Strengthening the Orange Door: Suggestions to improve the wellbeing service response for children and their families

Background

While the child and family services sector in Victoria has undergone, and continues to undergo, massive and complex changes, these are yet to cut through in terms of preventing children being removed from families and entering statutory services. Despite the redesign of child and family services, establishment of a learning system, extensive and ongoing family violence reforms, and deep-seated commitment to Aboriginal self-determination, the number of children placed in out-of-home care in Victoria has doubled in less than a decade.

As at 30 June 2018, over 10,000 Victorian children and young people, who have experienced significant forms of neglect and abuse, were in out-of-home care. Based on current trends, this figure will increase by a further 50 per cent in the next four years.[1] Once these children enter the out-of-home care system they are frequently subjected to multiple placements,[2] disrupted schooling, poorer mental health outcomes, sexualised behaviour and abuse.[3] Multiple reviews, inquiries, Royal Commissions and reports over the past ten years show that our institutions have consistently failed to keep our children safe. The State removes children from their families to protect them but frequently places them in settings that cause further harm.

The role of the child and family services system is to prevent families from entering more deeply into the Child Protection system. The Child FIRST and integrated family services platform was developed to provide a pathway for these families to make sure they receive the interventions and support needed to prevent further statutory response.

Child FIRST plays a crucial role in managing the demand into Child Protection and servicing families in crisis and growing numbers of children vulnerable in these settings.

It is within this broader environment of growing demand and multiple reforms that Child FIRST is being incorporated into the Orange Door model. The model is still in its infancy and teething problems are to be expected. The roll out of the Orange Door enables learning from one site to be shared with later sites. However, there are fundamental aspects of the Orange Door that require further consideration, clarity and refinement if the model is to function optimally.

Purpose

The purpose of the paper is to explore some of the impacts that have resulted from incorporating the Child FIRST platform into the Orange Door model and identify what could be done to improve outcomes for children and their families.

The paper seeks further clarification on the framework for the Orange Door and the need for strengthened capability if users of this service are to experience better outcomes than those they would have experienced without the Orange Door, and in the original Child FIRST platform.

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[1] Australian Institute of Health and Welfare (2018) Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW. Appendix A, Table A1, p. 63.
[2] Australian Institute of Family Studies, Children in Care Resource Sheet, https://aifs.gov.au/cfca/publications/children-care
[3] Victorian Auditor General's Office (VAGO) (2014) Residential care services for children, Melbourne: Victorian Government.

The Centre for Excellence in Child and Family Welfare (the Centre) embarked on the information gathering for this paper in the wake of significant concerns expressed by member organisations in the Orange Door.

The Centre has had consistent feedback from practitioners working in Child FIRST or integrated family services concerned about the rollout of the model and what it means for children and families and the future of early prevention services in the state.

Many Family Safety Victoria (FSV) documents plan for and write about the Orange Door as though it is a discrete entity rather than an agency in a continuum of services. Member agencies report uncertainty about the future of Child FIRST's functions and how the Orange Door connects with the broader service system.

The Orange Door represents a new piece of architecture in our service system. This paper provides a set of recommendations arising from our consultations aimed at further refining the existing model.

Methodology

This paper is neither an evaluation nor an academic paper. It is qualitative not quantitative in its approach. The conclusions in this paper are based on feedback from:

- practitioners in the quarterly Orange Door/Child FIRST practice network forums
- emails from practitioners in CSOs working in the Orange Door
- phone interviews with practitioners in CSOs working in the Orange Door
- semi structured interviews with a range of workers in four of the five Orange Doors and one access point for an Orange Door
- FSV documents including the 30-day reviews March 2019; and the PWC PowerPoint evaluation presentation.

In the time available it was not possible to speak with users of the Orange Door.

Key areas for improvement

1. Child wellbeing in the Orange Door

Child FIRST stands for Child and Family Information, Referral and Support Teams. Its key purpose is to link vulnerable children and their families to relevant services based on assessed need and risk. Its core functions cover screening, risk assessment, referrals into and out of the service, and home visits where appropriate. Child FIRST was set up to intervene early enough to prevent child wellbeing issues from escalating.

Incorporating Child FIRST functions into the Orange Door has necessarily changed its focus and practice. The 2015 VAGO report into *Early Intervention services for vulnerable children and families* noted that Child FIRST was not fulfilling its original purpose of early prevention because of the growing demand and complexity of referrals, which meant its focus was necessarily on high need families. In the Orange Door, Child FIRST has arguably become further removed from early prevention and now occupies an even more high-risk space – that of family violence safety screening.

The prioritisation of children's wellbeing and safety, which has been a critical component of Child FIRST, has been embedded in a model that is assumed by many to be a family violence model. Media releases, FSV promotional videos, discussions in various Orange Door meetings, and regular statements from the

family violence sector all reinforce the image of the Orange Door model as a family violence hub. For example, a recent media release stated that:

> *More than 5,000 Gippsland residents have been kept safe from the threat of family violence with help from the Morwell Orange Door, one of the Support and Safety Hubs rolled out by the Andrews Labor Government.*
>
> *A key recommendation of the landmark Royal Commission into Family Violence, the Orange Door gives Victorian women and children access to support services in one secure facility when they are experiencing family violence*.[4]

Such public statements, while celebrating the family violence work of the Orange Door, do not provide guidance to families struggling with other dynamics in the home that have led them to being involved with the Orange Door, who might previously have connected with Child FIRST.

The consistent language and assumptions about the Orange Door as pre-eminently a family violence hub have made it difficult for Child FIRST to function as an early intervention service, prioritise children, monitor cumulative harm or provide a holistic response to the family.

In some (not all) Orange Door outlets, members suggest that families are getting 'an inferior service' to that which Child FIRST used to provide. For example, child and family services workers report that they would regularly make a first visit to the family home under the Child FIRST model of assessment, where most referrals are now managed through a phone system.

It is not clear how consistently within and across Orange Door sites, Child FIRST is drawn into high risk assessments that also need to have the assessments of the children in the family as central to these judgements. Further, the volume of cases with high risk are necessarily being triaged and assessed as a priority, which leaves wellbeing cases on wait lists.

The danger here is that vulnerable family referrals, being diverted from Child Protection to the Child FIRST service, are not getting the prompt assessment and service previously offered, thus increasing the risk of these families entering the statutory system. Members report that some situations appear to reach or exceed the Child Protection threshold, but these families are closed at intake, not proceeding to investigation or response.

It would be timely to analyse the data in each Orange Door and across the sites to determine the number of child wellbeing cases as opposed to the number of family violence cases being assessed by Orange Door teams as this data is currently not separated.

The difficulty of being able to monitor cumulative harm in children is particularly problematic as a child mentioned in an L17 might be deemed low risk at the time but might in fact be high risk when seen in the context of a continuum of exposure to adverse events. It is not clear how many children who are included on the L17s are followed up in a timely way or set aside for follow up down the track or not given any response at all. Child FIRST practitioners in some Orange Door sites report children being not identified by police in L17s, not always being identified through screening and assessment as needing a service, and not always being followed up in a timely way where a service has been identified as appropriate.

[4] https://www.premier.vic.gov.au/5000-gippsland-residents-get-help-at-the-orange-door/

In the Orange Door, child and family workers have reported new difficulties in information sharing practices and in seeking to engage with universal services in the same way as prior to the Orange Door. They report difficulties in seeking information about children and undertaking assessments. In some Orange Door sites, routine practices such as contacting schools or maternal child health services have been questioned or discouraged: *Women in family violence don't need child wellbeing stuff forced on them.*

Members in some Orange Door sites report feeling that one set of skills and specialisations (in family violence) are privileged over another set of skills (working with children and families). Such skills and specialisations should carry equal weight in a model catering for safety and wellbeing.

Some members also report that their experience and skills in responding to family violence risk are not always recognised in the Orange Door sites despite child and family services having a long history of responding to referrals for families and children who have experienced family violence.

Another issue raised by members is the lack of referrals in some areas to integrated family services. This was described in terms of a lack of coordinated external service system response. *It's not a coordinated community response outside the Orange Door in the external service system*; *in theory, it's intake, assessment, plan, referral but there's a bottle neck*. Such 'bottle necks' within the system *delay service intervention and often only accommodate those families in crisis rather than delivering shorter term early intervention support*.

Members report that while there has been increased funding for an access response there has been no commensurate resourcing for integrated family resources. Removing the Child FIRST intake function to the Orange Door has not obviated the need for agencies to continue to provide their own intake functions, potentially a costly duplication. *The Orange Door doesn't create a single entry – just another entry. Every participant organisation still has to have its own intake in one form or another, as well as its staff in the OD*. Examples of intake functions that do not sit in the Orange Door, but which will still need to be provided include Parent Assessment and Skill Development (PASD), Families First, Day Stay Programs etc.

Because of the high number of cases coming through with family violence present, the majority of work being undertaken with families involves risk assessment, safety planning and responding to the immediate impacts of family violence, such as supporting individuals or families with intervention orders, legal assistance, flexible support package applications, and accommodation. *Funded hours are not able to be used in these instances for 'parenting' supports*.

Given the government intention of rolling the Child FIRST service into the Orange Door, it is critical that the role of Child FIRST and, crucially, of child wellbeing, is legitimised and valued, understood by every member of an Orange Door. Child FIRST needs to be able to continue its child and whole-of-family focus to make sure family members are not only safe from harm but able to access the supports they need to maintain wellbeing and for children to develop appropriately. We cannot afford to lose the vital function of Child FIRST as it is progressively rolled into the Orange Door given the demand from notifications reaching the Child Protection system.

Recommendation:

1 (a) That:

- each Orange Door site undertakes a needs analysis of their data to identify the number of child wellbeing cases as opposed to family violence cases to provide a more accurate picture of what is happening to children deemed 'low risk' in the Orange Door
- FSV collates these data analyses to gain a state-wide picture of what is happening to children experiencing vulnerability who come through the Orange Door
- this data is shared with agencies to inform decision making.

1 (b) That every worker in each Orange Door is given comprehensive training in the role and responsibilities of Child FIRST, the Best Interests Case model, statutory obligations of workers, importance/relevance of child wellbeing and attachment in the Orange Door model.

2. Need for an agreed theory of change

In May 2018, FSV developed a detailed program logic for the evaluation of the Orange Door. This program logic outlined inputs, activities, outputs, short-, medium- and long- term outcomes and alignment with other frameworks.

Given the Orange Door has been operating in five sites for some time now, it is timely to review the program logic and to develop an agreed theory of change and operating framework.

These documents would be based on the evidence of what works to improve the safety and wellbeing of children, young people, women and families. They would outline the intended outcomes. They would articulate why this particular model of collaboration is necessary for these outcomes to be achieved.

Articulating a theory of change and operating framework could highlight the 'how' of implementation and good practice in the Orange Door. It could also help build a shared vision about its purpose. Theories of change are not static and there can be multiple theories of change within the one initiative. This supports regular monitoring and review of the intended outcomes and process of change for achieving them.

Recommendation:

2. That FSV works with the sectors to refresh the Orange Door program logic and develop an operating framework that makes clear the underpinning research evidence; long term outcomes; beneficiaries; process of change to achieve the outcomes (including each sector's role in bringing about the desired changes); and underpinning assumptions that need to be tested.

3. Need for a common vision and agreed purpose

In the literature, a critical feature of successful collaborative practice is that there is a common agenda, purpose and commitment. This helps to make sure the goals of collaboration are clear and identifies the shared outcomes sought.

There is broad recognition that the Orange Door is not about long-term case management but is an intake phase with a narrow period of engagement. However, there are different views about the *purpose* of the Orange Door. One view is that it is a family violence hub requiring a specialist family violence response '*It's meant to be a pre-eminent family violence response'; 'Family violence lens has to*

take prominence'. Another view is that all intake should be whole-of-family assessment and work with the whole family even when family violence is present. *'These are mums and dads not victim survivors or perpetrators; they need to be acknowledged as parents'; 'All intake should be whole of family risk assessment – whether family violence, mental health – where does the risk lie?'; 'Aboriginal services have always had the child in mind and work with the whole family even when family violence is present'.*

It was suggested in some Orange Door sites that there needs to be better communication to make sure families and other stakeholders know that the Orange Door does in fact provide an intake and assessment function in relation to child wellbeing and family support. *Community feedback has echoed the OD being an FV resource*.

Members report robust discussions about practice and processes, including about the level of specialist expertise, engagement of universal services to enhance engagement with families (where family violence is present but there has been no engagement by the family), and application of the information sharing reforms. There is variability in relation to how collaborative and constructive these conversations have been with some reporting that the Leadership and Operational Leadership teams have dealt constructively with differences of view and others reporting tensions that are not easily resolved. Having a shared understanding of the purpose of the Orange Door could assist leadership teams in establishing a positive and respectful professional environment in which to discuss difference or concerns and agree on solutions.

The purpose of the Orange Door intervention could be made clearer by a better articulation of the expected outcomes through a re-designed operating framework and theory of change.

Recommendation:

3. That FSV articulates and disseminates a clear vision and purpose for the Orange Door, which is consistently reinforced in all public documentation and embedded at all levels of governance and in all Orange Door policies, processes and decision-making.

4. Need for state-wide consistency

A key element of the model is local variation. In practice, this means each Orange Door develops its own ways of working, templates, tools, checklists and processes. This, together with the time lag arising from the staggered rollout of sites, has led to considerable inconsistency within and across Orange Door sites and inefficiencies in terms of staff time.

While Orange Door staff have shown initiative in developing resources and trying out different ways of working together, this is not an efficient way of working when each site has to re-invent things for itself. This kind of siloed development of resources and processes also limits the ability to build communities of practice for shared learning across all sites.

There is no set of agreed common elements that constitute the core components of the model. Such a set of consistent 'non-negotiables' could form the foundation on which local Orange Door sites could build and adapt for local need. For example, there is no consistent practice framework for recording and case management. Another example given was of a resource that took months to develop because of the difficulty negotiating different views about practice. Members report that when tools are developed in an Orange Door not all workers will necessarily commit to using them.

The Centre believes it is possible to have more consistent approaches and practices across all Orange Door sites without jeopardising local or customised service delivery approaches.

Recommendation:

4. That FSV identifies a small number of core elements that all Orange Door sites, regardless of locality or lead agency, must embed. Local variation can occur around these non-negotiables. That FSV provides well communicated mechanisms for knowledge and resource sharing to encourage greater consistency in processes and in tools and resources.

5. Need for a shared understanding of 'integrated practice'

A common theme to emerge from the consultations was the lack of a shared understanding of integrated practice across the Orange Door sites. In research, integration is generally conceptualised at the end of a collaboration continuum that includes co-existing, networking, co-locating, co-operating, and coordinating, culminating in integrating, which is when parties merge to work as one entity rather than as a collection of individual parties. There has been some resistance to the use of integrated practice in some Orange Door sites with true integration seen as unable to be achieved – *We won't fully integrate into each other's work'* – and undesirable – because of '*fear of loss of specialisation'. 'Multidisciplinary is a better word: Integration might hold workers back because of the fear of losing their identity'.*

The consultations highlighted different understandings of 'integrated' as a concept and in practice. While the literature consistently highlights the value of 'joined up', coordinated service responses, this can only occur when there is a shared understanding or how each part fits together. Commonly used terms in the Orange Door sites were:

- Commonalities of practice
- Fields of practice
- Culture of collaboration
- Multidisciplinary
- Coordination, collaboration, consultation

There needs to be a more tiered approach to collaboration, embedded at every level in the Orange Door. Most Orange Door sites recognised the value of the increased professional interaction and learning that is occurring through the Orange Door approach. However, while collaborative work is occurring, *this is reliant upon individual members of staff promoting the need to do this and isn't a 'whole of staff approach'. A collaborative approach is not yet [e]mbedded across the OD. A consistent state vision is required.*

Recommendation:

5. That FSV defines, disseminates and embeds a clear vision of collaboration in a co-located, multidisciplinary Orange Door with a coordinated approach to intake, screening and assessment.

6. Need for greater clarity around roles and responsibilities

There are different titles, expectations, and industrial implications attached to the roles in the Orange Door and agencies. There is a lack of clarity around roles and responsibilities. For example, there is an advanced family violence specialist role but not advanced specialist roles in child wellbeing or men's behaviour change. The Centre is not suggesting there should be additional roles, only that the existing

roles and responsibilities need to be very clear to every worker in every Orange Door and in external agencies making referrals. For example, the Integrated Practice Leader role in one Orange Door is considered a de facto child wellbeing role, while in another it is recognised as leading reflective practice across the Orange Door. Without clarity about the core responsibilities of the various roles in the Orange Door, it is difficult to build trust and collaboration.

In addition to the lack of clarity about roles in some Orange Door sites, members have also suggested the Orange Door approach is an expensive model. One suggestion to increase the cost effectiveness of the model was to relieve the team leader role of some of the basic administrative functions and provide more administrative support. *The administrative function that the Team Leader manages, takes time away from practitioner availability, consults and capacity to manage complex client situations. Brokerage also takes time to accommodate, with the paper system being onerous*.

Recommendation:

6 (a) That FSV reviews all roles to ensure greater clarity around core responsibilities and accountabilities and that the clarified roles are communicated to all Orange Door workers.

6 (b) That the role of the Integrated Practice Leader is given clear authority to lead practice across the Orange Door. The purpose and seniority of this role needs to be made explicit and disseminated to all workers and agencies in the Orange Door and given clear authority by the local governance group.

7. Strengthening governance and leadership

Some of the tensions in the Orange Door can be attributed to a lack of clear leadership. The 'flat' or matrix model of management means there is no recognised leader with decision-making authority in each Orange Door. Members have variously reported: where there are differences of opinion a leadership vacuum means that debate can be stifled or decided on grounds that might have nothing to do with good practice. More dominant personalities can hold sway. '*The agency does what it likes. Where is the accountability?'* Information sharing is not being done in alignment with the legislative changes because some practitioners consider they do not want to put clients at risk. There is no overarching authority in the Orange Door to make sure legislative and policy requirements are being met and evidence-informed practice is consistently occurring. *'We need someone to make the call'.*

The flat model of management can inhibit accountability and actions: *Team Leaders are segued through program managers/OLG and OD issues require further discussion with HLG members, which can slow progress. Orange Door processes are reviewed and discussed at meetings that may (or may not be) held monthly. This also can inhibit progressing an outcome*.

Recommendation:

7. That FSV reviews the matrix model to make sure each Orange Door has an authorising environment for decisions to be made, consistent with evidence-informed practice and statutory obligations.

8. The need for an outcomes framework

Feedback from stakeholders raised a range of questions in the pursuit of outcomes for clients of the Orange Door. How do workers in the Orange Door, who cannot always access their own data, know if their clients are experiencing satisfactory outcomes? What are the intended outcomes in the Orange Door and how will success be measured? How will FSV, and the Minister, gain assurance that risks are

being managed effectively and that clients are getting a better service than they would have prior to the Orange Door?

There is a need for the development of an outcomes framework for the Orange Door that outlines the data and method to ensure continuous improvement in these services are achieved.

Recommendation:

8. That FSV develops an outcomes framework for the Orange Door that clearly outlines how success will be measured and provides data back to agencies on a regular basis to inform decision making and further refinement and strengthening of the model.

Conclusion

Are children and families receiving a better service than they were prior to the Orange Door? The substantive view emerging from this consultation process is that in some Orange Door sites, families are receiving an inferior service to the one they would have received under the Child First platform.

Agencies report that some families are not going to the Orange Door because it is perceived to be about family violence. Children in the Orange Door are often deemed to be low risk and it is not clear statewide how many are receiving a timely service response. The core functions of Child FIRST have inevitably changed in the context of the Orange Door and the implications of this need to be worked through. We cannot afford to lose the early intervention role of Child FIRST.

The bottlenecks in Orange Door screening and assessment appear to be at the expense of children and families where safety is not considered an issue but where cumulative harm could be hidden. Workers report long waiting lists in some Orange Door sites. It is not yet clear whether children, young people and families are better off in this new model. It would be timely for each Orange Door to review current data and determine the most appropriate responses to what the data is showing. However, changes in data systems have not provided the quality of data that would enable a sound understanding of the demand management response required.

Overall, the Centre has found that while there is a strong commitment to clients in the Orange Door regardless of sector or home organisation, many of the challenges and tensions could have been avoided with more time being spent on developing a shared understanding of the core components of the model. These include shared vision and purpose, better understanding of each sector's practice principles and frameworks, shared outcomes and rationale for the model to achieve these, clear roles and responsibilities, authoritative decision making and leadership in the Orange Door sites, and clear direction around the non-negotiables in the model.

The Centre puts forward our recommendations as a means of giving the Orange Door model the best possible foundation to work effectively with clients, particularly in relation to the best interests of children.

While we are unsure of the extent to which this model can be adapted and refined to address the above feedback, the Centre is committed to supporting government to reform the Orange Door model for the benefit of all children and families experiencing vulnerability in Victoria.