# Chapter 5

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# Working effectively with children in care

The Commission recognises increased services should be in place to prevent children and families requiring a tertiary prevention response. However, any reformed child protection system will always need to respond to the cohort of children that require emergency or temporary protective action.

This chapter explores four key issues relating to the effectiveness of the care system in working with children once they have reached the statutory threshold requiring state intervention. These issues are:

- the balance between family reunification and keeping children in out-of-home care
- provision of stable out-of-home care placements for children who need them
- the case planning and management system for working with children in care
- the need for out-of-home care placements to be appropriate and flexible.

Proposals for consideration will be outlined throughout the chapter.

The *Child Protection Act 1999* specifies that preference must be given to the least intrusive way of working with families to reduce risk factors and the exposure of children to harm (s 59(1)(e)). As outlined in Chapter 2, interventions of increased coercion can only be considered if the protection sought cannot be achieved by a less intrusive means. This legislation would suggest that working with families to secure the protection of children while the child is still living at home would be a preferred approach.

Figure 6 in Chapter 2 shows that intervention with parental agreement is not used as often as a child protection order (Figure 6 also shows a steady increase in the use of long-term orders). The Commission is not aware of any research that documents the reasons for this limited use of interventions with parental agreement, but some possible explanations are:

- a lack of funding available to support families subject to intervention with parental agreement as opposed to children in out-of-home care

- the fact that by the time children have a substantiated outcome recorded, the home environment has deteriorated to such an extent that the child cannot be supported to remain there
- the limited capacity of family intervention services because of the high staff-to-client ratios required to undertake intensive work with families.

Figure 7 in Chapter 2 indicates that the use of the less intrusive court orders – supervision and directive orders – has decreased marginally in recent years. This coincides with an increase in the number of children subject to orders granting custody or guardianship (Figure 8, Chapter 2).

The decrease in the number of less intrusive interventions is inconsistent with the principles of family preservation and reunification that underlie child protection systems in Australia and the United States (Tomison & Stanley 2001b).

## 5.1 Family reunification

Even where the more intrusive option is pursued – taking the child or young person out of their home – the goal is to reunify the child with their family. In Queensland, the child protection system currently operates on the initial assumption that a child will be reunified with their family:

> Where a child has been removed from the care of a parent, the goal of the initial case plan must be to reunify the child with the parents on a long-term basis, unless it is not in the child's best interests, not possible or not safe to do so (Department of Communities, Child Safety and Disability Services 2012c, Chapter 4).

The Commission recognises the importance for children to continue some form of relationship with their family and maintain at least a minimal level of ongoing contact. The Commission is also aware that children in the care system may be at increased risk of a range of poor outcomes as a result of actually being taken into that system. It is difficult to know whether poor life outcomes are the result of trauma experienced in early life within the family of origin, or whether these outcomes result from being the subject of poor standards of care after removal. However, it seems clear that in some cases deficiencies in the care system may mean the preventable harm caused by the system itself outweighs the benefits of removal ('systems abuse').

As outlined in Chapter 2, the Child Protection Act recognises the importance of the role of the family and the need to preserve it, by facilitating reunification after protective removal where possible and in a child's best interests. The Act assumes that a child's family has the primary responsibility for the child's upbringing, protection and development, and the preferred way of ensuring a child's safety and wellbeing is by supporting the child's family. If a child is removed from his or her family, support should be provided for the purpose of allowing the child to return home, if the return is in the child's best interests. That is, support and services should be provided to reduce

or remove risk factors, rehabilitate parents or strengthen care-giving capacity.

A reunification assessment must be conducted with every case plan review for children living in out-of-home care and subject to short-term child protection orders. When reviewing the suitability of reunification, the child safety officer must consider progress made in meeting case plan goals, the level of risk in the family, the safety of the child on return and the frequency and quality of parent–child contact visits (Department of Communities, Child Safety and Disability Services 2012c, Chapter 4).
There are three possible outcomes of the reunification assessment process:

- reunification is recommended, based on risk reduction, favourable progress with parent–child contact arrangements and a safe or conditionally safe home environment
- reunification services are continued, by maintaining the out-of-home care placement and continuing reunification efforts with the assessed household
- alternative long-term stable living arrangements are pursued and efforts towards reunification are ended. This does not mean that the child will cease contact with their family, but prompts a change to the case plan goal (Department of Communities, Child Safety and Disability Services 2012c, Chapter 4).

The Commission has received a number of submissions about family preservation and reunifying children in care with their families. One witness expressed the view that in many cases, especially where the biological parents have a 'chaotic' lifestyle, it may be in the best interests of the child that they are not returned, but rather there is an early decision to commence long-term guardianship or adoption.[1] Dr Elisabeth Hoehn,[2] Dr Jan Connors[3] and Dr Anja Kriegeskotten[4] are all of the opinion that existing reunification policies need to be reviewed to ensure that parents' rights do not outweigh considerations of the child's best interests relating to their security and emotional needs.
In the United States, Professor Richard Gelles (1996, pp149–50)[5] has argued:

> It is time to abandon the myth that 'the best foster family is not as good as a marginal biological family.' The ability to make a baby does not ensure that a couple have, or ever will have, the ability to be adequate parents. The policy of family reunification and family preservation fails because it assumes *all* biological parents can become fit and acceptable parents if only appropriate and sufficient support is provided [emphasis in original].

Foster Care Queensland contends that the Childrens Court's interpretation of the child protection laws has been:

> conservative and biased towards family preservation … Child protection workers are then bound to implement plans that give parents almost limitless opportunities to change before decisive action is taken.[6]

Despite efforts by the department to implement concurrent planning, whereby Child Safety works toward reunification while at the same time planning for alternative placement options should reunification not be achieved (Tilbury et al. 2007), the

emphasis largely remains on reunification. It is suggested that, because of this, efforts towards other forms of placement stability for children do not commence until several months after parental reunification efforts have failed (see Berrick 2009). Moreover, despite the intention of the Structured Decision Making assessment tools to help departmental officers make decisions about reunification, there have been claims that reunification is being pursued unrealistically in some cases and without reference to the parents' ability to change.[7] For example, Dr Elisabeth Hoehn, a consultant child psychiatrist, gave evidence to the Commission that:

> At present in Queensland, there is a strong focus on reunification, with variable support and intervention to provide high risk and vulnerable families with the knowledge and skills that they require [to] change their parenting practices effectively to retain their children in their care. However, there isn't always a clear assessment of the parent's capacity to change and it often takes considerable time to identify those families where the parents do not have the capacity to change. The consequence of this is that children often move between various placements with foster parents and back to their biological parents with the possibility of further abuse and neglect during the process. This can have potentially very negative effects on the developing brain and the child's ability to trust in relationships as being safe and secure.[8]

Calls have also been made to amend decision-making timeframes for reunification. The Queensland Law Society submits that before pursuing an order for long-term guardianship to another, the department should make 'timely' efforts to work with the family towards reunification. New South Wales is presently considering a legislative proposal that decisions about restoration be made within six months of removal for children less than two years of age, and within 12 months of removal for children older than two (Department of Family and Community Services 2012a).

In summary, evidence and submissions have suggested that the department has placed too much emphasis on defaulting to returning at-risk children to their families after removal rather than finding suitable stable, alternative long-term (even permanent care) options.

**Question 10**

At what point should the focus shift from parental rehabilitation and family preservation as the preferred goal to the placement of a child in a stable alternative arrangement?

**Question 11**

Should the Child Protection Act be amended to include new provisions prescribing the services to be provided to a family by the chief executive before moving to longer-term alternative placements?

## 5.2 Placement stability

Research has shown that high levels of stability for children are important for a child's development (Tilbury & Osmond 2006). This derives partly from child development theory and attachment theory. Child development theory focuses on the importance of a child's interactions with other people and their environment, and the impact of early experiences on brain development. Attachment theory asserts that a child's social functioning and self-perception are influenced by the quality of the child's connections with a primary caregiver in the infant years (Tilbury & Osmond 2006).

Once children are in the care system, research has found that those with higher levels of placement instability have significantly worse behavioural outcomes, independent of baseline attributes, and that placement stability is an important predictor of wellbeing at 18 months after removal (Rubin et al. 2007).

Comments relating to placement stability were made by young people in care themselves during a series of forums held for the Commission by CREATE Foundation. Some of the comments made by these young people emphasise the crucial importance of placement stability for the development of relationships between carers and children in care:

> 'Carers become your family.'

> 'Some carers treat the kids like their actual family. They should get to keep those kids.'

> 'I am glad for having a foster family; they are my family now.'

‘When I first came into care I was nervous and I got to be in a good place with good carers and a happy environment. I had the best foster carers ever; they help me whenever I need. When I first moved in I was angry and self-harming and they kept giving me hugs.’

‘It’s been good. I’ve only had the one foster carer and she’s my mum.’

‘It’s really hard when you get close and you have to move and then you’re not allowed contact.’

‘I feel very lucky because I haven’t changed placements. I know children who have changed placements and they are never happy.’

‘This is my 16th place and I’ve been in care since I was one year old. It’s not normal being in care and I deserve to have a real family.’

‘We move too often and often unnecessarily.’

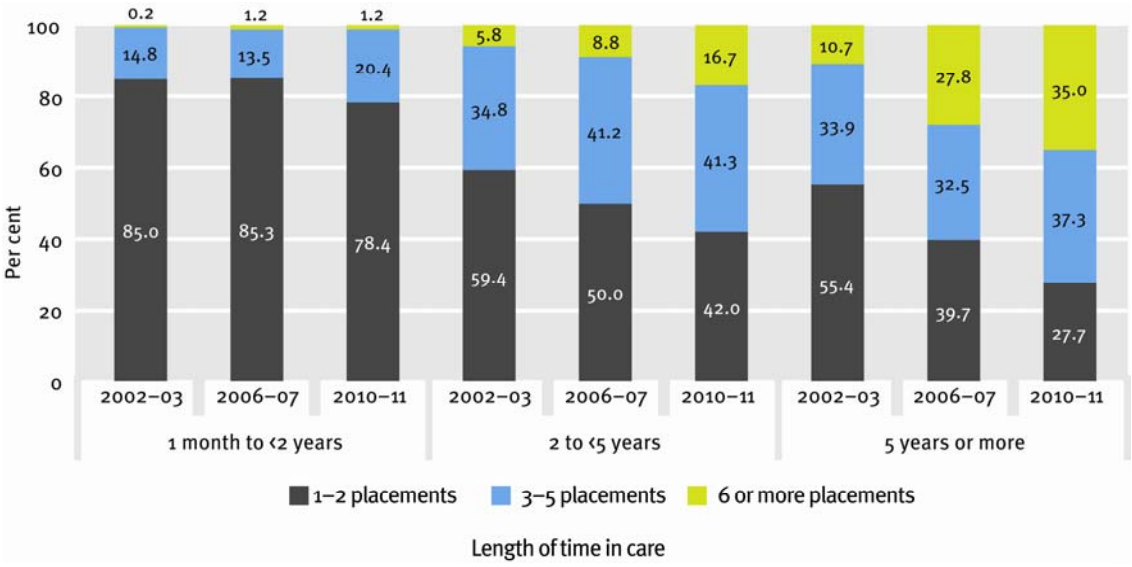
‘Moving placements affects you developmentally. Because you move around so much it affects your stability to build relationships, it affects your self-worth, you feel like you are being chucked around.’

‘Shifting foster carers and CSOs make it unstable. It affects schooling, relationships … everything. You’re constantly watching your back and never let anyone in your heart.’

Publicly available statistics about departmental placement trends are limited, and the Commission has sought additional unpublished data from the department to explore the topic of stability and reunification in more detail. Measures such as the length of time a child or young person spends in care, and the number of placements the child or young person has during care, are determined only at exit, leading to a delayed snapshot of the child protection system. In addition, data do not reveal a child’s progress through the system. For example, there are no reliable figures as to whether the benchmark periods of six, 12, 18 and 24 months for pursuing more long-term out-of-home placements are met. Furthermore, there is no available data on the number of reunification attempts.

Data that are available, however, show that placement instability tends to worsen the longer a child is in care (Figure 15).

**Figure 15: Children exiting out-of-home care by length of time in out-of-home care by number of different placements (proportions), Queensland, 2002–03, 2006–07 and 2010–11**




**Source:** Steering Committee for the Review of Government Service Provision 2012.

**Notes:** Includes all children exiting care who had been in care for one month or more and who had been on a child protection order at some point in the six months prior to exiting care.

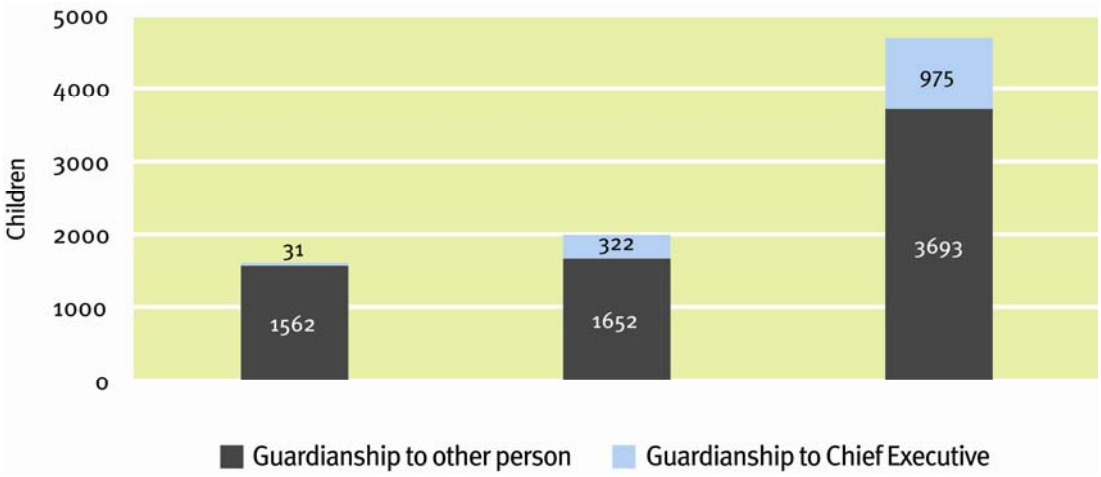
### 5.2.1 Options for consideration

#### Increased use of long-term guardianship to another

A long-term guardianship order enables a child to be placed more permanently. Building on this notion, long-term guardianship to someone other than the chief executive is more likely to increase placement stability than if the child's guardian is the chief executive. The Child Protection Act itself only enables granting of long-term guardianship to the chief executive if the court cannot place the child in the guardianship of another (s 59(7)(b)).

While it is encouraging that the number of children on long-term guardianship orders to another person has increased proportionally between 2001 (where 98 per cent of guardianship orders were to the chief executive) and 2012 (where 79 per cent of guardianship orders were to the chief executive), the number of children whose long-term guardian was the chief executive remains high (Figure 16).

**Figure 16: Children on long-term guardianship orders by guardian at 30 June, Queensland, 2001, 2006 and 2012**




**Source:** Department of Families 2003, p13; Department of Child Safety 2006a, p9; Statement of Brad Swan, 26 October 2012 [Attachment 4].

The Commission for Children and Young People and Child Guardian proposes that the majority of children and young people on long-term guardianship orders to the chief executive be transitioned to a person other than the chief executive as soon as possible. Applying this sort of approach, long-term guardianship orders to the chief executive would be reserved for children or young people with 'extremely challenging behaviours or disability'.[9]

The Commission has heard from some children and young people currently in care who have expressed a desire to remain living with their foster parents and to have those foster parents appointed as their long-term guardians. One 12-year-old girl indicated that she wished to remain with her foster family, a family she had been living with for the last 10 years. She was keen for her foster parents to become her long-term guardians.[10] However, according to her, the Department of Communities, Child Safety and Disability Services did not accede to this request.

Another child expressed a desire for her foster parents to become her long-term guardians so that they could 'be a family' and to ensure that the foster parents had greater autonomy in decision-making about her care without having to seek approval from the department.[11] These experiences are not isolated. In 2010, the Commission for Children and Young People and Child Guardian (2010, p ix) noted that many children wanted their carer to become their long-term guardian but felt that their wishes were not being listened to.[12] However, the same report noted that more than 40 per cent of children and young people wanted to see their birth family more often (2010, p ix). The Commission for Children and Young People and Child Guardian (2006a) has previously stated that a systemic investigation is needed to determine why the Childrens Court grants such a high percentage of guardianship orders to the chief executive, as opposed to others.

The Queensland Law Society takes a slightly different stance, submitting that the reunification obligation contained in the Child Protection Act could be strengthened in

favour of a child's biological parents (Department of Communities 2011b). The society also suggests that, given the 'seriousness and significance of these orders for children and their families', there should be 'capacity for a magistrate to determine that a particular application is so complex and serious that it should instead be heard by a judge'[13] (refer to Chapter 10 for further discussion of court processes).

It is unclear why long-term guardianship is most often granted to the chief executive, rather than to another.

**Question 12**

What are the barriers to the granting of long-term guardianship to people other than the chief executive?

## A new option – between long term guardianship and adoption

Concerns have been expressed to the Commission that long-term guardianship orders, both to the chief executive and to others, are not having the intended effect of providing a child with sufficient stability. It has been argued that they do not offer the requisite stability because they may be 'contested in court by birth families on an ongoing basis'.[14] This is said to impede a child's bonding with both the foster carer and their family.[15] Furthermore, long-term guardianship orders terminate on the child's 18th birthday. An alternative provided for in the Child Safety Act is that a child may be legally adopted (s 51Y(3)(c)).

Adoption is a controversial option which divides the community. Past practices of forced adoption, particularly in the Aboriginal and Torres Strait Islander community but also in the wider population have caused mistrust of adoptions generally. Humphreys (2012, p6) characterises it in the following manner:

> Children whose families reported members being forcibly removed show two to three times the social and emotional problems of those who were not removed. The fact that such actions by the state were rationalised as being in 'the best interests of the child' and that a destructive policy was vaporised through the mainstream mores of the times does little to assuage current concerns. In fact, it may well contribute to the continued wariness of adoption in the Australian context.

A number of parliamentary and law reform commission inquiries in the last 15 years have exposed and condemned past forced adoption practices in this country.[16] However, many submissions to the inquiry have argued that an adoption order with lifetime duration, enabling the child to 'belong to'[17] and inherit from adoptive parents, would be a preferable option in some cases.

In practice adoption is rarely considered by the department. As set out in the

Commission's *Options for reform* paper, in the 2010–11 financial year a total of 384 adoptions were finalised in Australia. Of the 384 adoptions, 169 of those children already lived in Australia before being adopted. Of those 169 children who already lived in Australia, five were adopted in Queensland (Queensland Child Protection Commission of Inquiry 2012). The remaining 215 children were adopted from overseas.[18] These data arguably support a submission by National Adoption Awareness Week,[19] and evidence given to the Commission by Mr Robert Ryan,[20] that adoption is under-used in Queensland in respect of children in care.

FamilyVoice Australia has called for adoption 'to be given more prominence as an appropriate solution for the long-term care of children who cannot be cared for by their biological parents'.[21] Barnados has submitted that government should create incentives to encourage adoption in Queensland, particularly 'open adoption',[22] a practice which enables biological parents and children to remain in limited contact despite the fact that the child has been adopted. The Royal Australian and New Zealand College of Psychiatrists has sought for adoption policies to be 'revisited and reviewed', given that adoption can give a child 'permanency' and 'an increased sense of belonging'.[23]

Others have warned against widespread use of adoption in the system. Professor Clare Tilbury argues that 'adoption should be an option, but shouldn't necessarily be the preferred option'.[24] Similarly, Mr Robert Ryan notes that adoption should be considered as part of a 'suite of options available' for out-of-home care.[25] Dr Stephen Stathis argues that only when intensive family support has failed should a child be removed and permanently placed elsewhere.[26] Professor Karen Healy for the Australian Association of Social Workers (Queensland) gave evidence that, since young people will often seek to return to their biological family after their exit from the care system, long-term guardianship is usually the more appropriate option, and 'under no circumstances, closed adoption'.[27] Ms Corelle Davies argued that, given restrictions placed on overseas adoption, there is an 'opportunity, especially for the under five-year-old cohorts, to stably place and potentially adopt out the younger children', but only in specific circumstances.[28]

It is important to note that no one has advocated, nor does the Commission propose, substantial changes to the Aboriginal and Torres Strait Islander Child Placement Principle. That principle states that, where out-of-home care is required for Aboriginal and Torres Strait Islander children, alternative care should be sought from the child's extended family, the child's local Aboriginal or Torres Strait Island community, and other Aboriginal and Torres Strait Islander people (in that order) (O'Halloran 2006, pp297–8).[29] Issues and challenges relating to the Child Placement Principle are discussed in more detail later in this chapter.

A decision to pursue adoption for a child in care cannot be taken lightly. Executive director of Child Safety, Mr Brad Swan, noted that:

> It is a very significant decision to make an adoption order for a young person that may have come into care. Adoption severs the rights, the parental rights and

> responsibilities, and also … severs that relationship with their siblings.[30]

As experience in the United States has shown, some children have been left in a situation where they have been 'freed for adoption but not chosen' by any adoptive parents (Cashmore 2001), which means the child is left 'in limbo'.[31] As at 30 September 2011, 104,236 children and young people were waiting to be adopted in the United States, and in 59 per cent of cases the rights of the biological parents had already been terminated. On average, children and young people waited 23.6 months between their parent's rights being terminated and finding adoptive parents (Children's Bureau 2012, p1).

The Commissioner for Children and Young People and Child Guardian, has argued that:

> … while adoption is a potential long-term option, and may reduce the strain on the tertiary system, such decisions must be made in the best interests of the child and other considerations, such as the child protection system workload, are extraneous and obtuse reasons for hastening any decision favouring adoption, given the potential long term impacts for children and families.[32]

Such comments are not isolated; attempts to refocus child protection systems on adoption are often seen as attempts by governments to reduce overall costs by shifting the burden to the private arena.[33] Financial disincentives may indeed discourage foster carers and long-term guardians from adopting children in their care (Cashmore 2001). A comparison of government financial assistance entitlements for adoptive parents and foster carers is outlined in Table 2, showing that adoptive parents stand to lose a series of allowances and benefits that offset the expenses of caring for a child.

Table 2: Comparison of government financial assistance available to adoptive and foster parents, selected jurisdictions

| Jurisdiction | Payment type | Eligibility | |
|---|---|---|---|
| | | Adoptive parent | Foster carer |
| Queensland | Fortnightly caring allowance | No | Yes |
| Queensland | One-off start-up allowance | No | Yes |
| Queensland | One-off establishment payment | No | Yes |
| Queensland | Fortnightly high-support needs allowance | No | Yes |
| Queensland | Complex support needs allowance – levels 1–3 | No | Yes |
| Queensland | Child-related costs reimbursement[1] | No | Yes |
| Commonwealth | Paid parental leave | Yes[4] | No |
| Commonwealth | One-off baby bonus | Yes[5] | Yes[6] |
| Commonwealth | Family Tax Benefit A and B[2] | Yes | Yes |
| New South Wales | Annual post-adoption allowance[3] | Yes | No |

**Source:** Compiled by Queensland Child Protection Commission of Inquiry.

**Notes:** 1 Provided for significant or ongoing costs that are specific to the child's individual needs over and above the financial support provided in the fortnightly caring allowance and the high-support needs allowance (Department of Communities 2011c, p11).
2 Income-tested.
3 Reduced in 2011 from about $16,000 per annum to $1,500 per annum: *Hansard*, New South Wales, Legislative Assembly, 9 November 2011, pp7235–8.
4 Pursuant to *A New Tax System (Family Assistance) Act 1999* (Cth), s 36(5).
5 Provided the child is under 16 years when he or she is entrusted to the care of the adoptive parent: *Parental Leave Act 2010* (Cth), ss 274–275.
6 If the baby comes into the foster parent's care within 26 weeks of the child's birth.

On a practical level, Associate Professor Cashmore observes that caseworkers do not always 'have the time and skills or the necessary supervision' to develop and implement plans for particular children to be adopted (Cashmore 2001, pp226–7).

However, part of the wider community's resistance to adoption may be because people are unaware of the manner in which adoption laws have recently evolved. Since 2009, Queensland's adoption laws have provided for 'open adoptions', which allow for the adoptive child and the birth parents to know one another. These contemporary practices are said to have overcome many of the previous problems of adoption (Tregeagle et al. 2012). The degree of openness can be settled through the agreement of an 'adoption plan' between the adoptive parents and the birth parents.[34] This change in practice recognises that 'children benefit from knowing their birth parents and the circumstances of their adoption'.[35] On the other hand, 'open adoptions' may be less attractive to some prospective adoptive parents than traditional forms of 'closed adoption' (Quartly & Swain 2012).

The commentary above indicates that significantly increasing the use of adoption in the care system in its present form would be widely opposed. However, adoption is a 'changing institution' (Rushton n.d.). While much of the above commentary highlights the need for caution, it nevertheless suggests that a new form of permanent placement

order, somewhere on the continuum between a long-term guardianship order and adoption, could be in the best interests of many children in the care system. The Commission suggests that the challenge for Queensland is to develop a new form of permanent placement option which would be attractive to prospective parents while at the same time being in the best interests of the child. Unlike long-term guardianship, adoption lasts for life, arguably increasing emotional security for the child and ensuring stability and continuity for transition to adult life.

Rushton points out that there are particular challenges in placing children from the care system with adoptive parents, given their often complex needs and behavioural difficulties (p12). But these challenges could be ameliorated if ongoing support was provided, similar to that available in the care system. In appropriate cases, there should also be continuing contact with the birth parents and siblings, and services should also be available to mediate these relationships.

Forensic social worker Grant Thomson[36] and Foster Care Queensland[37] have suggested that the department should have at its disposal a compromise order between long-term guardianship and adoption. Not dissimilarly, the Department of Child Safety in 2006 developed a proposal for a 'Permanent Parenting Order.' That proposal was limited however because the order was to only have effect until the child turned 18, and there was to be no ongoing monitoring by the department and no financial assistance.

**Question 13**

Should adoption, or some other more permanent placement option, be more readily available to enhance placement stability for children in long-term care?

## 5.3 Case planning and management

As outlined in Chapter 2, all children who have been assessed as being in need of protection must have a case plan. Case plans must be reviewed regularly.

The *Child safety practice manual* outlines that under the case plan, the child safety officer should:

- build positive relationships and engage with children, families and service providers
- monitor whether the parents are undertaking their agreed responsibilities, as recorded in the case plan, to meet the child's needs
- undertake goal-directed visits with the child and parents
- regularly visit the carer and support the placement, if relevant

- manage family contact for the child, including a clear plan for reviewing and increasing family contact over an appropriate timeframe, when the child is to be reunified with their family
- interact in a culturally appropriate way with Aboriginal and Torres Strait Islander children, families and communities and recognised entities,[38] and ensure that:
    - the recognised entity is given an opportunity to participate in the decision-making process for all significant decisions, and consulted for all other decisions
    - Aboriginal or Torres Strait Islander children are placed in accordance with the child placement principle
- interact in a culturally appropriate way with other cultural groups or communities
- facilitate and support the parent to work towards the actions and outcomes assigned to them
- complete the actions assigned to Child Safety in the case plan
- ensure that the case plan actions are coordinated
- liaise with other service providers as required
- undertake court-related tasks, if required
- place the child in out-of-home care, if required, and support the child and carer for the duration of the placement
- use professional judgement and all information gathered during implementation to regularly assess progress towards the case plan goal, and the appropriateness of the goal and outcomes
- record information about all activities with the child, family and carer in the Integrated Client Management System (Department of Communities, Child Safety and Disability Services 2012c, Chapter 4).

The advisory group to the Commission raised concerns about the level of case management skills of relevant Child Safety staff and advised that significant improvements in case management skills of child safety officers would result in better outcomes for children and families.

One impediment to effective case management is high turnover of staff. The retention of skilled staff has been identified frequently in evidence and submissions received by the Commission as a key problem facing the tertiary child protection system in Queensland. Currently within Child Safety, a family engaging in ongoing intervention will probably have contact with multiple case managers during the life of their involvement with the department:

> Due to Child Safety staff workloads and high turnover, it is not uncommon for an officer to have minimal knowledge about a child's circumstances, behaviour and needs. This has resulted in instances where children have remained, to their detriment, in a placement well beyond the original agreement.[39]

Unfortunately, staff turnover is one of the matters raised with the Commission as a shortcoming of the workforce. The forging of relationships between children in care and their case worker increases stability and improves outcomes for children in out-of-home care (Bromfield & Osborn 2007). In the current system this is undermined by the high rates of turnover. In addition, the problem of administrative tasks absorbing time that could be spent providing casework to families has also been raised. Excessive workloads, high administrative burdens and bureaucratic constraint prevent professionals from using their skills and carrying out their commitment to the welfare of children in the care system (Anderson 2000). These factors have been linked to emotional exhaustion and worker burnout and will be discussed further in Chapter 8.

A consistent case manager is a key factor in enabling strong working relationships with children, young people, families and carers, along with partner agencies and stakeholders (Queensland Child Death Case Review Committee 2011). Children in care themselves identify that the lack of stable support is a fundamental problem. The CREATE Foundation consultation report quoted children and young people in out-of-home care as saying:

> One of our workers told me five times she was coming to visit and didn't show up once out of the five times.
>
> Constant changing of CSOs limits the understanding and progress of your situation.
>
> I feel as if case workers don't take the time to connect with the young person and that they don't have an understanding of the young person.
>
> Some CSOs are good, some are bad, some of them are low lifes, some of them are just interested in the money they can make.
>
> Caseload too busy – employ more workers on a long-term basis.[40]

A further complexity for the case management of families is that they typically have multiple and complex needs requiring specialist intervention by a range of government and non-government agencies and professionals (Department of Communities 2009):

> The prevalence of multiple family and parental issues, combined with the complex needs of the children, highlights the challenge faced by the child safety service system in responding to complicated family situations and the need for an effective, coordinated multi-disciplinary response (Queensland Child Death Case Review Committee 2011).

The Child Death Case Review Committee annual reports consistently identify that coordination of multiple agencies to deliver services to vulnerable children and families through cross-agency communication, collaboration and planning is essential if positive outcomes are to be achieved (Queensland Child Death Case Review Committee 2009, 2010, 2011). The report for 2009–10 highlighted the need for the

child protection system to establish more intensive, diverse and specialised service delivery to meet the complex needs of young people (Queensland Child Death Case Review Committee 2010).

The Commission is unaware of any formal evaluation of current casework methods or of family intervention services provided by funded non-government organisations. However, the high re-substantiation rate is potentially one indicator that the current casework methods are less than effective (see section 4.2.3). Feedback from frontline Child Safety staff corroborates this. In summary:

- the burden of high caseloads reduce the capacity of workers to respond in a planned way to the complex needs of children and families
- the inability to backfill positions means full caseloads may be unallocated when staff are on leave
- the volume of forms and templates, duplication of administrative work and lack of administrative support prevent staff from performing casework functions (such as visits to children)
- there is a culture of blame so that child safety officers and team leaders are 'hauled into reviews' if something goes wrong, resulting in risk-averse practices
- there is a lack of professional development opportunities, inadequate supervision and no time to debrief.[41]

A survey of frontline child protection staff conducted by the Commission led to similar findings:

- 55 per cent of respondents indicated that the supervision they received was mainly administrative in nature
- 47 per cent of respondents indicated that when they had acted in higher positions their substantive work commitments went unfulfilled
- 49 per cent of respondents indicated that they were concerned about confidentiality when accessing staff support services, including the employee assistance service
- 59 per cent of respondents indicated that the workload of administrative and court related tasks was not evenly balanced with service delivery to families
- 56 per cent of respondents indicated that they were unable to spend sufficient time working with children and families to build a productive relationship
- 70 per cent of respondents indicated that pressure to meet performance targets made it difficult to work with families; only 12 per cent or respondents stated that performance targets had no impact on their work with families
- 76 per cent of respondents indicated that additional administrative support would allow them more time to work with families; only 5 per cent of respondents indicated that this would not increase the time they had for casework

- 46 per cent of respondents indicated that they spent 70 per cent or more of their time undertaking administrative work.

Overall, staff indicated that high workloads, inadequate support, an unwillingness from senior management, partner agencies and non-government organisations to share the risk of keeping children at home or in 'creative placements', and no resources for non-custodial or guardianship cases, significantly impair the quality of their work with children and families.

The Commission has also received numerous submissions from individuals and organisations relating to the quality of case work within Child Safety. The following is a snapshot of some of the themes from these submissions:

- further training and development for Child Safety staff is required in child development, attachment and trauma informed practice[42]
- there is too much focus on evidence-gathering for court proceedings[43]
- child safety officers spend little time providing direct services to families[44]
- there is a lack of coordinated support for young people[45]
- there is a lack of localised cultural knowledge among Child Safety staff.[46]

Decision-making in child protection can be affected by the experience or inexperience of workers.[47] To retain staff long enough for them to gain experience, the department needs to ensure that inexperienced staff work alongside proficient practitioners to feel supported by the department.[48] The Commission has also heard that there are issues relating to caseload management in circumstances where staff are on sick or annual leave or resign from the organisation, resulting in situations where there are insufficient staff to manage cases in the service centre.[49] Burnout is also a significant factor affecting child safety officers and is exacerbated by high caseloads, excessive paperwork and compliance requirements limiting the amount of time staff can spend working with families.[50] Factors influencing the quality of casework and decision-making by child safety officers were discussed in Chapter 4.

These factors lessen the quality of services provided to children and families, and may result in children entering and remaining in the child protection system for longer periods of time.

### 5.3.1 Approaches to post-intervention family support in other jurisdictions

The two main systems used for providing child protection intervention for children and young people who have suffered abuse are intensive family preservation models and multi-disciplinary team models. Though the principles of the two systems overlap in some respects, there are differences bearing on their suitability for implementation in Queensland.

Intensive family preservation models were developed in the United States and include the 'homebuilders' model and the 'intensive family preservation' model. These models require caseworkers to have small caseloads and they are also encouraged to spend as much time as possible in the home environment, including outside business hours:

> Services are tailored to families' needs and can include counselling, life skills education, parenting education, anger management, communication and assertiveness skills as well as practical assistance (food, clothing, housing, transportation, budgeting) and advocacy with social or other services. (Kerslake Hendricks & Stevens 2012, p59)

In Victoria, the Child FIRST service was modelled on the 'homebuilders' form of intensive intervention. It aims to reduce the number of children entering out-of-home care and shift emphasis from funding alternative care to funding services to keep children safely in their family home (Campbell 1998). As noted in Chapter 3, Helping Out Families was modelled on the Child FIRST service.

Research on intensive family preservation models over almost 30 years has often yielded mixed results as to their effectiveness (Berry 2005). Tomison and Stanley (2001b, citing Ainsworth 1997) state:

> Australian evaluations of family preservation programs have been small in scale and fraught with methodological difficulties. [Ainsworth] concludes that until the evidence can be produced about the effectiveness of family preservation programs, there should be a combination of both family preservation programs and the traditional forms of family casework, used in practice.

Research also suggests that intensive family preservation models are not as successful for families where children are in out-of-home care (Forrester et al. 2008; Littell & Schuerman 1995).

Sharing some aspects of the intensive family preservation approach, multi-systemic therapy is a case management approach that has been previously implemented in Queensland. Multi-systemic therapy is a licensed model developed in the United States. This model primarily relies on a highly trained professional who provides most services for a family. The worker receives intensive supervision and guidance as they often see families a number of times a week, including on weekends.

After the 2004 Crime and Misconduct Commission Inquiry report on abuse in foster care, the Department of Child Safety funded a trial of multi-systemic therapy by the Mater Hospital in the Logan/Inala/Mt Gravatt area. The trial was expected to cost $600,000 per year for three years and provide services for 50 clients in a 12-month period. The average caseload was anticipated to be five clients per clinician per six months and included capacity for 24-hour 7 days per week on-call capacity for four clinicians (Department of Communities n.d.). Treatment lengths averaged between six and nine months, with families seen several times a week initially, and contact gradually reducing as progress occurred. Services were generally provided in the home and other places suggested by the family, but rarely in an office setting (Stallman et al.

2010).

Research suggests that the model provided positive outcomes for children and young people (for example, Swenson et al. 2009), but the significant cost associated with the program made it prohibitive to continue and the Department of Child Safety did not continue to fund multi-systemic therapy beyond the trial.

The Department of Communities, Child Safety and Disability Services funds non-government organisations to provide family intervention services. These services work with families subject to intervention with parental agreement, supervision orders, directive orders and short-term child protection orders with the aim of preventing further maltreatment or reunifying children with their parents. These services differ from agency to agency in their approach to working with families. However, they generally share many features of the intensive family preservation model, including intensive practical in-home casework, after-hours support and small caseloads. The intensive nature of the work undertaken by family intervention services means that they have very limited capacity, in some circumstances with a caseload of one family per worker.

## Multi-disciplinary teams

Tomison and Stanley comment that:

> Most states [in Australia] have renewed respect for the role of other agencies, and are seeking to engage in partnership throughout assessment and the family support phases of cases. A key aspect of this is cross-sectoral partnerships – vital when working with multi-problem families. Precautionary note: interagency collaboration and communication is exceedingly difficult to undertake successfully – hence the frequently reported difficulties and case 'mishaps'. To make it successful requires the development of formal and informal structures for information sharing and working together, and importantly, effective case coordination. (Tomison & Stanley 2001b)

Evidence suggests that children with mental health problems and disabilities, and families who are disengaged from the service system, especially benefit from case management by multi-disciplinary teams of health professionals and social workers (McDonald & Rosier 2011). In this model, team members work directly with family members in the home within their specialist field, while coordinating any additional services provided by other government and non-government agencies. Teams are responsible for a large number of cases collectively, rather than individual team members holding responsibility.

An example of this approach is the initiative Reclaiming Social Work, implemented in Hackney in the United Kingdom, involving the establishment of small, multi-skilled teams. The teams consisted of a consultant social worker, a social worker, a child practitioner, a clinical therapist and a unit administrator. The teams were intended to have greater autonomy and a shared understanding of and responsibility for their

allocated cases. An independent evaluation carried out in 2010 reported positive results. The report indicated that Hackney had lower rates of children re-entering the child protection system than its comparable neighbours and the national average. The report found that the overall cost of child protection services in Hackney fell by 5 per cent and was linked directly to a decrease in the number of children and young people in out-of-home care. A marked fall in the number of staff days lost to illness, along with improved placement stability and very low numbers of children in out-of-home care, contributed to the savings (Cross & Munro 2010).

There are a number of key principles guiding the effective operation of multi-disciplinary teams. Kerslake Hendricks and Stevens (2012), in their extensive international literature review, identify the following elements of effective practice with families who have had children removed, and families with complex problems:

- careful assessment, including thorough reading of all files, consideration of parental history (abuse, domestic violence, maltreatment, care, substance misuse, mental health problems) and listening to the child
- assessment of evidence of change and progress, and the family's capacity to sustain change
- successful engagement balanced with critical questioning
- intensive casework
- effective, regular supervision of workers
- effective multi-agency assessment and intervention
- a mix of intervention lengths and intensities, which should be culturally responsive and mindful of families' strengths and capabilities
- programs that are effectively targeted – and, when they are standardised for each participant, program integrity is required to ensure they are working as intended
- referral for specialist treatment (for example, to mental health services) (Kerslake Hendricks & Stevens 2012, p67).

### 5.3.2 Options for consideration

#### Case work function

The intensive family preservation models focus on the provision of intensive support to families. Initiatives operating under this framework typically require the case worker to have low caseloads, and the ability to be available after hours and to spend extended amounts of time in the family home. Although the literature indicates that these programs may have some positive effect, it appears that they are most effective in dealing with problems before children enter the tertiary system, and that, given their short, intensive nature, they may not be able to sustain longer term change in a family. When considered in the Queensland context, the implementation and ongoing costs of an intensive family preservation model would probably require significant and

unsustainable additional expenditure.

Multi-disciplinary team models focus on using the skills of a variety of professionals with joint management of cases. This model requires professionals to work collaboratively with clients, using their specialist area of expertise. Results from the Hackney model have indicated that it can be cost effective and lead to positive outcomes for children, young people and their families. As well, the evaluation of the initiative showed reductions in residential care use and placement instability, both of which are of significant concern in Queensland.

Comments from the Commission's advisory group indicate that, while there are positive signs from the evaluation, the Queensland context is quite different to the United Kingdom, with the Queensland child protection workforce coming from a variety of professional backgrounds whereas United Kingdom staff are mainly social workers. It was also suggested there are different reporting requirements: the United Kingdom has a stronger requirement for child safety staff to report abuse and neglect, and there are negative implications for employment for failure to comply.

The Commission has identified that the establishment of a multi-disciplinary team casework model may help to overcome some of the deficiencies in the current casework system. A review of submissions received by the Commission has not identified any submissions which investigate or propose this casework approach. The Commission is therefore interested in stakeholder views on the proposal outlined below.

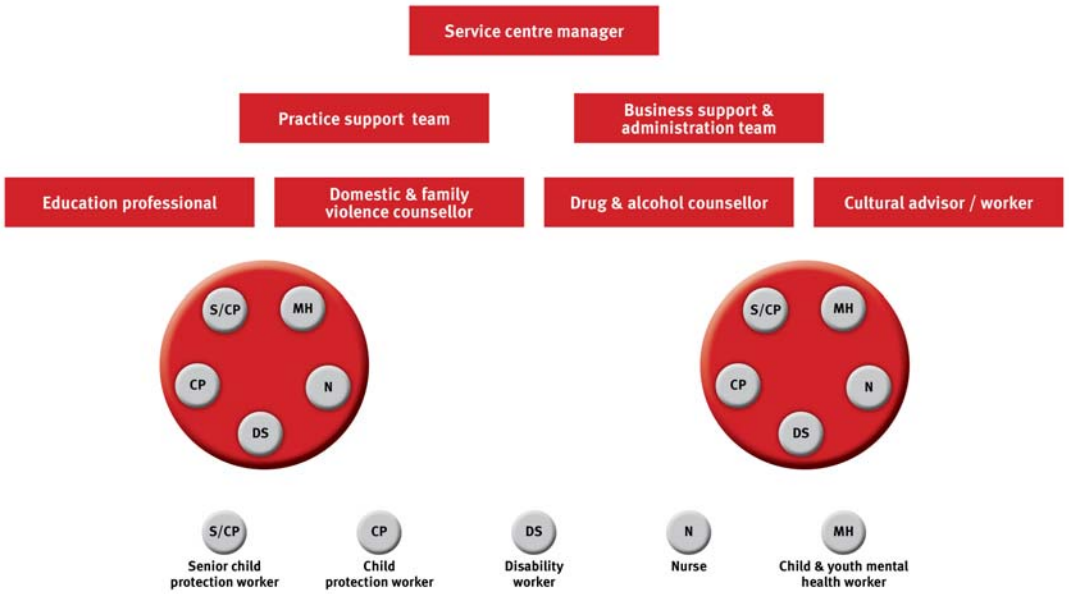
## A proposal for multi-disciplinary casework teams

A multi-disciplinary team model could be established in Queensland to provide direct service delivery to children and young people in the tertiary child protection system who have suffered abuse. The model would provide intensive casework to children and young people after the first occurrence of abuse. It would also draw on the skills of a range of individuals with the aim of reducing the likelihood of future abuse, and providing intervention and support to the young person to reduce the long-term impact of past maltreatment.

The multi-disciplinary casework team model would consist primarily of human service professionals (social work and psychology) with experience in child protection, a child and youth mental health worker, a qualified nurse and a disability worker. In addition to these team members, professionals from education, drug and alcohol counselling and domestic violence counselling, together with an Aboriginal or Torres Strait Island cultural worker, would be based locally and be available to provide intervention to families across multiple casework teams and advice on their areas of expertise. In this model, these teams would provide both professional case management and direct service delivery to families. The model also includes business and administrative support functions and a team of non-professional officers to provide support to the casework teams in a similar role to child safety support officers.[51] Figure 18 shows an

example of a service centre staffing structure using this approach.

**Figure 17: Child Safety Service Centre with multi-disciplinary casework teams and professional casework support**




The benefit of including professionals from a variety of backgrounds is that, in addition to being able to provide direct services to families based on their professional expertise, they are also able to better navigate other government and non-government systems. For example, a nurse may be able to efficiently and effectively navigate the health system, while an education professional may be better at accessing the education system. This would improve outcomes for children and their families by enabling services from multiple systems to provide streamlined support.

Although multi-disciplinary casework teams could provide an increased level of direct casework compared with the current system, there would continue to be insufficient capacity within Child Safety to deliver a comprehensive casework response to families without services provided by grant-funded non-government agencies. Implementation of this model would require increased funding to non-government service providers to ensure that services are available and appropriately targeted to work in collaboration with casework teams.

It has been suggested that, although employment costs may be higher in the longer term with the recruitment of nurses and mental health professionals, the ability to manage greater risk with children remaining in the family home, rather than in foster care and residential care, would help to counterbalance these additional costs. The qualification requirements of the identified professionals, particularly those from education and mental health professions, would need to be determined. For example, it may be worth considering the cost and benefits of recruiting a registered

psychologist, rather than a counsellor and mental health nurse, in the role of a child and youth mental health worker.

Multi-disciplinary casework team members could be located together and report to a senior child protection practitioner with significant experience in child protection work. Locating team members together would ensure that information is easily shared. This could be further enhanced by team members using a common information system.

The multi-disciplinary team approach allows for a large number of cases to be managed by a team and allows risk to be spread across the team. It is anticipated that this would reduce risk-averse practice, as each case is the responsibility of the team rather than the individual. Casework teams would also improve support and mentoring for less-experienced team members. The introduction of the multi-disciplinary team model or an adaptation would need to be accompanied by a change in management and training strategy. It would also have impacts on the proposals set out in Chapter 8 of this Discussion Paper, which deals more broadly with workforce issues.

Implementation in Queensland could occur within the existing regional structure, with each service centre continuing to be responsible for a defined geographical area. Structures within Child Safety service centres would require some change. Primarily, the qualification requirements of child safety officers would change significantly over time. This would require a change in recruitment practices and a decrease in the number of child safety officers currently undertaking the case management role, given the addition of staff with nursing, mental health and disability backgrounds. Within this model, casework skills training would be required for all members of casework teams, particularly staff transitioning from current child safety officer, team leader and senior practitioner roles to roles within a multi-disciplinary team. This would ensure that all staff have the skills to be able to effectively work with children and families.

Senior child protection workers within teams could provide leadership to the team while also providing direct services to families. These roles could be filled by current team leaders and senior practitioners. Service centre managers could continue to provide leadership to the service centre and report to a regional director. The use of current senior practitioners in addition to current team leaders as senior child protection officers could allow for an additional team to be formed within service centres and a smaller allocation of cases across teams. The current duties undertaken by the senior practitioner role could be fulfilled by the three senior child protection workers and manager for the service centre. Given that team leaders and senior practitioners currently have similar experience and qualification requirements for their respective roles, training, mentoring and supervision would be the responsibility of the senior child protection workers in the team.

Part of this model would include regionally-based senior social workers, nurses and psychologists, who would be responsible for ongoing professional development and supervision and the provision of expert advice where required. The advisory group told the Commission that professionals such as social workers, nurses and psychologists

undertaking child protection work would benefit from professional supervision and development arrangements similar to those in Queensland Health. An alternative to this would be to refer to senior professionals within existing Queensland Government departments for professional supervision and development. This supervision would differ from operational supervision, which would be provided by leadership positions within the service centre, including senior child protection officers and the service centre manager.

The Commission expects that the execution of this model using multi-disciplinary casework teams could occur over a five-year period, commencing with the establishment of one team within each Child Safety service centre in the first year. The senior practitioner position could be transitioned into the senior child protection officer role and the remaining positions within the casework team could be filled as positions become available due to natural attrition. The initial casework team for each service centre would focus on coordinating and providing family preservation services to children and their families who have suffered harm and are at imminent risk of removal.

**Question 14**

What are the potential benefits or disadvantages of the proposed multi-disciplinary casework team approach?

## Separation of investigation teams from casework teams

If the proposal in Chapter 4 were adopted (see 4.4), multi-disciplinary casework teams would be separate from teams investigating allegations of abuse. Ideally, teams working with children, young people and their families would be located separately from investigation teams. It is envisioned that separating these teams would allow parents to engage more freely with the intervention without fearing that evidence is being gathered for use in court proceedings. The investigative teams would be responsible for investigation and assessment work and would require a broad range of qualifications, with a focus on investigative and forensic skills.

In this model, cases would be referred to a multi-disciplinary casework team from the investigative team after investigation and a decision being made regarding the most appropriate form of intervention.

**Question 15**

Would a separation of investigative teams from casework teams facilitate improvement in case work? If so, how can this separation be implemented in a cost-effective way?

## 5.4 Flexible and appropriate placement options

Effective case management of children in out-of-home care necessitates access to a range of placement options. An overview of the out-of-home care system is set out in Chapter 2. Currently, placement options for children in out-of-home care are:

- family based:
  - foster care
  - kinship care
  - intensive foster care
  - specific response care
- non-family based:
  - residential care
  - therapeutic residential care
  - supported independent living
  - safe houses.

### 5.4.1 Issues associated with family-based care

A submission from Child Safety outlines several key issues relating to the provision of family-based options for children in out-of-home care.[52] These include the recruitment and retention of volunteer carers, relating to:

- demographic and social factors such as changing patterns of family life
- an aging population
- increased cost of living
- increase in women's participation in paid employment.

These have reduced the number of volunteer carers available to provide care for children who cannot remain in their own homes. Compounding this decrease in supply of carers, there has been an increase in the complexity of the needs of the children and families entering the child protection system. The department has identified that

researchers are now recommending a move to professional carers who are well-trained and well-paid.

It is acknowledged that the increasing numbers of children in out-of-home care and the limited number of foster carers has led to a situation where it is increasingly difficult to locate a family-based placement for children requiring out-of-home care.[53] In situations where placements with the child's kin or a generally approved foster carer cannot be secured, children are typically placed in residential care or in other non-family based settings. In particular, where there is no grant-funded residential care available, a placement is funded on a fee-for-service basis at significant cost.

These problems facing the family-based care system will be further explored by the Commission in the final months of its work.

## Issues associated with kinship care

The problems of finding suitable, willing carers is even more complex when dealing with Aboriginal and Torres Strait Islander children and young people. A strong link with family, community and culture is central to the long-term health and wellbeing of Aboriginal and Torres Strait Islander children (Human Rights and Equal Opportunities Commission 1997, Royal Commission into Aboriginal Deaths in Custody 1991). Severing these connections has been associated with a wide range of adverse consequences across the lifespan, including high rates of mental health problems, drug and alcohol abuse, child protection and criminal justice system involvement, and suicide.

The Commission has been repeatedly told, through its consultations and submissions, of the importance to Aboriginal and Torres Strait communities of having their children cared for by family members. The Commission has also been told that where this is not possible, children should not miss out on family and cultural connections or ongoing connection to their respective communities.

The Aboriginal and Torres Strait Islander Child Placement Principle is an important mechanism for preserving connections to family, community and culture for children placed in out-of-home care. The principle requires preference to be given to family members, family group placements and Aboriginal and Torres Strait Islander carers when placing an Aboriginal or Torres Strait Islander child or young person in care. It is recognised in either legislation or formal policy documents in all Australian jurisdictions (Australian Institute of Family Studies 2012).

The Child Placement Principle was first formulated by Aboriginal and Islander Child Care Agencies in the mid-1970s amid concerns about the large number of Aboriginal and Torres Strait Islander children being cared for by non-Indigenous carers. The principle recognises the importance of the extended family, kinship arrangements, culture and community in the raising of Aboriginal and Torres Strait Islander children (Queensland Aboriginal and Torres Strait Islander Child Protection Peak 2012).

The principle was placed in legislation as a result of extensive consultation with both the Aboriginal and Torres Strait Islander community and the broader sector, and to comply with Queensland's obligation to do so in response to the recommendations of the Royal Commission into Aboriginal Deaths in Custody. All states were required to implement the principle.

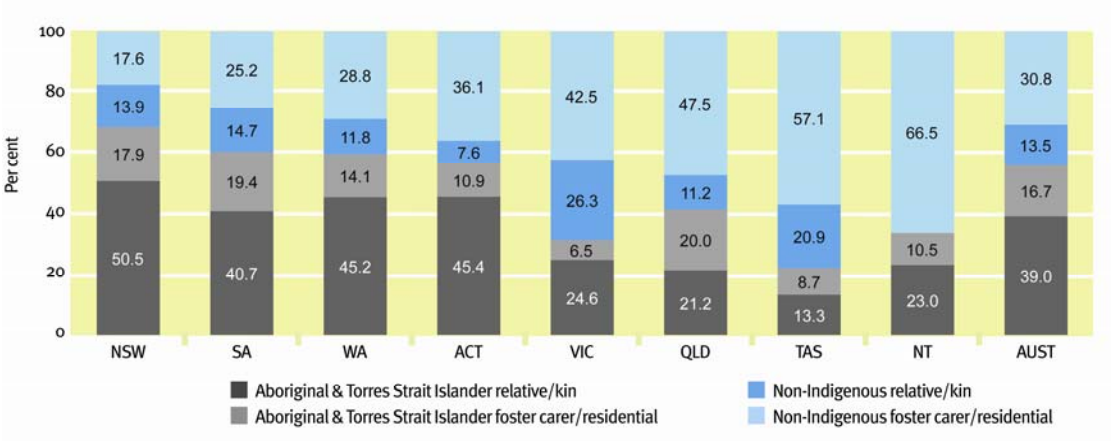
In Queensland, the Child Placement Principle is enacted in s 83 of the Child Protection Act. This section of the Act states that when making a child placement decision, proper consideration should be given to placing the child, in order of priority, with:

- a member of the child's family
- a member of the child's community or language group
- another Aboriginal or Torres Strait Islander person who is compatible with the child's community or language group
- another Aboriginal or Torres Strait Islander person.

The Act also requires that when making a placement decision regarding an Aboriginal or Torres Strait Islander child, proper consideration must also be given to the views of a recognised entity and ensuring the decision allows the child to retain their relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom. Before a child is placed with non-Indigenous carers, proper consideration is also to be given to the carer's commitment to maintaining and enhancing the child's connection to family, community and culture.

Currently, Queensland is placing only 52.4 per cent of Aboriginal and Torres Strait Islander children in accordance with the Child Placement Principle – well below the national average of 69.2 per cent (see Figure 19). Two audits by the Commission for Children and Young People and Child Guardian have found deficiencies in the department's processes for complying with the Child Placement Principle, particularly in the recording of placement decisions (Commission for Children and Young People and Child Guardian 2008, 2012d).

**Figure 18: Aboriginal and Torres Strait Islander children in out-of-home care by Indigenous status and relationship of caregiver (proportions), states and territories, 30 June 2011**



**Source:** Steering Committee for the Review of Government Service Provision 2012

The Commission has also heard in its consultations about the concern of many community members regarding a lack of appropriate cultural planning for Aboriginal and Torres Strait Islander children placed outside the Child Placement Principle. As stated by one parent of a child on a child protection order:

> Saying my child can attend NAIDOC week is not a cultural plan.[54]

A number of community consultations and submissions have called for increased scrutiny of cultural planning at both an individual and systemic level. In the coming months, the Commission will review a series of case files to gain an insight into the complexity of case management and planning, including an analysis of cultural support plans for Aboriginal and Torres Strait Islander children in out-of-home care.

The Aboriginal and Torres Strait Islander Kinship Reconnection Project was established in 2008, amid concerns about the increasing over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system and the lack of compliance with the Child Placement Principle (Testro 2010). The project made 28 recommendations to improve the services provided by Child Safety and Aboriginal and Torres Strait Islander child protection services. Some of these recommendations were to:

- clarify the respective roles and responsibilities of the recognised entities, family support services and foster and kinship care services in identifying and confirming family, community and cultural information
- enhance the role of the Aboriginal and Torres Strait Islander identified child safety support officer position
- review the arrangements for assessment, planning, delivery and review of interventions to ensure they are culturally responsive
- develop service system capacity to identify, assess and support family members who are willing and able to provide kinship care
- develop short-term placement and support options while family members and potential kinship carers are found and assessed
- increase the availability of culturally appropriate placement and support services.

The Department of Communities, Child Safety and Disability Services has reported that a reconnection project is currently in place in the South West Region, in partnership with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak that aims to increase compliance with the Indigenous Child Placement Principle.[55] Research by the Australian Institute of Family Studies has also identified a range of factors that are placing pressure on the ability to identify and place children with Aboriginal and Torres Strait Islander carers in accordance with the Child Placement Principle (Bromfield et al. 2007). These factors include:

- a disproportionately high number of Aboriginal and Torres Strait Islander children

in care and an increasing trend for children to remain in care for longer periods

- the relatively small proportion of adults in the Aboriginal and Torres Strait Islander populations
- approved carers already caring for multiple children
- willing and otherwise capable adults not having the financial or other resources to be able to provide care or due to over-crowded housing
- carers ageing out of the system or being 'burnt out' by attempting to meet growing demand
- potential carers being unable to provide care due to personal and parenting challenges in their own families.

It has been stressed that the shortage of Aboriginal and Torres Strait Islander carers is not due to a lack of willingness to care. It has been pointed out that Aboriginal and Torres Strait Islanders are more likely to be caring for a child in out-of-home care than their non-Indigenous counterparts (Bromfield et al. 2007). In fact, in its submission to the Commission, Child Safety has noted that Aboriginal and Torres Strait Islander adults are about five times more likely than non-Indigenous adults to be carers. During its inquiries, the Commission has been told that there is a range of systemic factors in Queensland's system that are making it difficult to recruit and place children with Aboriginal and Torres Strait Islander carers. The Aboriginal and Torres Strait Islander Women's Legal and Advocacy Service has expressed a view shared by a number of legal advocates that part of the problem is a lack of proper regard for the importance of the Child Placement Principle:

> Departmental staff are not giving serious consideration to the child placement principle. In our experience exploration of appropriate family members is often limited to asking parents to nominate a person who they think would be willing to take the child/ren into their care.[56]

A number of stakeholders have also commented that Aboriginal and Torres Strait Islander people can be reluctant to seek carer approval because they find the assessment process intimidating. Some potential carers have reported feeling that their own ability to care for their children is being scrutinised during the process. The fear and indignity experienced by some potential carers in the assessment process is illustrated in the follow statement received by the Commission:

> I found the whole process of applying to be a kinship carer very intimidating. The people from the department were not helpful and treated me with suspicion, I felt like I was treated differently because I was Aboriginal. I felt like that they thought that I was a 'dumb Abo'... I have worried that they might try to find things to take my own children away.[57]

The state's working with children criminal history check, or blue card system, has also been identified as a significant barrier to carer recruitment. There appears to be a widespread belief that carers are being, or will be, denied blue cards as a result of past and relatively minor offences or involvement with child protection services.[58] In its submission to the Commission, Child Safety has commented that while the majority of

Aboriginal and Torres Strait Islander applicants for a blue card have been successful, including many applicants with convictions for minor offences, the following barriers have been identified by the department:

- lack of personal identification documentation, particularly for those in remote communities
- language barriers for those Aboriginal and Torres Strait Islander applicants whose first language is not English
- those applicants with some form of criminal history are required to complete a lengthy and legalistic additional form that can prove onerous and complex
- lack of information about blue cards and, for those in remote locations, lack of support to apply
- the composition and fluidity of Aboriginal and Torres Strait Islander households may make it difficult for all members of the household to apply for and be issued with a blue card.[59]

It is not possible at this time to quantify the extent to which the assessment and blue card processes are preventing people from applying for carer status.
It has been suggested to the Commission that improving the range of placement options for children, particularly for children in remote communities, may help improve compliance with the Child Placement Principle and avoid the unnecessary removal of children from the community. The wider use of Safe Houses and residential style placements for new mothers have been put forward as two such options.[60]

The benefits of these models in terms of preserving connections have been described in a number of local consultations and submissions.[61] The Commission has been told that Safe Houses are allowing children to remain safely in communities while assessments are undertaken and safety concerns addressed. This is said to be reducing the need for unnecessary removals and increasing the likelihood of reunification. Safe Houses may also have the benefit of giving children removed from community a safe place of return for significant community and cultural events.

The Commission has been told that Safe Houses need to operate in conjunction with intensive family intervention services to support family reunification.[62] Without these services, children are prone to spending prolonged periods in care and are ultimately still being removed from community. The difficulties recruiting and maintaining suitable workers to these roles in some locations has also been noted.[63]

**Question 16**

How could case workers be supported to implement the child placement principle in a more systematic way?

### 5.4.2 Issues associated with residential care

Residential care providers are funded to provide care to young people in residential premises by paid or contracted workers and/or volunteers. The services predominantly involve small group care (up to six places) and are primarily for children aged 12 to 17 years. There are also provisions for residential care facilities to accommodate sibling groups or individual placements. Agencies are funded to provide places based on the complexity of the placement provided. Currently in Queensland, 8 per cent of children in out-of-home care are in residential care (Department of Communities, Child Safety and Disability Services 2012a).

A focus of particular attention for the Commission recently has been the operation and effectiveness of residential care as an out-of-home care option for older children with more complex needs. As at 30 June 2012 approximately 770 children resided in residential care, therapeutic residential care or safe houses, representing approximately 9 per cent of all children in out-of-home care.[64]

The commission has heard evidence about issues relating to residential care that broadly fall into two categories:

- deficiencies in the therapeutic framework for residential care facilities and a subsequent increase in problematic behaviour by residents
- the high costs associated with providing residential care.

#### Lack of therapeutic care

Care facilities should no longer be places where children are simply housed; instead there is a consensus that the child's placement must serve a therapeutic purpose.[65] As Cummins, Scott and Scales (2012) have noted, it is accepted that 'simply removing children and young people from at-risk or untenable family circumstances and placing them in care does not of itself lead to an improvement in their wellbeing' (p236).

The Commission has heard evidence about a lack of therapeutic care in residential facilities, resulting in the therapeutic needs of children being largely unmet. These needs are often expressed through high risk behaviours,[66] described by one witness as follows:

> We've had situations where workers have locked themselves in offices for fear of being assaulted. We've had incidents where one child in particular, he used to urinate in glasses and throw that over the workers. He put a sharp nail through a stick and threatened a worker with that, attempted to put a fridge over on top of a worker, and these are what I say are extreme safety issues in relation to managing this young person.[67]

The Child Protection Act requires that the care service must have suitable training for people engaged in providing care (s 126(f)). Beyond this, Child Safety sets no minimum qualification requirements for residential workers. Instead, 'it is the responsibility of

residential care services to provide training to staff as needed to ensure quality of practice'.[68] Consequently, Child Safety's assessment of Queensland's out-of-home care sector in 2012 concluded that training in some parts of the sector was 'piecemeal', whereas in other parts it was highly developed.[69]

While children and young people considered by Child Safety to have moderate or high needs can be placed in residential care after the age of 12 years, the vast majority of children and young people in residential care are considered to have complex or extreme needs (Commission for Children and Young People and Child Guardian 2012a). Behaviour consistent with complex or extreme needs includes:

- engaging in unpredictable acts of physical aggression or anti-social behaviour
- destroying property
- self-injuring or attempting suicide
- running away with prolonged absences
- abusing alcohol or other drugs
- having developmental delay or a disability that impacts on daily living and self-care
- needing medical or physical care (Department of Communities 2010c).

The outcome of these behaviours, which can potentially place members of the public at risk, often leads to an increase in the criminalisation of young people in care when police are called to respond. It could be argued that workers with better training, together with the implementation of a better therapeutic framework, may prevent the involvement of police and the escalation of responses to problematic behaviour.

## Cost

The Commission has heard evidence suggesting that the cost of providing residential care in Queensland is too high, specially given the lack of evidence about positive outcomes for young people.[70] Table 3 shows the approximate amounts paid to residential care providers per placement per annum.

### Table 3: Residential care grant funding per placement provided to residential care agencies

| Placement complexity | Funding per place per annum |
|---|---|
| Moderate to high support needs placement | $92,605 – $104,952 |
| Complex support needs placement | $123,473 – $209,204 |
| Extreme support needs placement | $234,598 – $345,724 |

Source: Department of Communities 2010c

These costs include the full range of service and corporate governance costs, including:

residential accommodation (such as rental) costs, program management and support, staff supervision and legal and contractual compliance (Department of Communities 2010c).

In 2011–12, Child Safety spent approximately $94 million on grant funded residential placements, including therapeutic residential placements and safe houses for children and young people. In addition, $75 million was also spent on transitional placements.[71] By contrast, approximately $169 million was spent on grant funded placement options[72] and the fostering allowance for the remaining 91 per cent of children in out-of-home care.[73]

### 5.4.3 The need for more flexible options

In the long-term, the goal should be to reduce the number of young people requiring residential care through targeted early intervention services (see Chapter 3). However, in the interim, to the extent that there may always be children who are difficult to place, other care options need to be considered.

The Department of Communities, Child Safety and Disability Services has identified the need for a range of diverse placement options to meet the needs of children in out-of-home care:

> Despite the progress that has been made in Queensland since the implementation of the CMC Inquiry report recommendations to expand the range of available placement and care options, finding and maintaining an appropriate placement for a child in out-of-home care remains one of the most challenging issues for Child Safety Services.[74]

The department proposes that increasing the range of options currently available could be done by developing the existing mix of options, and by integrating placement and support services to provide a continuum of therapeutic care to children in out-of-home care.

#### Out-of-home care options that could be considered

One option for reform could be the development of a shared therapeutic framework for all residential care providers. The primary purpose of residential care facilities could change from providing a placement for children to providing a therapeutic response for children. Therapeutic responses acknowledge that many children in care have suffered from trauma or attachment issues (Cummins, Scott & Scales 2012). This knowledge informs practice within the residential care facility. The focus is on attending to children's needs and emotions instead of responding to their behaviour (Macdonald et al. 2012; Commission for Children and Young People 2012b). The residential surrounding is characterised by 'the absence of threats to safety', 'a positive social and emotional climate' (Commission for Children and Young People 2012b, p9) and stability (Ainsworth & Hansen 2009). Residential workers are committed to building 'respectful, consistent, reliable, nurturing and empathic relationships with their residents' (Commission for Children and Young People 2012b, p10).

Other jurisdictions, such as South Australia, already require workers in the out-of-home care sector to possess mandatory qualifications and complete mandatory training courses which enable workers to obtain a Certificate IV in Child, Youth and Family Intervention (Residential and Out-of-Home Care). There is support among some in the non-government sector for there to be minimum entry-level qualifications for residential workers.[75] A Certificate IV in Child, Youth and Family Intervention (Residential and Out-of-Home Care) may be a starting point in setting a minimum qualification for the Queensland out-of-home care sector.[76] However, given that residential care currently caters for children with predominantly complex and extreme behaviour, a more specialised workforce is necessary (Ainsworth 2007).

The Commission has heard evidence relating to the establishment of a therapeutic secure care model of placement, or a 'containment model'.[77] Secure care would place children in a purpose-built lockup facility[78] where therapeutic work would occur with the child to address trauma and associated self-destructive behaviours (Roesch-March 2012). Models of secure care have been established in other Australian jurisdictions including New South Wales and Victoria. The Department of Communities, Child Safety and Disability Services state that the use of secure care is controversial because it breaches an individual's personal rights and liberties while also acknowledging the state's ethical and legal obligations to actively intervene to change patterns of self-destructive behaviour in children in out-of-home care.[79]

An alternative model that may be cost-effective could be the re-establishment of large scale campus-based residential care services. It has been argued that intensive support may be best delivered in a large scale model of care with multiple professionals coming together on the same campus to provide services to residents. This model has been used extensively in North America but has been largely unexplored in Australia (McLean, Price-Robertson & Robinson 2011).

**Question 17**

What alternative out-of-home care models could be considered for older children with complex and high needs?

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[1] Transcript, Corelle Davies, 21 August 2012, Brisbane [p100: line 5].
[2] Transcript, Dr Elisabeth Hoehn, 8 November 2010, Brisbane [p10: line 38].
[3] Exhibit 118, Submission of Dr Jan Connors, 28 September 2012 [p12].
[4] Exhibit 131, Statement of Dr Anja Kriegeskotten, 17 October 2012 [pp9–10].
[5] See also Gelles 2005.
[6] Submission of Foster Care Queensland, 15 August 2012 [p64].
[7] Submission of (name suppressed), 19 September 2012.
[8] Exhibit 116, Statement of Dr Elisabeth Hoehn, 16 October 2012 [pp21–2].
[9] Submission of Commission for Children and Young People and Child Guardian, 21 September 2012 [p91].
[10] CREATE Forum, 30 October 2012, Ipswich.

[11] CREATE Forum, 30 October 2012, Ipswich.
[12] See also Commission for Children and Young People and Child Guardian 2006b.
[13] Submission of Queensland Law Society, 19 October 2012 [pp9–10].
[14] Submission of National Adoption Awareness Week, 7 December 2012 [p3].
[15] Submission of National Adoption Awareness Week, 7 December 2012 [p4]. See also Submission of Foster Care Queensland, 15 August 2012 [p93].
[16] See for example: Community Affairs References Committee 2012; Standing Committee on Law and Justice 2009; Victorian Law Reform Commission 2007; Standing Committee on Family and Human Services 2005; Community Affairs References Committee 2004; Standing Committee on Social Issues 2000; Joint Select Committee 1999; Human Rights and Equal Opportunities Commission 1997; New South Wales Law Reform Commission 1997.
[17] Submission of National Adoption Awareness Week, 7 December 2012 [p4].
[18] The Commission has received a number of submissions from individuals that relate to policies and procedures for inter-country adoptions. However, prospective adoptive children who reside overseas fall outside Queensland's Child Protection Act and are therefore outside the Commission's terms of reference.
[19] Submission of National Adoption Awareness Week, 7 December 2012 [p2].
[20] Transcript, Robert Ryan, 31 October 2012, Ipswich [p92: line 37].
[21] Submission of FamilyVoice Australia, 24 September 2012 [p4].
[22] Submission of Barnados Australia, September 2012 [p5]. See also Submission of City Women (Toowoomba), 24 November 2012 [p2].
[23] Submission of Royal Australian & New Zealand College of Psychiatrists, September 2012 [p24].
[24] Transcript, Professor Clare Tilbury, 28 August 2012, Brisbane [p30: line 34].
[25] Transcript, Robert Ryan, 31 October 2012, Ipswich [p92: line 41].
[26] Transcript, Dr Stephen Stathis, 7 November 2012, Brisbane [p30: line 37].
[27] Transcript, Professor Karen Healy, 29 August 2012, Brisbane [p95: line 42].
[28] Transcript, Corelle Davies, 21 August 2012, Brisbane [p100: line 25].
[29] *Child Protection Act 1999* (Qld) s 83(4).
[30] Transcript, Brad Swan, 13 August 2012, Brisbane [p82: line 11]. See also Transcript, Linda Apelt, 16 August 2012, Brisbane [p102: line 20].
[31] Transcript, Robert Ryan, 31 October 2012, Ipswich [p19: line 27].
[32] Submission of Commission for Children and Young People and Child Guardian, 29 November 2012 [p8].
[33] For example, Mrs Jann Stuckey MLA, *Hansard,* Queensland, Legislative Assembly, 18 August 2009, p1667.
[34] *Adoption Act 2009* (Qld) part 8.
[35] Explanatory Notes, Adoption Bill 2009 (Qld) p92.
[36] Exhibit 144, Statement of Grant Thomson, 26 October 2012 [p38: para 9.1 - p39: para 9.5]. In contrast to the Department's proposed PPO, Mr Thomson proposed that the compromise order would still be a level of "child protection order."
[37] Submission of Foster Care Queensland, 15 August 2012 [pp94-5].
[38] A recognised entity is an organisation or individual that is to be consulted by the department on decisions about Aboriginal and Torres Strait Islander children.
[39] Submission of UnitingCare Community, October 2012 [p14: para 58].
[40] Submission of CREATE Foundation, 'Consultation report for the Queensland Child Protection Commission of Inquiry', January 2013 [pp15–16].
[41] Focus groups undertaken by QCPCI with Child Safety staff, 2012.
[42] Submission of ACT for Kids, 'Child protection systems and processes', September 2012 [p7].
[43] Submission of Australian Association of Social Workers (Queensland), August 2012 [p8].
[44] Submission of Australian Association of Social Workers (Queensland), August 2012 [p5].

[45] Submission of Australian Association of Social Workers (Queensland), August 2012 [p5].
[46] Submission of Townsville Aboriginal and Torres Strait Islander Health Services, October 2012 [p24: para 4.28].
[47] Submission of Australian Association of Social Workers (Queensland), August 2012 [p10].
[48] Submission of Australian Association of Social Workers (Queensland), August 2012 [p12].
[49] Transcript, Alex Scott, 6 September 2012, Brisbane [p53: line 1].
[50] Transcript, Robert Ryan, 31 October 2012, Ipswich [p50: line 6].
[51] See Chapter 8 for a list of current frontline positions in Child Safety.
[52] Submission of the Department of Communities, Child Safety and Disability Services, December 2012 [p28].
[53] Exhibit 9, Statement of Brad Swan, 10 August 2012.
[54] Submission of Aboriginal and Torres Strait Islander Women's Legal & Advocacy Service, September 2012 [p9].
[55] Submission of the Department of Communities, Child Safety and Disability Services, December 2012[p106].
[56] Submission of Aboriginal and Torres Strait Islander Women's Legal & Advocacy Service, September 2012 [p6].
[57] Statement of Maneisha Jones, 26 September 2012 [p1: para 10-13].
[58] Exhibit 63, Statement of David Goodinson, 5 September 2012 [p5: para 22]; Submission of Aboriginal and Torres Strait Islander Women's Legal & Advocacy Service, September 2012 [p7]; Exhibit 88, Statement of Gregory Anderson, 5 October 2012 [p5: para 25].
[59] Submission of Department of Communities, Child Safety and Disability Services, December 2012 [p74].
[60] Submission of Aboriginal and Torres Strait Islander Women's Legal Service NQ, October 2012 [p15]; Submission of Aboriginal and Torres Strait Islander Women's Legal & Advocacy Service, September 2012 [p22]; Exhibit 79, Statement of Karl Briscoe, 8 October 2012 [p4: para 10.2]; Consultation with Apunipima Cape York Health Council (Cairns), September 2012.
[61] Exhibit 58, Statement of Joan McNally, 5 September 2012; Consultation with ACT for Kids (Cairns), September 2012.
[62] Consultation with Aboriginal and Torres Strait Islander Legal Service (Mount Isa), 18 October 2012.
[63] Exhibit 58, Statement of Joan McNally, 5 September 2012 [p6: para 38].
[64] Exhibit 9, Statement of Brad Swan, 10 August 2012, Attachment 12(f).
[65] Submission of Royal Australian & New Zealand College of Psychiatrists, Faculty of Child and Adolescent Psychiatry, Queensland Branch, 27 September 2012 [p22]; Submission of Anglicare Southern Queensland, 5 December 2012 [p11].
[66] Submission of Commission for Children and Young People and Child Guardian, 21 September 2012.
[67] Transcript, Philip Hurst, 4 February 2013 [p14: line 25].
[68] Statement of Patrick Sherry, 25 January 2013 [p4: para 59].
[69] Department of Communities, Child Safety and Disability Services (2012), *Mapping of Learning and Development (L&D) for Out-of-Home Care Sector: Project End Report June 2012* – Statement of Mr Patrick Sherry, 25 January 2013, Attachment 1.13 [p4].
[70] Statement of Bob Lonne, 16 August 2012.
[71] Statement of Brad Swan, 14 September 2012.
Transitional funding is a funding source that is used to engage non-government agencies to source a placement for a child on a fee for service basis. Transitional placements are individualised funding packages for children and young people who cannot be placed in grant funded placements due to capacity issues or their required level of support. In circumstances where a child leaves a transitional placement, funding to the non-government agency to provide the placement ceases.

[72] Grant funded placements are provided by non-government agencies who deliver support to foster and kinship carers and deliver residential care, therapeutic residential care, safe houses and semi-independent living. Non-government agencies are funded to provide a certain type and number of placements for children.

[73]Statement of Brad Swan, 14 September 2012.

[74] Submission of Department of Communities, Child Safety and Disability Services December 2012

[75] Submission of Benevolent Society, 17 January 2013 [p19]; Submission of PeakCare Queensland, 22 October 2012 [p54].

[76] Department of Communities, Child Safety and Disability Services (2012), *Mapping of Learning and Development (L&D) for Out-of-Home Care Sector: Project End Report June 2012* – Statement of Patrick Sherry, 25 January 2013, Attachment 1.13 [pp40-41].

[77] Submission of Mercy Family Services, December 2012; Statement of Peter Waugh, 26 September 2012; Submission of Royal Australian and New Zealand College of Psychiatrists, Faculty of Child and Adolescent Psychiatry, Queensland Branch, September 2012.

[78] Submission of Department of Communities, Child Safety and Disability Services, December 2012.

[79] Submission of Department of Communities, Child Safety and Disability Services, December 2012.