Submission by

The Australian Association of Social Workers

Queensland Branch

Queensland Child Protection Commission of Inquiry

AASW CONTACTS:

Professor Karen Healy, AASW National President

Email: k.healy@uq.edu.au

Ms Mere Vitale, AASW Queensland Branch Manager

(07) 3369 9818

aaswqld@aasw.asn.au

August 2012

The AASW is the key professional body representing more than 7000 social workers throughout Australia. Social work is the profession committed to the pursuit of social justice, to the enhancement of the quality of life, and to the development of the full potential of each individual, group and community in society. No other professional discipline is so immersed in the areas of knowledge that are essential for quality relationship based child protection practice. As a result, Social Workers are recognised throughout the world as the core professional group in child protection policy, management and practice.

"In the long term, improvement in the quality of the service provided to children, young people and families (the quality of the journey) rests on having a well trained, well supported workforce that understands the underlying principles of child protection and has the space to assess how best to apply them."

(Munro, 2011, p. 18-19)

This submission by the AASW recommends a number of areas that require immediate attention to re align our child protection system to one that protects children and promotes child and family well-being. These include that:

- the child protection workforce at all levels, from the executive to the frontline, has a comprehensive understanding of the nature of the child protection work. This includes knowledge of what is required to effectively engage vulnerable children and families, investigate and assess risks and capacities, and to help families to change;
- early intervention and prevention activities are recognised, and resourced, as integral dimensions of an effective child protection service system. We argue for a greater emphasis on non-stigmatising and accessible early intervention services with a well resourced and skilled tertiary system that will together provide appropriate responses for keeping children safe and supporting vulnerable families;
- there is an investment in meaningful culturally appropriate processes for engaging, assessing and working alongside Aboriginal and Torres Strait Islander families and families from culturally diverse backgrounds;
- the children and young people in the child protection system and exiting this system are recognised and supported to levels commensurate with their peers outside this system.

We turn now to the AASW response to the Inquiry Terms of Reference.

Section 3(1) of the Commissions of Inquiry Order (No.1) 2012: Reviewing the progress of the implementation of the recommendations of the Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry) and Protecting Children: An Inquiry into the Abuse of Children in Foster Care.

The AASW recognises there have been improvements in child protection and juvenile justice services following the Forde and CMC Inquiries. Improvements include: better screening of staff to prevent the employment of personnel with prior convictions in relation to children; and the development of bodies, such as the Commission for Child and Young People and

the Queensland Civil and Administrative Tribunal, to review child protection decision-making and to monitor the safety of out-of-home care and juvenile justice institutions for children and young people.

Having noted the above, the AASW remains concerned with several aspects of the Queensland government's implementation of the recommendations of both the Forde and the CMC Inquiry. These concerns are:

- **The de-professionalisation of the child protection workforce since 2004.**

The Forde Inquiry acknowledged that the employment of social workers, psychologists and other human service professionals was linked to positive outcomes for children, young people and their families. The CMC Inquiry also noted the need for improved child protection workforce capacity, particularly in relation to practice with children and families. By contrast, the Child Safety Services agency adopted a deliberate strategy of diversifying the workforce away from people with qualifications relevant to working with vulnerable children and families towards the employment of frontline staff with backgrounds in fields such as criminology, policing and record keeping. This strategy was evident in the 2007 workforce consultation document by the then Department of Child Safety where it was stated that:

> Historically, these degrees [in social work and behavioural sciences] were well aligned with the underpinning knowledge required to work in the child protection sector. In all cases they contain material relevant to child and family issues which matched respective roles of CSOs. *This role has now changed.* The change is not merely been in the form of repositioning the department to a solely statutory child protection focus, but in the specialization of roles and the sophistication of systems and processes essential to working in a high risk, statutory environment. This sophistication has occurred in the form of increased evidentiary requirements, familiarity with the pseudo [sic] legal discourse, records management, forensic investigation, workload management and other specializations. (Department of Child Safety, 2007: 7, emphasis added).

Justification for the diversification of the qualification base was linked to alleged lack of supply of appropriately qualified personnel. Such a claim is spurious given the expansion of university based social work programs since 2004. Indeed, in 2004, in the South East corner of Queensland there were two professional social work programs with approximately 150 graduates annually. There are now five programs with more than 1500 current enrolments and with an annual graduating cohort of approximately 500 social workers in the south east corner of Queensland alone.

Further, the emphasis placed by Child Safety Services on the diversification of the qualification base is inconsistent with international best practice in child protection workforce recruitment. International evidence shows that frontline workforce turnover is lowest in countries where the child protection workforce has a standardised qualification base in social work and related disciplines, as the workforce is best prepared for direct practice. For example, compared to the Queensland child protection services where turnover is 73% in the first three years of practice, in the United Kingdom the child protection workforce turnover is around 11% per annum and in Norway is approximately 12% per annum (Healy & Oltedal, 2010; Local Authority Workforce Intelligence Group, 2006). In both Norway and the

United Kingdom, social work qualifications or similar are mandatory entry level qualifications for child protection workers.

Recommendation 1

The AASW recommends that child protection services workforce policy should recruit professionals who are qualified to work with vulnerable children, young people and their families. At a minimum, degree level qualifications in disciplines with mandatory child protection education, such as social work and some psychology, human services and behaviour studies degrees should be the entry requirement for child protection worker positions. Where workers lack these qualifications, they should be supported by the agency to gain appropriate qualifications.

- **The inadequate provision of resources for supporting children to remain with their biological families living at home.**

Both the Forde Inquiry and the CMC Inquiry recommended that child protection services have access to resources required to support child abuse prevention to at risk families. CMC recommendations 5.15 and 5.16 specifically referred to increased resources to working with at risk families with children living at home. Despite the veracity of these recommendations, the repeated experience of frontline practitioners is that they cannot access resources to support at risk children living with their biological families. There is no pool of readily available or accessible funding for supports such as intensive in-home supports or respite care.

Recommendations 2 & 3

The AASW recommends that child protection services have readily accessible and available funding for support services to maintain at risk children in their family home. These services should be monitored and evaluated so that the agency develops a strong evidence base of in-home supports that best support families to stay together and to reduce child protection risk.

The AASW further recommends that Section 159 of the Child Protection Act be extended to ensure that there is a whole of government responsibility not only for the sharing of information about vulnerable and at-risk families, and also for resource allocation to address the needs of these families.

- **The continuing and growing over-representation of Aboriginal and Torres Strait Islander children in care.**

The CMC Inquiry noted the need to address the over-representation of Aboriginal and Torres Strait Islander children in care. Yet the proportion of Aboriginal and Torres Strait Islander children in care has more than doubled since the CMC Inquiry. A range of factors have been associated with the increased removal of Aboriginal and Torres Strait Islander children

including: perceptions of the culturally insensitive nature of the Structured Decision-making tool; the increased risk averse nature of child protection practice in child safety services; difficulties in finding suitable kinship and foster carers due in part Blue Card requirements that automatically preclude many Aboriginal and Torres Strait Islander people; the lack of adequate support for the development of culturally appropriate Aboriginal and Torres Strait Islander support and child protection services.

Recommendation 4

The AASW recommends that the Child Protection authority establish, as a matter of urgency, a Taskforce of Aboriginal and Torres Strait Islander people with responsibility for engaging Aboriginal and Torres Strait Islander communities in developing solutions to the urgent challenges of developing culturally appropriate forms of child protection service work that recognise the unique traditions and needs of Aboriginal and Torres Strait Islander communities. The solutions proposed by the Taskforce must be adequately resourced and monitored to address the urgent need to reduce the unacceptable rates of child removal in Aboriginal and Torres Strait Islander communities.

- **The diversion of frontline staff resources to administrative and record keeping activities.**

The CMC Inquiry recommended an upgrade of information systems as a matter of the highest priority. It is not clear that the intention was for frontline service worker resources to be diverted to record keeping activities. Yet, frontline service providers report to the AASW that there has been a substantial expansion of record keeping activity with the majority of their time now spent on administrative activity rather than in direct service practice. This is most apparent in the requirements of the current Integrated Client Management System which requires workers to complete multiple screens to report one event and which does not support the holistic thinking required for sound assessment and intervention.

Recommendation 5

The AASW recommends that the administrative burden on frontline staff is reduced. Administrative responsibilities of frontline staff should be strictly limited to that which is essential to the reporting on their practice. Any proposal to expand administrative responsibilities of frontline staff should be rigorously reviewed by a taskforce including representatives of the frontline workforce so as to prevent an unnecessary expansion of administrative burden on frontline workers and to ensure the relevance of administrative responsibilities to achievement of direct service goals.

Section 3(2) of the Commissions of Inquiry Order (No.1) 2012: Reviewing Qld Legislation about the protection of children, including the Child Protection Act 1999 and relevant parts of the Commission for Children and Young People and Child Guardian Act 2000.

The AASW notes the following concerns in relation to existing child protection legislation.

i. Lack of legislation to require the State to recognise its responsibilities for early intervention and child abuse prevention with vulnerable families.

It is the view of the AASW that the Child Protection Act 1999 does not adequately recognise the responsibility of the State Government for the provision of early intervention or support for vulnerable families to prevent child maltreatment. Pursuant to Part 6, Division 1, 73(2) of the Act, the role of the State is currently confined to taking *"steps that are reasonable and practicable to help the child's family meet the child's care and protection needs."* The Act thus limits the responsibility of the State towards the prevention of maltreatment and support of vulnerable families to that which is deemed by the executive to be *"reasonable and practicable".* In the absence of a legal compulsion on the State to specifically provide adequate, accessible and effective supports to vulnerable families, this responsibility is currently discharged on a variable and discretionary basis.

Recommendation 6

The AASW recommends that the Child Protection Act 1999 be amended to mandate the State's responsibilities for the prevention of child maltreatment and the promotion of the well-being of vulnerable children in recognised.

ii. The failure to provide for non-adversarial and impartial decision-making forums

In 2004, The *Child Protection Act* was amended to provide for Family Group Meetings. As per Section 51(G) of the Act, the Family Group Meeting (FGM) is "a meeting to provide family based responses to children's protection and care needs; and to ensure an inclusive process for planning and making decisions relating to children's well-being and protection and care needs".

Section 51(L) of the Act further requires that there is "reasonable opportunity" for (family members) to attend and participate.

Observational research of these meetings, as well as the experiences of many family group meeting participants, indicates that the Child Safety Services is failing to meet its obligations in relation to sections 51(G) and 51(L) of the Act. This evidence from Child Safety Officers and observational research (see Healy, Darlington & Yellowlees, 2011) indicates that:

- FGMs may be used by child safety officers as a forum for collecting evidence against families;
- The FGM has become a case-management process to fulfil an obligation to the Courts under the Child Protection Act. The FGM intent has been diminished as workers experience the pressure to meet both Court and performance obligations;
- The FGM can be experienced by clients as prescriptive interrogative by way of a legalistic focus and adversarial;
- There is a perceived lack of impartiality of the FGM Convenor. This occurs because the Convenor is usually employed in the same Child Safety Service Centre as the child protection workers who are seeking protection orders for the child. In addition, the meeting is usually held in the same location where the child protection worker

seeking the child protection order is employed. These practices appear to contravene mediation principles adopted in other fields, such as in Family Law mediation, wherein the presence of impartial mediator in a neutral location is the minimum expectation;

- Support for families to participate is inconsistent between offices. Observational research has noted the lack of staff and infrastructure resources to adequately prepare parents, caregivers and children to participate and engage in a meaningful way;
- Children or their separate representatives are rarely included in these meetings.
- There is a dominance of professional voices and the absence of opportunities for private family time in these meetings;
- Mediators are employed in the administrative rather than the professional stream, meaning that it is not necessary for them to have any professional educational qualifications related to child protection or formal education in mediation practice except that which may be provided by the Child Safety agency itself.

Recommendation 7

The AASW recommends that the provisions of the Child Protection Act 1999 relating to Family Group Meeting (Section 51) be completely reviewed to:

- *Restore and reinforce the principles of child and care-giver participation in decision-making; and*
- *Ensure the impartiality of the Convenor in facilitating the decision-making process; and*
- *Strengthen the responsibility of the Department to support the achievement of plans developed.*

iii. Onerous liabilities borne by individual child protection workers (building a culture of non-blame)

It is the AASW's view that Child protection officers who are involved with adverse child protection outcomes bear an unacceptable level of personal responsibility for these outcomes. Under the *Commission for Children and Young People and Children's Guardian Act (2000, 4A*), the Child Safety Officer faces the possibility of criminal liability if they are found to have been negligent in their practice. Similarly, in Child Death Reviews (Systems and Practice Reviews), the review panel is obliged to consider whether disciplinary action should be taken against individual officers. The level of liability borne by officers can be a disincentive for workers to remain in frontline practice. Furthermore, such responsibility is untenable given that these frontline workers are usually the most junior officers in the Agency who, as a result of workforce policies, are increasingly likely to lack an educational background relevant to working with children and families, resulting in these junior staff being exposed to individual liability. Furthermore, these workers rarely have access to adequate supervision from an experienced child protection worker, nor is funding quarantined for ongoing learning and development in contemporary child protection practice. Finally, tragic case outcomes are almost never the result of a single decision-making failure

but usually reflect a series of decision errors (Munro, 2008). A culture of non-blaming and open review must be adopted if practice is to be improved.

Recommendation 8

The AASW recommends that the review processes of Child Death Review panels and the Children, Young people and Children Guardian Act be revised to ensure that the systems factors within the organisation and service system more broadly contributing to negative case outcomes are acknowledged and addressed. Panels conducting these reviews should include officers with current frontline knowledge to ensure that reviews are relevant to contemporary systems and practices. This could be achieved through a staff rotation system.

iv. Lack of response to high risk matters

The AASW submits that it is critical for the Child Protection Authority to be resourced with greater capacity to be proactive in high risk situations. Currently, reviews such as Child Death Reviews occur after the most adverse outcomes have occurred. The Child Protection Act should reinforce the importance of reviewing high risk and complex matters. For example, matters noted on the existing regional high risk register should be subject to review and a caseplan developed in consultation with both the direct casework staff and with staff, across government, with specialist expertise in the area of concern. For example, a young person in out-of-home care who is at risk of suicide should be subject to case review and intensive intervention on the advice of child protection and mental health professionals.

Recommendation 9

The AASW recommends that forums for serious case reviews are established in all regions. The circumstances of all children and young people who are on the high risk register should be subject to a serious case review involving a whole of government review and response to the matter.

Section 3(3) of the Commissions of Inquiry Order (No.1) 2012:c) Effectiveness of Queensland's current child protection system in the following areas.

i. Whether the current use of available resources across the child protection system is adequate and whether these resources could be used more efficiently.

Following the CMC Inquiry and the separation of Child Safety Services from Family Support Services, the Queensland child protection system became increasingly incident based, reactive and risk averse. Frontline workers report to the AASW that their work is focused on evidence gathering and administration rather than in engaging families in processes of assessment and intervention. The AASW is concerned about:

- The lack of balance in the investment in the tertiary child protection system compared to early intervention and targeted prevention services. Only 4.3% of Queensland's child protection budget is allocated to intensive family

support services; this is the lowest proportion of expenditure on intensive family support services of any State or Territory of Australia (Australian Institute of Family Studies, 2012). We are also concerned about the lack of transparent reporting by government on funding to family support services and other early intervention services, as this has contributed to a lack of accountability by government for provision of these important preventative services.

- Family support services need to be enhanced to better support vulnerable families to achieve child safety and child well-being outcomes. Time-limited services have little effectiveness for families experiencing inter-generational issues related to child abuse and neglect. There is a strong need for more intensive, accessible and non-stigmatising services for at-risk families. In particular, further investment is required in intensive 24/7 family support and preservation services to address child abuse risk and well-being concerns in vulnerable families.

- The failure of the child protection authority to involve Aboriginal and Torres Strait Islander workers in a meaningful way. The Recognised Entities are not adequately integrated into child protection decision-making and we believe this model need to be reviewed. The child protection authority needs to engage with the Recognised Entities to build more effective family support responses to Aboriginal and Torres Strait Islander families, with the Recognised Entity being funded to provide these services directly to families.

Recommendation 10

The AASW recommends that the Queensland Government invests in early intervention services that are delivered in accessible, non-stigmatising, culturally appropriate ways. The non-government sector is best suited to the delivery of these services. Referral and access must include a range of pathways, not only through child protection services. Further, the AASW recommends greater accountability from government in reporting on funding for primary, secondary, and tertiary child protection services. Governments (and the community) need clear information on the nature and range of child protection services being delivered and to ensure that there is an appropriate balance in service provision to help prevent children from entering the CP system.

ii. The current Queensland government response to child and families in the child protection system including the appropriateness of the level of, and support for, front line staffing.

The organisational structure in Child Safety Services does not adequately provide for the professional development of a frontline workforce with the knowledge and skills to undertake complex child protection work. Inadvertently, the consequence of separating Child Safety and family support functions, following the CMC Inquiry, was the Child Safety authority

devalued the knowledge and skills needs by frontline child protection workers to engage and help families. Indeed, engagement and helping vulnerable families were incorrectly seen by the Executive to be relevant only to family support functions rather than to helping families (Healy & Meagher, 2007). This understanding was erroneous and contributed to poor casework practice capacity among frontline Child Safety Officers.

In her review of Child Protection services in England, Munro (2011, p. 12-13) concluded that: *"Good social work practice requires forming a relationship with the child and family and using professional reasoning to judge how best to work with parents. The nature of this close engagement means that supervision, which provides the space for critical reflection, is essential for reducing the risk of errors in professionals… Social workers need to make best use of evidence on how to help families change. This should include both evidence about the nature of effective working relationships, and of methods to use within these relationships to promote change."*

In relation to staffing the frontline of child protection services, the AASW notes the following:

- The organisational structure of the Queensland Child Safety Services diverts resources away from service delivery functions and to administrative functions. In the former Department of Child Safety, approximately 40% of staff were employed in caseworker roles, including CSO, CSSO and Senior Practitioner roles, with the majority of the remaining staff are employed in managerial or administrative roles. For example, in 2006-2007 only approximately 800 of the 2051 staff were child safety officer or senior practitioner roles (Healy & Oltedal, 2010). Despite the recent cutbacks to staff there still appears to be a significant proportion of staff at SES, AO8, AO7 and AO6 levels employed in both Central and Regional Offices. Their value proposition to the frontline needs clarification.

- Turnover of frontline staff escalated significantly following the introduction of the reforms following the CMC Inquiry of 2004. In 2003, the reported frontline staff turnover was 28% per annum, by 2007 reported turnover was 42% in the first year and 73% by three years. The Department of Child Safety (2007) erroneously attributed this turnover to the alleged incompatibility between the changed role of child safety worker and the qualification base of workers (see Department of Child Safety, 2007). By contrast, research with frontline workers indicated that turnover was due to high caseloads, lack of professional support and valuing of frontline staff including an absence of appropriate supervisory support by appropriately qualified and experienced staff, the increased policing nature of the role, administrative burdens, the lack of resources for early intervention, and undue personal liabilities and responsibilities placed on frontline and junior staff (Healy & Meagher, 2007; Healy, Meagher & Cullin, 2009).

- The growth of the child protection bureaucracy itself contributed substantially to workforce turnover. Indeed, a substantial proportion of turnover each year can be attributed to child safety workers being promoted into administrative or managerial roles, where the salary is higher and where the liabilities borne by workers for case outcomes is substantially lower than for the frontline (Healy & Oltedal, 2010).

- The Queensland Government has failed to provide clear information about the size of the frontline workforce. For almost a decade, the Queensland government has used the term "frontline" to refer to a range of officers including those with no direct service responsibilities and with no client contact. The argument was frequently put by politicians and the Executive that officers, such as policy officers, could be described as frontline because they supported the work of the agency. This practice of referring to the vast majority of staff as "frontline" whether or not those staff have any client contact, has made it difficult to hold the agency accountable for expanding levels of bureaucracy**.**

- The majority of the executive staff appear to have limited background in, or understanding of child protection practice. The Executive is, in the main, drawn from disciplines other than child protection related disciplines and few have any professional experience of the sector. This fact, when coupled with the lack of feedback channels from the frontline to the executive, contributes to a perceived lack of understanding among the executive of the continuum of needs faced by vulnerable families. Some AASW members report that some members of the Child Safety executive failed to demonstrate a critical understanding of damaging impact of child removal on individuals, families and communities.

- The Executive has not fully understood the knowledge and skills needed for frontline workers to effectively work with families. The Child Safety workforce consultation document (2007) reflected the incorrect understanding of that Executive that the presence of Structured Decision-making Tools could replace the need for workers with a professional knowledge and skill base for working with vulnerable children and families.

- The culture that emerged following the CMC Inquiry contributed to a persistent devaluing of knowledge and skills involved in engaging families. The role of the child protection worker was erroneously understood as a policing and administrative role. As a frontline worker reported to the AASW *"We've lost the understanding of what it is to do family work, we've focused on case management not working with families and in doing that, we've lost the capacity to truly engage with families in ways that promote change."*

Recommendations 11-17

- *The Child Protection Authority must develop a common understanding at all levels of the agency of its goals. These goals should be consistent with international evidence of what effective child protection work involves. A common framework is needed to reduce conflicting expectations between the Executive and the frontline service of the Agency. Decisions about staffing and resource allocation must be consistent with that common framework.*

- *There should be standardisation of the qualifications required for Child Safety Officer positions. All professional staff should have professional qualifications in a field related to working with children, young people and families. Existing staff without these qualifications should be supported to upgrade their qualifications;*

- *The organisational structure should promote the development and utilisation of*

advanced practice capacities. We advocate that there should be at least three levels of frontline practitioner: child safety officer, senior practitioner and the consultant practitioner. These levels of seniority should reflect advanced practice knowledge and skills. The consultant practitioner should work alongside child safety officers in direct practice and decision-making particularly in high risk matters.

- *Ongoing educational and training opportunities should be provided to all child safety officers. The AASW believes that it is important advanced education is provided by researchers and practitioners with recognised knowledge and experience in child protection services, not only by workplace training units. The government should support advanced level practitioners to gain postgraduate qualifications in child protection practice from recognised tertiary education institutions.*

- *Workplace training and supervision of child protection workers should focus on developing the capacity for professional decision-making and effective practice with families. Structured decision-making tools should be recognised as only one part of the decision-making process. Workers need to be supported to engage with families as partners, to treat people with dignity and respect and to turn involuntary clients into voluntary partners through a process of therapeutic casework.*

- *There needs be more accountability in Executive decision-making to the frontline. Decision-making structures need to be established in the organisation so that executive gains insight into the demands of frontline practice and understands how executive decision-making will impact on the capacity of frontline staff to realise the organisational mission to promote child safety and well-being.*

- *Government reporting practices about child protection staffing need to be more transparent and accountable to the public. The general public should have ready access to information about the proportion of staff with direct contact with clients and, in particular, the proportion of child protection workers compared to other administrative and managerial staff.*

iii. **Tertiary child protection interventions, case management, service standards, decision making frameworks and child protection court and tribunal processes**.

An outcome of the CMC Inquiry was that a distinct Child Safety authority was established. The Child Safety authority adopted a forensic approach to child protection practice focused on: protecting children from parents; punishing them for the harm the child has experienced, or may do so in the future; with provided minimal support provided to assist families to meet needs of their children.

In the current Child Safety Service system, casework tends to focus on monitoring and reviewing of families with a focus on administrative functions, rather than educating and supporting families. Of additional concern is that once children enter the statutory child protection system in Queensland, the system that is meant to protect and care for them, tends to further harm them. This is evidenced by children who end up having multiple

placements, inconsistent workers, are returned home too soon or not at all, and in the increasing number of young people in care who end up in the youth justice system. Given the poor outcomes of children who have been placed in the care of the Department, the AASW questions how the Department itself would assess its own willingness and ability to meet the protective needs of the child. Early in this document, (response to C(i)) we outlined the evidence regarding the mal-distribution of resources towards investigation and away from early intervention and prevention services.

Parents and caregivers report being disenfranchised from child-protection and decision-making processes. Research conducted by Hardy (2005; see also Hardy & Darlington, 2008) found the parents wanted child protection services to involve them and their children in the assessment and decision-making process, rather than simply telling them what to do. These parents described relationships that were antagonistic and where they were left feeling powerless and helpless. Parents identified the need for a shift from unequal and adversarial relationships to ones that are more collaborative and co-operative. This is illustrated in the following comments by one of the parents:

> *Well um, let's put it this way, they stripped me of my parenthood, like um, even though I wasn't really focussed on my parenthood at the time, they did, they stripped me totally of my parenthood, I had no say whatsoever in the upbringing or care of my children….Welfare… they've got to have an understanding of families when they take kids from the families, they got to let the parents get more involved and listen to them, I know some parents don't deserve the children, I understand that quite clearly, but there are other parents…I believe they should have more interaction with the parents … listening to them about the children and that and the parents have more interaction with the children, as long as the welfare feels safe. And parents got to realise that welfare have got to do what they got to do for reasons* (Hardy & Darlington, 2008, p. 256).

Working from a philosophy of respectfully engaging with people requires developing relationships that are based on trust and collaboration (Dumbrill 2006; Hardy & Darlington, 2008). Staff need to possess the relevant human services qualifications and skills to be able to do this, thereby meeting the principles of the Child Protection Act 1999 in terms of working with a child and their family (S5(c, d, e, h)). In our response to the Inquiry's Terms of Reference C(ii) we outlined the AASW view on the importance of recruiting and supporting appropriately qualified staff to undertake work with vulnerable children, young people and families.

Recommendations 18 & 19

The AASW recommends:

- *Greater emphasis is placed by the Child Safety authority on effectively working with families to ensure children are able to remain at home safely;*
- *Funding to family support and preservation services is increased.*

Decision making frameworks

The current child safety system has a strong focus on the forensic investigation of concerns, is incident based rather than holistic, and operates more and more from a rule of evidence approach as opposed to an evidence based approach. The distinction is important, an evidence based approach takes the view that all information is holistically sought to inform decision making, whereas the current system tends to focus on evidence for specific incidents. While the work of statutory services has always involved working with 'involuntary

clients' the current philosophy can and has resulted in more adversarial practice, particularly where the staff undertaking the 'investigation' do not have the appropriate knowledge, qualifications and skills to effectively engage with clients.

The process of assessment is central to ensuring professionals are making informed decisions about the needs of a particular client group. Assessment frameworks provide us with an important tool to assist us in undertaking evidence based holistic assessments. However, the AASW has seen an over reliance within the child protection system in Queensland on actuarial decision making tools as the basis for decision-making about a child and risk, as opposed to using the tools to help guide a robust risk assessment process. The over-reliance on structured decision-making tools has contributed to a demise in the level of knowledge, judgement and expertise of staff who do not all possess a strong assessment framework. There is also some concern that in the political context of child protection an unwritten culture has emanated from senior management placing pressure on frontline worker to lower number of cases that are "screened in" as notifications.

The Regional Intake Services (RIS) has been a positive move to increase the level of consistency in decision making of children and families entering the tertiary sector. The AASW understands that the RIS services are being staffed by more experienced workers, which is necessary. The AASW supports the use of Structured Decision-making Tools as a complement to, not a replacement for, professional decision-making.

Effective assessment involves the process of formulation or statement at a given time, of the nature of the client's problems, resources, other issues. With any ongoing work with a client, the assessment will change with time, which is why all ongoing intervention needs to be based on a process of assessment, implementation, monitoring and review – this is a cyclical process that is ongoing. The Victorian Department of Human Services (2000) identified three overlapping processes to risk assessment: 1) gathering information; 2) analysis of information; and 3) judgement of risk. Being able to effectively undertake an holistic assessment requires that staff are properly qualified, trained and experienced. Just as we would expect a Surgeon to have the proper level of knowledge and training before making a diagnosis, we also require child protection workers to have the necessary knowledge, skills and analysis skills to put this all together. Developing a sound judgement involves forming an *"independent, balanced, courageous and sometimes critical judgements, based on critical thinking and the 'best evidence' available to us"* (Trevithick, 2000, p. 61).

Effective decision making involves seeking and valuing information from a range of stakeholders. While the rhetoric exists that this happens, and indeed does happen in different service centres, again, this is not consistently the case. The AASW has anecdotal information from key stakeholders such as mental health, health residential care services, family support services, substance abuse services, Recognised Entities to name a few, that their 'expertise' is not consistently valued and sought by Child Safety to inform holistic decision making.

In the past, the statutory services within Queensland provided hands on support and intervention when working with families and children where abuse has been identified. However, the role has now shifted to one of a case manager, and so much more administrative rather than providing and focusing on developing a 'therapeutic' relationship with children and their families to work towards addressing the concerns. The Department therefore relies much more so on outsourced services to provide family intervention support. However, this is not matched by appropriate levels of resources, intensity and program design. For example, not all regions in Queensland have had access to a Referral for Active Intervention (RAI) service, for example Browns Plains and Mt Gravatt. Not all regions have access to adequate Family Intervention Services (FIS) or reunification services. Without appropriately qualified and skilled workers, many service centres themselves do not currently have the skill level or staffing numbers to be adequately take on this role.

An effective tertiary child protection system requires access to intensive family intervention services that can provide in home/outreach support along with in office services. Without this uniformly being provided across the state, the tertiary system is not able to achieve meaningful changes to addressing child protection concerns. Furthermore, most family support services are time limited, that is, 3 months in duration, with limited in home support services and the intensity of support required for families subject to statutory intervention is often inadequate to address the child protection concerns in any sustainable manner.

Recommendations 20-23

- *Review of the assessment framework being used by Child Safety Services is required including the practices around use of SDM tools.*
- *The AASW recommends that the Inquiry review the current practices of case management, in particular, the understanding of and level of actual therapeutic case management and case work in engaging with families as opposed to administrative case management.*
- *The AASW recommends that a review of case loads for CSOs be reviewed as part of the Inquiry to ascertain levels of case responsibility borne by frontline workers.*
- *The AASW recommends that the Inquiry explore the effectiveness of the existing underlying assessment framework within the department. It is suggested that one way of doing so would be to undertake a review of a sample of cases from across Queensland to review the effectiveness and robust nature of the decision making frameworks used.*

Case work and case management

The Case Manager has overall responsibility for "the fate of the client" along with the "overall responsiveness of the entire service delivery system" (Moore, 2009, p. 34).

Core to effective case management is holistic and robust casework, that is, the work that is undertaken with the client, the child and their family. However, with the de skilling of the workforce within Child Safety Services we have seen an increased focus on case management as an administrative process, with little actual casework being undertaken with children and their families. This aspect of work tends to be outsourced to other services and consequently, Child Safety Services has had a fundamental shift away from engaging in family work. With this Child Safety has lost the capacity and understanding to work with and walk alongside children and families, in an attempt to respectfully engage with families to address child protection concerns. The research shows us that the majority of families who harm their children are experiencing a combination of multiple stressors in their lives, along with other challenges, such as substance or alcohol misuse, domestic and family violence, issues around disability etc. The majority of families require respectful engagement with them to work through the child protection concerns. This is more than an administrative or forensic role, however, with inadequately qualified and experienced staff, the focus has been on forensic investigation and case management as more of a process and administrative function.

Recommendation 24

The AASW recommends that the statutory Child Safety authority recognise and support frontline staff capacity to develop effective professional relationships with vulnerable children and families. Key relationship building skills include the capacity to demonstrate empathy, engage the families in decision-making and in change processes.

Service standards

The AASW will not be making a comment on service standards at this stage.

Child protection court and tribunal processes

The AASW is not making a submission on the Children's Court at this point but will do so in later submissions. The AASW makes the following observations about QCAT involvement in reviews of child protection decision-making:

- QCAT provides an avenue for children to bring their own applications, to speak with the Tribunal, to be represented, or for an application to be brought on their behalf. From this perspective, having such a forum remains important.
- Key to an effective QCAT process remains having a multi disciplinary tribunal panel, with child protection expertise being crucial. The AASW would further support the need for an increased focus on ensuring all tribunal members have particular understanding and expertise in child protection matters, as opposed to general tribunal experience. Further, we would be considered if the current panel constitution is further diluted by opening this up to panel members with non child protection expertise.
- While the focus is on the best outcome for the child, this process is hampered by the poor relationship at times between the Department and the applicant
- An issue identified has been the lack of appropriate expertise of departmental staff in dealing with "mandated "clients and a focus on a legal view of proceedings rather than a therapeutic approach, which has been linked to staff having limited understanding of child protection issues and the broader theoretical and evidence base that underpins this. As a result, staff tend to refer back to policy and legislation without being able to necessarily articulate the broader implications of their decisions for the child or young person and their family.

Recommendation 25

The AASW recommends continuing support for QCAT as a forum for enabling quality practice in child protection services.

iv. The transition of children through, and exiting, the child protection system

The AASW has significant concerns about the transition of young people through and exiting the child protection system. Our concerns include:

- The absence of information about placements of children and young people leaving care. Across Australia, approximately 30% of teenagers under care orders aged 14-17 years are released from care. The Queensland Department of Communities, like child protection authorities across Australia, does not keep any account of the living conditions into which these children are released. Yet, it is evident that teenagers who have been in care are over-represented in the homeless population (Healy, Lundstrom & Sallnas, 2011);
- Research evidence suggests that many teenagers are released from care without a care or educational plan (CREATE, 2011; Jurczyszyn & Tilbury, in press). Navigating through the transitions in the absence of a plan results in

inadequate supports, poor educational and health outcomes. Many young people are unaware of the supports available and where this is support provisions, access and coordination between agencies and departments in lacking. For example, the Create Foundation (2011) identified (42%) of young people had not heard of a National Allowance designed to supporting the transition into independent living (TILLA) let alone had the capacity to access and optimise the resources available. This suggests the coordination of transition planning is lacking and whilst supports have been implemented in some degree, young people are not provided the necessary support and information to improve their transition;

- Young people who have been in out-of-home care face significant educational disadvantage including lower level education attainment and access to post secondary education. Research demonstrates that children and young people in out of home care often fall behind in school, are excluded and after care, access higher and further education at a much less rate than their non-care peers (3% compared to 40%) (Jackson, 2006). This contributes to ongoing disadvantage with many young people leaving out-of-home care with limited opportunities to re-engage with educational opportunities such as enrolling in the vocational sector or higher and further education such as university given the eligibility for most of these programs include school attainment and capacity to engage in a learning environment.

Recommendations 26-31The AASW recommends that:

- *The Child Safety authority is more accountable for the well-being and safety of children and young people who are in or have exited the care system. This should include a database about the location and nature of placements of these children and young people who have exited the care system as well as a clear system of accountability for ensuring that these children and young people have a care plan and that the agency's responsibilities in that care plan are met;*
- *All children and young people should have a formalised leaving care plan facilitated by staff who have appropriate education and career planning expertise ,which outlines the transition stages, supports available and nominates key people to champion and facilitate the plan , including evidence of engagement with the child or young person.*
- *There is greater emphasis on education engagement appropriate to the individual exists during the leaving care preparation and planning stages. Reorientation of existing staff support (school guidance officers, TAFE career counsellors, Queensland Tertiary and Admissions Centre staff , flexible education program managers/leaders) to work with children and young people in out-of home care and their significant others , including Child Safety staff in supporting the cohort of young people in their transition phases including state schools, high schools, flexible learning schools and those who have been excluded from school or left prematurely;*
- *Appropriately qualified staff are appointed in the areas of career planning and education engagement to graduated entry programs to traineeships, apprenticeships and other higher and further education opportunities for young people during the transition into independence. This could include*

establishment of education officers in each region who have career planning and education expertise who are employed by Child Safety and report professionally through the Department of Education and Arts to ensure professional isolation is addressed.

- *Extend the age of formally leaving care with supports available to what is normative for their peers not in care. We need to consider the merits of better supporting our most vulnerable until at least 21, by including this in legislation and not leaving to the discretion of Child Safety staff interpreting the legislation.*
- *The establishment of an evidence based boarder parent model where if the young person wishes to remain with the approved carer, the carers are remunerated with the carers allowance as (boarder parent) if the young person enrols in full time education until they are 25 years of age as undertaken internationally such as in the United Kingdom.*

Inquiry Terms of Reference 4 and 5.

Throughout this submission we have discussed AASW views, concerns and proposed responses to issues of relevance to Terms 4 and 5 of the Inquiry. The AASW will not be making submissions on these points in this submission but we intend to do so in later submissions once further consultation occurs with our membership.

Conclusion

The AASW believes that the Queensland child protection system needs to change in order to better achieve child safety and child and family well-being. At its core, the child protection system must be unified under a common framework which recognises the rights and needs of vulnerable children and families to respect, participation and to services that build their capacities. Decision-making at all levels of the system must reflect a commitment to this common framework. Placing child safety and family well-being at the centre of Queensland child protection services will require changes in staffing practices and in resource allocation. It will require the recruitment and development of a workforce and a service system capable of responding to the strengths and needs of vulnerable children and families. The AASW believes that the key to effective child protection intervention at the tertiary level is having an appropriately qualified and experienced workforce. We thank the Inquiry for this opportunity to present the AASW view and we would welcome the opportunity to discuss this submission further.

References

Australian Institute of Family Studies (2012). The economic costs of child abuse and neglect. http://www.aifs.gov.au/cfca/pubs/factsheets/a142118/index.html, accessed 13/08/2012.

Create Foundation (2011). *An evaluation of CREATE's What the Plan? Campaign; Transitioning from Care in Australia.* Accessed 11 April, 2012.

Department of Child Safety (2007). *Review of qualifications and training pathways*. Department of Child Safety Consultation Paper. Brisbane: Queensland Government.

Dumbrill, G. C. (2006). Parental expectations of child protection intervention: A qualitative study. *Child Abuse and Neglect*, 30, pp. 27-37.

Hardy, F. (2005). *Parental perspectives of parenting challenges and family support in the context of child abuse.* Thesis. Queensland: University of Queensland.

Hardy, F., & Darlington, Y. (2008). What parents value from formal support services in the context of identified child abuse. *Child and Family Social Work*, 13, pp. 252-261.

Healy, K., Darlington, Y., & Yellowlees, J. (2012). Family participation in child protection practice: an observational study of family group meetings. *Child and Family Social Work, 17(1), 1-12*.

Healy, K, Lundström, T. & Sallnäs, M. (2011). A Comparison of Out-of-home Care for Children and Young People in Australia and Sweden: Worlds Apart?, *Australian Social Work,* 64(4) 416-431.

Healy, K. and Oltedal, S. (2010). Child protection systems in Australia and Norway: An institutional comparison focused on workforce retention. *Journal of Social Policy*, 39(2), 255-274.

Healy, K., Meagher, G. and Cullin, J. (2009). Retaining novices to become expert practitioners: Creating career pathways in direct practice, *British Journal of Social Work (39), 299-317*

Healy, K. & Meagher, G. (2007). Social workers' preparation for child protection: Revisiting the question of specialisation. *Australian Social Work*, *60(3)*, 321-335.

Jackson, S. (2006). *Going to University from Care. Paper for presentation at the Australian Child Welfare Association Conference*. Positive Futures, August 14, Sydney.

Jurczyszyn, R. & Tilbury, C. (in press). Higher and further education for care leavers: A road less travelled. *Australian Social Work.*

Local Authority Workforce Intelligence Group (2006). *Adult, children and young people: Local authority social care workforce survey, Report no. 36. Social Care Workforce Series*, www.lgar.local.gov.uk

Moore, E. (Ed.) (2000). *Case management for community practice*. South Melbourne, VIC: Oxford University Press.

Munro, E. (2008). *Effective child protection, 2nd edition.* London: Sage.

Munro, E. (2011). *The Munro review of child protection. Interim report: the child's journey.* London: Department for Education, Government of the United Kingdom.

Trevithick, P. (2000). *Social work skills : A practice handbook.* Buckingham : Open University.

Victorian Department of Human Services (1999). *Victorian Risk Assessment Framework*. Victoria: Victorian Government.