

## Women's Legal Service Inc.

### Response to Queensland Child Protection Commission of Inquiry - 2nd call for submissions

#### Discussion Paper (DP) - March 2013

Women's Legal Service once again, welcomes the opportunity to submit to the Queensland Child Protection Commission of Inquiry. We submitted to the previous discussion paper in September 2012 and reiterate our earlier points, especially about interactions between the family law, domestic violence and child protection systems.

As you are aware, the Women's Legal Service (WLSQ) is a Brisbane based community legal centre which has been operating since 1984 and has forged a strong reputation in Queensland for providing high quality legal and welfare services to women. Our staff comprises lawyers, social workers and administrative staff and we work in a holistic way with our clients, embracing a broader approach rather than looking only to legal proceedings as a solution for the complex problems faced by our most disadvantaged clients.

We provide the following comments:

#### **The need for research**

In the Commissioner's Overview in the Discussion Paper (p.xiv) *the paucity of research* into this area is noted, *including a shortage of research funding and an inadequate evidence base for sound policy and practice decisions*. Recently, the federal government announced the establishment and funding of a new National Centre of Excellence *to evaluate the effectiveness of strategies to reduce violence against women, improve best practice and support workforce development*. This is part of the National Plan to reduce violence against women and children. The Queensland Government could further support this initiative as a means of increasing the evidence base into the future on issues of child protection. The infrastructure for the Centre has already been established. The overlap between issues of violence against women and violence against children is clear and arguably within the terms of reference of the Centre's future research. Perhaps this could be explored.

***That the Queensland Government support an evidence based approach on child protection.***

***That the terms of reference of the newly established National Centre of Excellence be investigated to determine whether they are able to develop research on best practice approaches and responses in child protection but otherwise, funding of an ongoing research body to develop an evidence base for sound policy and practice should be established in Queensland.***

***That the current Inquiry investigate the research and practice basis for recognised best practice processes internationally.***

### **Interface between child protection, family law domestic violence**

In our previous submission, we spoke about the overlap between family law, child protection and domestic violence. We reiterate and support our previous comments and advise it is an ongoing issue that has been identified for 20 or more years without any real positive progress - women are told by DoCS to leave their abusive partner otherwise their children will be taken and to seek protection under family law where they are given strong messages about sharing parenting and ongoing contact in the family law system. This pressure on women has not, in our experience been significantly alleviated by the amendments to the Family Law Act, introduced in 2012. There is also the ongoing issue about focus and blame on the mother in a domestic violence situation and a lack of accountability for the perpetrator of the violence.

Since the last discussion paper the Commission for Children and Young People and the Child Guardian has released its report: *Fatal Assault and neglect of Queensland children report (February 2013)* relating to child deaths between 2004 - 2006.

Key findings were that:

- domestic homicide was the most common category of death examined in the project sample, more than double the occurrence of fatal child abuse which was the next most common category of death.
- In more than half of all domestic homicides there was evidence that a breakdown in the parental relationship was a factor.
- In 81% of fatal assault and neglect child deaths, the child's family had a protection history;
- In 81% the child was known to the DoCS within 3 years of the death.
- In 88% of cases, at least one of the child's parents had a criminal history.
- 63% had a domestic violence history.

- 63% had a history of drug or alcohol abuse.

The overlap is clear and a stronger multi-agency partnerships between domestic violence services and child protection (and probably family law agencies) is, we believe required.

These statistics clearly suggest a failure by DoCS to identify and respond appropriately to these families including intervening and providing support and assistance at an earlier stage prior to the crisis.

### **Greenbook Initiative in the United States**

In the late 1990's in the United States work began on interventions in families where there was the co-existence of domestic violence and, what they term, child maltreatment. This became known as the *Greenbook Project*. It recognised there was a lack of trust and suspicion between the domestic violence and child protection sector, notwithstanding they were invariably working with the same families.

The project involved the implementation of the Greenbook guidelines (previously developed) and putting them into day to day practice. It was a 'system's change initiative' undertaken by the US Department of Justice.

The final evaluation report *The Greenbook Initiative Final Evaluation Report 2008* is available online. WLSQ has no 'on the ground' information about the value or success of the project, however, it is interesting to consider and learn from their experience. The following information has been lifted directly from the final evaluation report.

*The Greenbook stated:*

*Child Protective Services, domestic violence agencies, juvenile courts and neighborhood residents should provide leadership to bring communities together to collaborate for the safety, well-being and stability of children and families.*

*It established a collaborative foundation between agencies. The Greenbook further recommended specific policy and practice changes within and across the community agencies and organizations that serve families experiencing child maltreatment and domestic violence, particularly child welfare agencies, domestic violence service providers, and dependency courts.*

**Lessons Learned from the project:**

Greenbook grantees' experience and reflections have identified a number of lessons for the implementation of this kind of system and practice change effort. Major lessons include:

**Accomplishing change requires significant resources and persistent effort.**

*Bringing about change requires time, effort, and other resources. Furthermore, the process of change often is uneven and requires revisiting issues and needs repeatedly over time. Limited staff, funding, and other resources are a challenge to collaborative efforts, especially if there are large differences among partners' resources.*

*Technical assistance from external consultants was a valuable resource for supporting change through the Greenbook initiative. One of the key roles of technical assistance was to help break down barriers and facilitate communication among partners. In addition, the Greenbook sites provided valuable peer-to-peer support to each other.*

**Shared focus and working together on problems that could not be solved without the efforts of multiple organizations was important for motivating and achieving change.**

*Because child protection and domestic violence are addressed by different organizations, child welfare, domestic violence service providers, and the courts had to work together to achieve Greenbook goals. Staff at all levels of the organizations worked together to carry out the Greenbook work—in the governance board and working groups, in cross-trainings, and in work on individual cases (through the work of domestic violence victim advocates and multidisciplinary case reviews).*

*This multi-level collaboration forced partner organizations and staff at all levels to address issues of trust, organizational philosophy, differential resources, and problem solving for families. Not all issues were resolved in all cases; challenges related to power, trust, information sharing, and associated issues continued to be faced. By working together, however, the partner organizations in the sites made progress on these issues.*

**Different partners, structures, and activities needed to be involved at different times, both in the larger cross-system collaborative and within systems.**

Achieving system change required work at multiple levels of the organizations and sustained work over time. Early in the initiative, the sites took time to conduct needs assessments, relationship building, and other preliminary activities, and saw this effort as important to successful implementation of the initiative. Practice changes focused initially on improved identification of co-occurrence within the child welfare system and on training for workers.

Over time, the structure and membership of the collaboratives changed. The structures evolved to include a decision-making body, a larger advisory group, and workgroups that focused on developing and implementing plans in specific areas. The sites added other partners, such as law enforcement or batterer intervention programs, as the initiatives' needs and focus developed. In other instances, changes were less positive. Over time, community and survivor input declined, and several sites noted that they should have devoted more efforts to communicating with and engaging the community. Similarly, lack of collaboration between dependency courts and other courts was identified as a gap in the Greenbook work. Sites varied in the degree and timing of worker involvement. They noted that implementing new policies at the frontline practice level was a challenge because of the gap between leadership and direct service workers, staff workload, high staff turnover and other factors. Once policy or practice was changed administratively, agencies needed to provide training and support for implementation. Several noted that engaging frontline workers earlier could have helped this process.

Some particular findings included:

***Through the Greenbook initiative, there were changes in practice at the level of work with families and children. The different partner organizations contributed to this change in different ways***

*The Greenbook initiative involved communities and child- and family-serving organizations taking the Greenbook guidelines and putting them into practice in their real day-to-day world for agencies, organizations, families and communities. To bring about change, organizations needed to undertake major changes in activities, operations, and ways of thinking. The literature on the implementation of evidence-based practices provides a framework for undertaking and evaluating change. Successful implementation requires a number of factors, including assessment of need and readiness for change, support of key stakeholders, training and other support for changed practice, and ongoing feedback and adaptation (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Metz, 2007; Metz, Blasé, & Bowie, 2007). The Greenbook demonstration initiative is one of a number of system change initiatives undertaken by the U.S. Department of Justice and other Federal agencies. (For results of the evaluation of the Safe Start initiative for children exposed to violence, see the winter 2008 issue of Best Practices in Mental Health.)*

*Partners contributed in different ways to the collaborations. Judges took a lead role, serving as chairs or members of steering committees, and lending their authority and influence within each community to help the collaborative do its work. Domestic violence service providers were actively involved in the collaborative leadership and working groups. They served particularly as agents for change, ensuring the concerns of domestic violence victims were articulated and their needs addressed. Child welfare undertook substantial change in agency practice. Stakeholders noted that the participation of child welfare agency leaders and their willingness to forge relationships with organizations with which they historically have had troublesome relationships was a facilitator to the Greenbook process.*

### ***Change to Child Welfare Agencies***

*Child welfare agencies were the focus of the majority of systems change activities. Early*

*practice-related activities focused on improving identification of co-occurrence through means such as revised intake and screening protocols and staff training. The focus on this area reflected both the perceived gaps in identification of domestic violence in child welfare cases and the fact that this was a relatively well-defined, concrete area for action.*

*Child welfare undertook additional training for caseworkers on domestic violence, cooccurrence, and the impact of domestic violence on children. Child welfare agencies also expanded their use of co-located advocates, multidisciplinary case review, and other arrangements for sharing resources and expertise to address cases involving domestic violence. For example, one site developed a child protection team protocol. All child maltreatment cases presenting with domestic violence were reviewed by a multidisciplinary case planning team that included a domestic violence advocate, and caseworkers were trained on the use of the child protection protocol. Also in this site, guidelines were developed to protect the confidentiality of adult domestic violence victims, and policy was changed so dependency and neglect petitions minimized the use of blaming language related to the non-offending parent. The effects of changed child welfare practice were seen in several areas. Over the course of the initiative, there was an increase in the proportion of child welfare case files that showed evidence of active screening for domestic violence (i.e., domestic violence was indicated by the victim during an interview or on a form as a part of the child welfare case file). The other main area in which change in practice was evident was in referrals to services, which showed increased referrals to treatment services for victims of domestic violence....*

## **What about Queensland?**

Clearly the lessons learnt from this overseas experience is that systems change will not happen quickly and a long-term view needs to be taken. Political will and leadership is required.

We would support a similar multi-agency, multi-disciplinary approach to change (as the Greenbook initiative seems to indicate) that brings a domestic violence lens to the child protection system and a recognition that making the mother safe, increases the safety of children.

***That a multi-agency, multi-disciplinary approach to the child protection system be adopted that brings a domestic violence lens to its work and has as one of its core values - that increasing the safety of women increases the safety of children.***

***That such an approach requires significant resourcing and expertise to assist agency and systems collaboration.***

***The need for collaboration can not just be stated as a goal, it will not happen if it is not backed up by resourcing, training at all levels, the established of common goals and objectives, common language and evaluative processes built in.***

***Experience and expertise on multi-disciplinary, multi-agency based systems approaches should be sought.***

## **Transparency and Public Accountability**

In our dealings with DoCS over many years there are ongoing problems with accountability and transparency in decision-making and dealings with our clients. This includes-:

- our client's issues and concerns about their children can get 'lost in the system' and not responded to at all and there is no way of following these up.
- There is a lack of publicly accessible written guidelines that establish when a child safety threshold is met and the system will respond and when it won't.
- There is a disconnect between what people believe DoCS will do and what they can actually do/ or their internal mechanisms or policies allow.

- The Commission for Children and Young People that is legislated to review child deaths and to promote the interests of child safety in Queensland sits within and is part of the Department of Communities (Child Safety), whose work, in many ways, they are reviewing. It must be difficult to make recommendations concerning their own Department's failures.

The lack of accountability results in inconsistent decision-making in an atmosphere of 'crisis management'.

We believe that a truly independent, statutory body needs to be established and sit in ongoing way to review and monitor any changes recommended by the current review and issues of child safety generally and have a complaints mechanism - an ability to hear, investigate and deal with complaints. It should not be a "toothless tiger".

One idea is the establishment of a parliamentary committee that calls key witnesses, departmental heads and other agencies to review progress. An annual report can be presented to parliament. We would similarly support a permanent parliamentary committee on issues of violence against women in Queensland.

At least the Commission for Children and Young People must be an independent agency, separate from government.

We think that the presence of lawyers in negotiations assists with issues of accountability and transparency. We would support more legal aid to assist these vulnerable families and children to navigate their way through the legal system.

***That a permanent independent body for child safety be established to review and monitor any changes recommended by the current review. One idea is the establishment of a child safety parliamentary committee.***

***WLSQ similarly supports the establishment of a similar State violence against women parliamentary committee.***

***We support, at least the Commission for Children and Young People become an independent agency, separate from Government.***

***That a person with systems knowledge and established credentials in organisational cultural change be appointed to lead DoCS transition to an open and accountable institution that follows best practice.***



***That there be increased funding for legal aid for child protection matters for women, children and families.***