QCPCI

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Statement of Witness

Name of Witness	Linda Apelt
Date of Birth	
Address and contact details	
Occupation	Previous Director-General Department of Communities
Officer taking statement	[redacted]
Date taken	/ 8/20

I, Linda Apelt State on oath:

Background

1. I was the director general for the Department of Communities for a period of 14 years. From 2008 to March 2012, I had direct responsibility for Child Safety Services. Prior to that time, Child Safety was a separate government department.

2. In 2004 the CMC recommended that there be a standalone department but by 2008 however it was then rolled back into the Department of Communities. I think it was about March after the election that occurred in that '08/'09 period, the Department of Communities was formed and that was one of the so-called 'super' departments, which rolled together all of the key human services functions for government.

3. This super department included disability services, the Department of Housing, the former Child Safety services and a whole range of other human services that came together to make up the Department of Communities.

4. The philosophy of government at that time was an efficiency driver to get economies of scale, and there was certainly quite a bit of downsizing of senior positions at that time in

order to save money for government. The primary driver from a client focus outcome point of view was the realisation that clients within the community services sector, whether you are a client of social housing, child safety, youth justice, disability, mental health, by and large you are the same person.

5. The same person as a user of multiple agencies, can be for the reason that you are in the child safety system is often because you've got a mental health condition, your parents are impoverished, you are the subject of a domestic violence situation, your parents might be in gaol, your parents might have mental health or intellectual disability, or you are in an impoverished situation with unstable housing, parents can't demonstrate they've got the wherewithal to provide a stable environment for their children, and so their children ultimately come to the attention of the state, and unfortunately, often into the care of the state.

6. (Is the current use of resources across the child protection system is adequate, and whether resources could be used more efficiently.) If you study the annual reports between 2008/'09 through to 2010/'11, it's recorded there the general move towards implementing the thinking about 'no wrong door', which is essentially structuring a service system around the needs of the client…

7. By way of example about 'No wrong door':

   > a young fellow, 16 years of age, he's got an acquired brain injury as a result of encephalitis, has very aggressive behaviour, his parents can't handle this young fellow in the home. He then goes into foster care because the parents are unable and unwilling to care for him any longer, and within that system he gets access to disability support, mental health support, schooling and a whole range of other support services that he otherwise was not getting.

8. That was able to be facilitated because within the one environment, Department of Communities, all of those services were part of the same family. So coordinating a case approach for this young fellow happened just so much more easily than it had done previously with separate entities all just looking after one element of his life.

9. I have absolutely no doubt that this system worked well. For another example, would be that often children come to the attention of the State because the parents are homeless, or don't have stable, affordable housing to care for their children. So within this environment through having a case management approach, using the Department of Housing arm, we were able to get stable, affordable housing for the parents, which enabled, the sole parent to keep the care of the child, but at the same time wrap around disability, mental health and other support services to ensure the family is well supported in order to care for their children.

10. This was a family/community context rather than just focusing on the children as a decision, obligation, statutory process if you like, through a decision-making process, off to foster care, off to group home, etc.

11. The philosophy was about looking at why it is that a child is in this state of vulnerability, that the State has to get involved in the child's life, and working on the assumption that everything that is possible can be done to support the family environment to have the strength and sustainability to be able to be responsible for the ongoing care of their children.

12. This approach was something that was borne out in the Forde Inquiry and subsequently in CMC and other Inquiries, that very often children find their way into the child protection system because the family environment is impoverished, or parents don't have the skills, or the wherewithal, or the context to be able to care for their children, they are not necessarily bad people.

13. If you look at the trajectory of the statistics in the child protection system in the last, ten years, you will see that there has been a disproportionate growth of children in this state coming to the attention of the statutory authorities through both child protection and also the youth justice environment.

14. Part of the 'no wrong door', is having youth justice part of that communities umbrella. More often than not, a child who finds their way into the child protection system has either already got a relationship with the juvenile justice system, or if they don't now, they soon will. So that ability to be able to manage the child, work with the child and their family as a

whole, rather than having multiple agencies all doing little bits and pieces in a child's life, the evidence is abundantly clear that an integrated, 'no wrong door' holistic approach to providing support to families and their children gets better results for the child, and indeed for the family.

15. The system is such that you come in one door, and it's up to the government, the state, to assess the needs and then wrap around the kind of support that is needed to get the outcomes that everybody agrees we are working to.

16. I've no doubt that integrated approach at the local service delivery front line area, where the child safety officer is able to work with housing officers, disability, mental health, youth justice, that from the child's point of view, produces a better result. If you look at it from a public service point of view, professional expert workers through our staff surveys on an annual basis, reported that this system is much better for clients. But I've no doubt that if you talk to individual officers, some people would pine for the days when it was simpler, and as an officer you only had to work with one part of the problem rather than the whole problem.

17. It is harder to work in a collegial way, team-based way, to assess the whole problem and then to put together the set of services that will inevitably guarantee a better result for the client. It's much easier to say 'this family is homeless, they can't care for their child, therefore we will put the child into foster care, or into the child protection system somewhere', rather than 'let's work with housing and other support services to see what we can do to alleviate the homelessness and therefore also alleviate the vulnerability of the child.

Does the department regard its role as a primary, secondary or tertiary intervention or more secondary or tertiary?

18. It was set up to have a concentrated tertiary, statutory intervention role. There were recommendations about the need for other parts of government to provide early intervention and prevention, but I can recall the experience of getting various ministers to work together to share budgets and invest in early intervention and prevention, it did not happen easily. It didn't happen seamlessly or naturally.

Department Dealing with the Minister

19. When the super department was formed there was more than one Minister that oversaw that department. There were four Ministers, so that brokerage between Ministers to share resources and invest in early intervention and prevention still needed to occur, but it happened more easily with having one Director-General having to broker it across four Ministers, rather than four Director-Generals and four Ministers all trying to broker a sharing of resources for a common objective.

20. In considering whether there was any inherent tension in the sense of reporting to four ministers; there is, because I each Minister is elected and accountable to the parliament for their budget and their policy objectives and their delivery. It's not always an easy thing for Ministers to share their budget with another Minister for something when there's so much stretch with resources, and there's just so many priorities.

21. Having a Senior Minister who is in charge of the integration and delivery of human services around the interests, in this case of the child, I believe, would be easier to mobilise resources according to need.

22. I believe there needs to be a central oversight, because the, if we look at the trajectory of what's happening with the system at the moment with child safety in Queensland, as in other states and churches of Australia, and in other parts of the Western world, there's an over-emphasis on the tertiary, statutory end. It's a lot of investment in computer systems, decision-making tools and an under-investment in prevention, early intervention and family support.

23. I am aware of criticism of, not just Queensland, it's across Australia and internationally, regarding the idea of tertiary input rather than primary. I believe putting more money in isn't really the answer.

Reports from police or other agencies

24. There was a huge increase in notifications to the department in a 5 years period and numbers staying fairly static for children in care. The reasons behind this increase is in part because of the requirement to report all domestic violence incidences a disproportionate reason for why a number of children are involved in the child safety system.

25. The other key reporters are the educational system and the health system. The nature of the reporting and the decision-making process sifts and sorts what is a notification that's worthy of investigation and others that are parked. In many cases nothing else happens, other than they are just information on the information system. That number of reports that are just information sitting on the information system is growing in number, and I believe that people in the community feel that if it's been reported, something is being done about it.

Investigatory Notifications

26. It's not practical to investigate 100% of notification and the numbers illustrate that. That is why other states and churches have moved away from that practice. It is possible to have a filtering arrangement so that those that are more low level reporting can actually be referred to non-government organisations, or perhaps back to the school, or back to the health authorities to do some further family work. Investment in recent years and initiatives like 'helping out families', have been set up as non-government organisations that have the ability to receive that lower level reporting and so some investigation and direct family support to help families manage child and family life themselves. That absolutely has to be explored further.

27. In the current system the resource tilt is automatically drawn towards the tertiary end because of the obligations to receive and investigation, attempt to investigate 100% to the full level of investigation rather than having a gradient from lower level to more serious level.

28. The interstate model in terms of response to significant harm. There is no 100% insurance policy in child safety because we know the Victorian experience of actually referring, what they believe, were the lower level cases out into their non-government sector. A bit equivalent to our 'helping out families' initiative. The ombudsman found lots of issues

there where the non-government sector wasn't able to provide a fail-safe mechanism either. But nevertheless it was, on balance, a better guarantee that children and families would get support than simply being reported and not able to be investigated and being put on some sort of a rating on a system through a decision-making tool on the computer with us that officers would work through.

Front line staff

29. In terms of the amount of information that they need to feed back into the system, and the difficulty for them when they are supposed to be delivering front line services it is an inevitable tension. We know from our study of other jurisdictions, that there's an absolute direct correlation between the resourcing that goes into supporting people on the front line, and the outcomes for children. A ratio of one worker to 25 cases is considered to be a reasonable level of risk for case workers to carry.

30. However, as time has gone by, after the CMC Inquiry and other inquiries, child death reviews the call for accountability with decision-making around children in care has got greater. There is more and more scrutiny around the decision-making, and so the investment in computer systems like the integrated client management system has been an enormous. It has been a great support to child safety workers on the front line because it's made it easier to record information.

31. One of the problems in the years preceding the Forde Inquiry was that people just didn't have records, they didn't have access to information that recorded their decision-making process, whereas I would say that one of the great benefits from that CMC Inquiry, and perhaps having child safety as a dedicated, standalone department for the period that it was, it enabled dedicated attention to put together the right information systems, decision-making tools, practice manuals, policies, procedures, all of that back end machinery that is absolutely vital to supporting front line workers make decisions, and do their work. The downside of that was the lack of connection with the other services that really needed in the primary and secondary sphere, to try and keep people out of the tertiary system.

32. What struck me when I first took on responsibility for child safety, integrated department was that the officers who had been trained within that system, saw their jobs as tertiary intervention.

33. Our officers did not see their job to be involved in primary or secondary service intervention, that was other people's jobs, but other people didn't necessarily understand what that meant.

34. I think having the standalone statutory department, distorts the whole system of more and more resources going into a tertiary response. I believe the department had got more responsive at a primary and secondary level, but I think that's changed again now, that it's gone back to disparate and different departments.

The apparent disparity of the departments

35. I believe is the decision around the machinery of government changed with the advent of the new government at the last election, devolving to the separate government departments again.

36. I think having social housing separate, and youth justice separate from child safety, people are going to have to work very hard to ensure that a holistic approach occurs to get better results for children and their families.

Support for front line staff, high turnover and programs developed to provide support to staff.

37. Over the last ten years, there has been an increasing investment in training and development of workers, development of practice manuals, decision-making support tools, after hours service for advice, a whole range of back end services that support the decision-making process, judgement making, reporting of front line workers.

38. From my mind it doesn't make a lot of sense when you are talking about child safety to say "well we are just putting our emphasis on front line", because the front line workers are often 21, 22 year old young women usually, straight out of university, well-intended, but in

a job that many of us would struggle to do. They need the back up support in the back end, to support them do their work.

39. So front line needs back end, so you get a full, confident, robust service. When we have young people going off to Cape York etc, and don't have the back up in the back end with policy, procedures, senior practitioners to help them check their judgments about whether to take a child away from the family or not, puts those workers in an even more vulnerable situation.

How successful the department as a whole has been in retaining middle management to provide support to front line

40. The turnover in middle management was in line with the public service average. But the turnover of front line workers was definitely above public service average and was probably akin to workers in youth detention centres, and front line disability service workers. It's an area of work that workers need a lot of support to be able to do such stressful work.

Children in residential care facilities and some of the particular problems during my time as Director General.

41. For a child, the state is not the ideal parent. It's a default position. The children who, by and large, find their way into group homes or little group homes, or safe houses, are children that have got very difficult, and challenging behaviours. It is unreasonable to ask a foster carer to care for the child in these situations. Therefore there are other therapeutic residential services that are better able to provide the kind of support that young people need, but it's difficult. These children are there because their parents have not been able to manage their behaviour in the family home. It's often assessed, or the experience has told us that a foster parent can't manage that behaviour either, and so you have a group residential therapeutic often, where you have people on a rotation, youth workers rotating in shifts.

The composition of persons who staff residential care facilities and how well they are supervised

42. This is done by non-government organisations. There is a very sophisticated contractual arrangement between the government department and the non-government organisations. There is a lot of accountability, one, for the organisations to become licensed in the first place, and then secondly, ongoing reviews of their practice and reporting. It provides an ongoing tension about the level of intrusion. The question remains: should the state have in independent organisations doing their work?

Indigenous issues and the over-representation of indigenous children, What might have been targeted by the department to address that?

43. The over-representation of indigenous people in the child safety system is disproportionate. From a 'no wrong door' point of view, it highlights the importance of the closing the gap initiatives for indigenous people so that they have access to education, employment, the domestic violence services, alcohol management plans, indigenous housing services, family support. Those initiatives are absolutely critical in order to have a flow on impact for children to live in safe environments.

44. The investment in family support, safe houses, domestic violence services, a whole rage of services for indigenous people and you'll see from the successive annual reports, it's been increasing expenditure over time. Yet despite that unprecedented investment, one in four indigenous children in this state are now under child safety. In the youth detention centres, you'll see that that ratio is even higher.

45. It's bigger than a child safety question as to why this is.

Issues of kinship and foster placements and Recognised Entities

46. This has been a fraught issue in the history of establishing recognised entities and people within the community that can liaise between the state child safety system and families. Given the culture complexities of often dealing with family members, or friends, or people in small communities, it's never been a straight forward process.

47. It is an area, that has been reviewed and restructured and reorganised many times to try and get a better result. When I last had responsibility for this area, the Minister, Phil Reeves,

saw this as a very high priority, and the whole system was reviewed and restructured to try and get a more workable system, but it was not a failsafe system. Often recognised entities were just not available, or felt they weren't in a position to advise for some children because of compromising family ties or cultural ties.

Reducing Notifications

48. That would be ideal, if there was resourcing to do that because the child safety statutory system is gearing around tertiary, and people refer primary and secondary issues into this one vortex which is really geared up around tertiary. Therefore because of the policy of investigating everything the system just grinds to this inefficient state.

Support for the department investigation less than 100%, and referral to primary and secondary services, rather than waiting for it all to funnel up to that tertiary body-intervention, expertise and resource options.

49. The child safety statutory area has been set up with people who are trained in tertiary response.

50. There has to be a stronger investment and therefore public confidence in being able to refer matters to, non-government organisations that are resourced and expert in dealing with family support, early intervention, prevention, to provide primary and secondary services.

Role of community based organisations NGO's

51. Life Line, any of the church-based organisations, Mission Australia and Red Cross operate some of the referrals for active intervention organisations. There's organisations that are capable of doing this work if they are resourced appropriately. However at the moment, the bulk of that resourcing is sitting in the tertiary system when a proportion of it really should be out there trying to prevent kids becoming a tertiary statistic.

Should be more self-filtering from other departments?

52. Yes I believe that, and one of the things we were doing is producing the decision-making kit, so that police, nurses, teachers, can work through that to work out themselves whether or not this is really a tertiary child protection matter or whether the parents need some support.

53. The system needs to set up the ability for people to refer what's judged as a primary or a secondary concern. They should refer it off to somewhere that has expertise to work with them, and work with the child and family. Whereas at the moment, because that option is not there in many places, the only option you really have is to refer into this tertiary system which is not really set up to deal with primary and secondary concerns, so you get this get big long list of notifications that should never have gone there in the first place.

54. The problem is at the moment with the statutory, and the mandatory notifications.

55. To change this situations, legislative reform is required to a variety of Acts within the education department, and within the health department that require that mandatory notification.

56. A further problem is how those different acts, feed into the child protection legislation, as there is no standardisation of reporting procedure in terms of what constitutes harm etc.

57. One of the things that I have discussed with the Police Commission at one point, was to just outpost child safety workers with the police to check off on some of the decision-making as to whether or not something really is tertiary, or are we better off referring this family to a drug and alcohol rehabilitation service, or making sure that they are linked in with mental health etc together with some other family support arrangement and monitor it and see how it goes for a while before you make it another, name sitting on the list that'll probably never get investigated or attended to. Having, I think having the confidence of someone who have got the child's safety expertise to support the decision-making has merit.

Declared before me at Brisbane

This day of 2012

Witness signature..... Signature of officer.....