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TRANSCRIPT
OF PROCEEDINGS

THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

MS K McMILLAN SC, Counsel Assisting
MR M COPLEY SC, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

BRISBANE

..DATE 12/02/2013

Continued from 7/02/13

DAY 44

THE COMMISSION COMMENCED AT 10.06 AM

COMMISSIONER: Good morning.

MS McMILLAN: Yes, good morning, Mr Commissioner. I appear this morning. The first witness will be Dr Michelle Fryer.

FRYER, MICHELLE ANNE sworn:

ASSOCIATE: For recording purposes, please state your full name and occupation?---Michelle Anne Fryer, child and adolescent psychiatrist.

COMMISSIONER: Good morning, doctor. How are you? Thank you for coming.

MS McMILLAN: Doctor, can I show you this folder. I'll take you through the documents in it to identify it if I could. If you turn to the first document in the folder, is that your statement, the first document there?---That is.

All right. Are the contents of that true and correct? ---They are.

All right, thank you. And that's dated today?---Yes.

I tender that, Mr Commissioner.

There's no reason why that can't be published in its current form, is there, doctor?---No.

COMMISSIONER: Thanks, Ms McMillan. I'll admit and mark the statement 166 and I'll direct its publication.

ADMITTED AND MARKED: "EXHIBIT 166"

MS McMILLAN: Thank you.

Then, Dr Fryer, in relation to your statement it refers to a submission authored by yourself in relation to this commission of inquiry referred to at paragraph 3 on behalf of the Royal Australian New Zealand College of Psychiatrists Faculty in Child and Adolescent Psychiatry. Is that document number 2 in the bundle before you in that folder?---Yes.

All right. I tender that, Mr Commissioner. I'll just leave them all in the folder for the moment.

COMMISSIONER: I'll just give them a number. What was the last number I gave?

MS McMILLAN: 166, I think it was.

COMMISSIONER: I'll make that exhibit 166.

ADMITTED AND MARKED: "EXHIBIT 167"

MS McMILLAN: All right.

And then at paragraph 5 of your statement you refer to supporting information marked as an appendix and there are five articles and studies that you have appended. Do they form the balance of the documents contained in that folder in front of you?---Yes.

I propose to just tender them as one exhibit, Mr Commissioner. They're identified in paragraph 5 as to their authors and the titles of them.

COMMISSIONER: How will I describe it? The documents referred to in paragraph 5 will be exhibit 168.

ADMITTED AND MARKED: "EXHIBIT 168"

MS McMILLAN: Thank you. Mr Commissioner, perhaps if that folder could then be handed up to you because the witness has her own copy of that material.

COMMISSIONER: Good. Okay, thanks. You continue.

MS McMILLAN: Dr Fryer, your qualifications are you're a doctor of medicine and you're a practising child and adolescent psychiatrist?---That's correct.

Just keep your voice up if you would. That doesn't amplify your voice. You are the current chair of the Queensland branch of the Faculty of Child and Adolescent Psychiatry of the Royal Australian New Zealand College of Psychiatrists? ---That's correct.

Right. And it's in this role that you appear before the commission?---Yes.

You are currently employed, are you not, with the Child and Youth Mental Health Service attached the Gold Coast Hospital? Is that correct?---That's correct.

But you don't appear in relation to any role with Queensland Health, do you?---That's correct.

Yes, thank you. Your formal qualifications are as set out in paragraph 2, which are bachelor of medicine; bachelor of surgery, Leeds University; Fellowship of the Royal Australia and New Zealand College of Psychiatrists; certificate of advanced training in child and adolescent psychiatry; and you're a fellow of the college. Correct? ---Correct.

All right, thank you. Now, doctor, if I could just ask you some questions. How long have you been in your current position with Child and Youth Mental Health Service?---I'm currently the acting director of Child and Youth Mental Health Services and I've been in this position for 18 months.

And can I just ask how many of your cohort, if I can put it this way - of your patients - would be either subject to or have had contact with the child protection authorities? ---The position of acting director is an oversight position.

Yes?---With some direct clinical work, but that's not the majority of the task. In my working history - so I've been a consultant psychiatrist in Queensland for over 10 years - I've worked in a general child and youth mental health clinic, and I also worked for five years with the Evolve therapeutic service on the Gold Coast. So obviously with the Evolve therapeutic service all the children were in care. That's what that service - - -

Provides?--- - - - provides.

Yes?---With the general child and youth mental health population we would estimate that at least a third have some form of contact with child safety services. So they may not necessarily be under an order but they will have had some contact or some concerns raised.

All right. Now, if I can just ask you about your time with Evolve. We've heard some evidence about Evolve and how in a nutshell, if I can describe it this way, it is a service that was rolled out, originally was it, from the Gold Coast Logan area. Is that correct?---It was rolled out - there were three pilot sites; Gold Coast, Sunshine Coast and Townsville.

Yes?---And it was progressively rolled out across the state from there.

All right. And it's been in existence since about 2005? ---The first training occurred - inter-agency training occurred at the end of 2005 - - -

And it was - - - ?--- - - - and the teams were up and running in 2006.

Yes. And it is open to, if I can put it this way, children who are in care, and it's a therapeutic service which not only supports the child but also their carer, whether that's a foster carer or a parent. Correct?---Correct. So Evolve Therapeutic Service is part of Evolve inter-agency service which encompasses disability and child safety as core members, and education, and they work together, so

Evolve Therapeutic Services provides that therapeutic aim, working with the young person where possible, with their foster carers or other carers, with the agencies, schools, and other agencies that are trying to look after them and improve their outcome.

All right. And in your view can I ask have you seen it's had an educative feature for other inter-agencies?---Yes, I've seen a lot of change over the five years that I was with Evolve and since then in the understanding of the impacts of child abuse and neglect, the way that these children behave and interact and what they need, and improvements in service provision over that time.

And I ask you that because - I'll come to it in a minute - but in the study outlined in your statement, namely, number E of paragraph 5, Secure Accommodation in Scotland, I note that one of the issues it identifies is that young people who have been in secure care and were interviewed indicated that they had, for instance, suffered the loss of a parent or had suffered early significant adversity and one of the issues highlighted, had there been greater support for them at an earlier age, that may have been of great assistance to them and perhaps - it's posed as a question, it seems - they may not have needed secure care in adolescent years?---Yes, I would agree with that. The earlier concerns are identified and intervention provided in support, the less likely we will end up at this extreme end of the trajectory.

And indeed in the submission you have referred to issues such as the brain development in young children and babies, zero to three, and I don't know if you're aware, but you know of Dr Stephen Stathis?---Yes.

All right; and their evidence to the effect they gave that evidence and indicated that, amongst other things, the impact on children who did not have secure attachments in those early years and suffered abuse and/or neglect was that issues such as memory, higher functioning, impulse control, mood issues - all of those, sort of higher functioning, impulse control – those issues are detrimentally affected?---Yes.

I'm obviously globally describing. Am I correct in understanding that?---Yes.

So that obviously flows on very much, would you say, to the position that these young people who find their place, say, in residential care as adolescents – that stems from that time?---Yes.

And have you observed that in your practice as a psychiatrist?---So when we've worked or when I've worked with young people through Evolve or through CYMHS clinics I've seen young people with those difficulties. They have trouble managing their emotions. They don't perceive adults as trustworthy and sources of care and support so they tend to disengage. They have a lot of risk-taking and impulsive behaviours much more so than would be normal for an adolescent and when we look back at their histories, they've usually got significant adversity in their early life and they've often had a difficult course through the child-protection system as well where they've had a lot of placement change or disruption and disruption to relationships particularly which seems to be the key to what outcome you will get for a young person.

Although obviously your statement and the attachments by and large don't dwell on those early years in terms of a child's development, what you say is those are key obviously, those issues of stability and security, for later development and if those are not put in place effectively, you see those longer-term issues percolate through to these adolescent young people and the difficulties that they face?---So what I was trying to cover with the submission was briefly a summary of that, brain development and the impact of adversity in early life.

Yes?---To talk then about the importance of prevention and early intervention, early identification and support and then I went on recognising the current situation that we have now where we have a spectrum of needs across young people, some with very server risk, difficulties and need and we need things in place to support them.

I just was looking for it at, Mr Commissioner, page 4 and 5 of the submission.

You talk about:

> *By three years of age a brain has reached 80 per cent of its adult size and a vast amount of development and organisation has occurred. Once a system in the brain is laid down or organised, it is less sensitive to experience and less amendable to change. This applies most to the more primitive areas of the brain, whereas more capacity for change, plasticity, is retained in the more complex systems such as the cortex.*

You go on to say:

> *Whilst the basics of food and shelter are, of course, essential to survival, the most important factor in successful growth and development for the human infant is the interaction with stable, attuned, care-giving adults, usually parents. Infants who suffer extremes of absent care-giving are at risk of failure to thrive, reduced brain size, impaired development and even death despite basic physical requirements being met. So the experience during infancy and early childhood determine the functional organisation of the brain. The current biological revolution –*

and I don't know if you're aware Dr McDermott gave evidence about that –

> *that childhood abuse damages developing brains.*

So that's what you're in part talking about in terms of you then talk about attachment and a consistent sense of nurturing and a secure base for a child to develop. Can I ask - Dr Stathis was very strongly of the view that children who did require - in cases where they could be safely left with their parent in those very young years that there be a permanency of placement for those early years. That's not to say that after that time that reunification may and probably should be looked at, but that it was very important for there to be security in placement in those early crucial years. Now, I'm paraphrasing his evidence, but what do you say about that?---I would agree with that. The stability and consistency of nurturing relationship in the early years particularly is of most importance and can be protective for future adverse to where it's occurred so that permanent – when an infant is identified as being at significant risk, that permanency placement is very important. Unfortunately what I and others have experienced is when we look back at the stories of young people, they were removed early in life but then there was an attempt at reunification and they were removed again and went somewhere else and again an attempt at reunification so you have got those fractured relationships very early on which then set a template for this young person that relay you can't trust adults to

stick around to meet your needs and that's at a very early level, but it then impacts on how they interact with adults and other relationships in a way that can be lifelong.

COMMISSIONER: The dilemma is to identify the right child before three who needs to be permanently removed, not try to reunify that child and discriminate between that child and the child who can successfully be reunited with their family in such a way as not to do any lasting damage. How do you do that before they're three?---You're right. That is very difficult. I would like to see a lot more accessible services. There's a lot of stigma in accessing services, particularly for families at risk and a lot of fear of their children being removed. So on the one hand we want to try and remove that so that services are accessible, so that parents feel they can come forward and get help, so that we increase the changes, so that we're not removing children where their parents could be good enough and there's - - -

True, but aren't we relying on the parents who may not be good enough to self-refer to these non-stigmatised and voluntary services?---There are points at which they can be identified antenatally and postnatally through antenatal clinics, screening - - -

But having identified the child at risk with a parent who may not be adequate or even had bonded with the child or the child is not attached to the parent, how do you get that parent to do the right thing by the child by self-referring to a service for support that the child and the parent both need?---There will be a proportion that won't and we do need safeguards in place to try and identify those and they are probably the ones most likely not to succeed in reunification anyway.

And they're also the ones most in need?---Yes.

So having identified the one who won't voluntarily refer, for the child's good, short of removing the child permanently from the parent, should there be a mechanism where there's some sort of involuntary early intervention service for that parent?---We have a mechanism for a sort of involuntary early intervention because we take the child away and we say, "You don't get your child back until you've done X, Y, Z."

Yes?---So it's not legally voluntary but it - - -

That's not really early though, is it?--- - - - can be perceived as being coercive.

Yes, and that's what happens sometimes, but probably the biggest incentive is the threat of removal rather than removal itself?---Yes.

Would you agree?---Sometime removal can be a big incentive to parents who want to do the right things by their child.

That assumes you have got a support system that the parent can then access to rehabilitate to the point of successful reunification?---So we might have a parent who's got significant drug and alcohol problems or mental illness that might be identified antenatally. They might have at that point limited insight into the effects of that so you might work with them through antenatal clinics, through anyone who has a relationship with that person that they trust with that parent, so that might be a GP. That might be a midwife who's able to establish that. That might be a child health nurse.

But is that how we identify them?---Often they will get identified at that time and there is provision in the act then for that risk to the unborn child to be informed to Child Safety Services, although there's not the further step then, but try and engage – and also gauge do they have an understanding of what their infant is going to need and do they have a motivation at that point. So then we have a system that does what it does now in terms of assessing how much can that parent meet the infant's needs and protect them as soon as they come to attention – and we're talking about the first three years of life, so we're talking about very early infancy. If the assessment is that at this point that parent can't then there may be grounds and good reason to remove the child. Ideally if the parent would agree I would put them into a setting together but that's not something that is very widely available at all.

Which then puts the spotlight on the assessment process, because if everything is going to depend on that it's got to be reliable, doesn't it?---Yes.

Now, how often does the department when it's making those judgment calls bring in someone like you to ask?---That's pretty rare, and in that instance I wouldn't be the best person, you'd be better off with a perinatal psychiatrist.

Okay, an appropriate expert?---Yes. There is some provision but the accessibility again of services is limited.

See, if we're making such a big call we need all the help we can get, don't we?---Yes, and - - -

Because the last thing we want to do is abuse the child we're trying to protect?---Yes, and with Evolve we've seen the benefit of good interagency working and the flow-on benefits that that can have. I guess - - -

MS McMILLAN: Doctor, do you – sorry. Do you see – go on? ---Sorry, can I?

COMMISSIONER: Yes?---If the infant is removed that foster placement – and I'm kind of talking about an ideal world here, but that foster placement could be protected, because that could be where the child always goes, and even if they're reunified, if they could go back to the foster parents that they know and if those foster parents could continue to have an involvement in the child's life even when they're not – don't have custody of them in a residential sense, then you would develop a protective relationship long term that would help support and compensate for the deficits that the parents have.

But aren't we talking about - - -?---That's a huge shift.

Aren't we talking about the child who needs to be removed permanently from parents before they're three?---You're talking about the difficulty in decision-making.

Yes?---So it might be that the child is removed to a foster placement, they stay in that foster placement but they continue to have contact with their parents or parent if the parent is showing a willingness to engage and to change, and we are helping them to do that.

Do we know if we do that, though? So far as you know is there any research that says we do that enough or we don't do that enough?---I don't know of any research and it's a difficult area to look into. We have to look at naturalistic studies that sort of look at the outcome and then look back and see what happened and see if we can spot differences, because we can't manage one group of children one way and another group of children another way and see what happens to them. That's not ethical.

Except you could with the marginal – the children right on the margin, couldn't you?---You need to make the decision in the best interests of the child with what's available at that point.

Sure, but the best interests might be that wide rather – the division might be a lot wider than you think and it's not like they're on a very narrow strip, because most notifications substantiations are based on a notional harm and neglect rather than any, you know, single point in time event. We've got a little bit of time to work with, haven't we, and we've got till three years and presumably our predictive tools and experience and expertise as identified with the child prenatally. So we've got up to three years to work with the family to make sure that removal is never a necessary option. Do we do that?---I don't work much with infants. I can't really comment on that.

Okay. Thank you.

MS McMILLAN: Doctor, do you think, just finishing on that topic, that it would be beneficial that if you had an agency like the Evolve idea where it was – rather than having to refer immediately to child safety there was a non-stigmatising type of agency, that there could be, if you like, what's called, I think, a soft referral, so that you could refer a parent off to them first and work with them. If they didn't manage to work with it, then it's effectively elevated through the system?---I think we need a spectrum that's available and at the early levels available to all parents, that we don't actually receive a lot of education around what infants need.

So not just the cohort, so to speak, that might fall within the child protection system?---No. So raising parent

literacy across the population so we pull that average up, and then, yes, lower levels of intervention and assistance that are destigmatised with safeguards to pick up those families that are disengaging and where the child remains at risk. I have seen the growth of some of those.

In the - - -?---So on the Gold Coast ACT For Kids now provide a service that can go into the home. So do The Benevolent Society. So those types of services are becoming more prevalent. That's come out of previous inquiries as well. They still tend to be quite fragmented and location specific. It depends where you live what you're going to be able to access.

All right, thank you. Doctor, if I could take you to page 22 of the submission that you authored under Secure Residential Care. Doctor, can I just ask you firstly, what would you define as secure residential care or secure care?---Care from which the young person cannot freely leave.

Doctor, is it the case, and correct me if I'm wrong, that you see it as part of a continuum of options which are available for a child who is within the child protection system?---That's correct.

I mean by that that it's obviously at one extreme end and so that obviously it seems from the literature, broadly speaking, appended to your submission, that one of the key issues to any success is the step up and step down services that are available in conjunction with secure care. That's a first option. Correct?---Yes. Secure care is kind of your last resort.

Yes. Secondly, what you identify here is, I would imagine, a small percentage of the cohort of young people who are in the child protection system?---Yes.

In your practice over the last 10 years or so what sort of percentage, in your view, would be of the nature that you've described here on page 22, in your view, that might tend to qualify for needing the intervention of that sort of nature?---It would be a very small percentage, maybe 1 to 2 per cent.

All right. Now, you say that you estimate the majority are adolescents but a few are younger. What sort of age would that go down to?---I've seen sort of 11, 12-year-olds, who are certainly on the border of requiring secure care. They certainly need a level of care higher than what is currently provided, or more able to meet their needs than is currently provided.

You say that they come to the attention of mental health, child protection and other social services through intermittent contact, usually in crisis, via emergency

department presentations or encounters with police. You say they rarely contact through business hours services and are difficult to access to and form relationships with. You say when placed they tend to exhibit destructive behaviours that lead to placement breakdown, such as physical aggression to carers, destruction of property and self-harm, then you go on to list engaging in behaviours such as substance misuse, antisocial peer group, high risk of homelessness, promiscuity, antisocial and criminal behaviours, at risk from exploitation and assault, including sexual assault. They are at increased risk of premature death from misadventure, eg effects of substance abuse, suicide, or even at the hands of others. They are often resistant to engaging in services and may not see themselves as having a problem.

And then you go on to say that, "Even with services such as Evolve they find them difficult to locate and engage with." Now, just a couple of points: is it the case - and I can take you to the article if need be - that within that cohort there is a distinction between the genders; with girls it tends to be more a risk of self-harming behaviours or exploitation of them, whereas young men or boys it seems to be antisocial, acting out, offending against others sorts of behaviours. Is that your reading of the literature?---Yes.

And is that your experience in treating young people? ---There is increasing crossover, particularly with girls becoming more aggressive. That's a social change which has been documented in a number of different forums and literature.

Is that because of the use of substances leading to aggression?---It seems to be to do with the female role in society and how we raise children, the expectations of them, and what is perceived. There is certainly - whereas girls used to be typified as internalising problems, so becoming depressed, anxious, turning their anger and stress in upon themselves, in a way, that is now changing so that they are also showing more symptoms in the externalising, so becoming aggressive, criminal conduct. There are probably a lot of reasons for that change.

Okay?---There's also - and what's reflected in the literature you referred to from Scotland - the perception of those assessing the risk as to what's a concern. And certainly still with girls the fear of sexual exploitation and sexual risk is more to the minds of people when dealing with girls, and that's a social cultural bias in how we think about girls compared to how we think about boys.

Yes?---At the individual level it's important when we're assessing a young person to try and keep those biases in mind and look at the risk to that young person and what is in the best interest of that young person.

I see. All right, thank you. I'll come back to those issues. You then go on in the submission to talk about that:

> *Occasionally they are admitted to mental health inpatient units in crisis in an attempt to engage them in service or appropriate placement. This approach is rarely successful as such inpatient units are designed for acute - say two to three week admissions - of young people with acute treatable mental illness, not long-term therapeutic work.*

Just pausing there, Dr Stathis gave evidence that one of the difficulties, for instance, is a young person might be brought in who'd been chroming and once they are lucid they

have to effectively release them or discharge them because they no longer qualify; obviously they're no longer able to be admitted under the Mental Health Act?---Yes.

Would you agree with that, that that's one of the difficulties?---Yes.

So there's no other mental illness present so there's nothing further legally that they are able to do to treat the young person?---Yes.

And is it the case that what you're talking about in the submission with secure care is not of a two to three-week admission, you're talking about as the literature refers to, sometimes 18 months to two years?---Yes.

Right?---You would aim to keep it as short as possible, but balance that against being effective.

Right; and:

> *For these adolescents their difficulties are longstanding, not amenable to acute treatment. These adolescents generally do not meet the criteria for detention under the Mental Health Act, they'd cause disruption to units and care of young people with acute mental illness.*

Now, you say that's because they don't have a diagnosable mental illness?---Yes.

All right. And also is that because the Mental Health Act is - in your view is it crafted to meet the needs of an adult with a mental illness?---It is. The Mental Health Act is much more around adults and it's around acute treatable mental illness, so part of the criteria for placing someone under the Mental Health Act is that you can effectively treat them by doing so, so it's quite a medical model in the way that it's conceptualised. These young people have longstanding difficulties, as you've mentioned, along the range of their behaviour; their capacity to regulate their emotions and their interaction with others. It's not acutely treatable in the way that the Mental Health Act is designed to be used so it's not appropriate. The way that units are set up to treat mental illness don't serve the needs of these young people well and the young people themselves can be very disruptive to the work that is trying to be done in those units for young people who do have more acute treatable mental illness.

And I imagine could it be stigmatising to these young people too to be admitted to a mental health unit?---Yes. I clarify that because these young people will sometimes tick the box for a mental illness. If you looked at DSM-IV or ICD-10, the diagnostic manuals, they might meet criteria

for conduct disorder, they might show signs of emerging personality disorder. We know that those disorders are not well treated by acute inpatient short-term stays and what's needed is long-term therapeutic work with the person, with the family. So it's around also what is actually going to be effective in achieving change.

I see. All right. And then you go on to say that the therapeutic management obviously deals with the emotional psychological and educational learning needs. And obviously that wouldn't be able to be catered for in an acute mental health facility?---Adolescent units have some provision for education but it is again designed around someone who's acutely unwell and short term.

All right?---And these young people are generally disengaged from the education system and have been for a long time.

And you say that currently the only framework in Queensland is the youth detention centre?---Yes.

And obviously the only time that young people are there is when they're significantly down the road with a criminal history?---Yes.

Correct?---That's correct.

And indeed Dr Stathis's evidence - and he is a visitor to the detention centre - says - his evidence was to the effect that often young people who are in there settle down, to use his words, once they're removed from, for instance, influences such as substance misuse et cetera? ---That's correct. And it provides a containing environment.

I was going to ask you about that. Is that in your view also because it does provide some containment?---It's very predictable, containing. So if the young person becomes out of control, which is a concept in one of the papers, the environment is able to help them manage that. And it provides a roof over their head and regular meals, which is something they may not be able to access in the community.

All right. And you then list - you recommend that the inquiry consider models for young people, the secure children's home that used in the United Kingdom. I take it that's why you've appended the literature that you have. Now, there's no doubt that that's a controversial measure, is it not?---It is, yes.

And the dot points that form the bottom of page 23 and on to 24, obviously you've identified there's a need for a legislative framework. That would need to, one would think, contain very clear framework for issues such as

oversight; rights to be recognised for young people; secured, would it not; it would need to be very clear and it would need to be very protective of the young people in those facilities, wouldn't it?---We need to acknowledge and learn from the mistakes of the past in the provision of care for young people and we need to set up systems of care and continuums of care that meet their needs safely. And especially when that's secure care because it's very intense in the relationship between the young people and the carers in that situation, that the workers are highly skilled, highly supported, and that there are systems of monitoring in place.

And your needs analysis, that's going to be clearly very important; that you screen, I would imagine, with great care, that only the children who really need to - or young people, I should say - need to go into those facilities that do in fact find their way there?---That's correct.

And I'll talk to you about risk in a minute. Appropriate facilities, one that obviously is appropriate, that wouldn't, I imagine, make a young people feel that they were effectively in some sort of imprisonment, that it would be conductive to their welfare, I would imagine? ---There are writings about the environment.

Yes, staff that are highly skilled in trauma based therapeutic care, ongoing support, supervision or professional development of those staff. Clearly that would be a very a difficult task for the staff working with these young people, one would think?---Absolutely.

They would need to, I would imagine, work, for instance, under the supervision of someone such as yourself, wouldn't you?---They need to have access to - - -

Access – I mean that you would need to be supervising? ---Yes.

Not necessarily on site but - - -?---I should define the word "supervision" because it actually has a slightly different meaning coming from psychiatry. So supervision is not just an oversight. It's actually a process of reflecting either individually or as a group on your practice; on your knowledge base; on events that have occurred.

Yes?---It might be day by day or in the therapy or in patterns that are seen and, as I say, that can be done as a group as well so what would be sort of recommended in an environment such as that is that the staff come together regularly with someone who is external but has a strong relationship with them where they can discuss and reflect on what's happened, their own behaviours as well and what they might learn and how they take that forward.

Is that a little bit like what's required of psychiatrists who do cognitive behavioural therapy where – isn't it part of your professional requirements that you need to effectively – and this is my layperson's description – debrief with another professional?---Through training.

Training?---Supervision has a role in training. Supervision has a role sometimes in cognitive behaviour therapy. It's also talked a lot in the psychoanalytic field. It is providing that space, and the College of Psychiatrists recognises that we need to reflect on our practice so the continuing professional development processes of the college include a requirement for peer review, so where a group of colleagues sit down together and reflect on their practice and this is similar.

Yes, right. So just to get an idea what practically you're speaking of, what sort of staff would you be looking at? Clearly they wouldn't be medical staff as such who would staff these, but what sort of qualification or skills would you think the workers at these sorts of facilities should hold?---I think we have a need to increase the skill base across the spectrum of looked-after children and really recognise in value that this is more than parenting what these children need. There are ones that come in for

various reasons - might be death of a parent - that are a normal family, good quality parenting will be enough for, but there are a lot that need more than that and need parenting by people who have an understanding of the impact of abuse and neglect and the way that the child will interact with them, their attachment style and how that will try and provoke behaviours in the carers that can be unhelpful and how to resist that. So I think we have a task of up-skilling across our workforce in terms of looked-after children. When we take the most severe children with the most difficult behaviours, we need the most skilled staff. They don't necessarily need to be mental health nurses or professionals, but they need to be supported by and informed by. They need to be trained in the impact of attachment, trauma, abuse and neglect and understanding the young people's behaviour in terms of their past experience. One of the most important things is that they're able to hold positive regard for the young people in their care; not necessarily accept behaviours but still like the young person and want well for them and that they're supported to do that so that they don't become punitive in their interactions.

Which no doubt would be easy to do in the face of very challenging behaviours?---Yes.

So collaborative behaviours with special services such as child protection; paediatrics; mental health; education; vocational funding. That must be given, mustn't it? ---They need strong leads. We need education services or vocational services that the young people can access again with teachers that are informed around the difficulties that the young people have.

And you would say, for instance, that those offers, that training such as vocational and recreational pursuits - would you say shouldn't be linked to their conduct, behaviour, shouldn't be punitive in terms of - what you would say is they should be offered regardless to these young people?---Yes.

So I take it that the idea that effectively if they engage in this, by virtue of that hobby or learn to train for a trade, for instance, their behaviour gradually, one would hope, would improve because of that?---Sorry, I was referring to my notes and lost concentration on you for a moment. There are a number of interventions or philosophies of care. So one of them sort of historically is behaviour modification, a sort of token economy where the better you behave, the more you earn. What we find with these young people, what we've learned, is that their expectation of success is very low. Their expectation of positive interactions, especially with adults is very low so we do need in the environment predictability, dependability of secure relationships, so the first thing that we want for the young person is to be able to

experience that adults can be protective and caring and nurturing whilst also setting limits around behaviour that's not acceptable, that's not safe. Within that we can then personalise some behaviour modification. We also want these young people to experience, ie, it might be a good thing to engage in a pro-social way with society. So we want them to experience success in education when they might never have before. We want them to experience success in activities and certainly from my reading and experience if we link those to behaviour, we set the young person up to fail so we actually need to say, "If your behaviour is aggressive, this will be the consequence and over here as a separate thing we have your positive activities that are part of your therapeutic plan and they will continue whether you've lost the plot in the last hour or not. You will always have access to those," because we really want to give those experiences to young people that, sadly, they haven't had.

All right; and then, lastly, the step-down services and supports and processed. I would imagine that that's crucial to the success for any young person who finds themselves admitted to secure care, wouldn't it?---In the writing and in my experience what becomes key is relationships and maintenance of relationships and transition planning.

All right. I just want to put a proposition from a submission that there is a lack of evidence to support the use of secure care to provide better outcomes for young people who have been removed from their family's care. Can I put two propositions? One is that's difficult to measure, isn't it, because that cohort who have been admitted to secure care might have always had unfortunate – been on an unfortunate trajectory in their lives so that's difficult to indicate whether that's been because of the use of secure care or would have occurred in any case and, secondly, wouldn't you need to measure it also about the availability of step-up and step-down supportive programs for these young people? That would be a key issue, wouldn't it?---So it's very difficult to look at one element in isolation and see the impacts of that element, for example, secure care, on the long-term outcome and it is very difficult to evaluate because where secure care exists, if that's in the best interests of a child or a young person, it shouldn't be denied to them to see what the outcome is. So it's very difficult and comes back to some of that risk analysis.

And I imagine for some young people, if they were admitted to secure care, they would have really been fairly much institutionalised in one way or another for much of their young lives. If, for instance, they had been in a number of foster care placements, then residential care which may well have been the trajectory, mightn't it, and then if

they did go into secure care, then for them, when they reached 18, unless there is some step-down program, they're really left to fend for themselves. Correct?---Yes.

And that would clearly be very difficult for anybody to survive and thrive, let alone a young person who'd had significant adversity in their lives. Correct?---Yes.

Yes, all right. I want to ask you also: this submission also purports to say the purpose of secure care in other Australian jurisdictions is to restrict the movement or activity of a young person so as to counter an imminent and serious risk to their personal safety and to provide opportunity to engage in assessment and planning for their needs. Would you agree that they're the two purposes, effectively?---I haven't looked a lot at interstate models. That does seem to be the way that they are being looked at or being set up at this point.

Is - - -?---They're important roles - - -

Sorry, go on?--- - - - but I'm not sure that they're enough.

Is your view – is there a third purpose, in your view, which underpins your submission that it's also protective of the young person?---Yes.

It's meant to be protective, in any case?---Yes.

All right. The submission also refers to the Disability Services Act and those provisions about restrictive practices. Are you familiar with those?---Not particularly, no.

Now, can I just ask you, in terms of looking at risk factors and admission to secure care, because that would seem to be one of the critical issues, is understanding who are the cohort who may be in need of this, and I'm in particular referring you to the article "Out of control. Making sense of the behaviour of young people referred to secure accommodation", in terms of this article, would you agree, seems quite apposite, because it appears – "out of control" seems to be the phrase utilised by many in assessing whether a young person, for instance, is in need of secure care. It's a catch-all phrase, it seems to be, to describe a constellation of behaviours which is looking at really approaching an unacceptable risk to the young person and perhaps to others?---Yes.

Now, that article refers to – it's page 2 when Mr Commissioner has a moment to look at it. She refers to – the writer Lupton says that the issues of risk, risk is effectively a subjective issue, she opines, because it's an aesthetic effect of a hermeneutic phenomenon grounded in everyday experiences and social relationships. Now, the important issue from this, the article continues, is that there are different thresholds of what is tolerable as risk. Correct?---Yes.

That, for instance, social workers are prepared to tolerate a greater level of risk to a young person in society than perhaps lay people who sit on these panels who make

decisions about whether a young person, for instance, is or should be admitted to secure care?---Correct.

Interestingly, that article talks about control, doesn't it, and it refers to control in the spectre of parental control within the Children's Act of Scotland and talks about the fact that adolescence obviously is traditionally a time when adolescents are making their way in the world as autonomous adults. It may be seen on page 4 that adults see this testing out of new freedoms that a young person is out of control. The issue seems to be that where parents or carers have neglected their parental responsibilities or feel they are no longer willing or able – and pausing there, it has particular resonance – I'm sorry, Mr Commissioner, I just – it's page 4 of that article, the first paragraph. It's, "Out of control. Making sense of the behaviour of young people." It is (c).

COMMISSIONER: Yes, got it.

MS McMILLAN: Yes, the first paragraph, "Out of control. Willing or able to provide limits in control. The state may intervene," which obviously is apposite for the Queensland situations. "Measures for care and control may include home supervision or placement away from home in foster care or residential care." Then it continues further down the page that it's important to recognise a process of identifying and identifying the risky or out of control behaviour, and our individual and collective ideas about what counts as the right level of parental control or self-control are socially constructed and therefore if you look at secure accommodation, at the bottom of that page, is one of the most controlling interventions and has as its aim to rehabilitate and to protect the public. These involve controlling the child, including taking away their freedom, assessing the child's behaviours and need and providing care, including health and education. So in essence, if you're looking at - one of the key issues from that is clearly obviously acknowledging that adolescence is a time where young people are obviously pushing boundaries, it seems, in terms of acting out, and might be termed out of control behaviour at times. Obviously where you've got absent or unwilling parents to control young people's behaviour, then you have the state obviously stepping in and exerting that level of control. Furthermore, findings from page 7, out of control behaviour, it seems, was an important marker of risks. It appears that those in the child protection field, for instance, referring practitioners, managers, and it would seem they are child safety officers, or the equivalent, all took out of control behaviour as a marker of risk. Would that be, in your experience, the way – is that translatable to our experience, that that is often what's taken as a marker of risk for a young person, is out of control behaviour? ---Similarly to what's described here, yes.

COMMISSIONER: Do you agree with the proposition that social workers are more tolerant to risk than lay people? ---I think – I'm not sure that it's specific to social workers, it's social workers in this context, because of the work that they do.

Or professionals?---I think clinicians working regularly with young person can be more tolerant of risk.

How does that sit with the evidence that seems to be conceded by the department that since 2004 child safety has become risk averse because of community expectations, fear of adverse media publicity and because of the net widening as a result of the definition expansion of harm to include emotional harm?---I think the role of the social workers as described in here is actually different to the role of child safety in our system, in that child safety are trying to protect children or trying to protect the public when the child's behaviour falls into that out of control, particularly criminal element. Here there is a component, from my reading, of trying to work with the young person to get a better outcome, and I think when you're in that position, particularly if you've got a therapeutic alliance with a young person, I would probably tolerate more risk than see my relationship with them fractured by a period in secure care, so weight up the risks and the potential adverse effects of each option – probably be more tolerant to that risk than someone looking from outside who might be quite concerned. Now, I would also use the sort of supervision and peer review that we talked about earlier to make sure that I'm not getting too tolerant to risk in a way that would be detrimental to the young person. So you're always in your own practice reflecting with peers, trying to make sure that you get the balance right.

Yes?---But I might see a progress of a young person engaging with me, forming an alliance with me, that has the potential for change. So I'm working with that and I'm tolerating the risk that's there because I can see a process of that gradually improving over time, whereas someone looking in would see that differently.

Are you using a predictive tool to asses risk? ---Unfortunately the predictive tools aren't terribly predictive. So we do - working in Queensland Health we have a number of predictive tools that we are required to use and tools at our disposal. They help in your thinking around the case, they help to structure your thinking, but the difficulty with all of these tools is that their predictive value, the longer you look into the future the worst their predictive value is.

Professor Eileen Munro says that their success rate is slightly better than professional judgement alone, 74 per cent to about 66 per cent?---Yes.

It's only a marginal improvement and it depends if it's actuarial or not. How do you use, say, the predictive tool which is context-sensitive in a culturally appropriate way, do you think?---That is a huge question and it would depend obviously on the culture of the young person on working with.

Would you regard things like risk and care and emotional well-being as concept that do have a cultural element to them?---Absolutely.

And would I be able to judge how much cultural tolerance there is in the indigenous community, being a white man? ---I would hesitate to do that without good information sources - - -

A white middle-class man?--- - - - culturally appropriate information sources.

So how would you do it in, say, the indigenous communities, working out risk in a culturally responsive way? Would you ditch the tool and just go professional judgement or what? ---I would look to colleagues who work in this area and see what tools, if any, they recommend; and I would also look to seek to establish links with the community - - -

You'd seek - - -?--- - - - with the key people in that community to help me understand both the risks and the protective factors for young people there and how we balance that up.

Yes, okay. So you'd find someone in the community who actually knew the culture of that community, because they're all different?---That would be the ideal.

Okay, thank you.

MS McMILLAN: In the Scottish study Secure Accommodation in Scotland, its Role and Relationship with Alternative Services, at page 7, just briefly take you to that:

> *In terms of alternative resources and the level of risk and what decision-makers were willing to tolerate, panel members - which as I understand were lay members - were willing to tolerate a lower level of risk than social work professionals and could be sceptical about the protection offered by individual packages built around an individual child. These arrangements were sometimes developed out of necessity when no secure place was available; but whereas some social work managers viewed this as an opportunity to extend the capacity to provide security without locking young people away, some panel members viewed them as a poor substitute. In light of this, giving panel members more authority will enforce the implementation of secure authorisations and may stifle the development of inadvertent practice.*

Perhaps that highlights neatly the differentiation between the approaches of the two - perhaps lay people and their body of experience as opposed to perhaps professionals, and looking at substitutes and alternatives which may be more supportive of the family as a whole. What do you think about that as a proposition?---I think that's reasonable. I think clinicians do look more at what can be done outside of secure care.

Particularly if your options are limited, I imagine, which given the state in terms of resources, must be an ever-present issue. Correct?---Yes.

Doctor, just in terms of referring to that out of control article - and this is what I spoke to you about earlier in a general sense - you commented on a survey of 110 referrals that indicated there was - page 11, Mr Commissioner - significant differences between the genders. This was a 2000 - there were a number of surveys, it appears, dating from 2001:

> *Young women were far more likely be causing concern in relation to risks they pose to themselves, primarily through their sexual behaviour, running away, and the uses of drug and alcohol. Young men were more likely to cause concern in relation to their offending behaviour and the risks posed to others.*

But you say that that's in fact become more blurred as societal norms have changed?---Yes.

And it says:

Most of the young people being referred to secure accommodation in the study - authority at the time of this study - were being referred from placements in open residential units.

Now, this was a study published in 2012. Over the page:

Young people described their move from their parental home into residential care as a confusing and unsettling time.

And further down that page:

All of the young people spoke about this feeling of reaching the end of the line after their admission to residential care. They felt their out-of-control behaviours escalated partly in response to this unhappiness.

So what would you say: does there appear to be a link that - we've heard quite a deal of evidence of destructive antisocial behaviour in residential care placements. What do you say? Do you have experience of seeing young people who are in residential care placements?---So it is at the end of the line so they haven't been able to live with their families, they've generally failed to be managed in foster care ought to be able to be supported in foster care, so they do have that perception of themselves as not being a good person, not having value. They've experienced often multiple abandonments or rejections, so we see a lot of aggression towards those that are supposed to be caring for them, that tends to be the target of that behaviour sometimes. And it becomes very difficult then for the presidential-type units we have to manage that behaviour as well, so they often then get a further rejection, that there moved or they can't be managed there.

So would you think that that was an accurate reflection, that perhaps their acting out, if you like, was an expression of their distress of being moved into the residential care facility and that really that was an expression, in effect - at least in part - of that and that was contributing, at least in Britain, into their movement into the secure care?---I think that's probably true. I think we need to remember that behaviour and the communications and the reasons underlying behaviour can be quite complex and may be in part conscious and in part unconscious on the part of the young person, so seeking to understand where that behaviour is coming from. I've similarly seen young people deteriorate in that there is an escalation in out-of-control or aggressive behaviour or self-harming behaviour at the prospect of a placement changing or when there is uncertainty in placement. And again I think that is the communication of: there is uncertainty in my life and I don't like that. That is troubling. That is distressing to me.

And one young person at the top of page 13 poignantly says:

> *Maybe if they listened to what I said as well as what everybody else said and listened to the reason why I was running away and drinking, then maybe I wouldn't have needed to go to secure. Maybe I could have gone somewhere else.*

So that the study comments upon the fact that the young people interviewed commented - bottom of page 12 - that:

> *Professionals and other adults had not done enough to try and understand their feelings and involve them in decision-making, notwithstanding that they were involved in the formal decision-making forums.*

Do you think that that's again and accurate representation, that young people don't feel that they're listened to and involved enough in decision-making?---I think that is often the experience. One of the strengths of the Evolve model is where they're able, involving young people in the stakeholder group and finding ways to give them a voice. It is difficult because at the same time they may not engage very well.

It's one of the problems, isn't it, because not only are they adolescent, they're also by this stage undoubtedly troubled adolescents too, and as you've said in the submission, they are difficult to engage with, aren't they?---And they, as I've said, may not have an expectation of adults being helpful to them and they may have been forced into situations of looking after themselves and surviving on their emotionally, if not literally, for a long time so they're trying to be independent and look after themselves without really the skills to do so.

Is it something that one needs to be aware of that sometimes these young people can appear to be sophisticated beyond their years but in fact they're in other ways immature for their age?---That's correct.

But at page 8 of the Scottish study it says:

> *One of the key roles for a social worker is to provide continuity over time, to link across relevant family members and a range of services involved with young people, because it is the ongoing relationship with families which involved intensive support to avert admissions when crises arose and also step-down programs.*

So that's still a key issue all the way along, isn't it; that there has got to be continuity, whether it be a social worker or other therapist or whatever you want to call them involved with this young person. Correct?---Relationship is key.

All right?---Continuity; stability; positive regard in that relationship.

In your experience, for instance, if they're in the child-protection system, is there a continuity of child safety officers with young people?---Generally, no. I have seen cases where that has been achieved and you can see the benefit of that and the young person's appreciation of that too.

All right. Further down that page it says that the young people who have been sampled – that the problems that first surfaced in their teenage years often related to earlier trauma or loss. A particularly high proportion of young people have experienced the death of a parent or other close relative so that the obvious answer is to make services available at an earlier stage. So perhaps does this come round to a full circle of in essence services of a non-stigmatised nature being available to families at an early stage, if possible?---The earlier intervene, the better. The earlier problems are identified in intervention is able to be taken up by the family. The closer the child stays to the normal trajectory, the easier it is to return them to that.

But if child protection is needed to intervene, there needs to be a continuity of, if at all possible, some figure in the child's life; whether it be a child safety officer or some figure, particularly when crises arise, there's a continuity through for the child. Correct?---I'll have to go back and check this reference. It's in here; one of these. There's a Clarke 2001 study that was cited in one of these references. That found that 70 per cent of the change came from the relationship. That was their

conclusion and they conclude relationships are key to change. Interventions were about 15 per cent, so your particular modality – the effectiveness of that was about 15 per cent and hope and expectation of change, so you're actually giving hope to the young person, giving them the sense that the worker believes that actually life can be better, that actually you can succeed and do well and go on and have a good life, however we define that – that was 15 per cent. So I have to go back and check the detail of that but I think it just speaks to the importance of relationship and even if you look outside of this sphere, psychiatric treatments and psychotherapeutic treatments, there's always found to be an important component - and the percentage varies but it's always significant of what tends to be termed "non-specific factors" or "therapist factors" that really speak to it's actually the relationship for all change for people.

So, in other words, the psychiatric patient, for instance, having to change the psychiatrist they see or the mental health worker is obviously a very significant issue for them, isn't it?---Yes.

So you're saying for a young person constant changes of personnel in their lives is, one would think, a very detrimental aspect?---Yes.

Now, in terms then even with programs such as Evolve and early intervention there will still be, from what you have said, a cohort that may well need to find their way into an admission to secure care. Correct?---I would love for that not to be the case. That would be an ideal world and I would expect we're at least a couple of generations from that even if it's possible. I think there will always be a small percentage and certainly at the moment we have a group that we are not meeting their needs. Talking about the risk and the assessment of risk, one of the key things for me would be looking at their disengagement from all services and secure care is that last resort to try and get them re-engaged in something that is going to be a positive influence for the future and, as you've highlighted, going from that stepping down, trying to maintain relationships as we transition across services or transition relationships as a minimum, again to try and give them the opportunity for a better future.

And the purposes, as we have recounted, are protection of the young person?---Yes.

In part some rehabilitative aspects; some ability to receive education, health, care, all of those sorts of issues?---Yes.

But also at times protecting the public in extreme cases? ---Yes.

All of this comes at a cost. Correct?---Yes.

These are not cheap facilities to run. At page 9 of the Scottish study – now, obviously they're quoted in pounds and I won't ask Mr Selfridge to translate, but it cites there:

> *Over the year prior to and following secure placement estimated costs for young people admitted to secure accommodation range from 66,800 pounds to 354,000 pounds. Corresponding costs for those considered for secure accommodation but not admitted were 20,800 pounds to 217,100 pounds. If one also takes into account that community based support works best if offered over several years, the cost differences may be reduced even further.*

Now, I take it you have not got personal experience of secure care?---No.

I take it you probably can't comment on the costings of it, could you?---I don't have the experience or the knowledge. I think it is expensive but these young people are often already expensive to the system and there is the difficulty of looking at the long term and the economic benefits of intervening even in teenage years for the next 60, 80 years of that person's life.

Just excuse me. Yes, thank you. I have nothing further, Mr Commissioner.

COMMISSIONER: Thank you. Mr Selfridge?

MR SELFRIDGE: Yes, thank you, Mr Commissioner.

Doctor, after accepting of the caveats that you have put in terms of your limited support for secure care – by those caveats I mean early intervention is always best and there's only a small cohort of young people who may benefit from secure accommodation?---Yes.

Secure care, sorry, and is done as a last resort. Those are the sort of caveats?---Yes.

Yes, limited support. In practical terms I'd like to ask you what you're suggesting and putting forward. As I understand your evidence, particularly your oral evidence today, you're saying that that small cohort of young people who may benefit are those perhaps where there's an immediacy of risk of self-harm, those of self-harm, et cetera, and it's a short-term safety net, but that's to be balanced with - I think I'll quote you as saying, "It's as short as possible but has to be long enough to be effective"?---Yes.

Yes, so in practice terms what are we talking about there, "long enough to be effective"?---It needs to be individualised to the young person.

Yes, each case on its own merits?---I think, looking at this, as a minimum if someone's reached that point of risk and disengagement, I'd say they probably need a three-month period to be a thorough assessment and opportunity for engagement. The overall periods of intervention might last as long as one or even two years, although I'd like to see that as very much the outlier in terms of duration. It comes back to if we're going to intervene we need to be as effective as we possibly can and give that young person the best possible chance of success and we're intervening at a point where we think this might be life-saving for the young person.

Okay?---There does need to be a lot of transparency. We've talked about the need for the young person to have a voice in that and have very effective step-downs so that we have processes that safely transition a young person into a less restrictive environment as soon as it is safe for that to occur.

Can I just pick you up on that last point, because that leads to my next question. If I was suggesting in terms of the parameters of secure accommodation being three months and possibly up to two years, is what you're saying really that a minimum of three months for that kind of assessment in terms of any overall intervention - the duration might be one to two years but it might well be done as part of a model where there's a transition to less intrusive or restrictive type accommodation. Is that what you're suggesting?---That's right, and the other thing that is talked about in terms – in the Scottish literature, is mobility.

Yes?---So that is the provision for a young person to have leave from the secure unit. So they might have leave to attend a school, or in our context a TAFE, they might have leave to spend time with family, but they come back to that secure environment, which hopefully is secure not just in terms of being locked but in terms of providing them with a sense of safety, containment, a place where they're undisturbed, a place where their needs are met, so that if they found being out stressful they can come back in, debrief, receive support, work on how they can manage that better next time, and that's a process that then looks to transition to, as we said, a less restrictive level of care when that young person – when that's right for that young person.

So the most restrictive level of care is during that initial – that you're advocating, albeit - - -?---With a lot of caveats, yes.

With a lot of caveats, but the most restrictive, as such, is during that initial assessment phase and/or when that young person is most at risk to themselves or to society? ---It's really about the risk, containment of risk.

Yes?---It's an opportunity then if we don't have a lot of knowledge about that young person to really assess and to assess where they're at now. So there might be knowledge about that early history but they might have been lost to follow-up for a period.

Yes?---So assessment on what their needs – they might have educational needs that have not previously been identified so those need to be checked, they might have health needs if they've been on the streets or couch surfing, those need to be checked and addressed as needed, for strong links with health, they might have mental health needs. So

again, it's an opportunity to really look at all of that, to spend time with the young person and get to know them, see how they identify their needs and then bring that together in a way that you can effectively plan, "Okay, where do we go from here? What's going to be helpful?"

So there's really two risk analyses, if I could say that. One is the short-term risk analysis and the other is a long-term risk analysis?---Yes.

Or getting that person, that young person, back into the community with – a possible time wherein it's still effective, still long enough for the intervention to be effective?---And much more than risk analysis. One of the things we found working – that I found in working at Evolve was that the backgrounds and histories of the young people had often become very fragmented. They'd had different child safety officers, different foster placements, so no-one had a knowledge of this young person's history and their life story, and there's an actual – there's a therapeutic intervention called Life Story Work which recognises the importance of pulling that together, because that is part of from which derives our sense of identity and who we are and where we fit in the world, which is important for psychological health. That opportunity in assessment includes looking back and pulling together that story, that history of the young person in a way that's meaningful in understanding where they are now, in seeing what their strengths as well as their needs are and in planning to go forward with that.

Is what you're suggesting – and it might just be my take on it but you tell me if I'm wrong. Is what you're suggesting that if there's going to be an intervention as such, the intervention should be able to be carried through to be most effective in relation to the child or that young person? So it might be that the time that the young person is placed in a restrictive or a secure accommodation might have to be lengthened in order to be most effective. Is that what you're saying?---So this is for consideration.

Yes, absolutely?---Part of reading and the work coming out of that and my previous experience is that we need a much better continuum of care and, as I've talked about, upskilling of those providing care to young people and really recognising and valuing that. In the UK now you can do university courses in child development, the impact of abuse and neglect, therapeutic parenting and those sort of things. So we need to value that, and that means we need to pay people, sometimes, too, accordingly.

Yes?---These are not cheap interventions. Then if we are going to intervene we need to look at international models, we need to look at best practice, we need to do all that we can to ensure that what we're doing is as effective as

possible for our local context looking at international models, because if we're going to intervene, particularly if we're going to deprive a young person of their liberty, we need to be as sure as we possibly can that what we're doing is going to be effective in giving them a better outcome in life.

Can I just pick up on that very point, because when I read paragraph 6 of your statement as such, and you mentioned it to the commissioner earlier, there's no evidence to suggest that such intervention would be beneficial or produces beneficial outcomes for young people as such?---It's hard research to do. The research that has been done has tended to compare children who ended – who received secure care with young people who were close to but did not. So we could argue that those are not the same group, not comparable groups, although we've gone for as similar as possible.

Yes, I understand?---We also know that the later we try and intervene the more difficult it is to change the trajectory. So we know that this model keeps young people safe in the short term, provides an opportunity to engage with them and provide help and intervention that we otherwise would not have. Unfortunately, sadly, at this point we don't have proof that it changes the long-term outcome.

COMMISSIONER: You could do that, you could compare apples with apples, better if you had a cohort who were all in the same group, they were all on the margin of going in or out, and then you divided them, some went in, some went out, when they could have easily gone the other way, and then measured their outcomes long term, couldn't you?---It's tricky, because ethically you need to do what you believe is in the best interests of the young person.

Yes, I know, but that's what I say, the margin of error is fairly broad, isn't it? There's no scientific method about what's the best or what's not the best? How do you know? As you say, how do you know that the decision you're making to put them in or put them out is in their best interests, because as you've just said, studying is tricky?---Short term, secure detention keeps them safe.

Safe from what?---I've lost a patient to chroming. That may not have occurred if he'd been in a secure unit short term.

Right?---So short term you might prevent – at the extreme, but this is what we're talking about - the death of a young person.

So what you're - - -?---Does it long term change their outcome? That's a lot harder, and I think any model and anything that we put in place, having structures in place

to evaluate and follow young people long term and also; we haven't spoken to it today, but to continue to provide support past 18, which at the moment our system stops. You turn 18; you're basically on your own. That's not the case for young people in families. We're talking about a generation that's still living at home at 25, 30, but, you know, parents provide support. The state is not very good at doing that, so however and whenever these young people transition down to lower levels of care we need to keep supporting them for as long as they need that and find ways of doing that effectively.

When you say "secure care" what do you mean? Draw me a picture. What does it look like? I'm walking past it down the street, along a - - -?---I've never walked with it. It doesn't exist in Queensland so it's not a model that I've worked with. From the outside it's somewhere that people can't easily get out of.

So how do you keep them in?---So you're looking at some sort of fence or some arrangement that this is secure. I think important - we haven't talked about it, but when we look at the Scottish literature people enter that kind of secure care through both youth Justice and welfare routes, so it serves almost two functions, although it is reasonable in that there's a lot of overlap in the backgrounds and needs of those groups of young people. But we're talking about something that the young people cannot leave, so it needs to be built in such a way that their liberty is restricted, it is difficult to escape from. Sounds hard. It needs also to be built in a way that - because environments have a big impact on us, so inside it needs to be as welcoming as possible and the aspect of it being locked as minimally intrusive as possible.

But effective?---Yes. And it needs to have space; young people need space. It needs to have provision for bedrooms especially that they can personalise; for living areas; for areas for education; for maybe a gym or something where they can burn off energy; some outdoor area. I'm talking kind of from an ideal standpoint. If this is something we would be looking to do in Queensland, we should look to do it as well as possible.

How big would it be ideally? How many beds would have? ---From the literature the preferred size seems to be eight to 10 beds, but you might co-locate the number of units in one place.

So we've got 600 young people in residentials at the moment. That's a lot - - - ?---Our colleague - - -

Lot of (indistinct)?---Not all of those young people in residentials need secure.

No?---A lot of them don't - - -

What proportion do?---They might need other things in those residentials that don't meet their needs.

What do you think? What proportion do you think do?---A colleague of mine who actually has some experience of the UK estimated - if you extrapolated from the United Kingdom, they have 4.2 places per million population, that would imply 19 or 20 for Queensland. From his experience with Evolve and where he works, he estimated around 67 places. Saying that, we have some particular challenges because in looking at the English and Scottish literature one of the barriers that they identified was distance from home, particularly in maintaining relationships with family and in their context, social workers, and transitioning young people out into lower levels of care. Now, if that's a challenge in Scotland that's going to be a major challenge in Queensland.

It's hard enough with foster care placements?---Mm.

Anyway, so I gather the upshot of that is that you need about 10 or eight beds in Queensland - eight and a half? ---The estimates would be somewhere between 20 to 70.

Beds?---We need to be careful - - -

Yes, but that would be eight different facilities?---So eight units, yes, sorry. We need to be careful that if we just build secure units we will have increasing demand for secure units.

You build it, they'll come?---Yes. So we need to address the whole continuum of care. So you if, say, there is - I have contact with a lot of young people that are engaged in a placement, they're not absconding, but their behaviour is such that it is not easily managed in that placement, so police are being called and they're ending up in ED or in youth justice, that's not a helpful intervention for a whole lot of reasons. It is not effective. We could better design and support and enabled youth workers to manage those young people within that placement in a way that under current legislation, the way the system is set up, they don't have the ability legally or practically to do.

What have you got in mind there? What can't they do that they should be able to do?---It's a contentious area, but they need to be able to sometimes restrain or otherwise place a child on their own. The extreme of that in a psychiatric unit is a locked room, and I know Dr Stathis has spoken to that - not necessarily that, but provision for helping a young person learn that if you start to lose control, actually going to a quiet place to calm down is good thing to do. At the moment if the young person becomes aggressive the message we usually get from the youth workers is that they cannot lay hands on the young person, they need to call the police. So we're criminalising 11, 12, 13-year-olds where the police are being called because they've got angry and they don't have - like, we've talked about the emotional regulation, the ability to manage that anger, they strike out, and rather than that being managed in a way that can just contain in that environment, which might be by holding them safely or taking them to a room to calm down - need a lot of oversight, need a lot of skilled staff, need a lot of supervision, reflection, support, monitoring - but maintain them in that environment rather than the disruption of them being taken to the police station.

Not to mention the redirection of police services from other areas?---There would be a lot of work in looking at how do we change? How do we improve across the continuum of care, how we manage these young people.

Are we getting more or less of them as time goes on?---I think that's a difficult question. I worry that there's more, I'm not sure if that's realistic. We are certainly getting them brought to emergency departments more and more.

What about parents? Are parents becoming more or less able to cope with their children with higher needs than most? ---We're often looking at intergenerational problems and we're - the childhood adversity has often been adversity for the family and for the parents.

So if we look at this, we're examining a child protection system?---Yes.

It's sort of broadly the same as most other jurisdictions in Australia and across the Western world, but everywhere - doesn't matter whether you live in a big state like Queensland or a little state like Victoria; whether you've got a high indigenous population or a relatively low one; whether you've got secure care or not secure care; the problems and challenges that all systems are facing across the world in child protection are the same?---Yes.

So we're not unique, we've got our variations. So there has to be something that we all share that none of us yet have really been able to pinpoint that's putting upward pressure on demand for forensic coercive intervention by the state. Now, what do you think that is? I mean, yes, the system is overloaded because there are a lot of notifications coming from mandatory reporters that they've got to investigate and then get rid of 80 per cent of them and then deal with the 20 per cent are left; and the 80 per cent that you get rid of, there's no secondary system to do anything with, that's a problem, that's pressure. Lots of pressure points that are obviously identifiable; not having enough foster or kinship carers, again that's a shared problem. But what is the root problem that everybody seems to be missing? It seems to me that it might well be that the parental capacity year on year is getting lower, not better?---I think there are huge social questions about how we support families, how we raise children, how we value children in our society, that people are avoiding because they're very difficult to answer and very difficult to address. We know that some of the factors that put families more at risk our poverty; it's hard to parent well when you're worrying about how - - -

There's no evidence that the prevalence of child abuse is increasing at the same rate as the incidents. There's no evidence to suggest that I'm aware of that there's more child abuse now than there was proportionately to the increases in population. So the notifications don't relate to an increase in the problem; they relate to increased incidents; that is, reporting on it?---Yes.

So if that's true, then something else has happened rather than more children being abused. There are still more coming into the system and staying longer; not because more of them are being abused but something else and it seems to me that there's a phenomena that has crept up on us and that is the relinquishment by parents of children with challenging needs that they can't meet. Is that something you have identified?---I think we have a system for children with disability unfortunately that when those children's needs are unable to be met within the family, no matter how caring the parents, then the only way the system works is for them to be relinquished into care. So that's one group.

Is that a growing group?---I can't speak to that. It's not my field. I think sometimes becoming more aware of a problem is a good thing so knowing accurately how much child abuse and neglect there is in our population enables us to plan and intervene. So if it's just that people are reporting more and we've got the same number, there are pros and cons to that, but that can be a good thing. From my work I sometimes have the impression that the expectations of the state to fix things and how services and child-protection services and those elements of the state are increasing - - -

That was rather my point. It seems to me that there has been a shift. The parents have got or the family has primary responsibility and that's traditionally been the case, the moral and legal responsibilities, but somewhere along the line there has been a shift to the state and that the expectations of everybody is that the state can step in more than it actually can under the law. The state's role is very limited by law?---Yes.

People keep talking about early intervention but the state can't intervene into a family's privacy and the parental autonomy unless there's a threshold that's been crossed. So unless it's voluntary, they can't act against the parental wishes unless and until they have got a valid justification for doing it which in our system at the very minimum is a reasonable ground to suspect that a child has been harmed or is likely to be harmed?---I think one of the big questions is how can we move from an adversarial system to a cooperative system, collaboratively supporting families.

I mean, whose job is that? What do you want to do? Do you want to have the state have more intervention power, only less coercive? How does that work?---That would be a contradiction.

It would, wouldn't it?---Mm.

So what are people looking for, more or less state involvement in families?---Less state involvement.

Right?---More accessibility to family support.

Yes, but what does that mean? Does that mean more provision of services by the state for people to access if and when they want it?---Some provision. It can mean a lot of things.

Yes?---I'm sorry, there is no straight in these questions.

How about this for an example? How do you do this: you say secure care for the children who need it. What about for the unborn child who needs help because the pregnant is drinking alcohol or is a victim of domestic violence? If something is not done, that child is going to be harmed are birth. Before the child gets a chance at life he or she is already going to be harmed. How do we help that child? ---By helping that mother.

Right; and only to the extent that that mother wants to be helped, isn't it?---Mm.

That's the answer?---We have a difficult – because we have an adversarial system, we have a difficulty in trying to balance rights and it becomes very complex around whose rights do we prioritise in that situation.

Clearly at the moment we don't prioritise the unborn child's rights because a child is defined as a person from zero to 18?---Mm.

I mean, it's not a big step to say you have secure confinement for children and for their benefit to say you have some sort of secure confinement for a pregnant woman who's not doing the right thing for the child who might be born with foetal alcohol syndrome disorder if some intervention isn't taken. I think the Queensland Police Union has advocated some form of containment for women in that category, but there are other risks to women who are pregnant?---We've struggled with that. It is a huge area of difficulty and ethical difficulty.

But the answer you come up with has to be logical and equitable and coherent across the board. You can't say secure care for one cohort but not for another even though the risk to a child is the same. It doesn't make sense? ---There is risk to the unborn child. Again, I guess, your

question: is there evidence that detaining the mother would change those risks?

It would keep that particular child safe, wouldn't it, on your argument about secure care keeping the child in need of it safe?---It would keep that child and potentially subsequent children safe if the mother could be engaged in looking at her difficulties, her drug use or whatever it is and making changes.

That's a big if. That's a big if, isn't it?---That's a huge if. The mother does have rights as well. There is no clear-cut answer as to what is right and wrong because we're balancing rights and risks and trying to estimate those and we have such an adversarial system that says, "We're going to work out whether you're a good parent or a bad parent and act accordingly," when the reality is most parents are somewhere in the middle and we're looking at parents with vulnerabilities and with difficulties often intergenerationally, as I've said, so - - -

Except that I'm inquiring into the child-protection system, not the adult-protection system so we have to look at - you know, the system looks after the children and it says that the best interests of the child prevails over the rights of anybody else. That's what it says theoretically? ---Theoretically.

Okay, sorry, Mr Selfridge.

MR SELFRIDGE: Yes, thank you, Mr Commissioner.

Dr Fryer, I'm a little bit fixated on this concept of secure accommodation and how that could be implemented in a practical sense and under what auspices. I'm not advocating for or against it. I'm just trying to understand how it can be implemented. With the caveats we have already described or accepted, I accept that there's – just to hypothesise, I have accepted there's a need for secure accommodation for a small cohort in terms of their immediacy of safety and risk that's related to that. It's not a subcategory as such. It's part of the same cohort, but keeping them in secure accommodation for as short as possible but long enough to be effective – it's this paragraph. Is what you're suggesting that there's a need for some form of stability, continuity or within hopefully a safe environment where you have a captive audience as such in terms of therapeutic intervention – is that what you're talking about?---Basically, yes.

Yes, so currently the Child Protection Act states that it's got to be the least intrusive order possible under section 59?---Yes.

Is what you're advocating that if they're going to intervene in these children's - the young people's lives, that that is the least intrusive order in order to facilitate some form of effective change? Is that what you're saying?---It's the same concept.

Yes?---And we - - -

COMMISSIONER: Except the problem with that is the least intrusive question isn't about where the child is placed, it's about whether you should transfer guardianship to the chief executive. Once you do that, once the chief executive becomes the guardian it's up to her to make the placement decisions.

MR SELFRIDGE: Yes. Under this current model that we have, yes.

COMMISSIONER: That's right.

MR SELFRIDGE: Which doesn't cater for secure accommodation, arguably, but I understand.

COMMISSIONER: So really that's it. Once the state says, "Okay, I've intervened in the family. This child now needs the protective care or the transfer of the parental rights and responsibilities to the state," and the court says, "Yes, that's right, I agree with that. Here's your guardianship," the chief executive normally becomes the substitute parent and then makes the placement decisions administratively. There's no statutory control apart from the principles in section 5(b) about what that placement should be - or section 82 as well, maybe. But the choice is hers.

MR SELFRIDGE: That's correct, under that current system. And I'm just identifying that under the current system as such it's also the least intrusive order possible, but what we're seeing here, just to understand what Dr Fryer has put before the commission, is again under all those caveats, but essentially that if a child is going to be taken - if the state is going to intervene in a child's life in terms of secure accommodation to provide a safety net for that child in the immediacy of risk, that as I understand the evidence, it has to be extended to include some form of therapeutic intervention or effective change in that child's life so that it's not for a short-term fix, as such, that it be cyclical.

COMMISSIONER: So the question is who decides whether secure care is appropriate: the chief executive who is the guardian, or the court?

MR SELFRIDGE: Well, that's essentially where I'm going with this because - - -

COMMISSIONER: That's what I thought.

MR SELFRIDGE: - - - I don't have clear instructions in relation to that and I'm not going to stand here before you, Mr Commissioner, advocating either way. But it's certainly something that is worthy of consideration.

COMMISSIONER: Somehow it needs to be regulated.

MR SELFRIDGE: It does.

COMMISSIONER: Yes. Because you can get a situation where the chief executive as a guardian actually ends up with more authority and parental rights and responsibilities than their natural parent had over the child.

MR SELFRIDGE: Yes. I understand, yes.

COMMISSIONER: I'm not sure whether that's necessarily where everyone wants to go.

MR SELFRIDGE: No. But the concept of secure accommodation, obviously as we've just identified, throws up a whole series of other considerations that are not suggested - - -

COMMISSIONER: That's an important consideration: how is it regulated; by whom; who makes the decision; based on what criteria; what reviews are there; what right does a child have to - for example, have the length of security or the type of security or the nature of the building reviewed by some administrative review body?

MR SELFRIDGE: That might be a matter for submission because Dr Fryer is a child and adolescent psychiatrist, yes. The evidence that I'm seeking to elicit just now is - - -

COMMISSIONER: No, but I'm just talking to you, I'm saying at some point you're going to have to get some instructions.

MR SELFRIDGE: Absolutely. Yes, absolutely.

COMMISSIONER: Yes.

MR SELFRIDGE: We're getting this evidence and some other's evidence. I have no further questions for you. Thank you, doctor.

COMMISSIONER: Yes, Ms Stewart.

MS STEWART: Good morning, Dr Fryer. I'm Lisa Stewart from the Aboriginal and Torres Strait Islander Legal Service. Just touching on some evidence that you gave

before which I think is based on your academic findings and the literature in regard to secure care from Scotland, and you've identified that distance was a barrier for maintaining relationships with the young people in the accommodation, if I've understood your evidence correctly? ---It was a barrier in terms of, yes, maintaining relationships and transitioning back to the community.

Considering we have about 40 per cent of Aboriginal and Torres Strait Islander children in out-of-home care and some of those children could possibly be in secure accommodation, how do you propose to incorporate indigenous professionals in probably both the decision-making process in relation to those young people and working with the young people?---I would look first to see if there are international models that have worked with indigenous peoples that might give me some ideas and guidance about what would be important to think about and work with. I would want a lot of input from people who have expertise in that field and from Aboriginal leaders themselves and workers in the field around - and there would need to be a lot of careful thought about the particulars of the Queensland situation and what would be appropriate. We have a lot of history to take into account and to be cognisant of, and I refer particularly to the stolen generations; and as you say, the situation now where we have a lot of Aboriginal children in care, and a disproportionate amount. We don't want to replicate the mistakes of the past, we need to learn from them, so whatever we create - and I don't have the answers for you right now, but there would be a lot of work finding the best way forward because whatever we create does need to be culturally appropriate. Have input - one of the things I touched on earlier was the importance of your life story to your sense of identity and well-being and psychological well-being. It may be things that we can learn from indigenous cultures about that and that storytelling that might help not only in us providing good care for young people with indigenous backgrounds, but also for all young people. So there are a lot of information sources I would seek and advice that I would seek in planning. At the same time I don't want to deny a young person an effective intervention which might give them a lot more hope and opportunity for the future because of their indigenousness or because of other background factors, and very much looking at that young person and what's in their best interests.

I suppose my question is more directed over the cultural competence of the intervention and how that leads into the positive experience or goes towards a more positive experience in care. But it leads me into my next question - - -?---And it's an important question of whether that can be achieved and whether it is the right way to help those

young people or not, or whether there are alternatives that we should be looking to. And that's a whole piece of work that should be done.

Because many indigenous children have strong linkages the family, and by that I mean their extended family and the country, and those experiences can be positive and may not relate to the reasons why they're actually in care. How do you see you can maintain that connection when young people are in secure accommodation?---Again, that's a huge question. I will try not to remove them from that community in the first place unless it was absolutely necessary to their safety and well-being, and especially to their safety. We have huge distances in Queensland so being thoughtful about where such units are, how they link back; we also have a history of being very innovative use of telemedicine and videoconferencing. It's not the same, but there are innovative and technological ways that we can keep young people in touch with their communities.

Like Facebook as well?---Like Facebook. So we need to be very creative with the distance and how we minimise that distance using all the resources that are available to us. The ideal would be for any young person - the ideal is to stay as connected to the community and particularly to those positive relationships and continuity of relationships that we can manage, and particularly as you're highlighting, there are - just because a family is unsafe doesn't mean a community is, and those protective factors.

Just leading onto a question that you were asked by the Crown before to do with what safeguards you could have in place once you have a young person in secure accommodation, once that young person has been assessed as meeting the criteria - - -?---Yes.

- - - which, from my understanding of the evidence, if they exhibit high risk to themselves or to others, is the type of behaviour that - - -?---Yes.

As a practitioner, I suppose, working within that sphere, what kind of checks and balances or oversight do you identify would be needed to balance the young person's right, and you spoke to this before, against, you know, what interventions that young person could require to meet the needs?---So ways of helping the young person express their views and their needs and having input?

Well, having input, but once they've been assessed as being suitable for – well, needing secure accommodation. What happens there as far as overseeing - - -?---I think the first part of that is having a transparent assessment and decision-making process that doesn't come down to one person to make that decision. So we have a process for entry for young people into the Evolve intervention system which is a panel composed of different agencies and that seems to work well. So the first part of what you're asking is making sure that the process eventually in itself is transparent, then it's - - -

Would that – sorry?---Yes.

Would you also see the benefit of perhaps that being an order from the court rather than – or do you see that sitting outside the court process?---The models I've looked at, that's an order from the court and I think that's appropriate. I think there does need to be some sort of oversight of that and systems of regular review. In terms of the oversight of units themselves, I think we need to – we're very good at talking about oversight and monitoring. We actually need to set them up in a way that best sets them up to succeed. So I've talked a bit about the training of staff, the expertise of staff, high staff to patient – or young person numbers. They're not really patients, I'm sorry, that - I'm a doctor and that tends to be the language that I use, but high ratios, and look at rostering. Then you can develop indicators of how well your unit is functioning. So you keep a measure of incidents of aggression or self-harm or conflict and you need a safe system where the staff can reflect on what has happened and learn from – work with the young people. "How do we progress this, how do we reduce the frequency of these instances, how do we move forward?" So you need both that level – and I talked a bit about the supervision in the context that I understand it. Then you need oversight, so you need someone who is monitoring those figures. We have a system of official visitors, community visitors, for young people in care, so that is another way that can provide a voice. There's someone coming in who has some independence that the young person can talk to. Skilled management staff and leaders in that that are also supported through the hierarchy of that to monitor and feel safe to say, "Hey guys, I think things are going a bit awry here."

Just talking about - - -?---Contact between units, research, outcomes, evaluation, there's a lot of – yes.

Yes, because you've identified you see the benefit of that being an order from the court, but your evidence is that it should only be the shortest term possible but long enough to be effective. I suppose I'm looking more do you see that oversight of the order always being maintained in the court so, you know, we have a therapeutic order, or whatever term we want to put on it?---Yes.

Should you see that as being reviewed every six months by an external agency, perhaps, and that evidence of the health professionals that are working with that young person being provided to that external – to see whether we need the next six months, do we need another six months after that?---Given the level of restriction that we're placing on a young person I think that's reasonable. Again, I'd like more time to look at international models and how they work, but I think my sort of best case scenario is that is someone who is external but has understanding of these young people and what they need so they can make decisions – so they can ask the questions that encourage professionals to think about what they're doing and how things are progressing and what might be done, what needs to keep going, what might be done differently, how we're moving this young person forward. It sounds very imposed on. I actually think it should be a lot of working with at that level.

And a process of stepping them out?---And that we're not delaying transfer and we need good step-down and transition planning. There's a comment in the literature which I think is very pertinent, is that discharge planning should start at the point of admission. So almost from the moment they come through the door one of your goals is where are they going to go to, and that enables much more effective planning. It keeps that goal in sight so you don't get stuck in the day to day but it keeps that goal in sight from the moment that they come in. Also, if that transition is planned the young person has a sense of certainty and predictability over where they're going to go. They can visit, they can get to know the staff or the foster carers or whoever it's going to be where they're going to do. You're increasing the chances of the young person having success in that transition. The poorer outcomes, and that's commented on in the literature, are where young people are moved out very quickly, without a good transition process, without a time to make those linkages and start to form those relationships.

I just want to touch on a conversation that you had with the commissioner and perhaps with the crown about the youth workers should be better supported in that environment. I just want to flesh that out to the extent – I suppose you've heard the saying if you invest a dollar here you'll

save seven later on. Do you see - - -?---Not quite in those terms, but yes.

Yes. I don't think I've probably correctly phrased – but just in the context of that particular saying, do you see that something needs to change in residential care? Do you see a link between perhaps the young people's needs not being met there and those behaviours escalating to the point that we need now to - - -?---I think we need an upskilling and valuing of our workforce, from foster carers through to residential care workers, through, especially if Queensland decides to go down that route, into secure care. So I think that needs to happen across the board. I work with some very – or have worked with very dedicated youth workers who are really working hard, really trying to do the best by the young people that they're trying to work after, but they come in at a relatively low skill level and they're not particularly well paid and often there are financial restraints that make it difficult for them to access ongoing training, and that needs to change. That's my experience, and as I said, we need to upskill and really value what they do. The more severe the young person the more skills you need in working with them.

Just on that point, we've heard some evidence about some young people - having problems engaging the young people with their psychologist or their psychiatrist or their youth worker. There can be a disengagement and it makes them difficult to work with. How do you as a practitioner overcome that difficulty of not labelling the child as being too difficult to work with, or it's their behaviours that are a barrier to engagement, as opposed to trying to - - -?---I try to come from a position of understanding and empathy for the young person and one of the key things is appreciating that they are moving away from the help that I'm offering, because their experience is that adults are not helpful and not protective, they need to look after themselves. They make believe that they can but at the same are using drugs or couch sitting or homeless, and so I also am trying to, what I talked about before, holding the hope that actually things can be better for them. They may well not see that for themselves, because they think that this is all that life will offer to them.

How do you overcome that? Is it just perseverance, is it - what's the - - -?---Reliably being present and unconditional positive regard. "No matter what you do, I will be here for you and I can see good things about you and within you even when you cannot see those for yourself," and it's repeating that and repeating that and repeating that in experience and relationship over a long period of time to try and help them learn that there can be better ways of relating than what their early experiences were. We talked about the brain development and the templates that have been laid down, so we're trying to change, and that's hard.

I have nothing further, commissioner.

COMMISSIONER: Thank you. Mr Capper?

MR CAPPER: I have no questions, thank you.

COMMISSIONER: Yes, Ms McMillan?

MS McMILLAN: Just one issue. I understand there was some evidence given last week where at least one young person who was in residential care had been relinquished because of their behaviour toward their siblings in the family, that they were effectively uncontrollable and posing risks to their siblings. I take it that might be, if all else fails, a further necessity for something like secure care in the most extreme of cases?---I think that's true. I think we need to – children in care and children even in secure care have families and those families remain important. In that instance there may be a lot of work that can be done with the family that might enable the young person to go home. I don't know the details of that, but I think one of the ways of working, one of the things with Evolve, is we work with everyone involved in the life of the young person, and a piece of learning for us, when Evolve started it was these children are in the care of the state. They're suddenly coming into this very new model, as it was in Queensland at the time. We sort of had the impression that we weren't going to be working a lot with families and part of the learning for us was that families are important, that they remain important. The vast majority of young people will make contact with their families and return to families when they leave care and family is a very important part of that system. Even after a child has been removed attempts can be made and success can be achieved in helping facilitate the best possible relationship that the young person can have with their parent or with their family, even if it's not living together. That's something that we strive to as part of the treatment plans, is facilitating within the bounds of safety, as the primary concern, obviously, the best possible relationship that there might be between that young person and their family.

Yes, all right. I have nothing further for the doctor. Might she be excused, Mr Commissioner?

COMMISSIONER: Yes. Doctor, thanks very much for coming. Your help is very much appreciated?---Thank you.

You're formally excused from your summons?---Thank you.

WITNESS WITHDREW

MS McMILLAN: Mr Commissioner, might we have a short break just to rearrange ourselves for the next witness?

COMMISSIONER: Okay. What are we looking at?

MS McMILLAN: 10 minutes – five minutes, I'm told; five minutes.

THE COMMISSION ADJOURNED AT 12.19 PM

THE COMMISSION RESUMED AT 12.27 PM

(Reporter's note: recommencement not recorded)

MR HADDRICK: .....order; that is, the transcript of just this particular witness so as to allow this witness an opportunity to consider the contents thereof and also seek guidance from her superiors in the New South Wales government in respect of what matters can and can't be made public. I understand that this witness has the permission of her superiors to appear here today, although she also appears here by reason of summons and she has also had the advice and assistance of the legal representatives of her superiors in knowing what she can and can't say here today, but out of an abundance of caution I propose that those particular arrangements be put in place in respect of the evidence of this next witness.

Furthermore, that gives rise to one final aspect and that is: what is to be made of those who are in this commission room or courtroom in respect of what they hear? I remind you, commissioner, that you made orders on Monday of last week in respect of non-publication of identifying children who are subject to the care system or, indeed, identifying any child and that order that you made on Monday last week continues to apply to all those in this room who will hear the evidence of the next witness.

Much the same as section 121 in the Family Law Act permits the Family Court and the Federal Magistrates Court to allow persons to remain in the public gallery but obligations of confidentiality in terms of non-identification of parties apply to those persons in the gallery, the same principles would apply to the way this further evidence is heard. So with your permission I will call the next witness and ask you to make an order that live-streaming be deactivated for the purposes of that witness's evidence.

COMMISSIONER: Yes, I direct that the live-streaming be terminated now and I will direct that the transcript of the witness's evidence not be released until further direction which I might give privately and I direct that everybody in the public gallery - while you are more than welcome to stay and hear the evidence, you must not publish what you hear to anybody else outside the room. Yes, thanks, Mr Haddrick?

MR HADDRICK: I call Ms Janice Carroll.

CARROLL, JANICE affirmed:

ASSOCIATE: Please state your full name and your occupation?---My name is Janice Carroll and my occupation is – I'm employed by Family and Community Services as the director of intensive support services.

Please be seated?---Thank you.

COMMISSIONER: Good afternoon. Thanks very much for coming; welcome. Yes, Mr Haddrick?

MR HADDRICK: Thank you, Ms Carroll. Just for your purposes, as you were walking into the commission room the commissioner made an order that live-streaming be switched off for the purposes of your evidence and you will be afforded an opportunity - you and your superiors will be afforded an opportunity to examine the transcript prior to the transcript of your evidence being published so that you can raise matters with officers of the commission that are of concern to yourself and your superiors in respect of the operations of secured care in New South Wales. Thank you very much for coming along. The commission greatly appreciates you travelling up from Sydney today to provide us with evidence from New South Wales. Now, you mentioned to us your title. Can I just get you to repeat that title?---Yes, I'm the director of intensive services.

What does that mean to ordinary people?---About nine years ago – 2003, I think. About nine years ago the department looked to see how it could better improve its service, the whole of the service system, for children.

Now, this is the New South Wales Department of Family and Community Services?---Now it's Family and Community Services, that's right.

Yes?---Looked to see how we could really strengthen the delivery of services to children who were in out-of-home care and for those children who have very high and complex needs. We, you know, kind of lovingly call them "high-needs kids" often so that's a term that we sometimes use to describe that cohort. My position was created as part of that response and there was also a commitment of specialist case worker positions created that are state based and in regional teams throughout New South Wales and they're case workers who specifically work with children with high and complex needs so they carry a reduced caseload.

Now, you're the head of this team, are you?---I'm the head of the team that sits in Sydney. The Sydney team provides a service to three metropolitan regions.

And the Sydney team is charged with the running of a secure-care facility in the greater Sydney area?---Yes, Sherwood House and Sherwood Cottage, the two residential units that the department operates, also report to me.

We will jump into that bit in a second. I just need to identify – now, what is your professional background? What are your qualifications for your current role?---My initial

training was in nursing but I'm not currently practising as a nurse and don't keep that current. I have a masters in management and I'm currently undertaking a masters in forensic mental health.

Now, how long have you held your current appointment as director?---I think it's about nine years; eight or nine years.

And always in charge of this area of departmental activity, that is, intensive services or intensive care?---In this current job?

Yes?---Yes, so responsible for the metro ISS case work team, the secure-care unit, but that hasn't always been there. That's a relatively new addition.

Certainly?---I also look after the practice, so I have a statewide practice role for the other ISS teams, although not a direct line management role.

What's an ISS team?---Intensive support services team.

Because we're obviously using New South Wales' descriptors for activities and government services and, of course, we're in a different jurisdiction - - -?---Yes.

- - - I might just get you to treat us like we're - - -? ---Try not to do that.

So that we can marry up what's happening down there with what we understand is not happening here. So what does ISS do?---The intensive support services system is a case based – case work-based teams who carry a smaller, reduced caseload and case manager a small number of children who are in out-of-home care who have very complex needs. Usually the children are living in either foster care or residential care, either directly with our own agency or with one of our non-government partners.

So it's professional therapeutic services provided to children who are in out-of-home care, be that residential care or foster care?---And the ISS teams hold the case-management responsibility for those individual children.

When you say "case-management responsibility", are we talking about psychologists here or are we talking about social workers? What disciplinary training are we talking about?---Case workers in New South Wales come in with a tertiary qualification relevant to the field but that varies in terms of what those qualifications are, but, you know, there's a high presence of social workers and people with social science-type degrees.

But in addition to BSW's, can you have someone with a nursing, science background or a community - - -?---You could have, but everybody is still employed as a case worker against that particular category and award.

Now, you have told us about broadly three different categories of activities you're in charge of?---And just one more. That's also the management of the vacancies and referrals across the state for the intensive residential care beds that we have in the residential system.

So that's almost like a placing service, is it - - -? ---That's correct.

- - - for children who need to be placed in what, residential care facilities that are described as intensive?---That's right.

Now, how many employees report to you, roughly speaking? ---Just direct reports?

Break that down if it doesn't make sense?---No; no, direct reports four; four direct reports.

And how many public servants effectively are under your command all the way down?---Public servants probably about 30. The staffing arrangements that we have in our residential units, in our secure unit and our cottage, are not public servants. We contract those staff from an agency.

So there are public servants who report to you. There are a number of people who are contracted to provide services that you supervise on behalf of the department?---That's right.

And then there are a number of other persons who are associated with residential and foster places that interact with you and your officers?---That's correct.

Okay. Now, you mentioned the name Sherwood House before. Can you tell us what is Sherwood House?---Sherwood House is our therapeutic secure care unit in New South Wales.

Where is that located?---In the south-western suburbs of Sydney.

Which suburb?---[redacted].

And that is close to where?---To [redacted].

How long has that house existed?---We only opened the house in - you'd think I'd know that off the top of my head, wouldn't you – from 2008 to 2009.

Why did the New South Wales government decide to open the house?---We had had some preliminary discussions around knowing that there was a small cohort of children whose care needs were not being able to be adequately met in the service system at the time.

How did that need manifest itself? How did it bubble up to be an issue that the government needed to respond to?---It was really on the back of one individual young person whose circumstances were such that there was no other care facility available for him in New South Wales.

Obviously throughout your evidence please don't identify individual children, at least not the correct names, but did that child become publicly known or was that a child who's - concern in relation to that child was simply known to the department?---He was a child known to the department already, so he was in out-of-home care and he'd had several placements and case-managed by the ISS team.

What were the features about that child's care or conduct that meant that he tipped over, so to speak, from needing to be in a residential care to something more significant?---The lead-up to our decision to establish something special for him came after a series of some months of deteriorating behaviour. For him we could identify what the trigger had been, he had lost somebody very close to him. He had been very difficult to care for in residential placement because of the level of property damage that he was exhibiting and it was at a very extreme end. He really had destroyed two residential homes and a number of motor vehicles. What he was really after when he was destroying property was items for which to hurt himself with.

So the secure care option in New South Wales grew out of a response to one particular child?---That's correct.

Was that a ministerial decision to create secure care in New South Wales, or did the department - could it have gone alone and opened up that form of care option?---It wasn't a ministerial direction. My memory is we would - and, you

know, what I think in terms of our usual procedures is we would have advised the minister that that was what was occurring, but it was initiated within the department as a means to address that boy's needs.

So the government of the day received advice from the department that that one particular child needed a response greater than the current system present at the moment?---Yes. We had also to other matters who were both also children in out-of-home care who were subject to containment orders through the Supreme Court in exactly the same way as we manage the children of Sherwood who were being cared for in sort of an interim arrangement of a secure-type care setting but not as part of a formal program.

So the concerns in relation to these three children could effectively be bundled together and responded to in an organised fashion?---One of those people was exiting care and going on to adult services so her need expired by the time we looked at the opening Sherwood, but one of the other young people also then moved into the Sherwood program after the first lad came.

So what year did Sherwood open again?---2008 to 2009.

So it's been operational for about five years now or - - -? ---Yes, it was just - - -

- - - in its fifth year?---Yes, in its fifth.

How would you describe the success or otherwise of Sherwood House?---I think it's been very successful.

I've always wanted to use this line: but you would say that, wouldn't you?---Yes, of course I would, but I think it's done what it - I mean, and I need to sort of I think give it a little bit of context around that. We set it up in a big rush. Without being fancy about that, it was a really big rush. I think we established the program and had it up and running and staffed and functioning within about three weeks of thinking that that's what we needed to do.

Why the rush?---Because the boy and we set it up for, although in New South Wales in the mental health unit had agreed for him to be admitted into one of their adolescent wards, he actually destroyed the inside of the child and adolescent psychiatric unit on the Christmas Eve that he was admitted there.

So time was of the essence?---So time was of the essence. He was moved to - the only way that the health system could contain him was to remove him to move him to one of the forensic adult wards and to have him special with a

number of staff. His level of self-harm had become so life-threatening that there were no options for him.

You mentioned Sherwood House, also mentioned - or I think were at about to mention Sherwood Cottage. What is that? ---Sherwood Cottage is a residential house in a local neighbourhood that isn't a secure premises but it's part of the Sherwood program, it's our transition unit and a step down program, although the children call it the step-up program.

Would be similar to any other sort of residential home in New South Wales?---Yes, very much so.

The only difference between that - - -?---For the cottage?

Yes?---Yes.

The only difference between that facility and other residential homes in New South Wales - as we understand the expression residential homes - is that it's somehow connected with Sherwood House?---That's right.

And it is a transitional placement facility?---Yes.

For Sherwood House?---That's right.

Okay. Now, I want to delve deeply into what Sherwood House is, how it's set up, what it looks like, how it's run; so I'm going to step through each of these bits and pieces as we go along because this is important evidence for the commission. So we'll start with a few photos that you provide to us if I can get this thing operating. I'll get you to tell us what we're looking at here so we can get a good idea of what Sherwood House is. Okay, what are we looking at there?---So that's just the side of the building.

What is the capacity of Sherwood House? How many children can live there?---At the moment our policy, which is probably due for revision, says four. We have capacity for six children and we have at times had six children.

What do we have there?---Again, that's just the side of the - the brick wall to the right is where the walkway is up into the front of the house, and so that wing that you see there are some of the children's bedrooms.

When you say the brick wall up to the house?---Yes, that's it.

You're referring to this wall here?---That's right. So that's just a ramp up to the front door.

Where is it located? Is it amongst other residential homes? Is it out in the plains? Where is it?---It's very much in suburbia but we were very fortunate that the department owned this unit and it sits on quite a large acreage.

So this was a pre-existing dwelling?---It was a pre-existing dwelling. I think it was - you know, in the 50s it had been used as a children's home. It had been renovated some time before we occupied it. There had been some plans around its use for an assessment centre for children and then I think that didn't come to realisation because of, you know, available competing demands on funding. So it was periodically used by the department for staff to sit in when other buildings and offices were being refurbished.

But essentially it's effectively a recommissioned children's home?---That's right.

COMMISSIONER: So say with New South Wales, how many children or young people do you accommodate in your secure care?---At any given time?

Yes?---Up to six at Sherwood House and three in the cottage.

So nine?---Nine children.

Out of a population – a care population of how many, approximately?---I think maybe 10,000.

10,000. Well, we've got eight?---10,000 children in New South Wales.

You have 10.

MR HADDRICK: There were figures that I provided the commission on Monday of last week, Mr Commissioner, where residential care in New South Wales was about 450 whereas in Queensland - - -

COMMISSIONER: 600.

MR HADDRICK: - - - it's 619.

COMMISSIONER: Right.

MR HADDRICK: If that can be used as an indicative figure.

COMMISSIONER: So is that enough, nine places, for the state of New South Wales?---Possibly not.

How do you work out – how do I qualify to get in there? ---We have a very strict entry criteria, and it is very much based on the risk that a young person - - -

So it's a priority list?---It is. I think having one facility as well as and the particular facility that we have, means that we, you know, have some program restrictions based on what we have available to us.

So what happens to the 10th child?---We're not always at capacity, so we don't tend – we don't keep in effect a waiting list. We tend to call – we don't tend to really call for referrals. Referrals are nominated through regions if they are – if they have a child who they think would perhaps meet that criteria for entry.

Would you say – this would be my test, subject to someone suggesting a better one, but would you say that in your experience the young people who go through the Sherwood House and other facility are better off for having done it than they would have been if left in any other alternative?---Certainly.

Is society generally better off for them being there than it would otherwise have been?---Certainly.

[redacted]

Pages 62 and 63 have been removed from this transcript under a not-for-publication order that relates to exhibits 170 – 177 and 180.

COMMISSIONER: None of those exhibits from exhibit 169 to 179 inclusive are to be published without further direction.

MR HADDRICK: Now, I take you to one of the documents, and that is the Out-of-Home Care Service Model Therapy and Programs document. It's not necessary for you to read along but I know you have it there. I'll just read some aspects out to you and ask you to tell us what these mean. That document is effectively, as I understand it, a policy manual almost for the broad principles of the operation of Sherwood House or secure care in New South Wales. Is that correct?---That's correct.

Now, how does a child end up in Sherwood House?---Children are usually identified through their owning region. The children that have come into Sherwood House, it would be fair to say tend to be quite well-known within the region and by the senior people who are supporting staff in terms of working with those children. When a child is identified as perhaps being suitable for Sherwood House I would attend a meeting about that child. There's a whole system and structure of meetings across New South Wales about children who have high support needs and I attend those panels across the state as well, so those children would usually be the subject to a panel discussion. We would look more closely at the specific case plan for that child and to see whether there are gaps in services. Very interestingly, I think, that for all the children who have entered Sherwood House it has never been on the basis of a gap in service, it's just about being able to have that child access the service, usually because they're fairly hard to keep still to be able to afford the benefit of those services. So we would look first at the child's case plan and to look at whether there was any service systems issues that needed to be addressed in terms of - whether there was additional support that could be provided to that child. If it is deemed that the child is potentially going to make the Sherwood House criteria for entry then child is presented before an intake panel.

Deemed by whom?---By their region. If the regional director, who is the most senior person in the region in community services, wants to proceed with a referral to Sherwood House in the child is presented before an intake panel.

And that intake panel is comprised of whom?---The intake panel is comprised of myself, the manager of Sherwood House, the director of psychological services from community services, the director from ICMHAS the Infant Child Mental Health Adolescent Service at south-west Sydney, one of the managers from our Aboriginal services unit at the head office, that's all.

And what are - - -?---And our clinical director, sorry, for the programme.

And what is the decision to be made by that body?---Whether the child meets the criteria for Sherwood and also what Sherwood would be able to offer that child in terms of suitability for placement.

So there are two aspects examined there. If the group forms a view that the child is not suitable for Sherwood House, the child remains in the current care arrangements in the residential care equivalent in New South Wales. That's correct, isn't it?---That would be right.

How often does that group had to consider an application, a request or a referral of a child for placement in Sherwood House?---We do it on a needs basis, so we do it when there is either one or more than one child presented for referral.

Are we talking about twice a year, 10 times a year? ---Probably three times a year, four times a year.

Now, I tendered to the Commissioner a decision of the New South Wales Supreme Court in a matter of re Thomas. Can you explain to us how the statutory machinery works as you understand it in New South Wales that applies to the placement of a child in secure care?---Within our own department after the panel has met and if it makes a recommendation for a child to enter then we first go through an internal process of approval up to our deputy chief executive officer who endorses that panel decision, and her approval also then commences and gives approval for legal services to engage Crown Solicitor's Office and for them to engage who they need to engage.

So after your departmental officials all the way up to the senior executive make a decision that the child X would be best placed in secure care, the department brings an application it in the court, does it?---Before the Supreme Court, that's correct.

What piece of legislation is that under?---Under the parens patriae jurisdiction in the - - -

So it's under the inherent jurisdiction of the court, there is no particular piece of legislation - - -?---No, there isn't.

- - - the law is made under?---That's correct.

The - - -?---When we make an application to the court we appear before the duty judge in equity and make the application that way by whoever is the duty judge of the day.

So there's no piece of legislation that says, like, the Secure Care Act that sets out the criteria - - -?---No, there isn't.

- - - for the identification of a child that could be the subject of a secure care order?---That's correct.

So it's merely the court's inherent jurisdiction in one of its quite frankly ancient jurisdictions that the Supreme Court of New South Wales makes an order that is broadly described as a secure care order?---That's right.

What are they correctly known as, these orders? Do they have a particular name? When you talk to other department officials and you know that the child is subject to the order, what would you say the child is subject to?---The order usually specifies specifically what the Supreme Court has made judgement on, so it's about - it usually reads something like, "To take and" - particularly in the initial one - "and to detain the child at the premises."

COMMISSIONER: I think you can call it a detention order. It's 1 o'clock, Mr Haddrick. How much longer are you going to be with the witness?

MR HADDRICK: Quite a while this witness, given the contents.

COMMISSIONER: We'll adjourn until quarter past 2.

THE COMMISSION ADJOURNED AT 1.03 PM UNTIL 2.15 PM

THE COMMISSION RESUMED AT 2.17 PM

COMMISSIONER: Yes, Mr Haddrick?

MR HADDRICK: Thank you, Mr Commissioner.

Ms Carroll, before lunch I was asking you questions about Sherwood House and secure care. Now, just as the monitor comes up here again, could I just ask you to have a look at these photos again? I took you to this photo here before. Could you tell us what you mean by "secure care"? What is the definition of "secure care" as you understand it and apply it?---In terms of our application of that at Sherwood?

Yes.

COMMISSIONER: How do you secure the place?

MR HADDRICK: Because I can't see any fences around that perimeter?---At the back of the property there's a garden area which the children have access to which is fenced, but it's fenced with the same type of fencing that schools have around so it's the same as the Department of Education in New South Wales uses for schoolyard fencing.

COMMISSIONER: Like tennis court fencing?---It's kind of black poles but not very far apart.

MR HADDRICK: I have a photo here that might be of some assistance, Mr Commissioner.

COMMISSIONER: So they can't get out the front way. Are all those doors and windows locked?---That's correct. None of the windows in – so the unit is divided into a section that the children have access to and a section that the children don't have access to.

Right?---The area that the children don't have access to – so that's the back garden straight out from two of the living areas to the – just to the play garden.

That fence keeps them in, does it?---Mostly.

Mostly?---No, in fact - - -

It doesn't look all that intimidating to me?---I don't think we've actually ever had anybody go over the fence. I believe a child could easily go over that fence.

MR HADDRICK: We'll accept that evidence, yes?---I don't think I could do it but I think they could. The children have – there is some restricted access in the unit so there

is a sort of – the building, as you could, I think, get a sense of when you see it, is not like a standard home. The areas – there's an administration section where the manager has an office and we have some admin support based there and some rooms for people when they come to work there, the caseworkers, et cetera. The children don't have access to that section of the home.

Just before we explore the house a bit more perhaps we should just – I asked you a question before about: what do you understand by the expression of "secure care" and how do you apply it?---Okay. We have it so that the children can't leave of their own will if they're not safe to do so.

How is that effected?---It's effected by having a unit that has got some provisions in it that means you can't access all of the external doors without a key so it's locked. It's a locked unit. The children can't move into certain areas in the unit at all and some they can move through accompanied by staff when doors are opened for them.

I think you have half answered this. Is there a portion of the premises where you can – I don't want to express this incorrectly and pardon me if I do, where a child can be locked in that area and cannot get out from that area?---Yes.

How much of the premises would answer to that description?---The whole living area that the children live in. They can go out into that courtyard garden that you showed the photo of.

So does that include their bedrooms?---Their bedrooms are usually locked during the day, so they need to have access to their bedroom but they're never locked their bedroom.

So that's that side shot that you pointed out and you indicated the bedrooms were along that side there?---Yes.

From a distance that doesn't appear like there are any sort of bars or typical features of secure - - -?---The windows are a Perspex-type material and there's no bars but the windows don't open.

If I suggested to you a particularly industrious 17-year-old boy, perhaps someone that shared my weight, might have no problem at all getting through or getting off the premises, would that be correct?---Well, we have some physical restrictions in the house that I do think make it much more difficult to leave than it would in an ordinary residential home, but we also have a staff category that would prevent somebody from leaving.

What does that mean?---We have a two-tiered staff group. We employ carers and we employ security staff.

So the security staff along with the carers would physically detain a child - - -?---That's correct.

- - - if the child decided to decamp off the premises?---If that child was not meant to be decamping off the premises.

So by "secure", the secure is effected by the personnel there, not by the premises themselves?---I think the premises are certainly – go some weight to that because it's - I think the physical premises lends itself to interrupting a child in the process of their behaviour which, you know, doesn't exist in an ordinary group home where a door can just be flung open and you've gone. There are some barriers that would prevent you doing that, but, yes, staff would also intervene in stopping a child from leaving.

Wouldn't it be cheaper and also effective to complement staff with physical features that also aid and assist a secure environment, for instance, a perimeter fence?---But we have one in the back garden.

Okay; a perimeter fence that in itself was something that could stop children leaving, if that was the desired objective?---I mean, I think that we've tried to keep our level of restriction to as minimum as we can. So although we are a secure unit, the most significant emphasis is on our therapeutic and treatment component of our care. Yes, it's in a secure premises. What we're trying and wanting to do all the time when working with the children is about helping them to self-regulate and to self-manage and sometimes that's best effected when there are actually opportunities that you can use as teaching moments for children.

Can I just tease it out? Last week we had a witness here who was a young person as a witness. He was 16 years of age and he was a couple of inches taller than me. I'm not very tall but he was a couple of inches taller than me and he was a big lad and he demonstrated in his appearance here in the commission of having very little attention span and I think it would be fair to describe as there was a hint of aggression throughout his evidence. Now, if that young person was a person in secure care in your facility and there was a prohibition on him leaving the facility, am I to understand you correctly that if he has impulses to leave literally on a minute-by-minute basis, the only way to secure him in reality is for the security staff to literally detain him physically? How do you deal with a kid who's just determined to get out of there at all costs?---Do you know one of the things that's been quite interesting about Sherwood in the time that we've been running it is that very few of them want to do that. I actually think that what we see very often for children who are the kind of children that we're speaking of today – and

we know and understand now so much more from a neurobiological point of view in terms of what's happening to that child at a time when they are very aroused that, you know, they might fight or flee or freeze, but that's actually just a reaction as opposed to necessarily their intent and so some of those physical barriers that we do have in place is sometimes just enough to slow a child down and to give them opportunity to work with a staff member about being able to self-manage better, but it is of interest that in fact we haven't had – certainly we've had kids abscond but that's usually when we're on outings in community. We actually haven't had kids got from the unit.

And you put that down to environment factors - - -?---I put it down to a number of things. Environmental factors is one, but it's also for some of these children the very first time they've ever been safe in placement.

Okay, what are we looking at there?---That is one part of the larger recreation room.

Would this be the other part?---That's the other end of that larger room, yes.

Is that an area of the house where you would consider it a secure space?---Yes. So that room has a doorway out to the grassed garden area and it has another locked door that goes through into the corridor into the main body of the house.

Now, if we look very closely it appears up in that top corner that there is some sort of CCTV camera thing?---We don't have CCTV. It might be a leftover Christmas decoration. We don't have CCTV in the unit.

How do you monitor the kids around the clock?---They're always within staff proximity.

So there'll always be a human being laying their eyes upon the child at any one point in time?---Yes. Not all children have to be in line of sight all the time. It would depend upon the individual child and their safety assessment. Some children have to be in line of sight and other don't.

Would it aid at all in providing care for the children in terms of both their supervision and also protecting the establishment of the home if there was closed-circuit TV cameras there so that if any issue did arise down the track - much the same reason why police are quite happy to wear recording devices these days, because it provides the police officer with protection against allegations of impropriety down the track - would there be any benefit in having closed circuit television in the house to record the comings and goings and protect the integrity of what's going on in the place?---I understand why people have it and I know that lots of similar facilities across the world do it. We elected not to at the time, but we also made that same decision about it not being in our interview rooms in the office at metro ISS where the caseworkers work. We did that on the basis that really many children behave sometimes for the camera and we thought that in fact it isn't particularly home-like to have a CCTV camera.

Would it be fair to say that the absence of CCTV cameras and perhaps high fencing around the facility, it's all designed to create a home-like environment?---It's our intention to make what we know is an unusual setting as home-like as possible.

What's this a photo of?---That's out the very back of the house. So there's a fence that runs - that fence that runs at the back of the property, that sort of grey thing there in the corner, they're neighbours behind us.

Okay. And this final photo, obviously some celebration was occurring?---Indeed. And that's an older photo with our older furniture in it. We've got our nice orange and green. Now, that's back in that same recreation room.

Some of the basic statistics, you told us that there is currently four, but capacity for six children?---There's currently five children in residence.

But a capacity for six?---Capacity for six.

Is there any special science around that number six? Say for instance Queensland want to go down the track and say, "We're going to open up exactly the same sort of facility but it's going to be for 12 kids. Why six?---Probably in terms of how many bedrooms we have and the ones that would be - the sort of occupancy capacity of the premises. I think in terms of any thought about numbers and what you would do, you would just want to make sure that your premises is designed in a way that can accommodate larger numbers if you were to think of doing larger numbers.

So you see no problem in a figure larger than six so long as the premises is tailored for that larger number?---And I wouldn't be recommending that you care for them in a larger group, so it would be about if you had a premises that really was divided into separate sort of sections that didn't mean that 12 children were coming together.

So it might be the one premises but they might be clustered together, if I can put it that way?---Something - yes.

How do you get along with the neighbours?---Quite well, actually.

"Actually", what does that mean?---Well, because I think often people would expect is not to.

Okay?---Now, we are of slight benefit to the neighbours because this was a property that had been really underutilised for a long period of time so it sort of attracted some local neighbourhood youth who were not - they were not so popular with the neighbours.

So Sherwood House is a step up from what was the previously?---I think that would be fair to say.

From the neighbours' perspective?---But we certainly, you know, get on very well with our neighbours. Certainly the house manager knows some of them quite well. They, you know, will ask us sometimes for access through our premises to do things to their houses, which we're always very happy to accommodate.

Are there any issues that arise in respect of any of the children when they go outside the premises, that they inappropriately indirect with the neighbours or the property?---No, we haven't had that.

Now, could you tell us what sort of restrictive practices - and by restrictive practices I mean deprivations of liberty in some respect - do the staff at the house utilise to provide care and protection for the children?---It would depend on both the individual child and also the cohort of children collectively because sometimes one's behaviour and restrictions do impact on other children. We are authorised as a part of our order from the Supreme Court to use restraint and we do use restraint as a method of keeping children safe.

How regularly is that method utilised by staff? Daily, weekly, monthly?---Probably not daily. I would think at the moment with the particular cohort of children that we have would be once a week, twice a week.

And when you say restraint, what are we talking about? Two security staff pinning a child to the ground or - - -? ---No, we don't do any floor restraint, any prone restraint. We don't have children on the floor except on the occasion that the child throws themself to the floor, which does sometimes occur. But we have a very set number of approved restraints that we've approved of internally. The first point is always just that the child is escorted away from whatever it is that happening if that's possible, and that's probably the one that we see that most of, which is just a staff member on either side walking - helping the child and walking them to another area and in the company of a carer so that the thing that is upsetting them can be moderated for them.

Do you ever engage in any form of restraint that is in essence punitive?---Never.

So all restraint is designed purely for the purposes of - - -?---Of safety.

- - - of safety of that individual child or others - - -? ---That's right.

- - - that child could affect?---That's right.

What are the restrictive practices do you engage in? Say for instance if a child requires medication do you have any particular role to play in that respect?---In fact all the medication that children are prescribed at Sherwood all fall within our parental responsibility in the act, so there isn't anything that's used at Sherwood that wouldn't be used for any other child in out-of-home care.

I'm not speaking of the use of the medication, I'm speaking of the administering of the medication. So for instance a child is prescribed to have some sort of drugs for the purposes of - mental health reasons?---Mm'hm.

And they're tablets; the child doesn't want to take those tablets. What happens?---We don't force tablet into children's mouths, so we would always give a child an opportunity to have a bit later if that meant that they were able to be more compliant in a minute that they perhaps are now. But if a child absolutely refused to take the medication we would note that and advise their treating doctor that that was what was occurring.

But you'd never take it that one step further and force administration of that drug?---No, we don't. There's one - I mean, we've had a couple of people who were on antipsychotic drugs by injection, but that is given as part of a routine medication and done by our colleagues in mental health.

So someone arrives at the premises, administers the drugs, and then departs?---That's right.

Do they ever need assistance in the administration of those drugs?---No.

By assistance I mean restraint of the young person?---No.

What if that was required? How would you respond to that? ---I think we would make a decision in consultation with their treating psychiatrist, because I think we'd need to understand what the presentation of their behaviour was and if it was driven through – because of reasons of mental illness then there might be need for that child to go to hospital and to be cared for and managed under the Mental Health Act.

I just want to focus in upon staffing and training and the composition. So you're the departmental official who has responsibility for Sherwood House and a number of other services?---That's right.

Who is beneath you? Sketch out the staffing composition for us – and perhaps I should also ask you before you answer that, did I understand you correctly before that you say there's outsourced staff functions?---That's right.

Explain what you mean by that?---So at Sherwood House and Sherwood Cottage it was a decision – it was really a decision that was borne out of that immediate necessity of setting up a service quickly where we purchase our care staff from an agency that provides staff.

So the house belongs to the State of New South Wales? ---Correct. The house manager is a departmental employee.

But who are all the other people?---So then the other people that sit in the house and form part of the staff support are carers and they come from an agency.

So you pay them by the hour or contract the job?---We pay the – yes, we pay the agency in terms of those staff.

How many carers are we talking about?---There would be up to about 18, probably.

That's the total composition of the caring staff of the facility?---Yes.

How many would be on duty at any one point in time?---The ratio we aim for is one carer to two children. So if there's six children there would be three care staff and two security staff depending upon the individual kids.

How many security staff are there all up?---Again, we purchase them from an agency. I would say there's about 15, 18 – no, actually, there might be less of – I'd say there's a few less than carers. They work longer shifts.

Are there any particular qualities or training that the security staff are required to have to work in this facility, and if so, what are they?---I think that that's an excellent question, because I think it's one that I would like to spend a little bit of time talking about.

Certainly?---One of the things that happens – that I know people are sometimes a little surprised about, is that we do have security staff as part of the staff group, but I also – but I'd like to impress that we have the security very much as a backdrop in the children's lives. So if you think of the child in the centre and the carers around them, that security are really on the perimeter of the child's life.

Do they wear uniforms?---They were a very basic uniform, which is like black pants and a white polo shirt with a little logo on it from their company. The reason that we have looked at the uniform issue and we have decided to maintain it, because the times that we have had any issue in community where the security staff have been required to assist, it's very helpful for them to be able to be very formally identified as a licensed security person.

What sort of issues in the community are you talking about? ---If we've had children's behaviour escalate to a point where they've needed to be physically assisted back to the car to come home to Sherwood. So those things have included one young woman who took off all her clothing and jumped into a creek. The security staff had to help the care staff to get her out of the creek and that, you know, did cause a moment of community - - -

Concern?---Concern.

COMMISSIONER: So you didn't want good samaritans coming in to the aid of the young lady?---That's right, and so it needed some – it needs sometimes for them to be able to be very formally able to identify who they are and what they're doing.

So they are highly visible?---But in saying – but just a little bit more about it, we are – this was not by design, and so it was one of those moments in time that was just very lucky and we have really capitalised on that lucky moment. The company that we use was the department's contracted company and it transpires that the majority of the fellows who are employed by that company are mostly from overseas and the majority of them are very highly skilled and experienced people from very different walks of life whose qualifications don't carry to Australia when they left their own country.

MR HADDRICK: This is the security personnel?---The security personnel. So in fact our security personnel, although they're working now as security staff, have - - -

They could be, for argument's sake, a medical practitioner from the subcontinent?---That's right.

So they have some - - -?---So we have a very high calibre of security staff, and as I said, that wasn't by design. We didn't know it at the time. We became aware of it fairly early on in the piece as we got to know the staff.

What you're saying there is effectively the security staff – the house benefits from having security staff who have a – who are highly trained in some respect?---That's right.

In more than just simply plain old crowd management skills? ---Absolutely. So one of the things – and as I said, security are very much on the perimeter of the program. They only become more present at a time that the child is very unsafe. They don't interact with the children to the degree that carers do. So they don't eat with the children, for example. The care staff and the children have their meals together but security don't. The reason that we've done that is that the intent is that we can fade security from a child when they don't require that. So although we have a secure care unit, and as I – we'll talk, I think, about the therapeutic points of that, the security fades when a child's behaviour is such that they're safe or safer to manage and that security presence is only there when they're not safe.

Do the children ever attempt to develop friendly relations with the security staff?---I think they absolutely have a relationship with the security staff, as they do with all the staff that work in the program. One of the things that became apparent to us and which is why we have the great fortune of a staff group in security who are so skilled in many areas is that they provide for us quite a significant amount of information in regards to what's happening in the unit in a way that I think care staff involved in the day-to-day care perhaps don't see as readily as somebody who is just observing.

Turning to the care staff, I've asked you about the skillset of the security staff. What about the care staff? Are they run of the mill people who work in residential care units or are they a more highly skilled group of professionals?---They are the run of the mill youth worker who are I think cert III and cert IV trained. Most of them have had experience working in group homes, in residential care. The thing that we have done is invest heavily in terms of their ongoing training and support, for which we believe is not only absolutely necessarily but I think has also given us, you know, a really good retention rate amongst that staff group. The form of help, supervision and training that they get is that they all have face-to-face supervision either with the manager of the program, so all the team leaders – there's a team leader on

each shift. The team leaders all have face-to-face supervision with the manager.

How long is a shift?---Eight hours.

So there's three shifts a day, obviously?---Yes. The other care staff have face-to-face supervision with the program coordinator from the placement agency, the staff agency, and she's on site with us two days a week as part of that package that we purchase. The staff have an ongoing training calendar that we deliver for them, bringing different people around different areas of training. That's about every - I think that's every second month and we pay staff to come to training so they're all rostered on and they're paid to be there.

Okay. Now, what do you do in a situation where I'm the kid in the facility. I have got certain behavioural problems. You're a staff member there. I don't get along with you. You're employed by the service company that provides you as a carer and the best way to effect peace in the house is to get rid of you. How is that managed?---If that's the child that's attempting that, do you mean?

If a situation is observed where the relationship between a child in the house and a regular staff member is not conducive to that house's dynamics or the treatment of that child or any one of the children in the house?---Providing the staff member isn't doing anything wrong, so I'm just clarifying that - - -

Perhaps I will give you an example and you might be able to translate that across. We have heard evidence last week in residential-care houses that on occasions smart kids can play off staff against one another or indeed effectively drive a staff member out of a residential-care facility. How do you stop that happening in your facility?---I think going through some of the things I just started to talk about in terms of the supervision for staff, the training that we provide. There's also an eight-weekly debrief that's facilitated by our clinical director and that's for all staff employed in the program so security and care staff. We've worked fairly hard at having a very transparent and open process of people raising issues and we do that as part of that group supervision and debrief. If we thought that there was a child or children targeting a staff member, we would address that with the children. If it was about improper practice from the staff member that was beyond, you know, developmental needs, then we would be addressing that through a disciplinary process.

Now, if I could just return to perhaps a couple of what probably should have been my first questions, what is the gender make up of the house?---At the moment it's all girls.

All girls?---All girls. It's five girls in the house and two girls at the cottage.

What do you put that down to?---A number of things.

It strikes me as strange but I don't know why. What do you put that down to?---It's actually pretty consistent with other units that I visited. It comes down to there being a gender difference in terms of behaviour and with girls with a propensity to be more inward in terms of their expression of distress so, you know, you'll see self-harm sometimes be more overtly obvious in a female population. Boys might be doing it too but it might look a bit different so it might involve fast cars and alcohol, whereas you might see a higher level of self-inflicted harm in girls.

As you say, it's currently all female. Is it usually all female?---We've only had one boy in the program.

In the four and a half years the program has been in operation?---Yes, although we don't have huge numbers. We've only had 12 children through the program, but only one boy.

So only been one boy in New South Wales has required secure care and there have been 11 girls?---I don't know if that - - -

Required in the sense that the department has formed the view and there has been a court order and it has happened? ---That's right.

Now, you touched upon a second ago about the reasons why girls might be in the facility. Can I just take you to that document I referred you to earlier called "Out-of-home care service model, therapeutic secure care programs" and on page 5, please? The department identifies human services as a part of the Department of Community Services, I assume, in New South Wales. Is that correct?---Sorry?

On the front page of the document?---On the front page. We keep changing our name.

Okay; like many government departments around the country? ---Yes.

So we return to page 5. Now, I'll just read out to you what the policy document describes as the "target group for the model":

> *Only a small number of children and young people are expected to require a therapeutic secure-care placement. The defining feature of the target group is behaviour which places the children or young person's life at extreme risk of harm.*

It goes on to say in the next paragraph:

> *Behaviours that are so extreme they cannot be safely managed in a less restrictive setting and may lead to a child or young person entering therapeutic secure care include: (1) serious or life-threatening self-harming behaviour, (2) serious risk-taking behaviour that leads to severe abuse and exploitation, particularly sexual exploitation and (3) drug or substance abuse that leads to severe harm or risk of death.*

Now, we might know what some of those are, but could you tell us what are the examples of each of those categories that the children – not necessarily the children there now but the children there over the last four and a half years

have displayed that conforms to those descriptors?---So some of the behaviours that we've seen in the children with serious self-harm have included one fellow who would insert objects into his body so things like pens, nails, any piece of – anything that was sharp and that he could penetrate through his skin he would push those in.

So just through the skin, not through an orifice?---No, into his arms and legs particularly.

Okay?---And those things needing surgical intervention to remove them and then usually resulting in very large surgical wounds for which he would not - - -

Properly recover from?---Well, he wouldn't leave them closed so he would re-open everything.

COMMISSIONER: Did he have some diagnosed disorder or something?---No.

MR HADDRICK: Okay?---Another girl that we cared for used to ingest non-ingestible items and it was her – it was her way, as it was his way, of in fact eliciting a care response so seeking medical attention as a means of some comfort to them, but in order to do that they needed to harm themselves so - - -

That's a couple of examples of the first category?---Yes.

What about the second category, serious risk-taking behaviour that leads to severe abuse and exploitation, particularly sexual exploitation?---So we had a little girl who was - I think she was still 12 when we went before the court. She might just have been turning 13. She has a mild intellectual disability so she's quite a vulnerable person anyway, but she was chronically absent from her placements and was often found in the company of very harmful adult men.

And there was a belief that she was being sexually abused, was there?---That’s correct.

Any other examples in that category?---I mean, yes, I think that applies probably to a number of the girls that are there now. They would all have been really seriously sexually assaulted and been in very high-risk situations in community, including prostitution.

Just teasing that out a bit, why would it be seen necessary for those girls to be placed in secure care rather than the protection that they could get away from those activities in residential care?---Because they wouldn't – they don't stay away from those risks. So even by living in a house supported by staff, then they leave the placement and continue to place themselves in situations of great risk.

The risk of harm was seen as so high that residential care could not respond to that challenge?---That's right. The residential care couldn't keep a child from running away.

Okay. What about the third category, drug or substance abuse that leads to severe harm or risk of death?---So one of the – and it's unusual to be just one of these behaviours. We often see them go hand in hand.

So a child might fall into more than one category? ---Absolutely; usually all three, but a little girl who was drinking great amounts of alcohol, particularly neat spirits, and using any form of drug that she could access.

Like what drugs?---Ice, ecstasy, marijuana.

How old was the girl?---13.

What is the age range of the current girls in the residence?---14 to 17.

What is the youngest you've had in the house?---We had one child and she was either still 12 or just turning 13 when she came in. I just can't remember exactly, but she might still have been 12.

The sorts of things that you've described there, at no point have you described any child who has a behaviour management issue insofar as that behaviour is violence for oppression to other people. In the categories you have – the examples you've given us so far are all a form of self-harm. Do you have any children, now or in the past, where for whatever reason their conduct is harmful to others?---All of them.

In what sense?---They all exhibit or have exhibited – I mean, some have made enormous progress so aren't doing that now, but a very high level of assault, particularly on care staff, but we don't see that that's kind of the main reason for having a child in secure care.

So they could get, in your view, the care and protection that they require to stop them engaging in the violent behaviour at another care option?---Some children have been able to have – support that behaviour in another care option to make that different. Not all, but as I said, the thing is that it's rare that one child exhibits one behaviour.

But the primary reason why the children are in this facility - - -?---Risk to self.

Risk to self, okay. Do you accept as a broad proposition that there is a category of child who – risk to others might necessitate a form of secure care?---Look, I mean, as I said, all of these children also exhibited that behaviour, you know, so it's - - -

Difficult to delineate between them?---You can't really delineate, but I think that we need to first understand what that behaviour means in terms of ensuring the right response to it. So if it's a child who, you know, is hitting when very distressed then, yes, I think that is somebody who might be able to be cared for in another setting that keeps other people safe, but if it's a child who perhaps is out and rolling people for their mobile phones and wallets, that might be seen as a different type of behaviour.

What is the potential for one child, child A's, antisocial, criminal or dangerous conduct rubbing off on child B in the house?---I don't – I know that this is a big issue and it's an issue in residential care generally. We tend to – I

think it's because the setting that we have designed is, you know, every day a therapeutic program, that if issues like that come up we deal with them. So we would talk to that child who is exhibiting a new behaviour and help – and name it for them about what it is that's happening.

What I'm suggesting to you is for much the same reason why there is a great reluctance in the broader community to put young offenders in adult prisons, you don't want to mix the kids with the worst of the worst because that culture rubs off on young people who wouldn't otherwise be absorbed into that lifestyle, if I can put it that way, or that conduct, what do you do to make sure that that does not occur in the house?---We would just manage it. So we just manage it by supporting children through the staff that we have available to us about not negatively influencing. This particular cohort of children, though, very similarly to the larger cohort of children in residential care, have significant problems in terms of relationships with peers that stretches back to their poor attachment in infancy and childhood. So in fact the shared setting can help with children learning about getting on with peers.

Let's talk about peers and visitors. Do residents at the home ever get to have visitors?---Yes.

Family, do they get to come and visit them in the home? ---Yes, if that's part of that child's plan, depending upon who the family is and, you know, what the family have available to them.

What about peers? Do they ever get friends come over? Does little Johnny have - - -?---No.

Or little Joanna, in this case, ever have a friend come over and visit?---No, but we do facilitate – as part of a child's sort of journey, I guess, through the program, once they're no longer requiring the sort of more intensive end of support - because it is very much a staged program as children transition through it where we'll have children on different sort of levels of support. You know, we will facilitate children who are perhaps now attending a local school to be going out on an outing with a chum from school and supported by a carer.

So how often do the residents of the home attend school? ---We have a partnership arrangement with the Department of Education and Communities, or Sherwood has, so we have a full-time teacher.

Who comes to the home to deliver school programs?---Who comes to the home, but we have a small school building separate from our house. So there's another little building on the premises that we've converted to a schoolroom.

And that - - -?---And the children go every day to school, which I think is probably one of the real strengths of the program for them, because some kids have been now reintegrated into education having not been in it, sometimes for some years, and they love it.

How do you stop – you told us there's a maximum of six places there and you've had 12 children over the four and a half years. If I was one of your colleagues who ran a different area somewhere else in the state and I had a particularly troublesome child, for whatever reason, I suspect I would find it difficult to not refer that child for inclusion in the home. How do you keep the numbers down so low so that you don't have that number creeping up and up and up as more and more problem children are identified and the solution is to send the child to the secure home?---We have – I mean, we have a fixed number of children that we can care for in the unit, so that in itself, I guess, is at the moment a – you know, creates a boundary around numbers, but it also – at present in New South Wales the threshold for coming into secure therapeutic care is very high.

COMMISSIONER: You can have secure care without it having a therapeutic dimension, I suppose?---You could.

Would you see any justification for that?---None. Absolutely not. I think then that is the bit that's the very controversial issue. It's really just about containing the child but not treating and helping them to heal.

So you would say the rationale for the containment is so that they get the help they need and they wouldn't otherwise get?---That's exactly right. That's exactly right.

MR HADDRICK: What about if the help they need was there but the child for one reason or another didn't avail themselves of that, or it was just impractical to deliver that? Do you still see no value at all in containing a child whose conduct, behaviour or risk to others, most importantly, warrants containing that child?---Is at risk to others or risk to self, because if it's about – if it's what you just described then there is a system for that, and that's juvenile detention.

Juvenile detention is a punitive process whereas secure care might be a preventative process. Do you see any value in having a way to prevent a child who is at extremely high risk of harm to self or harm to others?---I think that the place that that becomes very relevant is about whether you have - you know, you consider developing a system of secure care that has different programmes for different reasons and the different types of children. So one thing that I do think is very worthy of further thought is about secure unit - therapeutic secure unit for much younger children.

By "much younger", what age group are you recommending or suggesting consideration of?---I think that the group of children around the age of from nine to 12 needs to be looked at.

Is that something that has been a problem that you've observed in New South Wales over a period of time, or is it a growing problem?---I think in New South Wales and in other jurisdictions we've seen younger children into residential care, and the reason that they're entering is that they've had multiple foster care placement breakdowns.

COMMISSIONER: How old would the youngest be?---In New South Wales at present?

Ever?---Ever, I don't know ever; at present I know that in New South Wales we currently have one little boy who's six.

Six?---That's right.

And he's there because?---In residential, not insecure care.

What about in secure care?---I think the youngest we've had is 12.

Do you have a therapeutic residential as opposed to a therapeutic secure care?---Some of our residential providers are developing, you know, within therapeutic frameworks.

Would you see that as a step down? It would be both a step up and a step down, I suppose, but would you envisage that there would be a flow down from secure care to therapeutic residential?---Yes. So our cottage - our three-bed cottage is part of that system.

Yes?---But certainly some of the children who have then left the program altogether have gone to providers of residential care.

Do they transit out of the system from secure care?---From care completely?

Yes?---We have had one young person do that.

How did they go?---She went with a very specially designed and set up program for her through - there's a program in New South Wales called ISP - intensive services program - it's auspiced by ADIC, which is now part of FACS, the Department of Age and Disability and In-Home Care, it's - - -

I'm with you?---Yes, you're with me? It's a Treasury-funded program auspiced by ADIC but with a number of government partners involved in the delivery of services to a special group of adults who really don't fit anybody's system.

All right?---So it was specially funded a group of people that - - -

So it's a system of its own?---It's a system of its own.

And so this young person - - -?---So she went - - -

- - - transferred - - -?---To there.

She moved into that system. How is she now?---She's 18. She was 18 in May.

Okay?---She'll be 19 soon.

Do you ever do any tracking of young people who have exited the care system, particularly secure care, to see how they're faring at 25, at 30?---We haven't got that formally, no. I mean, the reality of it is that we know them still because the relationships in fact that were built by them being able to be safe and still has meant that those relationships endure so they remain in contact.

I was just wondering, though, given that you've got that dual obligation not only to keep them safe but also preparing them for adulthood, and the object would be to make them adequate adults, responsible adults who are potentially better parents and their own might have been, it would be a good performance indicator to see how well they adjusted to adult life, you know, say at 25 or 30? ---Mm.

Otherwise you can't tell you had a net gain, do you?---No. We have a - in the metro ISS office, so where our casework teams are - we've dedicated one of our casework positions for an after-care caseworker and so for the children who've come through metro ISS who are also the same group of children who are at Sherwood, because they end up being referred to - for intensive case management usually way before they've come to Sherwood - she maintains contact the people who have left care that our office was supporting.

So up to 25?---Yes, she - - -

Is that the limit?---She keeps regular contact with them as they've exited. We had a very nice Christmas party for our care leavers last year and lots of them came back with their partners and children, which was nice to see.

Of your care leavers, do you know what percentage of them end up in the homeless system within 12 months?---I don't know the answer to that.

I've heard figures of up to 30 per cent.

MR HADDRICK: Just following on from the Commissioner's questions to you, you've told us a little bit about the transitional arrangements that you put in place and you've spoken a couple of times in respect to the cottage, which as we understand it is a sister facility but located in another suburb, which provides transitional placements at a different level than secure care facility. The Commissioner asked you about what happens effectively to kids after they're 18. Could you give us any advice or assistance on whether you see any value in secure care being a type of care that is available post-18 years of age? For instance, should the department, where the child's needs not be addressed by their 18th birthday - should the department be able to get an order that the child remain in that secure care facility, say, to 20 or 21?---Whether it be the department that runs the facility that provides that or whether there needs to be something specifically designed for adults would probably be - you know, you'd want to look at more to understand stands. Certainly I think the children that we see that are going to be the most difficult to transition are kids who have an intellectual disability and so whether then, you know, there needs to be some sort of specialist service for that cohort, might be appropriate.

Putting aside those who as a result of mental health issues or an intellectual disability find themselves in the system, are there other young children who may just require an additional year of participation in the secure care facility or perhaps stepping down to another level of care, so they may have been in secure care but now it's time to try them in some sort of semi-independent living or in a residential care home post-18 years of age?---I think if I was thinking about applying a later care leaving age there would be - you would be thinking about it across the whole cohort of kids in care, not just its in secure care.

Now, I just want to turn, as a final topic, to public accountability mechanisms associated with the secure care option. What sort of external review is there from the department's perspective as to how the Sherwood House is operated? For instance, is there someone who has particular responsibility high up in the department to keep an eye on you and all your staff and how you manage the

facility?---My position reports to the executive director state-wide services, so she has a range of program areas that she's responsible for. We have re-present to the Supreme Court on a very regular basis and I think the Supreme Court has quite an oversighting role.

That's just pause there because I want to tease that out about the Supreme Court's role. You've told us you had 12 children over four and a half years. How many of the current five who are in care have been there for more than one order from the Supreme Court?---All of them.

Okay. Of the five who are there who are on more than one order, how long on average are subject to an order of the Supreme Court to be there?---We've got children there who have been there for about 18 months and then somebody who's just come in the last three months.

And how regular are these orders? What time frame on average are these orders from the Supreme Court?---Our experience to date has been that we make an application on the day that we're seeking that to the duty judge. Our experience in all cases that were heard by the duty judge has been that the duty judge has elected to retain case management for that child so that means then we always reappear back before that child's judge. I think we've had about five different justices, six maybe, in the time that we've been operational. I think five of those six or four of those five have all visited the unit so they've come to see where the child is residing.

I take it you think that that's an important thing?---I do. I think it's terrific.

Now, you told us that there's at least one there?---Yes, and so usually we – so we present on the day. We're usually asked to come back in a week to give an update on whether we were able to manage to get the child into the program and to let the judge know how the child is and to what our plans are going to be for the child. Usually we'd go back again in about a fortnight for the judge to be updated about how we're going with implementing what we said we would be doing and once sort of the matter is kind of quite well established, then it would be usual for us to reappear before that child's judge every three months.

So the order that a child is under on average lasts for three months?---That's right, once they're established.

So, for instance, the one or more children you referred to before who have been there for 18 months – you have been in front of that child's – you or your lawyers have been in front of that child's judge at least six times - - -?---At least.

- - - to maintain the order, to affirm the order, that the child shall remain in secure care?---And so as part of that process we put into evidence – we have one manager from our department who also then carries that child's matter so one departmental officer would be on affidavit and providing a very full update in terms of the progress for that child. All our documentation pertaining to that child, our case plans, our formulation meetings, you know, reports from the psychiatrist, reports from counsellors – all of those things would all be tendered into evidence. We do a monthly report on each child. They are attached to the affidavit as a monthly progress report on each child living there.

Can I just put to you a suggestion and ask you to comment upon it? Three months is perhaps a little short in terms of a life of an order that keeps a child at one of these facilities. Do you see any benefit in perhaps if

Queensland went down the same road, perhaps having a lifespan of up to – and I emphasise the words "up to" – six months that the court can order a child remain in one of these facilities?---Look, on a busy day I would say that would be a great thing because certainly there is a – it is a very resource-intensive process with multiple children and multiple matters before the Supreme Court. However, I think that there is real relevance for children when we have made this decision on their behalf for their matters to be heard frequently and for them to have their views put to the court and an opportunity to know that that's occurring and that - for a service such as ours to be, you know, very open to the request for information from a judge. So it's a lot of work but I do think that there is real benefit for the child in somebody taking that.

But you have got two competing demands there. You have got the need for accountability and the need to constantly ensure that the order is tailored for that particular child's needs versus public expenditure and also perhaps a degree of certainty associated with a longer order that allows transitional planning to actually be done and take effect. Why wouldn't a six-month maximum for an order be a healthy balance between those two competing demands?---I don't think there's any limitation. There's no limit or - I think a judge could make that decision. I think we've once had one probably for holiday periods or something be about four months. I think the accountability is a good thing.

You would be familiar with any corrective service facilities and other facilities. You have what's called the "visitorial jurisdiction". That is, quite frankly, an ancient role whereby there is somebody appointed who's external to the facilities, is not a government employee, and it's somebody who has the rights to visit the facility at any time, speak to the people in the facility and raise matters on behalf of the facility in general or the residents of the facility with the powers that be. Do you have a visitorial function or role attached to Sherwood House?---Yes, the community visitor from the New South Wales ombudsman's office visits both the cottage and the office.

How often do they visit?---I would think every two to three months would be about the regularity we would see her.

And you see value in that exercise?---Certainly.

What sort of good things has the visitor been able to do? ---We haven't had terribly many issues raised. I'm just trying to cast my mind back to the last few reports. In fact the visitor has often paid quite heartfelt compliments to the level of care that the children receive and our

record-keeping and capacity and program, so we haven't had too many issues. One child raised one thing which she followed through for that child, but it does give the children an opportunity to speak to somebody completely independent of our service and the children also, of course, have their own legal rep who's attached to them for the duration of the court – the order as well. So each child has their own legal person from Legal Aid.

Just bear with me for a second?---I think too that we have a number of agencies working in partnership with us as well who are also - - -

Like who?--- - - - relevant in terms of our - you know, that we're not all in-house – Department of Health. So all the children have a treating psychiatrist from the local mental health service and education - - -

Do you ever need to call out the New South Wales Police Force, I think it is in New South Wales?---We have asked for police assistance when we've had a child abscond and we've had absconding when we've been in community outings. We haven't ever had the – we've never called the police for assistance into the unit.

As a final topic - - -?---I think there was one time the police came but I think it was they were called by the ambulance when we needed ambulance support.

As a final topic, what things do you provide or do you organise for entertainment or activities for the children to do? Rather than just sitting there, what is there for them to do at the facility?---One of the things that is - you know, the whole essence of the program really runs to a very planned and organised schedule. All the children have individual planners which helps them manage their day in terms of knowing and understanding a predictable life. They're all school attenders and they're all full-time school attenders. Not all of that school attendance is face to face in the classroom time. They also maintain – they have other projects that they are working on. They're doing a sustainable garden project somewhere in the local area that they do as part of education. While the children are residing with us in a secure therapeutic unit they actually do spend a lot of time in community. So they're not homebound by any means. The children all use the local swimming pool for swimming during the summer. They all belong to the local library and access that as appropriate. We run a number of group activities within the unit, two therapeutic programs a week facilitated by one of the psychologists from Quovus. We also have a music therapist who comes weekly and we also run a sensory program for the children in terms of some sensory integration work around helping them to regulate.

But in terms of other sort of features of a modernity, do they have access to television, Xbox, all those things? ---Yes. There's a television, but we monitor what children watch. So it's not unfettered access to television. They have their games and TV sets that they play games on, but we don't do a lot of that. That's structured time as opposed to an all day occurrence. The kids have input into their daily program, but they have – it's a very structured program. We don't have a lot of sitting around time. There is a component every afternoon which I think is for half an hour that the children have time – like, time on their own. It's about half an hour in the afternoon. The kids – you know, we celebrate heartily birthdays and festivals and celebrations.

That's the evidence of this witness, Mr Commissioner. In terms of the photographs, I tender the bundle of photographs. I've marked A to C on photographs that should not be published but I also ask that all the photos not be published until such time as the other exhibits from this witness are approved for publishing.

COMMISSIONER: Okay.

MR HADDRICK: But A, B and C will not be published at all.

COMMISSIONER: The photographs will be exhibit 180. Those marked A, B and C are not for publication. The balance are not to be published until further directed.

ADMITTED AND MARKED: "EXHIBIT 180"

MR SELFRIDGE: Yes, thank you. Ms Carroll, were you in court or within the precincts of the (indistinct) or outside to hear the evidence of Dr Fryer?---Just for a few minutes.

Okay?---But we were also talking, so I didn't see – I just saw the last little bit.

She's the child and adolescent psychiatrist that gave evidence just immediately prior to you, obviously. In fact, you made it clear in response to some questions from the commissioner that you're not supportive of a secure containment solely for the purposes of containment, are you?---That's right.

In terms of this – when I look at this document, the implementation of Sherwood House valuation project plan, background information, "Sherwood House is a therapeutic secure residential program with a bed capacity of six," and so on, to some degree at least you've just described to Mr Haddrick in response to his question about what the therapeutic aspect to it is, and as I took it, it was group activities, therapeutic programs per week and then you talked about music therapy and sensory integration. What does that look like? What are we talking about in terms of that group activity and the therapeutic programs? Is it cognitive skills or what - - -?---I mean, it's a multi element program. We rely on a framework, a therapeutic framework, called ARC, which I'm not sure if you're familiar with.

No. Is it ARC, A-R-C?---A-R-C.

What's that a variation from?---Attachment, regulation and competency. In one of the documents that I put into you, which I think – if I find it - - -

Is this the one, therapeutic secure care, the document? ---No. The first bit, the, "Intensive support services therapeutic secure care, the Sherwood program."

Yes?---If you look at page 11 and pages 12 and 13 of those documents.

I've got that, yes?---So page 11 shows you how we integrate the different – that's the circles.

Yes?---Integrate the different elements of a child's care around them. So we have the clinical support to the child, the case work support and the day-to-day care. On page 12 we just do some brief mentioning there in regards to ARC, which is the attachment, regulation and competency model,

and that we see as being a multi element model where we assist the child to learn new ways of managing, and if you look at page 13, they are the elements of the program that make up the therapeutic milieu that is Sherwood.

So this program is offered to every child – or 12 children thus far, young persons who have gone through Sherwood House?---That's right, and so they're really the building blocks of the program and we translate those into our everyday care for the children. So when we talk about carer attunement, for example, if we looked at our proactive strategies, and that's where I think the one thing that I am hoping I'm impressing today is that this very much about helping a child to heal. It isn't about just containing them. So if we look at those different strategies that we have in place, they become our whole in terms of caring for the child. So we call it carer attunement, and that's really about our training and support of carers in order for them to be able to work with children who have so many presenting needs and we need our carers to be able to be very well regulated themselves in caring for children who are often so very disregulated.

Looking at this, those three pages you referred us to, 11 through to 13, the thing that stands out to me is this doesn't sit independent of anything else that's happening that child's life, it sits as wholistic in its approach? ---That's correct.

Including the day-to-day management, care, welfare, education, so on and so forth?---That's right.

That's what I read from that, yes. Okay, I understand that. In terms of those specific therapeutic programs as such does that change obviously from time to time in terms of what's on offer or is that consistent - - -?---No, really just when you drill down into those, we then look at how does that translate to a child's case plan.

Yes?---So the case plan is developed based on what we have an initial – well, every child is reviewed monthly, so that's separate to any of the core processes. This is now just about how we manage and structure the care and the program design for an individual child. Every month there's a meeting of the child's treating team, but the meetings change focus sort of every third month. So the first meeting in that three-monthly cycle of meetings is a formulation meeting, and that's where the very high level goals for a child would be determined according to where that child is at present.

I think you just beat me to the punch there, and I suppose that's the question I was going to put to you, that that model, ARC, and other persons – the case plan, et cetera, will all be tailored to a child's individual need?---That's right.

Depending where they are at any given time?---Correct.

Right, okay. So those group activities as such might be varied and be different for each child, for each of the five that are currently there, depending on their individual needs?---That's right.

Okay, but there will obviously be some overlap. It won't be one-on-one intensive therapy, it will be overlapped in relation to those group modules?---Well, the children would have the group work, but children also have an allocated therapist, which is where they do their individual work.

Okay, I understand that. Now, the evidence of Dr Fryer was that in her estimation there should be a three-month assessment process followed by a – if you're really going to work with a child it would take between 18 months and two years, and that would be said in the loosest of terms. What's your view on that?---I think that's really interesting because that is what we're finding so we do - - -

Who's "we"?---"We" as in the Sherwood program.

Okay. What's the average of a young person's time in care? ---Stay?

Yes?---Length of stay about 18 months.

About 18 months; and do you say that achieves results with a very small - - -?---It's a very small group of children.

Yes, and everyone gets set so far in terms of - that have left Sherwood House and you have got five that have come to there. That's my understanding of it?---Well, it's probably a bit smaller than that that have exited. I think exited the program entirely is four.

I see; okay?---Currently five in the house and two in the cottage.

Five in the house and two in the cottage, yes; my apologies, yes. Now, you quoted or I'll quote you something you said to Mr Haddrick when he asked you some questions. You thought that the positive responses that Sherwood House have had was, "First time that they've actually been safe in placement." What do you mean by that?---Very often with the behaviour exhibited by these children that we've cared for they're actually unsafe most of the time. They live in a perpetual state of unsafety so they might not be in placement very much at all.

Can I stop you just for one minute there? What makes them safe at Sherwood House because, as we have already described, to some degree at least these are artificial barriers that are put in place and straightaway a young person could easily make good across the fence. That's an artificial barrier even though it's a physical presence as such?---I think safety - - -

What makes them safe there?---Well, we don't – I mean, not that residential services allow children to be unsafe but very often they can't stop them from being unsafe and we stop a child from being unsafe.

Through the security?---Through the physical environment, through the assistance of supportive staff if we need to but also through the targeted care and treatment of them because - - -

How much emphasis do you place on that as opposed to what is suggested to you about what are perhaps to some degree are at least artificial barriers, including security?---How much - - -

How much emphasis do you put on that therapeutic intervention because that could be done elsewhere? That could be done in a residential setting, could it not?---But not if they're not there and that's really - the issue is that often they're just not there.

Physically?---Mm.

If not in their mind and spirit?---Absolutely in that but very often physically not there. I mean, many of these children that we've had at Sherwood, as I'm sure is exactly the same in Queensland, have had multiple placements because placements haven't been able to be sustained and so – and that's not safe for a child. That doesn't feel safe when you're a child to be moved regularly to brand new places to have another go.

So have a captive audience by means of a secure facility. Is that what you're saying?---Well, I think absolutely does give the child the benefit of being able to experience what help feels like because very often they haven't felt that.

So really what we're talking about is forcing children – no, I'll withdraw that one. Helping children help themselves by containment models. That's what you're saying, isn't it?---And by doing the things that children generally have an opportunity to do in life when they're just ordinary kids; like, to have a trusting adult relationship and to participate in ordinary life.

Okay?---They have multiple placements but also multiple stays in detention, these children, and often multiple stays in hospital.

As a secure facility like probably Sherwood House in particular, apart from the obvious like those barriers we talked about and the security personnel, what else does Sherwood House have that any residential facility might not?---I think that we have – and I don't think that it can't be done in residential facilities, but for a very strong therapeutic focus and for the – to understand what it is that's brought the child to this place and to be able to help by addressing what's happened to them.

Well, I understand what you're saying in response, but I was actually thinking more about the physicality of it because when I look at the photographs and I look at the – two things instantly spring to mind. One is you described to Mr Haddrick that the windows and how the windows weren't barred but they were Perspex and that they were fairly intact and solid and hard to dislodge. Another one was about the – when I look at the photographs – and I might be wrong in this, but it looks like a bit of a Spartan environment in some places. Am I wrong in that?---I mean, it's not the perfect building by any means. It's not as Spartan, I think, as some of those photos perhaps show. We have at times had to have a very modified environment and in fact perhaps those photos are a little older but - - -

Is that because of risk?---Correct.

Yes, okay?---So the young woman who's not long left us used – and I said about, you know, that one of her behaviours was ingesting, but she also used any implement she could find to - open up her abdomen was her particular behaviour and so she would often use anything that she could get to insert into her abdomen.

That wasn't screwed down, so to speak?---Well, nothing's screwed down, but it would be potentially the screws off from under a chair or something that she would use to penetrate her abdominal cavity.

So obviously those factors are in mind whenever – well, Sherwood House in particular whenever - the physicality of it when it's constructed or – it's part of an ongoing thought process that you people will have in relation to - - -?---We've needed at times for it to be quite safe but we absolutely don't have it as a sterile environment in terms of not being able to do things.

I think that was also obvious with some of the photographs that were put before the commission. Lastly, legal process – given the nature of the young person that's in care and predominantly at risk of harming themselves, self-harm, with the model you described about attending upon the Supreme Court and (indistinct 3.44.22) jurisdiction, what scope is there there for emergency procedures as such?---We have on occasion made a decision, you know, like today to go tomorrow to court and we've been able to effect that usually with a lot of work and a late night but we can do it - - -

Do you think a child at immediate risk – that would instigate or initiate an application for immediate – the child to be taken into immediate secure environment, ie, Sherwood House?---Yes, we can. We have effected it in a very short space of time. We've also though used - working with our partner agencies to be able to keep a child safe to enable that application to proceed.

Yes?---So potentially New South Wales Health will - you know, because very often these children have escalated over a period of time and will be well known to the local mental health unit and, you know, if – one of the things that we always do as well in terms of an application is that we would have it involve all that child's treating team which might be from Health and Education in terms of their thoughts and views around the child going to Sherwood. So, you know, usually by that stage it's a very well supported application and, you know, necessary and supported. So sometimes Health will hold onto a child for a few days to enable that application to be made.

Okay, but it really matters – I suppose the question I'm asking you is: does it matter – child-protection-type

applications are made outside the scope of secure environments and I suppose the answer is, "Yes," isn't it, you know, in terms of that immediate risk as such?---Yes; yes, I mean, the Supreme Court would see us this afternoon if we had to be seen.

Okay, thank you. I have no further questions.

COMMISSIONER: Thank you. Yes, Ms Stewart?

MS STEWART: I just want to pick up on some evidence that you gave earlier a little while ago now when you were first discussing the assessment process for when a young person comes – well, is going to be considered as a possible referral to secure care and you listed the members that form the panel and you have said that there was a representative from the Aboriginal service?---Yes, that's right, from our head office, Aboriginal services branch.

Okay. What level of participation do they have in that process? What level of professional is it from that service? Just to give you a contrast, in Queensland we have under our Child Protection Act the recognised entity that participates in decision-making. I understand New South Wales has a different model to that?---We have the Aboriginal consultation process within the department, that's for all children in out-of-home care and it's part of their care arrangements and case planning, that there is capacity for Aboriginal consultation for all those children.

Are they involved in actually case management of the young person, or is that just consultation?---For the person on the panel?

Yes?---No, she's there are just as a person on the panel, so she doesn't do direct case management of children.

Okay. And you touched on this earlier before, and he said that the young people that are in secure care don't have their friends around but have that contact with family. In the context of, I suppose, Aboriginal and Torres Strait Islander young people where family can be extended family, how do you incorporate those considerations in the programs that you develop for your young people to retain the connection?---Each child has an individual case plan and cultural planning is part of a child's case plan, so it would be very much we would use the consultation process within the department in terms of working with an Aboriginal staff member around the development of that child's plan, but also, you know, the specific cultural components for the child or things that child has got broader connections in that community, then we would access those things. So one of the children at the moment in the program is an Aboriginal girl and she has quite strong - well, we've made it a strong connection for her to an elder in our local area. Her family at the moment are refusing to participate in her life but we have connected her elsewhere and locally.

If I can turn to your Winston Churchill document and the research that you undertook over in North America, in Queensland we have a high representative of Aboriginal and Torres Strait Islander in care, about 40 per cent?---Mm'hm.

As part of the research that you've conducted over there would be correct to say that you've developed quite an understanding of the native American child rearing practices?---Yes, I have, a little; I'm not an expert by any means, but certainly an area of interest, I think particularly through one of the organisations, Reclaiming Youth, which is an agency who have developed a model based on North American parenting, the Circle of Courage.

Yes. I was going to ask you a few questions about that but I'll be interested to hear your observation of how that's incorporated into the particular child protection responses?---I don't know that I'm an expert enough to answer that but I do know that it's a model of care that this agency in particular, you know, attests to, with very similar, though, things in it to that of the ARC model.

Yes?---Because they're the same - in some ways they're very similar themes in terms of - about attachment and belonging, I think they call it. I think we say competency; I think they say mastery.

Yes?---You know, so some of those things are again fairly consistent. But there's a terrific fellow associated with this organisation, Martin Brokenleg is his name, and he's a real expert in the area of North American services for kids - indigenous kids.

Just a second?---There's also an agency in New South Wales that uses this model.

Yes?---Allambi Youth Services.

Okay. Can you just talk about your understanding of the Circle of Courage?---Yes. As a model, again it is not - in some ways, as I said, not dissimilar to ARC. And when you look at many of the therapeutic frameworks that people perhaps take from, there are many elements that have similarities. So the Circle of Courage is a model that Reclaiming Youth have developed and it talks about - this will be a test for me, won't it - is mastery, belonging - there's four elements. Have I written down in here? Mastery, belonging - I can't remember, I'm sorry.

But would it be fair to say that that particular program, for want of a better word, is an example of indigenous values?---Yes.

That's just been formulated and incorporated into - - -? ---But it's also trauma-informed so the people who - and, you know, people like Larry Brendtro who are part of this organisation are also great experts in the area of understanding the impact of trauma.

So were there any particular benefits that you saw that benefit, say, the practitioners working with the child? Just using that example of, say, the Circle of Courage; did you have an opportunity to observe that?---Well, my greater observation of it is really with one of our providers in New South Wales because they use that as their model. I mean, I think it - as I said, I think it mirrors a lot of what we say about ARC as well.

Yes?---But I think that obviously it's got great applicability in North America in terms of the communities there.

Sorry, I haven't got my glasses on, so I'm squinting at what I'm trying to read here. With the circle of - say, the Circle of Courage, and you've given quite a detailed summary of other models from that era, what are the learnings from those models and concepts, do you think we should be incorporating?---I think with all that I saw when I travelled and what I've learnt through the process of Sherwood and that very much - I mean, out of an absolute, like, passion for it, you know, sort of really have delved into looking at how we do things so we can do them the very best way possible - I think that I can't emphasise enough the therapeutic milieu in which a child lives. And so it isn't just about having an hour a week of counselling, it's about their every interaction in the day needs to be contributing towards their healing.

And from your observation of when you were conducting your research, would it be, like, the indigenous people actually providing these intervention to the children? I'm thinking more in the North American concept?---Not all, no, and I think that again the agencies that are visited across America in particular have really integrated the science and understanding around the neurobiological impact of trauma on the developing brain and about then that helps to really form and drive how we need to manage those children in a way that gives them every chance of recovery.

I just want to touch on - when you were describing the secure care, and I'll just give it the loose term "the practice model", you seemed to be describing a blended service delivery that includes, you know, professional qualifications as well is paraprofessional qualifications. Is that different from the New South Wales practice framework in residential care?---I don't think that it's particularly different. I guess one of the things that you can do more readily if you have you have a little bit of size - and I know six is certainly - we don't have other residential programs really in New South Wales that are six, you know, they tend to be two and four or three. I guess sometimes when you just get to a bit of size you can have more things in at the same time, which I think provides an environment of support for staff that sometimes isn't so readily available in a very small setting in residential.

Just perhaps one final point. The Alexander Youth Network and the Wraparound philosophy - - -?---Yes, so that was the Milwaukee - - -

You comment about that on page 23?---So that was the Milwaukee Wraparound, I think, and then the Alexander Youth Network is a provider for Milwaukee – no, the Alexander Youth Network – sorry, I'm mixing them up. They have Wraparound but the very – the real expert in Wraparound is the Milwaukee Wraparound program.

To your knowledge, have those models been incorporated in any Australian jurisdiction?---There's a pilot to look at something similar to the Milwaukee program that's just about – that I think is just – I don't know that the tender is actually finalised, but there has been an expression of interest for somebody to run a small Wraparound pilot.

Do you recall what particular state?---In New South Wales.

In New South Wales?---I think it's for the Hunter Central Coast area. The Milwaukee Wraparound program has had extraordinary results in their state there.

I think it might be beneficial if you could just describe the philosophy behind the Wraparound approach?---I'll speak to the Milwaukee one in particular, because I had the privilege of spending about three days with their service. They developed out of – I mean, really driven by – the person who runs it now had been, I think, you know, the director of a psychiatric service that covered Milwaukee, and they used – they really took away – took out some of their funding of providing residential psychiatric beds to kids and looked at translating that back into sort of the right help at the right time and in the right place. So they developed up a service system where they sit as the sort of the hub of the system and they hold the dollars associated with individual children. They contract to local government – non-government organisations, case coordinators. So there's case teams sitting in non-government agencies. A referral can come in and it can either be a voluntary referral or the child and families volunteered by the court to participate. A care coordinator will go out and it's a very rapid and sort of effective, efficient program. The care coordinator goes and sees the family and really works out what it is that they need and I think that one of the things that they've developed which we could take great learning from is that very often what it is that families need isn't actually what we've got available to us as services. So they developed up a suite of services and they maintain and manage of register of providers of all sorts of things that can be purchased in for that family. It can be things like, you know, someone in to help them go shopping or somebody to some and do some cleaning, as well as family

therapy, psychiatric services, so all the things that a family might need in terms of being able to manage and care for a child who is struggling in their care. The care coordinator has that plan approved, goes back to the hub for approval, and they've developed up a very clever system whereby the hub maintains that register of providers so that case workers don't need to spend any time at all in terms of ringing or getting prices or quotes. All of that is done by the hub. Anybody that's on the register knows they're on it at a fixed price. There's no discussion about that. It's what you're paid if you're on the register. They've developed a very clever automated system whereby once it's put on the system a person is just paid automatically. So that happens. The register is also available for families to look into so that they have some decision in who they choose to help them with their family. So they can look up who all the family therapists are, if they home visit or where their rooms are, if it's near a bus, you know, if it's next to the one – so they could maybe pick the one near the school so they go straight after school, that sort of thing. The other thing that complements that service is they also have a rapid response team, which is an after hours team that goes out to any family in crisis who is part of the Milwaukee Wraparound program and they will manage the crisis with the family overnight, if necessary.

I have nothing further, commissioner.

COMMISSIONER: Thank you. Mr Capper?

MR CAPPER: No questions, thank you.

MR HADDRICK: Mr Commissioner, no re-examination. Might this witness be excused and particularly thanked, given that she's travelled up from Sydney today to give evidence. So thank you very much, Ms Carroll.

COMMISSIONER: Thank you very much for coming all the way from Sydney to give evidence. It's much appreciated. I'm sure what you've told me will help in trying to find a solution?---Good luck.

I'm sure it exists somewhere?---Good luck.

Secure care and related subjects have been seen as an important matter for us to consider. Whether we ultimately accept it or not is yet to be seen. The evidence that we've heard so far seems to suggest that there may be room for something more than what we have. Exactly what it will be or might be is something we'll have to ponder over the next couple of months, but thank you for your help?---My pleasure.

WITNESS WITHDREW

COMMISSIONER: Yes?

MR HADDRICK: Mr Commissioner, I regret to have to say this but there is to be one other witness. He's sitting up at the back of the room, Mr Nussey, who has provided a statement, a 14-page statement to the commission. Mr Nussey is a psychologist, general registration, and has worked with four of the different suppliers of residential care, Mercy Family Services, Pathways, Lifestyle Solutions, Lifelines and others. So his evidence is particularly relevant as to particularly transitional placements.

Now, the problem I have, obviously, is time. The matters that this commission needs to canvass with Mr Nussey are far more extensive than the amount of time would permit. With your approval, I propose – and with the kind assistance of Mr Nussey – working with him and Mr Copley, my fellow counsel assisting, to find a time where we can bring Mr Nussey back where he would be the first witness at that appointed time so that we can hear his evidence.

COMMISSIONER: How long do you think his evidence would take?

MR HADDRICK: I think an hour.

COMMISSIONER: Right.

MR HADDRICK: I can also commit myself to restraining myself to keep within that hour.

COMMISSIONER: You don't want to take the hour now, or does Mr Nussey want to take the hour now?

MR HADDRICK: Well, my inclination is just to be – I mean, an hour would take us to 5.00, or just after 5.00, obviously.

COMMISSIONER: Banking hours.

MR HADDRICK: Sorry?

COMMISSIONER: Banking hours. Most business are open till 5.00.

MR HADDRICK: I don't know which bank you bank with. Out of fairness to the other parties I think I should not. I think the more profitable way is to find a time with Mr Copley where I can steal some time off him, effectively.

COMMISSIONER: Okay, well, if you can sort that out with Mr Nussey.

MR HADDRICK: I'm just very reluctant to not do a proper – not just as a courtesy to him - he has very kindly sat here throughout the whole day and effectively the previous

witness has jumped his position in the queue, but there are matters that go above and beyond the evidence that we've heard from other witnesses last week which are salient to our terms of reference.

COMMISSIONER: All right. Well, I'm content with that.

MR HADDRICK: So that's what I propose to do, but putting aside that issue, that brings us to the end of the residential care and transitional hearings. That's five days of hearings. I just wish to before you adjourn for another day record counsel assisting's appreciation to certain officers of the commission who have put a lot of assistance, a lot of work into preparing for the last five sitting days.

In particular, I'd like to thank Jason Schubert who is perhaps the principal officer of the commission who has been pulling together the residential care week; Sharon Simms, Dina McRae, Jason Garrick and Stephen Muir, who all are officers of the commission and have played an integral role in pulling together the last five sitting days. The type of evidence we received required getting copious statements from witnesses in far-flung places and it was a laborious task. I'd also like to record the commission's appreciation Mr Geoffrey Gunn of counsel, who was commissioned by the commission to assist in obtaining that information from a variety of witnesses and played a particularly helpful role in eliciting the happenings in the various houses that we heard from.

Commissioner, you'll recall that we heard from houses A to F and we saw pictures of inside those homes; we heard about the duality acidities and we got a real disparate picture as to the quality or otherwise of the various residential care options. So I'd like to record the counsel assisting's appreciation to all those officers I've named and Mr Gunn of counsel.

COMMISSIONER: Thanks, Mr Haddrick. Now, before we break, I think - Mr Selfridge, I think we have one more witness in this bracket.

MR SELFRIDGE: Yes.

COMMISSIONER: And that will be the chief executive.

MR SELFRIDGE: Yes.

COMMISSIONER: Just excuse me. I think my intention was to call Ms Allison on the last week - the beginning of the last week - first day of the last week of February, which I think will be Monday the 25th. That means that that Friday will be 1 March.

MR SELFRIDGE: Yes.

COMMISSIONER: So I am tentatively minded to direct those with leave to appear in non-3(e) terms of reference to provide their written submissions by the close of business on 1 March, not to exceed 50 A4 pages of typing; and that oral submissions, if any - I don't want you to get the idea that I'm overly encouraging them. However, if you feel the need for advocacy and are sceptical of my reading capacities, I'm thinking that I'll set aside Wednesday, 7 March for oral submissions. That will give you each about two hours to talk to obviously anything that you see as being significant that you don't want me to miss in findings or recommendations.

Now, that brings me to the submission dated 24 December 2012 that I received from the department or Ms Allison, which I've mentioned before and haven't yet released.

MR SELFRIDGE: Yes.

COMMISSIONER: I propose to release that to the parties or their legal representatives on 18 February, so that before Ms Allison actually gives her evidence the others will have a period of time to have a look at the submission and frame their questions. However, I'm not fixed on that date. I'm mindful that I think Mr Hanger was ambivalent, shall I say, about me releasing it at all publically. So he may, or you may, or your client may want to argue that it shouldn't be released. If you do, can you let Mr Haddrick or Ms McMillan know.

MR SELFRIDGE: Yes. Can I say that I intend to - anticipate that I'll get instructions - either myself or Mr Hanger or both of us - to oppose the release of that statement. That was my last instructions.

COMMISSIONER: Yes.

MR SELFRIDGE: However, I'll take fresh instructions on it and we'll get back to you soonest through the official systems, Mr Commissioner.

COMMISSIONER: Yes. Okay, that's fine. Can I - okay, just think about these things: on my reading of it there's nothing startling in it or particularly confidential in it.

MR SELFRIDGE: That's rather dispirited.

COMMISSIONER: Nothing that I didn't expect would be said was said, if you know what I mean.

MR SELFRIDGE: Yes.

COMMISSIONER: I thought it was very comprehensive, don't get me wrong.

MR SELFRIDGE: Yes.

COMMISSIONER: But they're the sorts of things I expected would be said, and there may be others that need to be added now in light of the subsequent evidence. And I myself, subject to being persuaded otherwise, couldn't see any disadvantage, forensic or otherwise, to the department in releasing it to the other parties so that I could get the benefit of exactly that, informed questions asked of the chief executive who operates the system that's under review.

MR SELFRIDGE: I don't know that it just falls down or rests with the chief executive, because obviously you

understand that we represent the state, as such, and make up a series of entities.

COMMISSIONER: Yes.

MR SELFRIDGE: We might have disparate views on different things, and perhaps therein lies the issue. But that's a matter for us.

COMMISSIONER: Therein lies the problem of centralisation.

MR SELFRIDGE: I don't need to express that any further.

COMMISSIONER: No. Fair enough. I can see where you might have rival interests there.

MR SELFRIDGE: Yes.

COMMISSIONER: But in any event, I'm flagging that for you just to think about and I'm open to persuasion. Don't think I'm not.

MR SELFRIDGE: I'll seek - - -

COMMISSIONER: There's something I want to ask you because it's been intriguing me. From a machinery of government point of view you represent the department, which happens to have three arms to it.

MR SELFRIDGE: Yes.

COMMISSIONER: It's go the communities arm, it's got the child safety and disability services as two other arms.

MR SELFRIDGE: Yes.

COMMISSIONER: But you've got a $4 billion budget for the department; 800 million or thereabouts is allocated to child safety, but that doesn't mean that the other money allocated to the department is not available for such things as a secondary service framework, is it?

MR SELFRIDGE: I don't know that I'm the best person to answer that. I'm probably the best person to find out that information for you. And based on the question you've just put to us I think I'm obligated to come back to you with some form of answer in relation to that.

COMMISSIONER: Okay.

MR SELFRIDGE: I understand too why you're asking the question, but I don't know whether I can answer it.

COMMISSIONER: I just want to know - you represent the department - - -

MR SELFRIDGE: Yes.

COMMISSIONER: - - - as opposed to child safety, because child safety is just a component of the department.

MR SELFRIDGE: Represent the department per se on my instructions.

COMMISSIONER: Now, it happens that the chief executive is also the director general of the department.

MR SELFRIDGE: That's so.

COMMISSIONER: As I understood from the annual report, that the way the department saw it was that child safety does the tertiary side of things and communities does the family support side of things.

MR SELFRIDGE: That's my understanding too, yes. And what you're asking me, as what I understand it is: what part of the moneys for the overall budget, is there a strict delineation between the two?

COMMISSIONER: Yes, because the act doesn't seem to make a delineation between the two and it hasn't done since 1999. Okay, so that's what I was intrigued about. Okay. So how are we going to sort this out, then, about publication and - - -

MR SELFRIDGE: (indistinct) just identify my proposals, except as I go back, seek instructions in relation to the same.

COMMISSIONER: Yes.

MR SELFRIDGE: And whether it be we're here for terms of reference 3E or otherwise - - -

COMMISSIONER: We can argue it.

MR SELFRIDGE: - - - we can argue the point; we can come back to you in relation to it.

COMMISSIONER: All right. Okay.

MS STEWART: Commissioner.

COMMISSIONER: Yes. Sorry, Ms Stewart.

MS STEWART: Sorry, just on the issue of the publication of the submission of 24th of the 12th, we did raise that earlier.

COMMISSIONER: Yes, I know.

MS STEWART: We'd probably like to be heard.

COMMISSIONER: Yes.

MS STEWART: I think it would be in the public interest for that to be available to the - we might want to respond to things that are being raised in it.

COMMISSIONER: Yes, that's why I foreshadowed it. But if there's going to be an argument of it you can all be in it.

MS STEWART: Yes. We don't attend 3(e), though.

COMMISSIONER: No, we'll let you know.

MS STEWART: Okay.

COMMISSIONER: I think Mr Selfridge is just going to let me know - - -

MR SELFRIDGE: Yes.

COMMISSIONER: - - - when he gets a chance, whether I'll do whatever I'm doing, and if it turns out that there's some opposition to the release then I'll have it argued by everybody.

MR HADDRICK: Same time as we do Mr Nussey, perhaps, for convenience of all parties.

COMMISSIONER: Yes, that's not a bad idea. Yes, good. Okay. 10 o'clock tomorrow morning.

THE COMMISSION ADJOURNED AT 4.18 PM UNTIL WEDNESDAY, 13 FEBRUARY 2013

12/2/13