Department of Human Services

Child FIRST and Integrated Family Services
Evaluation Summary Report

February 2011
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1 Introduction

This summary presents the main findings of the Final Report for the Evaluation of Child FIRST and Integrated Family Services. It also highlights some opportunities to strengthen the implementation of Child FIRST and Integrated Family Services in Victoria.

Readers should note that this Report reflects findings up to July 2010. Any changes in the status of Child FIRST and Integrated Family Services since this time have not been reflected in the analysis, unless otherwise noted by the Department of Human Services.

1.1 Reform context

In the last two decades, Victoria has undergone fundamental social change. Factors such as socioeconomic disadvantage, unemployment and lower housing affordability, together with increasing complexity of issues being experienced by families (including family violence, drug and alcohol use and incidence of mental health issues), have impacted significantly on the capacity of some parents to care for their children and enable their healthy development.

Concurrently, with the introduction of mandatory reporting by selected professional groups, Child Protection had been increasingly treated as a specialised service, with the safety of children and young people considered to be a State responsibility, rather than that of the broader community.

In this context, increasing demand was being placed on Victoria’s statutory Child Protection and Out of Home Care Systems with: increasing notifications, investigations and substantiations; growth in the number of children, young people and families with complex needs; the emergence of the ‘revolving client phenomena’ with a substantial number of clients being re-notified and re-investigated; more children in Placement Services; and continued high levels of overrepresentation of Aboriginal children in Child Protection and Placement Services.

At the same time, there were critical problems with the secondary Family Services System:

- Family Services was not always visible or accessible within the community. As a result, Child Protection intake had inadvertently become the major pathway by which families could gain access to these services and supports

- there was limited capacity within the Family Service System to respond to more chronic and complex needs

- there were multiple entry points with uncoordinated waiting lists. This made it difficult for families and professionals to navigate the service system.
Family Services did not operate as a coherent system. Each Family Services agency had developed its own intake, model of service delivery and was maintaining its own waiting list.

This analysis suggested the need for greater support for more vulnerable children, young people and families, who either were struggling to access appropriate secondary services or were cycling between Child Protection and other supports, and could be best supported in a community setting.

In 2003, the Department of Human Services developed the Family Service Innovations Projects (FSIPs), bringing together Family Services, Child Protection workers, and local services for the first time, to identify families at risk and provide practical early intervention. In the particular locations in which the FSIPs were implemented, they enabled:

- connections between Child Protection and the wider local network of community based services
- use of a central intake process in the Family Services sector, helping to identify high need referrals and target the most appropriate and coordinated response
- a focus on working with parents to address children’s needs.

As an outcome, the Innovation Projects demonstrated a 7.5 per cent reduction in notifications, a 10.1 per cent reduction in investigations, and a 17.2 per cent reduction in court Protection Applications in the first nine months of 2003 compared to 2002.

In April 2007, the enactment of the Children Youth and Families Act 2005 (CYFA 2005) provided the legislative basis to expand the FSIP response state-wide through the development of Child FIRST and Integrated Family Services (an integrated service response that addresses risk and need).

1.2 An overview of Child FIRST and Integrated Family Services

Child FIRST and Integrated Family Services were incrementally introduced into 24 sub-regional catchments throughout Victoria from early 2007 to mid 2009. As reflected in Section 22 of the CFYA 2005, the intent of Child FIRST and Integrated Family Services is to:

- create a coordinated and visible point of access to Integrated Family Services (rather than relying on Child Protection as a gateway into the service system)
- provide the capacity to receive referrals about vulnerable children and families, where there are significant concerns about wellbeing
- undertake assessment of children and families’ needs and risks, and assist with the provision of services when families have difficulty protecting their children from harm and promoting their development
organise Integrated Family Services into sub-regional catchments with coordinated intake and the capacity for prioritisation based on need

provide a platform to drive stronger shared governance and responsibility between services involved with children and families. This includes:

- strengthening the relationship between Child Protection and Integrated Family Services, through other development of the Community Based Child Protection Worker role
- working more closely with Aboriginal Family Services, enabling access to Aboriginal specific services for Aboriginal families, or alternatively use of joint visits and secondary consultation
- facilitating the development of an integrated network of other related local services

appropriately target and prioritise services to more vulnerable children, young people and families.

To enable the effective operation of Child FIRST, Child and Family Services Alliances were established within 24 sub-regions throughout the state. Comprising representatives from Integrated Family Services, Child FIRST, DHS Policy and Partnerships staff and Child Protection, the Alliances are charged with operational management responsibility, catchment planning and providing service coordination at the sub-regional level. The staged implementation of Child FIRST is summarised in Table 1 below.

Table 1: Staged implementation of Child FIRST by DHS Region

<table>
<thead>
<tr>
<th>Region</th>
<th>2006-07</th>
<th>Sub-regional Child FIRST catchment</th>
<th>2007-08</th>
<th>2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMR</td>
<td>• South East</td>
<td>• Frankston / Mornington Peninsula</td>
<td>• Inner Middle</td>
<td></td>
</tr>
<tr>
<td>N&amp;WMR</td>
<td>• North East Metro</td>
<td>• Brimbank / Melton</td>
<td>• Western</td>
<td></td>
</tr>
<tr>
<td>EMR</td>
<td>• Outer East</td>
<td>• Hume / Moreland</td>
<td>• Inner East</td>
<td></td>
</tr>
<tr>
<td>BSW</td>
<td>• Barwon</td>
<td>• South West</td>
<td>• Colac-Otway</td>
<td></td>
</tr>
<tr>
<td>GIPP</td>
<td>• LaTrobe / Baw Baw</td>
<td>• Wellington</td>
<td>• East Gippsland</td>
<td></td>
</tr>
<tr>
<td>HUME</td>
<td>• Greater Shepparton</td>
<td>• Wodonga, Indigo &amp; Towong</td>
<td>• Lower Hume</td>
<td></td>
</tr>
<tr>
<td>LMR</td>
<td>• North Central Victoria</td>
<td>• Mallee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRA</td>
<td>• Wimmera</td>
<td>• Greater Grampians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: DHS

Funding for the phased roll-out of Child FIRST and Integrated Family Services was secured through the 2006/07 Economic Review Committee process, in addition to
reprioritised funding from contingency. This funding comprised additional funding for Family Support Innovations Projects to complete the state wide roll out of innovation projects, and ongoing funding for the staged implementation of the 24 Child FIRST sites, commencing 2006/07. The recurrent Child FIRST funding provided for an increase Community Service Organisation staffing levels by 46.5 EFT to provide community based intake within Child FIRST. No additional funding was provided for the establishment of the Community Based Child Protection function, rather, these staff were sourced from existing Child Protection resources.

1.3 The evaluation

In June 2008, the Department of Human Services (DHS) engaged KPMG to conduct a three year evaluation of the Child and Family Services Reforms.

The scope of the Stage 1A evaluation involved Child FIRST and Integrated Family Services.

The purpose of this component of the evaluation was to assess progress in implementing Child FIRST and Integrated Family Services, providing an analysis of work to date - including evidence of emerging good practice, enablers and barriers to success and areas for improvement – to ultimately draw conclusions about the extent to which Child FIRST and Integrated Family Services is achieving its objectives under the Children Youth and Families Act 2005.

During the evaluation KPMG produced a range of reports at the state-wide level, as well as a series of case studies which set out the experiences of implementing Child FIRST and Integrated Services in selected catchments, across Victoria.

This report draws upon the Final Report for the Evaluation of Child FIRST and Integrated Family Services, submitted to the Department of Human Services in September 2010.
2 Key findings: Developing the partnership and governance structures

Child and Family Services Alliances were conceived as the platform for integrated and coordinated governance:

“At a sub-regional catchment level Child and Family Services Alliances will be established. These will include Family Services, Child FIRST, Child Protection, Department of Human Services partnerships staff and, where capacity exists, an Aboriginal-controlled family service.”

This section focuses on answering the question of whether the introduction of Child FIRST and integrated Family Services has contributed to partnerships, collaboration and integration across Family Services, between Family Services and Child Protection, and between Family Services and the broader service system.

2.1 Partnerships amongst Integrated Family Services

Child and Family Services Alliances have now been established state-wide, and are proving a valuable means to manage Child FIRST and Integrated Family Services. Alliances have created: shared responsibility for service delivery to vulnerable children and families, within sub-regional catchments; a mechanism to support consistent intake, prioritisation and allocation based on need and risk; an opportunity to consistently improve the service provision; capacity for joint planning; and a shared approach to demand management across Family Services.

Characteristics which are influencing the capacity for shared governance include:

- **shared vision, goals and actions** - with a strong capacity to place the collective interests of the Alliance ahead of individual organisations' interests, engage in shared decision-making and share resources between Alliance partners

- **high levels of commitment to the partnership** - with strong attendance at Alliance Executive, Operations and Practitioners Group Meetings

- **effective resourcing of the partnership** - with the employment of project officers to support the Alliance as a whole and minimise the burden of participation

- **a focus on equity and inclusion** - applying strategies to maintain the engagement of smaller (lesser funded) organisations and ACCOs

- **a growing emphasis on critical reflection and review** – with an emphasis on adapting the Child FIRST model over time, and measuring progress towards goals.

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Most Alliances are demonstrating these characteristics, which are creating the platform for shared responsibility between Family Services. However, in the minority of Alliances where these elements are not evident, Alliances more likely to face challenges to sustainability. Early indications of this noted by the evaluation included:

- declining participation in governance structures
- reversion to individual agency, rather than collective focus
- less senior representation at Executive meetings (as an indicator of lower commitment)
- smaller agencies questioning the value of participation
- disintegration of governance structures.

This suggests that three years after their initial introduction Alliances are proving themselves a valuable mechanism to oversee Family Services at a catchment level. However, there is a need for continued investment of time and resources to sustain the partnerships.

### 2.2 Partnerships with Aboriginal agencies within Alliances

In developing Child FIRST and the Integrated Family Services system, one of the key considerations was increasing the accessibility and uptake of Integrated Family Services to Aboriginal children and families. This recognises that prior to the reforms, there was a gap in the ability of services to respond sensitively and appropriately to the needs of Aboriginal children and families. This included a lack of sufficient Aboriginal-specific Family Services and culturally responsive mainstream services, which (together with the impact of land dispossession, the stolen generation, social exclusion and policies of protection and assimilation of the past) have contributed to under-representation of Aboriginal children and families in Family Services and over-representation in Child Protection.

From a governance perspective, ACCOs are now formally engaged as Alliance partners, Alliances are increasingly using strategies to ensure partnership participation is relevant to ACCOs, there appears to be a growing commitment to working in a culturally competent manner, and a stronger emphasis on mutual support.

At a service delivery level, secondary consultation and advice to mainstream agencies is supporting skills transfer and confidence amongst staff in mainstream organisations, and offering greater choice in service providers to Aboriginal children and families. Specific strategies used include:

- the creation of an Aboriginal Child FIRST Liaison Worker (ALW), a position which is filled by an ACCO worker seconded to Child FIRST, and jointly funded by Child FIRST and the Alliance to provide culturally responsive services to Aboriginal people.
Impact of capacity constraints:

Some 18 months after the Alliance was established, the Family Services Manager position in one ACCO was filled, and started attending Alliance meetings.

This position has been crucial in strengthening the role of the ACCO in the Alliance. Opportunities for mutual capacity building between the ACCO and mainstream Family Services agencies are under discussion through the Alliance, and a renewed commitment to partnership expressed.

The ACCO also indicated a willingness to assist Child FIRST and Alliance members through joint visits and secondary consultations. A key focus was on how this could better support Aboriginal children and families.

- joint service delivery, e.g. a mainstream organisation and ACCO working collaboratively to engage Aboriginal families and offer a therapeutic model of support for mothers and babies with attachment / bonding issues
- job exchange arrangements between ACCOs and mainstream organisations.

However, ACCO engagement is concurrently being limited by capacity constraints within organisations, a tendency for some catchments to not give Aboriginal issues the attention they deserve, and lack of local ACCO which is reducing the extent of local knowledge available to the Alliance in some catchments.

While the capacity of mainstream agencies to work with Aboriginal children and families is improving, the capacity building journey is still in its infancy. There is a need to learn from the early successes about ‘what works’, with DHS showing leadership in ensuring these good practice strategies are implemented consistently state-wide.

Further, there is a real requirement to focus on workforce strategies to enhance ACCO sector capacity.

2.3 Partnerships between Integrated Family Services and Child Protection

The CYFA 2005 was designed to create system-wide improvement in the relationship between Child Protection and Family Services. Child Protection is identified as a key partner within Child and Family Services Alliances, so as to support shared responsibility for child and family services at a catchment level, and the capacity for coordination between Child Protection and Child FIRST intakes.

This recognises the significant changes in the Family Services role introduced through the CYFA 2005: namely, the legislated capacity for registered Family Services to receive significant wellbeing referrals, and the related requirement to support ongoing coordination with Child Protection, as the recipient of reports.

Role of CBCPW

The Community Based Child Protection (CBCPW) position is the primary contributor to collaboration with Child FIRST and Integrated Family Services. Co-located with community services for a discrete period each week, this role has the capacity to facilitate referral between Child FIRST and Child Protection, offer secondary consultation and advice, undertake joint visits and joint case management, participate in allocations meetings, and educate Child Protection and Integrated Family Services staff about the relative roles and responsibilities of each sector.

Overall, the role is identified as one of the core strengths of the reform process, providing substantial value to the Child FIRST and Integrated Family Services workforce including:
Capacity to manage risk:

The CBCPW role is seen as important in supporting risk assessments, planning and delivering creative interventions which may engage families at risk. Because of the strength of the relationship with Family Services, workers are also able to have the hard conversations with Family Services about ‘what’s required to engage the Family or maintain them within the community’, which can enable better outcomes for families”. Alliance feedback

Improved working relationships:

“The role of the Community Based Child Protection Worker is vital to the reforms, acting as a conduit between Child Protection and individual family services’ agencies. The Community Based Child Protection Worker can provide case-specific mediation, and can explain (to either Child Protection or Family Services) why certain courses of action have been taken”. Alliance feedback

- improved information sharing
- more comprehensive and accurate risk assessment and prioritisation
- greater capacity to manage increasing risk and complexity (work with more vulnerable children and families)
- diversion from and / or minimising the progression into Child Protection
- improved working relationships between Child Protection and Integrated Family Services more broadly.

However, there are a number of pre-conditions to the role’s success: regional commitment to ensure the role remains fully filled; a skilled capable incumbent to the role; and accessibility through regular co-location. These conditions are now in place within the majority to catchments.

Overall, this position has been the “lynchpin” between the two-sub sectors, supporting more consistent collaboration. However, reliance on the CBCPW to create system-wide improvement in the relationship between Child Protection and Family Services poses a risk to the ongoing achievement of the reform objectives.

Relationships with Child Protection more broadly

The evaluation has observed considerable variation across the sub-regions with respect to the relationship between Family Services and Child Protection. Overall, there has not been a significant systemic shift in the relationship between Integrated Family Services and Child Protection (although recognising the strong value of the CBCPW role). While there was some good work early on to encourage a shared approach, a shared understanding and relationship building (i.e. joint best interests training), this has generally not been sustained.

Barriers to achieving a collaborative culture and practice consistently relate to:

- the resource intensive nature of collaborative practice, with a requirement for adequate resourcing for collaboration to succeed
- demand pressures, detracting from available time for relationship development with Integrated Family Services
- workforce culture with a tendency for the Child Protection workforce to regress to procedure driven patterns of behaviour when under higher levels of pressure. In this regard, Child Protection practitioners noted that with case loads demands there was only a capacity to undertake ‘those actions explicitly prescribed by practice instructions’, with collaboration with other sectors was perceived as ‘good practice’ but often not feasible
• continuity and capacity, where workforce turnover in Child Protection creates challenges in terms of maintaining momentum where effective relationships are established

• inconsistent practice, resulting in systemic problems such as a lack of facilitated referral from Child FIRST / Integrated Family Services to Child Protection

• a lack of shared understanding between Child Protection and Family Services about when a child / young person warrants statutory intervention, as opposed to Integrated Family Services support.

There is a requirement to further enhance the capacity for Child Protection and Integrated Family Services to work together. This includes creating a shared understanding between Integrated Family Services and Child Protection about the roles each perform, the relative value of each and the benefits of collaborative practice, in terms of outcomes for children and families, and the threshold for statutory intervention as opposed to Integrated Family Services intervention.

2.4 Partnerships with universal, secondary and specialist services

Overall, the reforms have made a positive difference to the relationship with universal and secondary services. There is now a stronger imperative to working collaboratively, so as to support better support outcomes for clients, as well as an increasing willingness amongst universal and secondary services to come to the table and have conversations about the parameters of the service system and respective roles.

However, differential progress has been made between sectors and catchments:

• The most significant progress has been made in sectors that focus on children as the client (e.g. schools or maternal and child health), or alternatively have experienced a complementary reform agenda (e.g. Family Violence).

• Less progress is perceived to have been made with adult services, including mental health, disability, and alcohol and drug services.

Of note, within a number of catchments there is still a need to ensure that:

• all services have a consistent understanding of the different roles performed by Child Protection and Child FIRST / Integrated Family Services, and when it is appropriate to refer to one or the other

• service partners fully understand the intent of the CYFA 2005 (and the information sharing provisions) and are willing, prepared and capable of delivering on its intent
that children and families are able to access the full suite of services required to address issues underlying vulnerability.

Further, the emphasis of relationship building is at the catchment level, with many Alliances investing significant time in this endeavour. To strengthen relationship building capacity, there is also a requirement for whole of government direction and support.

DHS has a key role in this area, using cross-department and cross-government mechanisms to draw together the full range of universal and secondary services, which it and related Government agencies fund, to support more integrated practice, better use of resources across programs and funding streams, and a shared focus on the best interests of children.

3 Key findings: Establishing Child FIRST and Integrated Family Services

Child FIRST and Integrated Family Services have been established to provide:

- a visible and accessible point of entry to secondary Family Services
- improved needs identification, prioritisation and targeting of services
- coordinated and effective intake and allocation
- a more timely response to vulnerable children and families through use of active holding.

This section sets out the progress of Child FIRST and Integrated Family Services in terms of these objectives.

3.1 A visible and accessible point of entry

The CYFA 2005 identifies the notion of enhancing the visibility and accessibility of Family Services as a primary objective of Child FIRST and Integrated Family Services. The intention is to provide a point of entry into an integrated local service network, that is readily accessible, allows for earlier intervention in support of families, as well as receiving referrals about vulnerable children and families.

Alliances have introduced a centralised intake point (a single telephone number) to increase visibility to those without an established relationship with Family Services or referrers operating at the catchment level, while (to varying degrees) maintaining a localised presence. In practice this has involved maintaining access to pre-existing local entry points, alongside Child FIRST. However, the operation and level of reliance on local entry points (as opposed to Child FIRST) differs across catchments.
Local intake points are particularly valued in more rural catchments - local knowledge and trust is seen to be critical, given that the Child FIRST Service can be physically located kms away in the regional centre.

Professionals also know a Child FIRST referral will simply be redirected back to their local agency and prefer to ‘work with the locals’.

The impact of the establishment of a centralised entry point has been to increase the capacity for service system navigation (for referrers and for clients), while reducing the level of case handling, and the requirement for families to repeat their stories. Concurrently, maintenance of a local presence is critical to supporting accessibility and service uptake (particularly for families) by enabling:

- choice
- engagement of families at first point of contact
- re-engagement of existing clients
- the maintenance of local relationships.

As an outcome of the introduction of Child FIRST and Integrated Family Services, there has been a steady increase in referrals from a range of professional sources including: schools, preschools and child care centres; hospitals (particularly social work departments); maternal and child health; police; housing and youth services. Child Protection referrals also increased substantially in the 2007-08 and 2008-09 financial years, before declining marginally in the 12 months to December 2009. This is set out in Table 1 below.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Child Protection</td>
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<td>2,615</td>
<td>2,613</td>
<td>2,372</td>
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<td>Community welfare and related</td>
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<td>professionals</td>
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<td>Disability</td>
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<td>58</td>
<td>36</td>
<td>41</td>
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<tr>
<td>Drug and alcohol</td>
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<td>66</td>
<td>48</td>
<td>54</td>
<td>43</td>
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<td>Family violence</td>
<td>123</td>
<td>110</td>
<td>161</td>
<td>110</td>
<td>113</td>
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<tr>
<td>GP, Hospital, Health, Community</td>
<td>1,425</td>
<td>1,285</td>
<td>1,442</td>
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<td>Health</td>
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<tr>
<td>Maternal and child health</td>
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<td>676</td>
<td>678</td>
<td>723</td>
<td>740</td>
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<tr>
<td>Mental health</td>
<td>328</td>
<td>360</td>
<td>371</td>
<td>357</td>
<td>418</td>
</tr>
<tr>
<td>School/ child care</td>
<td>1,006</td>
<td>1,187</td>
<td>1,396</td>
<td>1,654</td>
<td>1,728</td>
</tr>
<tr>
<td>Not stated</td>
<td>6,036</td>
<td>5,851</td>
<td>5,437</td>
<td>5,331</td>
<td>4,880</td>
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<tr>
<td>Other</td>
<td>1,191</td>
<td>1,200</td>
<td>1,711</td>
<td>691</td>
<td>320</td>
</tr>
<tr>
<td></td>
<td>522</td>
<td>517</td>
<td>754</td>
<td>985</td>
<td>968</td>
</tr>
</tbody>
</table>

Source: DHS IRSI data. * The 12 months to December 2009 was used to avoid the impact of data reporting lags.

While there has been a significant reduction in referrals from community members, this is likely to reflect increasing awareness amongst families that Child FIRST and
Integrated Family Services is now targeting a more complex client group (i.e. they are no longer eligible for a service).

**Accessibility has also increased**, with substantially more families (including more Aboriginal families) receiving services since the introduction of Child FIRST and Integrated Family Services, as a reflection of increasing service system capacity. Between June 2006 and June 2009, the number of cases grew by 9.3 per cent.

However, there is a tension between supporting improved access to Integrated Family Services and targeting more vulnerable children and families. As illustrated in Figure 1, as the complexity of families has reached a peak the number of families being supported has started to decline.

*Figure 1: Active substantive cases (June 2006 – March 2010)*

![Active Substantive Cases](chart)

Source: DHS IRIS data

Overall, this suggests that Child FIRST is supporting greater visibility and accessibility of Integrated Family Services (with a need to monitor patterns in Child Protection referrals over time).

### 3.2 Improved needs identification, prioritisation and targeting

Under the CYFA 2005 there is a clear expectation that Child FIRST and Integrated Family Services will prioritise the most vulnerable children and families (within their catchments). The primary target group for Integrated Family Services is vulnerable children and young people and their families who are:

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2 Substantive cases only are included (i.e., total of 2 hours or more of service activity for the whole case). Only active cases with service provision are included for each financial year. A case is active in the year if it has a referral date before the end of that year and a date of closure after the start of that year. This is equivalent to the case being open for at least one day in the year. Cases with no closure date are assumed to be still open at 31 March 2010 and are included in the active cases. An active case is flagged as having a service activity in the given year if there is a service activity recorded for that case in the year concerned. That service activity must have some service time recorded against it, i.e., the total hours for the case's service activities in the given year must be greater than zero.

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likely to experience greater challenges because the child or young person’s development has been affected by risk factors and/or cumulative harm

• at risk of concerns escalating and becoming involved with Child Protection.

A range of strategies are improving the targeting of Integrated Family Services in this regard:

• Use of the best interest case practice model to identify pattern, history, risk, as well as families’ strengths and capacity.

• Centralised (or common) intake and needs identification, supporting consistency of decision-making about eligibility of access to Child and Family Services across the catchment as a whole.

• Engagement of Community Based Child Protection and other services to inform needs identification. In 2005-06 Family Services consulted with Child Protection in relation to 1 per cent of cases (162 cases); by 2009-10 this had increased to 18 per cent of all Family Services cases (2,714 cases).

• Prioritisation based on risk and need.

As an outcome, children and families receiving support from Child FIRST and Integrated Family Services in 2009-10 were substantially more likely to have complex needs than before the reforms. This includes a greater likelihood of involvement with Child Protection, mental health issues, substance abuse, family violence, and intellectual disability.

Table 2: Proportion of substantive cases by complex issue category, by financial year (Jan 2004 to Mar 2010)1

<table>
<thead>
<tr>
<th>Issue category</th>
<th>2004-05</th>
<th>2005-06</th>
<th>2006-07</th>
<th>2008-09</th>
<th>2009-10*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Involvement</td>
<td>1,409</td>
<td>1,896</td>
<td>2,137</td>
<td>2,918</td>
<td>2,814</td>
</tr>
<tr>
<td>Disability – Intellectual</td>
<td>719</td>
<td>786</td>
<td>787</td>
<td>1,023</td>
<td>980</td>
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<tr>
<td>Disability – Physical</td>
<td>371</td>
<td>342</td>
<td>276</td>
<td>353</td>
<td>297</td>
</tr>
<tr>
<td>Family violence</td>
<td>2,969</td>
<td>3,500</td>
<td>3,389</td>
<td>3,916</td>
<td>3,786</td>
</tr>
<tr>
<td>Juvenile Involvement</td>
<td>79</td>
<td>75</td>
<td>70</td>
<td>103</td>
<td>68</td>
</tr>
<tr>
<td>Mental Health</td>
<td>3,406</td>
<td>3,830</td>
<td>3,688</td>
<td>4,521</td>
<td>4,098</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>587</td>
<td>558</td>
<td>537</td>
<td>608</td>
<td>524</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>1,045</td>
<td>1,306</td>
<td>1,383</td>
<td>1,982</td>
<td>1,812</td>
</tr>
</tbody>
</table>

Source: DHS IRIS data. *2009-10 refers to the 12 months to March 2010.

1 Substantive cases only are included (i.e., total of 2 hours or more of service activity for the whole case), and cases are counted according to referral date, i.e., each case is counted once only, for the financial year. * Data are available only until 31 March 2010. Data for 2009-10 cover the 12 month period from April 2009 to March 2010. Note that there appears to be some under reporting for the March quarter of 2010 that will affect the 2009-10 financial year.
3.3 Coordinated service delivery

Within Integrated Family Services there is now greater evidence of coordinated intake, allocation, service delivery, and demand management.

Many Alliances, either have Child FIRST undertaking the intake function on behalf of the Alliance or alternatively, there is a requirement for all local agencies to use a consistent (catchment wide) intake framework. This means that wherever children and families enter the system they receive a consistent response.

Case allocation now occurs collaboratively amongst agencies, either at the catchment or LGA level; alternatively, this function may be coordinated by Child FIRST on behalf of the Alliance as a whole. Catchment wide allocation offers the capacity for shared understanding of agency demand pressures, and for the redistribution resources and service capacity flexibly. LGA based allocations are generally supported by Child FIRST oversight and / or the principle of flexibility enabling the resource shifting between LGAs to meet priority needs.

Coordinated allocation and service delivery also offers other benefits to families, with capacity to access the ‘most appropriate service within the catchment to address their particular needs’. This may involve using specialist agencies (i.e. those that provide education and support services to vulnerable young people, adolescent parenting support, and home based, early parenting education) in an advice or consultation capacity, to complement generalist case management services or as an important source of group-based interventions for families awaiting allocation to a case manager or transitioning to lower intensity Integrated Family Services support.

Demand management is also coordinated, with a tendency for a single strategy (or suite of strategies) to be applied to the catchment as a whole. While approaches vary, most catchments have established a graduated demand management system, with the nature of the response dependent on the defined demand trigger, immediacy of operational pressures, quality and safety issues, and organisational risk level of demand and organisational risk. The range of demand management strategies observed in case study sites are discussed in detail in the Stage 1A Evaluation report.

Alliances as standard are now establishing the partnership capacity (in terms of hours and targets), and are monitoring demand on an ongoing basis. As a result, Alliance partners now have a shared understanding of demand and system capacity, and are managing demand in a systematic and considered manner.

Despite strong progress in this area, there are a range of remaining challenges to coordination. This reflects the lack of a common assessment framework:

- The use of different intake and initial assessment tools at the Alliance level may reduce the consistency of the eligibility determination process, and the capacity to prioritise the most vulnerable children and families across the catchment.

- Further, the lack of a consistent intake and assessment tool at the state-wide level, reduces the capacity to assess:
3.4 More responsive services

With the introduction of Child FIRST and Integrated Family Services there has been a strong emphasis on improving the timeliness of response, actively engaging children and families at the point of referral where a case worker cannot be immediately allocated.

Active holding responses may be used to:

- address immediate needs / prevent needs from escalating
- link children and families into appropriate universal and secondary services, while they are waiting a response
- reduce the drop out rate amongst children and families waiting for more extended period
- act as a valuable early intervention / prevention mechanism for families who may not meet the threshold for Integrated Family Services
- effectively divert families from requiring a longer term case management response.

The evaluation identified that amongst many Alliances, active holding has evolved to include, conducting assessments, undertaking home visits, offering group work, referral to other services, case conferencing and / or offering material aide, dependent on the particular needs of the family.

However, some Alliances are still maintaining ‘telephone contact’ as the primary active holding response, or have experienced a reduced capacity to provide innovative holding work over time.

Barriers to system responsiveness

While there has been substantive improvement in system responsiveness to vulnerable children and families since the implementation of the reforms, barriers are increasingly relating to demand. Many catchments are experiencing increasing demand pressure, associated with increasing rates of referral and client complexity, a requirement to provide more intensive and sustained interventions and a reduced capacity to take on new cases (due to slowing throughput). For some, this has reduced the ability to provide holding responses of a more active nature, as the reforms have progressed.
Alliances have put in place a range of strategies to address this demand. Where demand is moderate, these have been relatively effective. However, in sub-regions experiencing demand at a less sustainable level, this is proving more difficult, with less capacity to undertake active holding and a requirement (in a number of cases) to restrict their intake of new clients in order to effectively manage organisational risk. This is reducing accessibility for families, Child Protection, and professionals to Integrated Family Services, with a tendency for referrers to ‘give up’ when faced with these constraints.

The release of additional targeted funding in January 2010, for Child FIRST catchments to address demand issues and increase accessibility, has acted to relieve this demand pressure in some catchments in the short term. However, in the last few months at least one Alliance (in receipt of additional funding) has had to restrict intake once again, thereby reducing available service access.

There is a need to take a stronger state-wide approach to demand management, analysing the profile of demand within catchments, regions and across Victoria (i.e. key drivers for referral), and identifying and piloting a range of evidence based models to better address demand.

**Key findings: Building the capacity to intervene earlier with vulnerable children and families**

Under the CYFA 2005, Family Services are required to prioritise the most vulnerable children and families including families where children have been exposed to multiple and co-occurring risk factors and/or cumulative harm, and those who, without appropriate support, are likely to progress into the statutory system. As such, the intention is that Family Services will intervene earlier, “providing critical, timely and responsive services before the risks and concerns escalate and lead to Child Protection intervention”.

This section draws on practice workshops and analysis of IRIS data to consider whether Child FIRST and the creation of an integrated Family Services System has enhanced the capacity to respond to more vulnerable children, young people and families (i.e. capacity to respond to more complex clients and increasing numbers of clients).

**Findings**

Child FIRST and Integrated Family Services is successfully enabling earlier intervention with vulnerable children and families. The evaluation has identified that:

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• Child FIRST and Integrated Family Services are targeting more complex children and families.

• There have been an increasing rates of significant wellbeing concern referrals, as the reforms have progressed.

• Practitioners are more frequently using practice approaches consistent with earlier intervention including Section 38 consultation with Child Protection, trauma informed practice, holding of risk, active engagement of families and a stronger emphasis on child development (refer table 3 below)

• Cases are being worked more intensively, with an increase in the proportion of families receiving in excess of 40 and 110 hours of service provision (refer figure 3 below)

A mum and her young child were referred to Child FIRST. She had experienced family violence, and was living in a refuge. The CBCPW undertook a joint visit with Child FIRST. The assessment identified a range of significant risks (exposure to family violence, mental health issues, mum had been incarcerated). Discussion with mum allowed her to recognise that she wasn’t in the best position to care for her young child and needed to spend some time addressing her own issues. She voluntarily placed her child (on a temporary basis) in her own mother’s care. Importantly, had she not done this, the CBCPW would have had to report the child.

Table 3: Use of earlier intervention with children and families

<table>
<thead>
<tr>
<th>Practice elements</th>
<th>What this involves</th>
</tr>
</thead>
</table>
| Trauma informed practice | - Workers using research (about the impact of trauma) to educate parents  
- Supporting parental understanding of the implications of their behaviour on their children; motivating personal / behavioural change |
| Emphasis on child development | - Workers have a stronger understanding of child development  
- Supporting parental understanding of developmental milestones, including importance of development (e.g. school attendance, basic needs (nutrition, personal care), routines)  
- Linking children into required universal, secondary and specialist services |
| Consideration of cumulative harm | - Consultations with the CBCPW and information gathering from other services  
- Supports a more holistic understanding of children and families needs (including patterns of harm and neglect)  
- Provides a basis to address underlying problems |
| Relationship based practice | - Focus on building trust and rapport with families, i.e. outreach base work, home visits, addressing basic needs, setting achievable goals |
| Listening to the voice of the child / direct work with children | - Assessment process focuses on each child in the family  
- Direct work with children  
- Providing feedback to parents about children’s development: provides additional weight to the case for behavioural change |
| Partnerships with other services / multi-disciplinary practice | - Stronger use of care teams – universal, secondary and specialist services more likely to participate  
- Services operating from a child centred perspective |
Analyses of Child Protection activity indicates that up to June 2009, Child Protection reports, investigations, protective orders have grown at a far lower rate in Victoria compared to other jurisdictions. While reports have shown an increase over the last three years, significant contributors include:

- the measures introduced through the reforms themselves. There is new capacity to report on and investigate children impacted by cumulative harm, and to accept reports and conduct investigations in relation to unborn children

- factors outside the control of the Child and Family Services System. Prevalence and identification of family violence and drug and alcohol misuse have increased, and there has also been notable growth in the child population (over and above previous expectations). Requirements related to Police reporting of sexual offenders, the release of the Victorian Ombudsman’s Report and recent extensive coverage of Child Protection in the media have also impacted (and were felt exclusively during the 2007-2010 period).

Taking the level of growth in the external demand factors into account, in the absence of the FSIPs and Child FIRST and Integrated Family Services, it is likely that Child Protection reports and investigations would have shown a more significant increasing trend in the years subsequent to the introduction of the legislation. That is: there would potentially have been 10.9 per cent, 12.5 per

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Note: the 2009-10 AIHW Child Protection in Australia Report was not available on writing this report. This statement reflects Australian Child Protection activity to June 2009.
cent and 13 per cent more reports respectively, in the 2007-08, 2008-09 and 2009-10 financial years, with a significant flow on effect to investigations.

**Challenges to earlier intervention**

Despite these positive findings, there are a number of factors limiting the extent of what Child FIRST and Integrated Family Services can achieve. This includes:

- variation in workforce skill and capacity (both within and between catchments)
- variation in the extent to which catchments are prepared to hold risk
- capacity to actively engage, with 14 per cent of cases closed in the 12 months to March 2010 for these reasons
- the requirement to effectively manage service demand and ensure throughput, which may limit the capacity for longer term work and sustained change in families
- the interface with Child Protection. Different perspectives about the threshold for statutory involvement and the conditions that constitute cumulative harm, may result in less than optimal handling of cases, for which there should be shared responsibility.

Each of these issues needs to be addressed in order for Child FIRST and Integrated Family Services to achieve its full intent as an earlier intervention service.

5 **Summary and opportunities going forward**

Overall, there are clear indications that Child FIRST and Integrated Family Services are being implemented in line with expectations, and are contributing to the overarching intent of enabling earlier intervention when families have difficulty promoting the safety, stability and development of children and young people.

Child FIRST and an integrated Family Services System have contributed to improved partnerships and collaboration, at all levels. This has occurred more extensively amongst Integrated Family Services, with a requirement for continued focus on the relationship with universal and secondary services and Child Protection.

There are strong indications that Child FIRST is contributing to the development of a visible and accessible point of entry to the Family Services System. As an outcome of the introduction of Child FIRST and Integrated Family Services, there has been a steady increase in referrals from a range of professional sources. Referrals from Child Protection have also increased substantially over the life of the reforms, although noting a decline in 2009-10.
In considering service coordination, there is now greater evidence of coordinated intake, allocation, service delivery and demand management. This is offering significant benefits to families with increased capacity to redistribute resources between LGAs to support equity of access, and better matching of services to families’ needs.

Finally, Child FIRST and Integrated Family Services is enabling earlier intervention, enhancing the capacity to respond to more vulnerable children and families, and reducing the extent of Child Protection involvement. Child FIRST and Integrated Family Services are targeting more complex families, working cases more intensively, receiving increasing numbers of significant wellbeing concern referrals, and are reorienting their practice so to better identify and address cumulative harm and support children’s development.

However, there are still a range of opportunities to strengthen Child FIRST and Integrated Family Services going forward.

5.1 Opportunities to strengthen the reforms
The evaluation has identified a number of opportunities to enhance Child FIRST and Integrated Family Services capacity going forward:

- **Strengthening the sustainability of Alliance partnerships** - providing Alliances with tools and resources to monitor partnership health and enable effective management of leadership succession; clarifying the role of DHS PASAs and Family Services Managers in supporting effective partnerships, including stronger accountability for partnership performance; and consistent resourcing (across all catchments) for an Alliance project officer.

- **Further strengthening ACCO involvement in Alliances**, and capacity for improved services to Aboriginal children through: establishing an Aboriginal Liaison Worker in all Child FIRST catchments; reviewing funding allocations by region, to determine whether current funding is sufficient and equitable to meet Aboriginal population needs; and sharing and disseminating good practice in working with Aboriginal organisations and Aboriginal children and families.

- **Enhancing the interface between Child Protection and Child FIRST and Integrated Family Services** at the governance and service delivery levels.
  - To influence governance level change there is a requirement for a clear accountability framework for the reforms (at the catchment, regional and divisional level).
  - To influence change at the broader workforce level considerations include:
    - co-location of Child Protection and Child FIRST intakes – which would enable ongoing relationship development, more effective transition of
cases, shared understanding of risk thresholds and also strengthen the capacity for earlier intervention.

- implementation of a common state-wide intake and assessment framework for Child Protection and Integrated Family Services. This would offer clarity about the relative risk and need associated with vulnerable children and families accessing Child Protection and Family Services, the differences in risk thresholds, and enable thresholds to be monitored over time.

- ensuring that Child Protection in all regions operates at a catchment level, e.g. creation of catchment level Child Protection teams (in regions which currently do not have these) to support effective relationship building and continuity of these relationships.

- use of other supports to create basis for collaboration between Child Protection and Family Services practitioners, e.g. use of the specialists (such as the Principal Practitioner, Senior Practitioner and Family Decision Making positions being trialled in the Eastern Metropolitan region Demonstration Project) to role model multidisciplinary / collaborative practice and achieve shared responsibility for case management; increasing opportunities for joint training amongst Integrated Family Services staff and Child Protection staff; and creating opportunities for secondments and job swaps, to support a shared, cross-sector understanding.

- Enhancing the level of collaboration with universal, secondary and specialist services – through continued and ongoing leadership from the Children, Youth and Families Division in engaging related DHS and Government agencies to support a shared, whole of government approach to supporting vulnerable children and families.

- Establishing real demand and investment requirements for Child FIRST and Integrated Family Services - establishing a consistent state-wide methodology to ascertain the core drivers of Child FIRST and Integrated Family Service demand; assessing the available catchment infrastructure and investment to meet this demand; and where necessary allocating additional funding to enable demand to be met in an ongoing and sustainable manner.

- Taking a lead on a stronger public health approach to demand management - viewing Child FIRST and Integrated Family Services as part of the continuum of universal, secondary, and tertiary services and recognising that every part of the system impacts on their work. Operating from this perspective, it is highly likely that Child FIRST and Integrated Family Services will be unable to control their growing demand in some catchments: however, they should have a stronger capacity to understand the sources of demand and identify (with support from the Department) where preventative measures can be undertaken (with leadership for cross-sector collaboration from DHS).
• **Improving the consistency of eligibility determination** for Integrated Family Services and capacity for DHS (as the funder) to assess the equity of access - this would involve developing a common state-wide intake and assessment framework at the state-wide level (for both Child Protection and Integrated Family Services, as noted earlier).

• **Development of a clear tiered planning framework** - with catchment plans used to inform regional and state-wide planning, thereby supporting more strategic sector development.

• **Strengthening earlier intervention capacity:**
  
  - Undertaking a research project to consider the increasing number of Integrated Family Services clients requiring longer term intervention, their characteristics, extent to which they are cycling between the Integrated Family Services and Child Protection systems, and interventions required to support sustained change for this group. This will guide the need for new models of service delivery and additional investment, so as to effectively divert and minimise the progression of families into Child Protection.
  
  - Ensuring the Integrated Family Services workforce has consistent capacity to intervene earlier - through DHS funding for a Senior Practitioner within Integrated Family Services, ongoing joint sector training with Child Protection, and development and dissemination of a suite of evidence-based practice resources and tools (i.e. articulating ‘what works’ in earlier intervention).