over the long term this complex range of functions under such conditions. Their achievements are all the more remarkable for this.

11.5.2 Policy Ambiguity—Early Intervention and/or Protective Intervention

One of the larger issues revealed by this rural picture, and one possibly shared by metropolitan SIPWs, is the boundary between early intervention and protective intervention, and the policy ambiguities around this. The issue arises in part from the nature of external infant case consultation conducted by child protection staff. The HRI project was clearly intended to target high risk infants known to the Child Protection Services, rather than to broaden the reach of the Child Protection Services to lower risk infants in the community. The Victorian Child Protection Services has seen the introduction of the Enhanced Client Outcomes (‘ECO’) approach to protective investigation, which calls for closer collaboration with external service providers and the option of more planned and less confrontational forms of investigation. The HRI project has also coincided with introduction of the ‘Strengthening Families’ program in some areas, allowing diversion of families with ‘welfare concerns’ rather than ‘protective concerns’. Despite these case deflection initiatives running alongside the HRI project, it remains the position with respect to consultations about children thought to be at risk in the community is that these queries are registered as notifications to Child Protection Services.

SIPWs building community linkages on behalf of infants at risk will attract such consultations and may well stimulate a rise in notifications. As experienced child protection or family workers, SIPWs are understood to be well positioned to make appropriate judgments about such referrals, and it may be that rises in notification rates do reflect previously hidden pockets of need and risk. Nevertheless, these processes of external liaison may bring to Child Protection Services families who would not otherwise have come to protective notice, or who would have done so at a later stage. The impact may be, and does often appear to be, that they thereby gain access to resources and case planning expertise that facilitate productive early intervention to prevent further risk and harm, but this is at the cost of becoming registered Child Protection Services clients with all that this involves. This evaluation has no evidence that the HRI program is guilty of sanctioned netwidening for Child Protection Services, but it has drawn attention to the need for more readily accessible forms of intensive early intervention. This concern has also been raised by the PASDS, who argue that their service has much to offer lower risk families in the community. Their voices join those of both Family Support Services and the new Strengthening Families providers who have from time to time expressed their concern that families may not get the help they need unless they agree to be (or are involuntarily) referred via the protective gateway. This concern is also raised in the New Partnerships in Community Care discussion paper (Department of Human Services, 2000).

The particular difficulty with infants is that every intervention, however intensive and intrusive, can be seen as an early intervention, while even apparently minor professional actions (like calling a family conference) can, for an infant, be profoundly protective in intent and effect. Thus the long-held concept of a continuum of service from primary through to tertiary intervention, serving different clients with different needs, is both artificial and misleading at the level of the infant needing help. Even with clearly necessary improvements to a community-based service system for infants, the high level vulnerability of infants in communities deprived by domestic violence and substance abuse, means that they may well continue to be notified to Child Protection Services, quite reasonably, and this will be their route to services.

With many of the parents presenting a risk profile normally handled by other service systems—drug and alcohol, mental health, disability services, and domestic violence services—there is also some question about appropriate cross-sectoral responsibilities. Might some of the work of the HRI be done as well and more appropriately under the auspices of holistic, family sensitive services in those service systems, where the primary sources of infant risk can be handled with appropriate expertise? Could some troubled clients of these other systems just as appropriately gain access to the same HRI parenting services but funded by the other service systems without the drawbacks of protective registration? What coalition of professional contributions can maximise remedial attention and relapse prevention for the parent along with quality of care for the infant? Some Regions and PASDS are currently exploring these questions through various strategies, and these will be further examined in Phase 2 of the PASDS evaluation.

11.5.3 Central Support for the Regional Initiatives

The role of the Head Office HRI senior program advisor was discussed in Interim Evaluation Report 2C. Having a central person as the ‘lynch-pin’ of the program has been found to be very valuable, and there would be concern if the support functions performed were to be reduced. While a very limited resource in terms of time available, the senior program advisor builds bridges between Regions, organises training and staff development for SIPWs, investigates program and policy issues, facilitates cross-Regional and cross-agency work, and pursues further development of the yet to be implemented aspects of the HRI project. Some specific examples of this work over the implementation and consolidation phases of the program included:

• Professional development sessions four times a year for SIPWs and HRI managers.

• Training child protection workers regarding the HRI project in conjunction with the Departmental training unit:
  • Induction: a full day four times per year, including training on SIDS risk factors.
  • SIPW training four times per year for new SIPWs, interested team leaders, and workers acting in SIPW or advanced infant case worker roles.
  • Convene and chair HRI managers’ meetings four times per year.
  • Community sector presentations at agencies and professional meetings.

• Four professional conference presentations, national and international.

• Representing the HRI project on references groups in other Divisions or a Region.


• Liaison between Head Office and Regions on infant issues.

• Development of Practice Enhancement Guidelines and contribution to the development of Practice Instructions.

• Contribution to policy development (for example, guidelines for selection process for PASDS).

• Members of project management and reference groups.

• Convene HRI meeting of Federal, State and Territory HRI representative.

• Liaison between Head Office and Regions.

• Liaison between Head Office and Regions on infant issues.

• Liaison between Head Office and Regions on infant issues.

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12.1 Introduction

The overriding conclusion drawn by the evaluation team is that the program of HRI initiatives is impressive and functioning well but the program is barely beyond its post-implementation early consolidation phase.

The initiatives have demonstrated significant enrichment of protective practice, particularly with respect to infant-specific risk assessment and well-informed case planning. The initiatives have strengthened the service options, allowing intensive intervention to secure the high risk infant’s safety at home or in alternate, hopefully permanent, care. There is a growing body of trained staff with enhanced experience in infant protective practice and infancy-informed family service. The use of specialist roles within child protection services has proven a vital ingredient in better meeting the needs of these very vulnerable babies from families with many and significant needs and difficulties. These achievements are far from comprehensive and deeply embedded in the fabric of the services, and there is a great need and ample scope for continued targeted program development.

This section will elaborate on this conclusion, opening with an overview of key findings according to the proposed outcomes hierarchy (see Figure 2, section 1.2.2). The conclusions will focus on the Child Protection Services’s integration of the HRI initiatives and their contribution to child protection practice, touching on implementation and usage issues relating to the PASDS. The practice and results of the PASDS themselves will be the focus of the PASDS Evaluation Phase 2, to be covered in a later report.

| Conclusions | Within child protection services has proven a vital ingredient in better meeting the needs of these very vulnerable babies from families with many and significant needs and difficulties. These achievements are far from comprehensive and deeply embedded in the fabric of the services, and there is a great need and ample scope for continued targeted program development.

12 Conclusions

- Production of published and unpublished information to inform the community, child protection workers and SIPWs about the HRI project.
- Research and literature reviews on specific topics (for example, drug transmission into breast milk).
- Management of the evaluation contract.
- Preparation of briefings to senior management and the Minister on infant matters.

Despite such inputs, it has been argued throughout this report that there is still significant developmental work to be done within the HRI project and the Child Protection Services. Topics requiring further development include infant risk assessment, case planning and case management; the SIPW role; training and diffusion of learning; the PASDS theory base and operational shape; service system linkages; and alternative HRI service configurations. Interdivisional and inter-Departmental policy and practice issues are also on the planning agenda. In a system based on the primary principle of devolution of operations and service planning to Regions, programs that link providers who straddle Regional boundaries, as does the HRI program, have a long term need for someone responsible to oversee issues of consistency and standards setting. Programs that lose this central mentorship drift into a policy vacuum, in which clients can suffer through inconsistent service delivery standards and gaps between services and Regions. When these clients are vulnerable infants in families marked by volatile lifestyles, a strong infrastructure of standards and protocols is particularly desirable.

| Figure 20: Outcomes Hierarchy Summary | within child protection services has proven a vital ingredient in better meeting the needs of these very vulnerable babies from families with many and significant needs and difficulties. These achievements are far from comprehensive and deeply embedded in the fabric of the services, and there is a great need and ample scope for continued targeted program development.

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12.2 Conclusions Regarding the SIPW Role

Overall, despite uncertainty about specialisation within Child Protection Services, the SIPW role has proven invaluable to improving protective practice for infants.

12.2.1 SIPW Appointments

Most SIPW appointments have been of well-qualified and experienced protective or family services practitioners, with different contributions to role brought by existing Child Protection staff and external recruits. This mix within teams appears desirable. Specific base qualifications appear to be less significant than the mix of experience and subsequent post-basic education and training, commitment to the position, and an appropriate match of skills with specific local aspects of the SIPW role. While early consultations suggested child protection workers had considerable reservations about non-child protection workers as SIPWs, they have become valued mentors and program staff by virtue of their clinical and programmatic skills and lateral thinking. The attributes of the SIPW position that are critical to their acceptance and positive contribution appear to be:

- Location outside the everyday team structures, to allow ‘thinking outside the box’.
- Non-line case and supervisory responsibilities, to allow a ‘clear head’.
- Time to focus on one age group and area of practice—saturation learning.
- Time to build external service networks—resource enhancement.
- Capacity to build workers’ engagement and intervention skills through modelling.
- Training, resources and time to build workers’ case analyses through content input.

12.2.2 SIPW Team Location and Structure

There is no clearly emergent model for the ‘best’ deployment of SIPWs. The relative under-staffing of the HRI teams rural Regions leads to creative community linkages and good monitoring practices, but is operationally difficult and the teams are vulnerable to staff overload. Both these small team issues and specific rural factors mean that the needs of outlying offices are under-serviced. Whether metropolitan or rural, it seems that child protection workers prefer a SIPW to be co-located with each relevant unit/office for ease of consultation and a close working relationship. This is counter-balanced by additional considerations for the HRI teams: the need for a measure of...
12.2.6 Increasing Selectivity and Use of Mentors
After an initial focus on broad scale monitoring of infant cases for quality control and consultation on request or as triggered by the quality control efforts, there has been a shift toward more hands on mentoring and modelling in selective cases in most Regions.

12.2.7 Staff Turnover Inhibits Diffusion and Embedding of Learning
Child protection staff turnover makes it difficult for Regions to be confident that knowledge can be mainstreamed and the functions dispersed.

12.2.8 Infant-Related Network Development
External liaison has had a focus on infancy (for example, PASDS, and building mutually respectful relationships with maternal and child health nurses) and with clinical psychologists (in the main) and other specialists whose services are purchased by the flexible budget. There has been less routine liaison with other specialist adult services (especially drug and alcohol services and domestic violence services) but this appears to be increasing.

12.2.9 Strategic Early Intervention
Variable strategies have been used for building links with external networks, especially in the country, where there has been a strong focus on hospital discharge planning for at risk parents and, in association with this, pre-birth notifications. The separation between primary, secondary and tertiary interventions and levels of prevention is by no means clear, nor can it be for very vulnerable infants in families with many serious risk factors but often no experience of child care. The SIPW role re-opens the debate about the dividing line between community case consultations and protective notifications.

12.2.10 Devolution of HRI Initial Screening Function is Essential
There has been continued debate over identifying which infants are sufficiently at high risk to warrant intensive SIPW input and access to other HRI resources. The high numbers of infant clients means that broad screening by SIPWs is very time consuming, so that excellent intake practices and sifting by other team leaders are both critical to the viability of the SIPW function.

12.2.11 Position Vulnerability
SIPW managers (CAPW S), as senior Regional staff, have been vulnerable to encroachment by management for other tasks, functions and positions. Where they perform SIPW functions along with other line management roles, it appears that the operational imperatives of line management roles overshadow the more deliberative and considered work required of HRI manager role. This has led to a struggle for program integrity, especially in the rising workload of rural Regions. This struggle is unfortunate given the large amount of knowledge diffusion and developmental work still to be done.

12.2.12 Case Activities Swamp Program Activities
Under such pressures, casualties of the SIPW role set have been community and service system development, formal training, practice-based research, with the exception of PASDS and some small time-limited training endeavours.

12.3 Conclusions Regarding the Use of PASDS
Overall, the PASDS have proven an exciting addition to the service spectrum. They are developing knowledge and skills that have the potential to inform not only protective and support services for high risk infants, but also targeted early intervention for other high needs families with vulnerable infants who do not enter the Child Protection Services system.

12.3.1 Acceptance with Acclaim
Initial evaluation efforts suggest PASDS are achieving what they were set up to achieve, and are highly valued by SIPWs, other Child Protection Services workers, DHS Partnerships and Service Planning staff, and the PASDS providers. Most appear to be meeting the modified targets negotiated after the initial implementation phase. Residential PASDS are valued for their intensity and safety. Home-based PASDS are valued for their infant-specific work in situ.

12.3.2 Variability and the Apparent Need for More Commonality
Within their residential and home-based streams, PASDS appear to perform similar functions, but vary widely in their assessment approaches, measurement of parenting change and modes of reporting, and they express an interest in developing more commonalities. Improved consistency, particularly in relation to the measurement of parenting competence and change, should assist learning across programs and Regions, the use of PASDS by child protection staff, quality assurance for families, and sustainability of arguments at Court. The possible benefits, as well as the limitations, of diversity of form, orientation and methods have not yet been explored in depth.

12.3.3 Contribution to Case Resolution
PASDS have enabled case resolution through testing the viability of parental care and establishing the kinds of follow up required. For some families they have been able to dispel the assumption that the parents would be unable to care. PASDS evidence has been critical at court in moving some cases toward a timely permanent care alternative, often with kin. The degree to which the assessment function outweighs the skill development function is not yet clear and will be pursued in the next evaluation phase.

12.3.4 A Service to the Infant and Family, Not a Substitute for Child Protection
PASDS experience some tension in sitting mid-way between the parent and the child protection system, and they and SIPWs agree they need to resist pressure from child protection workers to assume the whole protective assessment function. How the PASDS’s parenting assessment is best integrated with other forms of assessment (including the child protection worker’s use of the VRF is not yet clear. For most PASDS, it appears that the assessment/skills development distinction is experienced as artificial.

12.3.5 Short-Term Service Constraints
The brevity of PASDS creates expectations and reveals needs requiring intensive and long-term follow up. This is often scarce in the Regional service systems, especially in rural Regions. This is felt to be particularly problematic where the short-term achievement and demonstration of child care skills is good, but maintenance of these skills in the long term is likely to be under-mined or prohibited by the family’s severe enduring problems (such as intellectual disability, substance abuse or family violence). There is some fear that an unintended consequence of the PASDS is that while they work well within the spirit of the Children and Young Persons’ Act 1989 (with respect to family integrity) they may in some of these cases delay needed permanency planning.

12.3.6 Contribution to Professional Education
The clear focus on infant development and specific parenting behaviour has been shown to have educative potential for child protection workers and other professionals (such as lawyers or magistrates) as well as families.

12.4 Conclusions Regarding the Flexible Budget
Overall, like brokerage in other programs, the Flexible Budget has been a key to offering a rapid, well-informed, and highly tailored response to individual infants and their families, and it has also allowed some HRI managers to build the Regional program strategically.

12.4.1 Emphasis on Enhancing Assessments
A very large proportion of the budget has been spent on augmenting the assessment and reporting functions of Child Protection Services. The second largest usage appears to be for a variety of support staff (often contracted from human services personnel agencies), undertaking in-home supervision and parent support, among other functions.

12.4.2 How To Balance Flexibility and Innovation with Systems and Standards?
The reverse side of innovation and creativity can be the relative lack of systems and standards, such as standards about how the mix of support and surveillance is to be managed and reported when outsourced to agencies or individuals. Regions vary in their documentation of relevant procedures and standards.

12.4.3 The Need for a Balance between Kinds of Function Is Essential
There are varied and creative uses for the budget at both case level and program level, and an appropriate balance of case, program and training uses has not yet been clearly articulated across Regions. The budget is an important tool in enhancing the quality of parents’ and infants’ lifestyles in individual cases, but the need to be responsive to staff in such matters may work against strategic use for the program overall.
interaction with parents and caregivers, though less clear improvement in the translation of this infant assessment into intervention. Infants still tended to receive less than adequate attention when part of sibling groups, in the transition between units and Regions, and when their parents were missing. Closer attention was paid to the emerging consequences to the infant of parental factors believed to place the child at risk of harm (notably such factors as domestic violence, untreated and symptomatic mental illness, unmanaged substance use). More active efforts were made to intervene to moderate those risk factors in order to safeguard the infant’s wellbeing and development. There was evidence of a much more sophisticated approach to the assessment of parental capacity and motivation through the use of direct, informed observation and analysis of the effects of parenting interventions.

12.4.4 Insufficient Program Accountability for the Flexible Budget

The budget appears to have been used well and wisely across most sites. Yet from a program perspective, given the early stage of program development, there appears to be insufficient clarity about the reasonable limits to Regional delegation of decision making with respect to the flexible budget. It is not always clear that the principle of quality improvement for infants has been central to Regional decision making with respect to this budget item, especially concerning salary allocations. The HRI manager’s role has not always been as central as one would like for program integrity purposes.

12.5 Conclusions Regarding the Infants and their Families

Overall, the infants who reach Child Protection Services are clearly among the most disadvantaged in the community, and the complexity of their families’ problems and needs means without infancy-informed advocacy the needs of these very vulnerable babies are often overlooked. The solution to their difficulties almost always involves a complex set of informal and formal intervention across service sectors and disciplines.

12.5.1 Difficulty of Prediction

Randomly selected infants for the CFRs show the difficulty of checklists of risk factors as a tool in identifying the highest risk infants once in the protective system. Given the vulnerability of infancy, especially in the neo-natal period, it is even more difficult to justify which infants require intense diversionary efforts on the brink of Child Protection Services, and the judgements of trusted community-based professionals are critical to this decision making. More than half of the families had 10 or more of the risk factors noted on the basic tool of risk descriptors used in the HRI publications. Serious risk emerges through the assessment process, and is a matter of interacting factors.

12.5.2 The Higher-Risk High Risk Infant Child Protection Clients

Analysis of the various data sources suggests that operationally, within the protective population, the ‘high(er) risk infant’ is one who:

- Has demonstrable developmental delay and health problems, with no current effective service response to these, despite an apparently higher than usual level of vulnerability.
- Has parents with at least one of the major risk factors affecting parenting capacity or performance (untreated mental illness, unmanaged substance abuse, high risk adolescent lifestyle, or intellectual disability) under-scored by a known history of violence and/or refusal of worker access to the child.
- Lacks additional competent nurturing adults in regular and frequent contact with the infant.
- Is from a family where children have been removed previously and there is no evidence of positive change in patterns of past parenting behaviour relevant to the infant’s care.
- Feeding and sleeping difficulties.
- Mother’s poor antenatal care.
- Younger ages.

While the focus of the HRI program is on preventing harm to infants, it appears that the indigenous infants exist in a community context that is so tenuously connected to officialdom, that the risk of case drift and family disconnectedness is still a constant threat to their development.

12.6 Conclusions Regarding the Impact and Contribution of the HRI Initiatives

Overall, the HRI initiatives to date have shown a marked impact in those cases where there has been specific deployment of the HRI initiatives, especially with respect to risk assessment, case planning, and infant-relevant parenting assistance. There is some limited evidence of a wider impact on the whole population of infant child protection clients. The wider systemic effects of infant-awareness throughout the service system are beginning to emerge, but there is more to be done.

12.6.1 Initial Impact—Risk Assessment and Case Planning

The CFR 1999 Infant Case File Review (a records-based evaluation strategy) demonstrated improvements in the first instance in the areas of documented risk assessment and case planning, with strong adherence to formal procedural requirements for protective case management. There was less evidence of improvement in engagement practices with families, especially those where the parents were hostile to involvement. Improvement was seen to be needed with respect to risk management in cases of domestic violence, and analysis of the condition of the infant him/herself, attention to extended family and social context and the use of infant-specific services.

12.6.2 Subsequent Impact—Infant-Informed Case Planning

The CFR 2000 (which focused on cases that had remained open and which therefore should have an increase in available information) showed improvements in the documentation of the condition of the infant, and observations of the infant in

Satisfactory case outcomes for lower-risk infants who do not progress to long term orders are created through a mix of infant-specific community-based services, specialist adult services, and engagement of kith and kin in the protection, case monitoring and family support processes. For higher risk infants, it appears that PADS 5 are a critical step in determining whether longer term protective involvement is necessary. Good outcomes over the review period for these infants tended to involve either intensive parenting service followed by a package of longer term formal and informal community care, or resolution of parental inability to care followed by early confirmation of a plan for permanent care with kin or another foster carer.
• Insufficient longer-term family support and parenting-focused support services in rural Regions generally, and accessible to more remote families in particular.

• Similar but lesser difficulties of access to longer term services in metropolitan Regions.

• Under-use by protection staff of specialist paediatricians, and queues for paediatricians in some rural areas.

• Too few permanent care placements.

• Few accessible day-stay and other parenting programs of mid-intensity that bridge the gap between parenting groups and PASDS.

• Few early intervention/prevention services, such as playgroups/parenting suitable for more marginalised families, including adolescents and refugee families.

• Developmentally sensitive domestic violence intervention programs.

12.7.3 Practice-Theory Gaps

The evaluation team suggests that some of the most crucial areas where infant protection practice is not adequately conceptualised and then operationalised are:

• The lack of a robust model for assessing parental change—the potential for change, the substance of claimed changes, the durability of change, and conditions necessary to sustain change.

• Reconciling abstinence and harm minimisation models when working to protect infants whose parents abuse substances.

• Differential assessment of kinds of family violence and its implications for family change and infant protection and wellbeing.

• Early intervention for the very high risk young first time mothers and their partners, and within this:
  • Possibilities for indirect Child Protection Services early intervention through high need indigenous communities, with particular attention to outreach education and support of first time parents, through the medium of offering resources to and working in partnership with existing community leaders who can provide positive and credible models of family life.
  • Engaging the protective potential of the parent through enhancing the voice and visibility of the infant and the needs of the infant—learning from infant mental health and other practice settings.
13 Recommendations

It is recommended that the High Risk Service Quality Improvement Initiatives be retained as a core program within Child Protection Services, with each of the three major program components to continue: the SIPWs, the PASDS, and the flexible budget. It is also recommended that these initiatives be strengthened by the remaining planned initiatives that have yet to be implemented, the demonstration projects and the PASDS assessment tool development.

Specific recommendations follow with respect to particular aspects of the program, policy issues and program development needs. Where these recommendations impinge on Regional management autonomy, it is understood that there may be local issues to be resolved that cut across these recommendations. It is suggested that the core principles for resolving such tensions are that resources earmarked for quality improvement for high risk infants should not be diverted to compensate for lacks in other areas, and that the HRI staff and the central program adviser should be consulted on programmatic implications of local management decisions.

The range of recommendations below indicates the continuing need for senior policy advice at Head Office level. It is suggested that much could be achieved by the assignment of a project or advisory team at Head Office for a year to work with the HRI managers to achieve the program documentation and developmental goals embedded in these recommendations. The key to many of the following recommendations is the centrality of the HRI manager role in each Region, and of the HRI program advisor at Head Office, as a working team with time and legitimacy for joint program development. The HRI managers (and many of the SIPWs alongside them) constitute a body of skilled and creative managers and practitioners, whose capacity for a concerted impact on practice theory and program design has not yet been fully realised at State level.

13.1 Recommendations Regarding the SIPW Role/HRI Regional Teams

13.1.1 Staffing and Structure

(i) Review the adequacy and equity of staffing models, with particular attention to the apparently widening disparity between rural workload and HRI establishment.

(ii) Validate and strengthen the HRI manager (SIPW CAFW 5) role, and protect from encroachment of other line management duties that would impede HRI program development. HRI managers to take responsibility for participating in or delegating to SIPWs cross-Regional policy and program developments (see below) and for Regional inter-agency and inter-disciplinary program planning.

(iii) Ensure SIPWs carry program portfolio responsibilities (such as developing specific network collaborations) as well as case consultation roles.

(iv) In filling SIPW positions, give priority to mature and high quality staff, with a mix of clinical and programmatic skills, and a mix of social and psychological practice bases, able to attract high levels of credibility for their content knowledge, inter-personal skills, and organisational and inter-organisational understanding.

(v) If diffusing HRI responsibilities, ensure all designated staff members receive central HRI training, participate regularly in statewide and other cross-Regional SIPW meetings, and have workloads that allow for HRI program development, knowledge acquisition and knowledge dissemination activities.

(vi) Proceed with caution with the CAFW 3 level Advanced Infant Caseworker. While an excellent way of diffusing knowledge and succession planning for SIPWs, and for coping with the problem of embedding HRI thinking in sub-offices, these positions can be very isolated and need both training and to be integral members of a team, whether HRI or mainstream. The demands of a high risk infant caseload can be unrelenting. Ensure back-up case coverage.
13.2 Recommendations Regarding PASDS Development

The PASDS will be examined in detail in the next evaluation phase. On the basis of the existing implementation data and stakeholder feedback, the following interim recommendations are made.

(i) Examine the impact of the PASDS component on providers’ pre-existing service delivery and clientele.

(ii) Make programmatic links with specialist drug and alcohol, mental health and disability services.

(iii) Share assessment and intervention approaches and protocols across Regions through implementation of the planned research into the feasibility, potential benefits, and possible disadvantages of common assessment tools and intervention models.

(iv) Review options for dealing with spasmodic flow of irregular referrals and reconsider the funding formulae in each Region in the light of case flow and the staffing implications of this.

(v) Attend to the professional development needs of isolated rural providers.

(vi) Strengthen availability of support from SIPWs and HRI managers.

13.3 Recommendations Regarding Flexible Budget

The variable quality of data on the flexible budget expenditure limits the force with which these recommendations are made, but some possible future directions are indicated.

(i) Have HRI managers review expenditures that reflect policy gaps in other parts of the service system that require policy responses (such as after-hours family support, consistent trained legal representation, or the widespread problem of housing unavailability) and consider these Regionally and cross-Regionally.

(ii) Consider a three-way distribution of flexible budget funds once basic operational needs are met—assessment, case plan implementation and family support, and knowledge diffusion. At each level, expenditure needs to be strategic and defensible within goals of the program.

(iii) Share learning across Regions about use of consultants: the kinds of professionals used for assessment, how, when and why.

(iv) Develop consistent arrangements about consultancy, including band-width for fees for service, and attention to problem solving protocols.

13.4 Recommendations for Policy and Program Consideration

The following recommendations encompass issues the program seems ready to confront at a statewide level, though there are often Regional variants and ramifications.

They are issues that could be addressed through working parties or position papers prepared by SIPWs from more than one Region. Where the HRI teams in a Region or several Regions have substantial relevant experience and might be in a position to take the lead in such programmatic work, this is indicated in brackets at the end of the recommendation. The possibilities are many and some are equivalent to full scale research projects suitable for workers undertaking higher degree research or advanced...
students. While the list is daunting, it is testimony to the conclusion drawn above that the HRI project is still in a developmental phase, and that there are still infants experiencing significant acute and developmental harm whose families could be assisted more effectively to prevent such harm and meet their needs, or entrust their care to other more able caregivers.

### 13.4.1 Practice Framework

HRI staff have accumulated experience (internally and from their knowledge of the helpful contributions of external experts) that would allow them together to distil infant protective guidelines for use in consultation, supervision and training. These might include:

(i) **Basic requirements for infant wellbeing and the threshold for protection:**

   This refers to what a baby needs, and what a child protection worker must do to establish that a baby at risk of significant harm has what is needed. Direct assessment of the child’s development and wellbeing needs to be placed at the centre of the protective assessment. (The international work on the ‘Looking After Children’ and ‘Children in Need’ frameworks might contribute to the review of existing training and practice guidelines in this area.)

(ii) **Assessment and planning process:**

   Strengthen attention to the interactional effects of risk factors, their direct impact on the care and development of the infant, the potential for, and process of, change, and the significance of the underlying forces of poverty and educational deficits for intervention. (SMR, NMR)

(iii) **Engagement and narratives of hope and competence:**

   Further diffusion from the PASDS and SIPWs of methods for respectfully engaging parents in making sound decisions on behalf of their high-risk infants. (BSW, NMR)

(iv) **Ethical and justice issues:**

   Given the extreme vulnerability of babies and mothers (especially in the neo-natal period and in the context of widespread family violence and commonly parents’ low cognitive functioning), there is a need for extra vigilance and attention to rights issues, including information flow and the nature of consent to intervention.

(v) **The role and needs of kin:**

   Develop approaches to work with kin, in accordance with their major role in planning, support and care in infant cases. An infant-kin working party could consider the indicators for and against the use of family group conferencing, arrangements for follow-up of the stability of kinship care placements, and kinship carers’ feedback on support and resource needs in temporary and permanent placements. (WMR)

(vii) **Indigenous infant health and wellbeing in high risk families:**

   The HRI program could work with other Departmental initiatives on this matter and attend to infant issues in the relationships between the Department of Human Services, Victorian Aboriginal Child Care Agency (VACCA), other Koori agencies and the primary health care system and its contact with young pregnant and post-partum women. (Loddon Mallee, NMR, Hume)

### 13.4.2 Court Issues

There is already work done in these areas in the Department of Human Services that needs to continue. With appropriate time allocation to programmatic work, the infant teams could contribute:

(i) **Court outcomes tracking:**

   Systematic tracking of infant court outcomes from contested by HRI managers, analysed by type of argument and level of expertise used in the presentation. (SMR, EMR, Hume, BSW)

(ii) **Further analysis of successful applications by submission, and analysis of cases settled out of court with safe outcomes for the infant and positive gains for the parents.** (AHS, Gippsland, SMR)

(iii) **Disseminating across Regional boundaries the strategies and devices that have proved helpful in putting cases at court, such as different types of chronologies, ways of organising information.** (EMR, Hume, SMR)

(iv) **Consideration of mechanisms to allow modified workloads (with backfilling) for workers preparing for selected categories of complex cases.**

(v) **Continuation of the dialogue already begun with the court, which might usefully focus on feedback mechanisms to the court regarding outcomes of decisions, conduct of representation, use of expert witnesses, use of HRI resources, and issues with access arrangements.** Specific questions might include:

   - An examination of the reasons for repeated adjournments of cases both before and after a Protection Application is granted, with the aim of differentiating between avoidable inefficiencies and productive interjections in the process.
   - Analysis of the legal pathways to permanency planning for infants, compatible with the scope of the Act, natural justice, and the developmental imperatives of infants.
   - Tracking the consequences of contentious court outcomes for infants, families, workers and the service system and developing appropriate dialogue about these and policy responses.
   - A review of copious parent-child access by the court, and attention to the research base for making access decisions.

(vii) **Development of a strategy plan to address the specific tensions between the Child Protection Services and the CAU, noting where such efforts are already in train and seeking feedback on their implementation.** Priority areas might be:

   - More continuity in legal representation for cases, and resolution of whether market or regulatory principles are to apply in briefing barristers.
   - Formal trial of an improved court report format.
   - Development of a clearer system for handling feedback and complaints between child protection workers and legal representatives.

### 13.4.3 Inter-Organisational Network

(i) **Inter-divisional planning at central and Regional levels to devise funding models for the purchase of PASDS places from mental health and disability, along with models for jointly designed service options for both intensive and longer term parenting help in situations where the conditions that inhibit parenting are cyclical or permanent.** (EMR, Grampians, Hume)

(ii) **Preparation of an options paper to initiate cross-sectoral planning for HRI/drug and alcohol service pathways that deal with both acute protection needs and longer term relapse prevention.** (WMR, SMR)

(iii) **Critical appraisal of each Region’s culture of inter-organisational relations, including the capacity to hear the views of other professionals as valid in their own right, to seek appropriately mediated solutions when there are important differences of perception, and to achieve joint ownership of case goals and means.**

(iv) **Build on the emerging shift from liaison to co-working, with key external agencies.**

(v) **Documenting, from an infant perspective, the service needs of families experiencing domestic violence, and learning from interventions to date, including young fathers’ programs from the perspective of infant protection.** (Hume, Gippsland)

(vi) **Document pre-birth hospital liaison and discharge planning developments and link with developments in maternal and child health outreach to ensure adequate educational input and support for vulnerable mothers.** This has two main foci: both first time adolescent mothers with troubled/protection history and also mothers who have already had children removed. (LM, BSW)

(vii) **Documenting joint work with disability services.** (Grampians, EMR, Hume)
13.5 Recommendations for Further Training and Knowledge Diffusion

Training has varied forms, targets and levels. These following observations provide options for these various needs, both within Child Protection Services itself and in the associated service network, Regionally and statewide.

Some require full training sessions, some might be dealt with through practice notes or newsletters. If the HRI teams are to be retained with the expectation that their own training responsibilities are continued and enhanced, the most critical training need is for them to have their specialist learning continually updated and reinforced. If this is achieved, they should in turn be able to offer training both internally and externally with increasing credibility, especially if this is in concert with external experts familiar with the HRI program and, possibly, PASDS providers. While there are distinct internal and external training needs, the analysis from the evaluation suggests that the HRI work is increasingly and necessarily conjoint across agency and disciplinary boundaries, and protective training would be enriched by a series of offerings that cross disciplinary and agency boundaries.

In the High Risk Infants Literature Review (1999: 57) there is reference to Myers, who talks of the concept of an inter-agency training pool with a shared agenda. Several Regions have made efforts in this direction, and further Regional development could significantly extend the process of mutuality and a shared basis of knowledge and values in service provision.

13.5.2 Other Child Protection Staff

Most of these areas for training require that child protection workers are exposed to the professional knowledge and perspectives of workers from other disciplines and fields of work. It is likely that some PASDS staff and other external service providers who work frequently with infant protection might be interested in some of these areas.

(i) Infant development as a core component in the induction program, with advanced modules available for workers at least annually, including infant observation and assessment.

(ii) Infuse child development implications through other areas of training (for example, court training or substance abuse training).

(iii) Parental drug and alcohol issues covering both the impact and the process of change for the user.

(iv) Assessing and working with domestic violence from the perspective of the infant.

(v) Court report and presentation training should address the specific issues of likelihood of significant harm cases for infants in both new parent and prior parenting families, and deal with the place of theory in court reports and testimony.

(vi) Explicit training on how to make use of external consultants in risk and needs assessment, Court cases and case planning, focusing on paediatricians, clinical and forensic psychologists, and infant attachment specialists. Training should address criteria for selection, specification of the parameters of the report required, critical review of the strengths and limitations of the product, and incorporation of the material into the protective assessment and intervention.

(vii) Using the voice of the infant to engage parents in making protective decisions.

(viii) Working with parents with personality disorders.

13.5.3 Internal/External

(i) Working collaboratively with Maternal and Child Health.

(ii) Working together in the court: joint training for child protection staff and Departmental legal representatives. Working collaboratively with disability services.

(iii) Building parent-child attachments and infant-safe environments for agencies used for longer term service for high risk infants, such as family support.

(iv) Making the most of access arrangements—issues in facilitation, supervision, recording, reporting and analysis, for both child protection staff and contracted access supervision providers.

(v) Joint training, planned collaboratively, with lawyers used by the Department of Human Services legal service, to include exchange of functions and perspectives, periodic update of senior staff on legal processes; preparation of workers for the negotiation process that is likely to arise within or outside the court room.

(iii) Involve PASDS staff in core content training, in the interests of broader perspectives and the development of a shared knowledge base.
References


CAFW: Child and Family Worker. Industrial position classification for protective workers in Department of Human Services. CAFW 4 is at team leader level, CAFW 5 is at unit manager level.

CASIS: Client and Services Information System, the Department of Human Services client record and client management database.

CAU: Court Advocacy Unit, a legal service run by the Department of Human Services to manage the Children’s Court/Child Protection Services interface.

CC: Children’s Court.

CCC: Children’s Court Clinic.


DHS: Department of Human Services, Government of Victoria.

ECO: Enhanced Client Outcomes approach to flexible protective response to child abuse and neglect notifications.

HRI: High risk infant. General terminology to describe infants known to child protection services. In this context, high risk refers to multiple biopsychosocial risk indicators, rather than to medical descriptors as may occur in the paediatric literature.

HRI: High Risk Infants Service Quality Improvement Initiatives: the cluster of program elements devised by the Department of Human Services to address the needs of infants notified to the Child Protection Service.

IAO: Interim Accommodation Order. An order granted pending a final child protection hearing, before a Protection Application is proven.

IPO: Interim Protection Order. A final but short term order.

Koori: Refers to indigenous or Aboriginal people in Victoria/south eastern Australia.

MCHN: Maternal and Child Health Nurse, the universal mother-baby infant primary health care service, delivered via local government.

PASDS: Parenting Assessment and Skill Development Services. The residential, in-home or day-stay services funded by the HRI initiatives.

PA: Protection Application. The application made to the Children’s Court by a child protection worker alleging that a child is in need of protection.

PW: Child protection worker employed by the Department of Human Services Victoria.

SIPW/s: Specialist Infant Protective Worker/s.

VACCA: Victorian Aboriginal Child Care Agency.


Glossary / Abbreviations

Statewide

CAHCPs: Central After-Hours Child Protection Service or AHS, After Hours Service

Rural

BSW: Barwon South West

Gipps: Gippsland

Gramps: Grampians

Hume: Hume

LM: Loddon Mallee

Metropolitan Melbourne

EMR: Eastern Metropolitan Region

NMR: Northern Metropolitan Region

SMR: Southern Metropolitan Region

WMR: Western Metropolitan Region