Submission by Professor Bob Lonne in response to the Carmody Inquiry Discussion Paper

What is the best way to get agencies working together to plan for secondary child protection services?

In many ways the poor cooperation and collaboration that innumerable child abuse inquiries have identified seems intractable. However this is, in my view, an unsustainable position to adopt because we can also identify circumstances and locations where things work very well indeed. That said, there is a wealth of research data on interagency collaboration and the Australian Institute of Family Studies has published good summaries in 2011[1]. In short, interagency collaboration is not a panacea but works best when the problems and issues being dealt with are complex and inter-related, and where the coordination undertaken brings changes to professional-client interactions. Whilst there must be broad systemic mechanisms in place to facilitate communication and cooperation, for benefits to ensue for families and children, it is critical for strong local systems to be in place amongst local agencies and for these to have a shared vision and a commitment to partnership and collaboration, with an ethical sharing of power. If systems are dominated by the powerful they can quickly fail. Moreover, if these systems are merely for the benefit of increased social surveillance of particular families or groups, this can actually be a retrograde step because clients will react by not trying to seek help from people or agencies they conclude are acting to harm or thwart them.

In essence, collaboration mechanisms must be localised and be an instrument for providing and efficiently accessing effective family supports. They must be built on a power sharing arrangement that emphasises shared values and vision, and be a mechanism for coordination and role/boundary clarification. It should be a way to forge relationships at multiple levels (not just leaders and managers) and which both challenges agencies to innovate, as well as problem solve. The quality of the inter-agency, inter-disciplinary and inter-professional is foundational to overall effectiveness and therefore needs to be part of the ongoing evaluation and sought after outcomes. The ChildFirst system in Victoria, while not perfect is nonetheless generally seen as being effective. The Outcomes Based Service Delivery system in Alberta is also demonstrating real benefits and progress. But a key point here is that all collaboration systems have to be contextually congruent and merely transplanting a “one size fits all” approach will generally fail. Searching for a neat "best way" model that meets the needs of all communities and sectors is particularly fraught.

What is the best way to get agencies working together to deliver secondary services in the most cost effective way?

See above

Which intake and referral model is best suited to Queensland?

This is a difficult question as the answer is probably that different systems may suit different parts of the state, and whichever system is adopted needs to be linked very closely to the systems put in place to promote inter-agency and cross-system collaboration. Many regional, rural and remote

[1] Australian Institute of Family Studies (2011a) Interagency Collaboration – Part A: What is it, what does it look like, when is it needed and what supports it? And Australian Institute of Family Studies (2011b) Interagency Collaboration – Part B: Does collaboration benefit children and families? Exploring the evidence.

communities already have highly effective systems for identifying people and children in need and making appropriate referrals. My point here is that leaving locales with the responsibility to develop effective intake and referral systems but not imposing a single model will probably be the best way to go. That said, of the options provided I believe that the first one is likely to be the most suitable to the Queensland context but my concerns about it is that it is reliant upon there being accessible services and resources in the community-based sector and at present this is not apparent to the sorts of levels that are required. My concern about the non-government sector taking on this role is that it will surely fail if there is a shifting of risk and responsibility from the government department but no commensurate resourcing to the levels that are necessary. That said, I think that a generally effective system has to be developed within a framework of the dual imperatives of protecting children from harm and supporting families. The two need to go hand in hand.

Another point needing to be made here is the potential undermining that would occur if the problems of mandatory reporting (either legislative or contractual) are not addressed. If the intake and referral system is to be seen widely by families as a good way to go to get help, then it has to be unhitched from the current broad perception of being a social surveillance system. In other words, unless families feel safe in reporting their troubles, and don't fear that asking for help will lead to removal of their children, then the new system will likely fail.

What mechanisms or tools should be used to assist professionals in deciding when to report concerns about children? Should there be uniform criteria and key concepts?

Answers to this question are pivotal to reforming the system. We need to replace the current blanket approach to mandatory reporting with a much narrower and more nuanced system that requires a limited range of professionals to report matters of suspected child abuse and neglect when there is a likelihood of a criminal offence having occurred, or when there is a significant risk of serious harm having occurred or being likely to occur. Most of our current community expressed concerns and notifications are about neglect or the catch all category of emotional abuse/harm. This reflects that the actual concerns and needs are mostly about families that need help and services rather than investigation and labelling as being risky people. Hence, the mandatory reporting regime needs to be wound back and very tightly focussed. Providing professionals and the community with guidelines about what exactly to report to the Department is a good step, but perhaps more importantly is advice and guidance about how to refer people in need to localised sources of assistance and support.

We need to also have a system that positively reinforces notions of the primacy of everyday social care being delivered by family, friends and neighbours, and to promote ordinary citizens playing a strong role in this civic response, rather than just seeing formal agencies as the be all and end all. The Strong Communities initiative in South Carolina USA is a case in point about how community involvement can protect children and help families[2]. Outreach workers were used across a range of urban and rural communities in a community mobilisation strategy that was inclusive of the broad diversity found in them, including involvement of churches,

[2] Melton, G. B. (2010a) Angels watching over us: Child safety and family support in an age of alienation, *American Journal of Orthopsychiatry*, 80(1), 89-95.

businesses, civic organisations, the fire brigade and regular citizens who together became active participants in looking out for and helping families in need of support. The evidence base for its success is impressive and includes declining maltreatment reports, reported greater social support and more frequent help from others, a greater sense of community and personal efficacy, more frequent positive parental behaviour and less frequent disengaged parenting, as well as less frequent neglect and assaultive behaviour[3]. Results of this major project will soon be published in detail in an upcoming issue of *Child Abuse and Neglect The International Journal*.

Whichever tools are used they need to be done within an organisational imprimatur that views them as an aid to decision making rather than a tool to be slavishly adhered to, with consequences to follow for those that ignore the directives. While they should be evidence based where possible, it is unwise to uncritically adopt an evidence base that is not relevant or generalisable to the Australian and Queensland context. Unfortunately this was not the case with the SDM. We should learn the lessons from this.

What role should SCAN play in a reformed child protection system?

SCAN has had a long history, but this is very mixed as far as historical outcomes. That said, when it works well it can be highly effective as a system for combining key agencies. When it doesn't work well it is often seen as highly contested and conflictual with its internal relationships characterised by abuse of power and organisational rivalries. In practice, it generally has a limited role for community-based and Indigenous agencies including REs. In a reformed system it should be retained but also reshaped to include a far stronger role for REs and community-based agencies. Perhaps more importantly its functions should be reshaped to be more of a focus on assessment of need and provision of access to family support, rather than being dominated by an investigation role.

How could we improve the system's response to frequently encountered families?

The Discussion Paper (pp77-85) provides a very good summary of what the data tell us about our current system. The system is confronted by a relatively small proportion of people and families who have high and complex needs that require a holistic systemic response to address the multiple levels and inter-related nature of the issues they face (housing, poverty, mental health, trauma, drug and alcohol, disability etc etc). Yet they frequently find themselves unhelped by interventions that are unrealistically geared to short-term intensive interventions and case management and crisis intervention approaches that do not properly recognise that these folk tend to go from crisis to crisis. In essence, there is a serious mismatch of the service model with the nature of the problems being dealt with. These folk are the 'hard edge' of structural disadvantage and inequity within our society. Sadly, they are often alumni of the care system in their younger days. Removing children from these complex situations often just compounds the issues and promotes intergenerational transmission of trauma because our care system, at least for many long term stay children, does not always provide ideal care and is increasingly prone over time to entail increasing placement changes, which in and of themselves contribute to poor psychosocial outcomes for children in care.

[3] See special edition of *Family and Community Health* 2008 Vol. 31, No. 2 for details on outcomes.

In essence, what we need to do is reshape our social care and assistance responses to explicitly recognise the complexity and extent of the social problems these families face and to provide a long term, and occasionally highly intensive range of interventions. This must be a combination of departmental and community-based agency programs/services in order to bring them up to a standard of care that is 'good enough' rather than a higher level. We should understand that the supports and interventions need to be aimed at ameliorating as much as possible the compounding impacts of multiple problems and issues. So my recommendation is to change the model from a largely punitive statutory response that has removal as the key intervention to one that is mainly focused on family support and protective interventions over the long haul, albeit mostly delivered in intermittent periods of high need or where the family system is in significant crisis.

Is there any scope for uncooperative or repeat users of tertiary services to be compelled to attend a support program as a precondition to keeping their child at home?

This sort of compulsion should be part of the response I have outlined in the response above, but it should be limited to periods of real family crisis where the children are at risk of serious neglect and other harm, and where the parents are unwilling or unable to effectively respond to the situation and circumstances.

What changes, if any, should be made to the Structured Decision Making tools to ensure they work effectively?

My views on this are known to the Commissioner. They have become part of the problem. In short, get rid of them and replace them with contextually-appropriate, evidence-based frameworks and guidelines for professional practitioners, or as a second-best option, de-link them from the current Information and Communication Technology that drives case reporting and instead have them as a tool to aid but not determine professional decision making.

Should the department have access to an alternative response to notifications other than an investigation and assessment (for example, a differential response model)? If so, what should the alternatives be?

Yes, although it needs to be recognised that there has been a variety of differential responses implemented in Queensland and across Australia over the past two decades. The critical thing to watch in doing this is that we ditch the "one size fits all" lens of harm to children and replace it with a more nuanced approach that recognises the variety of needs and issues that families and children present with.

I am supportive, in general, of the suggested separation of forensic investigation teams from casework teams, but not because it is supposedly impossible to do both simultaneously but, rather, because nowadays the system discourse and responses are completely dominated by the risk-averse, punitive investigation and surveillance approach to the almost complete exclusion at times

of a helping approach. Further, the department has for many years given children in care the 'short straw' when it comes to getting the staff time and resources they need to assist them and their carers while they are in care placements. An organisational separation would make it far easier protect the respective resource allocations and not have finances siphoned off to deal with investigations. Perhaps more importantly, such a change would take us to a place where an investigation of family circumstances is properly seen as a highly intrusive examination by the state into the privacy of citizens, which should therefore be limited to situations where there is real risk of serious harm coming to children or where criminal offences might have occurred or be likely to occur and a formal investigation is warranted.

I must admit that I was dismayed, but not surprised, when reading page 98 in the Discussion paper to find that the location of legal advice staff in Service Centres had led to increased litigation as the preferred response but a commensurate decrease in the provision of 'independent' legal advice. My four years heading up the Department's Court Services branch and working closely with Crown Law officers convinced me that having sound independent legal advice was critical if front line staff were to get the sort of feedback they needed to ensure court action was taken only when there was not other satisfactory way to protect children. Having a separate entity to conduct litigation is essential.

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

When the history and nature of the problems being faced, combined with the circumstances and history of failed rehabilitation demonstrates to a court's satisfaction that the child's best long term interests require a stable alternative arrangement. There should not be a legislative time period set because this immediately sets in place rehabilitation efforts that are driven by the clock rather than the circumstances. For example, many people have problems with mental illness, disability and drug and alcohol abuse that are seriously problematic and preclude their ability satisfactorily parent for a number of years, or make it at best spasmodic, but there is either not yet the parental decision making or services/programs to enable effective treatment. Moreover, relapses are common and are part of the process for most who make the journey of rehabilitation. Also relatively common is people getting themselves back on the right track when they reach their 30s or when they mature. Life is complex and getting over serious life problems is a tough act, but one which many people achieve, while others fail. But rehabilitation does not operate to a specified timetable.

Perhaps more importantly, children are more often than not interested in maintaining or resuming their relationship with their parents. When precluded from this they will often distort or fantasise reasons for the separation, and some will actively work to bring their placements to an end in the hope that this will lead to them being reunited. When in their teens there is an existential drive for many children to return to and know closely their "roots". It is therefore unsurprising that many children who leave care return quickly to their families of origin to address deep seated longing to know themselves and their familial identity. The recent report on Past Adoption Practices by the Australian Institute of Family Studies as well as numerous CREATE reports chronicle these sorts of emotional responses and behaviours and we should learn the lessons from those who have been

part of the system and found that “having a happy alternative home” did not prove to be a panacea to their life issues.

Kenny, P., Higgins, D., Soloff, C., and Sweid, R.(2012) *Past adoption practices: national research study on the service response to past adoption practices,* Australian Institute of Family Studies, Melbourne.

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

Legislative provisions would help place some necessary conditions around the decision making , and would help by hopefully making departmental practice more consistent in relation to what circumstances are required to make such a decision in the best longer-term interests of the child.

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

There are many barriers but the biggest ones are the relational factors that abound and the problems that flow when carers are left unsupported to deal with a host of behavioural and emotional issues apparent for the children, not to mention the financial costs of care and getting ongoing treatment and support.

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

While these options should be open and available, force adoption should not be allowed as the long-term consequences are often too profound and debilitating for all concerned (see the AIFS report on Past Adoption Practices). The trouble with so called “permanent placement options” is that all too often they end up being very temporary and the solution of choice results in major relational issues and damage for all parties. Courts are the proper bodies to oversight and determine the outcome of all applications by the range of parties for long-term care. Children’s own views should be central to the decision making.

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

There is a wealth of literature on the problems and advantages of multi-disciplinary teamwork. Teams work best when they have a diversity of perspectives, when power is shared, and when shared visions and values are mixed with high commitment to the task and the best interests of all family members. They don’t function well when they are ideologically driven, narrow in their perspective and proceduralised.

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

As outlined earlier, I am supportive of such an organisational separation given the circumstances and characteristics of our current approaches and system. The split can be done through implementing divisions within the Child Safety Service organisation, with one for investigations, one for casework support and one for working with children in care. To be frank, there is a lot of waste within parts of the Department that can be addressed to make it more efficient and effective. For starters, reducing the investigations would save a lot of money which could then be used for support services within and outside of the Department.

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

The primary issue is that the system is overloaded and buckling under the demand pressures. These have to be reduced in order to enable effective change. The current demand increases in investigation and children in care and the resultant court work are unsustainable and, if left unaddressed, might well bring the whole system to a point of collapse.

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

The issue with the large numbers of children with complex and high needs can be directly attributed to the blow out in the length of stay in care and the placement instability, coupled with the general lack and haphazard nature of therapeutic responses early on. Too many children in care are assessed as not having problems that need addressing when they are young, the difficulties of course typically emerge when they are going into adolescence and identity and other needs come to the fore.

I am not in favour of secure care as an option except in the most extreme circumstances, particularly self harming behaviours. The Barrett adolescent psychiatric centre which is now to be closed has traditionally been very hard to get children and young people into, and the public mental health system has been identified in numerous reports including Senate Inquiries as being part of the problem. I am old enough to have worked with a system where Care and Control orders meant that behavioural problems, particularly for girls, led to their incarceration in secure custody. The unintended consequences of these practices are still being felt.

To what extent should young people continue to be provided with support on leaving the care system?

I will leave this section to my colleague Dr Phil Crane to address, but suffice to say that the leaving care system clearly has to be placed with the community-based system if it is to be an effective support for young people.

In an environment of competing fiscal demands on all government agencies, how can support to young people leaving care be improved?

Does Queensland have the capacity for the non-government sector to provide transition from care planning?

Not at present but it needs to be resourced properly.

What would be the most efficient and cost-effective way to develop Aboriginal and Torres Strait Islander child and family wellbeing services across Queensland?

This section is best addressed by Indigenous peoples and communities, and their organisations. However, it is clear that community-controlled and operated agencies are much more likely to be successful than government run services and programs.

Could Aboriginal and Torres Strait Islander child and family wellbeing services be built into existing service infrastructure, such as Aboriginal and Torres Strait Islander Medical Services?

How would an expanded peak body be structured and what functions should it have?

What statutory child protection functions should be included in a trial of a delegation of functions to Aboriginal and Torres Strait Islander agencies?

Complete authority to undertake the full range of statutory roles, functions and interventions should be given over to properly constituted Indigenous agencies. But a lesson from Canada is that if these agencies are not given the authority and properly resourced to address the structural disadvantage, the impacts of long standing colonisation, and the consequences of inter-generational trauma, then a likely result is that there will be more Aboriginal children taken into care. So, merely handing over responsibility but not the requisite resources might make the situation worse.

What processes should be used for accrediting Aboriginal and Torres Strait Islander agencies to take on statutory child protection functions and how would the quality of those services be monitored?

Should child safety officers be required to hold tertiary qualifications in social work, psychology or human services?

Yes. Frontline staff need to have the knowledge base and skills to deal with a diverse array of social problems, not just be able to assess risk of harm to children. For example, they need competence in areas such as working with Indigenous peoples and communities, mental health assessments, drug and alcohol abuse and its treatment, family systems and how these function, the impacts of trauma, how family support interventions work effectively in addressing complex needs, housing and homelessness, etc I noted in the recent CDRC report the problems identified with staff's ability to undertake mental health assessments. These jobs mean staff have to be "all rounders" with detailed knowledge of both assessment and treatment interventions. The core disciplines of social work, human services and psychology have these but the broad array of other social and behavioural science graduates often do not have the scope of expertise required. When coupled with the major shortcomings and legislative focus of departmental training we should not be surprised when they struggle to adequately and appropriately deal with diverse and complex problems and people they come across in their jobs.

Should there be an alternative Vocational Education and Training pathway for Aboriginal and Torres Strait Islander workers to progress towards a child safety officer role to increase the number of Aboriginal and Torres Strait Islander child safety officers in the workforce? Or should this pathway be available to all workers?

Let me put it this way, without this there is no realistic way that the Department and sector can build the workforce that is required. I am unconvinced that such pathways should be broadened to include others, except perhaps peoples from refugee backgrounds who are also increasingly over represented in our systems.

Are there specific areas of practice where training could be improved?

The departmental training was in impoverished when the 2003 CMC inquiry was conducted. It was significantly expanded but its history is deeply problematic and it has always "chased its tail" in trying to meet the unrelenting demand for increased staff on the frontline to do investigations. A variety of approaches have been tried both on the job and block mode "in situ" training but overall it is characterised by its very narrow focus on legislative and procedural compliance and a consequent under focus on developing practice knowledge and skills. As I said earlier, staff need competence in areas such as working with Indigenous peoples and communities, mental health assessments, drug and alcohol abuse and its treatment, family systems and how these function, the impacts of trauma, how family support interventions work effectively in addressing complex needs, housing and homelessness, etc. These have by and large been ignored by the departmental curriculum. Hence, practice standards have tended to be driven by on the job learning which is highly variable in quality and thereby deeply flawed systemically speaking. The whole responsibility for initial and ongoing training, and continuing professional development would be best addressed through partnerships between the Department, the community-based sector and the universities.

Would the introduction of regional backfilling teams be effective in reducing workload demands on child safety officers? If not, what other alternatives should be considered?

Yes. I worked in this sort of system in Western Australia in the late 80s-early 90s and it was highly successful in addressing issues of recruitment and workload demand variations.

How can Child Safety improve the support for staff working directly with clients and communities with complex needs?

Generally speaking there have been great strides in the levels and systems of staff support within the Department since the CMC Inquiry. Responses to work-related traumas and incidents are not perfect but it is nonetheless reasonable. The central issue to my mind is not having staff who feel out of their depth in dealing with the situations they face. Hence my suggestions are that further training and ongoing professional development is central to an effective solution here.

In line with other jurisdictions in Australia and Closing the gap initiatives, should there be an increase in Aboriginal and Torres Strait Islander employment targets within Queensland's child protection sector?

My views are already known by the Commissioner. Effective reform and addressing the increasing over representation of Indigenous Australians in our child protection systems is not possible with the current workforce. We need to within a decade have a system whose workforce is indigenised and this includes having Aboriginal world views incorporated and embedded into the policy and practice frameworks and approaches. This requires a detailed workforce plan, and appropriate incentives and supports for Aboriginal people to be able to take up the opportunities.

Are the department's oversight mechanisms – performance reporting, monitoring and complaints handling – sufficient and robust to provide accountability and public confidence? If not, why not?

As the discussion paper highlights, there are any number of oversight and accountability mechanisms on the Department. But this is to be expected given the profound powers and authorities departmental officers have, combined with the vulnerabilities of the clientele. That said, it is highly debatable about how effective they actually are, and the extent to which they trip over each other in the exercising of their responsibilities. I pose this question to the Commissioner: Who among these various authorities recognised the dire state of the situation for child protection in Queensland and publically called for the system to be over hauled? It took the Opposition to raise the issues and the incoming government to establish the inquiry, which had been needed for a long time. My central trouble with the accountability system is that the courts are not generally well positioned to review case-related matters and decision making, and nor are the other bodies, apart from QCAT which has been seen to be quite active and competent in challenging the professional validity of these aspects of departmental practice. A culling of some of the oversight agencies and placing these responsibilities with fewer bodies would save resources and make it easier for people

to challenge circumstances which they believe have intruded upon their rights or which are not justifiable on the facts.

Do the quality standards and legislated licensing requirements, with independent external assessment, provide the right level of external checks on the standard of care provided by non-government organisations?

No opinion is offered.

Are the external oversight mechanisms – community visitors, the Commission for Children and Young People and Child Guardian, the child death review process and the Ombudsman – operating effectively? If not, what changes would be appropriate?

I think partly yes and partly no. The community visitors seems a rather expensive way to go to my mind, although I acknowledge that the past failures and abuses in care highlight the need for external scrutiny of care arrangements. I repeat my earlier point about the lack of public statements by the Commission and other bodies about the dire state of the child protection and care systems. I am confident that this Commission of Inquiry will correctly identify the disrepair and parlous state of the protective systems and the potential for the system to collapse if these issues and problems are not addressed.

Does the collection of oversight mechanisms of the child protection system provide accountability and transparency to generate public confidence?

Again partly yes and partly no. It is clear that there is widespread public support for the state to intervene into family privacy in order to ensure that children are not harmed. The ongoing exposure of systemic failures seriously dents public confidence in how well the system is functioning. However, for the most part, it remains very difficult indeed for the media to report on system outcomes, other than the annual reporting of data by the Australian Institute of Health and Welfare, and the Department's Annual Report to Parliament. There are many who have concluded that the legislative requirements for confidentiality have become a wall behind which the Department hides to protect itself from media and public scrutiny. Many families complain that these systems ignore their pleas for help and that it is nigh impossible to find their voice. Perhaps the solution is to have a one-stop shop for accountability and transparency, and to enable the aggrieved to seek review and redress of their matters?

Do the current oversight mechanisms provide the right balance of scrutiny without unduly affecting the expertise and resources of those government and non-government service providers which offer child protection services?

To my mind, these mechanisms, taken overall, are not satisfactory and that the balance is weighted too much in favour of the Department as the primary holder of the information. I realise that there is a right for people to access information but the Department does not undertake any research from a client perspective about how aware they are of their rights and the complaint mechanisms. The Victorian CAFSOS study that I informed the Commissioner about identified this area as one where improvement was needed, and when one thinks about it, sharing of power and information are central to the sorts of staff-client partnerships that are the hallmark of effective interventions. We have a right as a society to expect high standards of practice in this area, particularly because it deals with children and highly vulnerable people who for the most part are socially excluded and disadvantaged. We know that social systems that are powerful can at times be abusive. These factors warrant close external oversight of decision making and practice. In a sense, it goes with the territory.

At the same time, we have to create enough space for the exercising of justified professional discretion in the exercising of statutory power and authority, while knowing that there are accessible mechanisms available to ensure proper standards and quality professional work is being undertaken, and that when things go awry they will find the light of day. Ethical professional practice emphasises that clients should be made aware of their rights, be given opportunity to put their views forward, as was as be able to seek review of matters by an independent party. Apart from QCAT, I have reservations about the ability of other systems to be able to be in the right position to be fully informed of appropriate child protection and family support practice and thereby to be able to provide wise oversight of complex situations. Good casework relies upon effective feedback mechanisms, and I am not convinced that the current range of accountability mechanisms assist in this regard, rather than merely heighten defensiveness in what is already a departmental environment that is often highly sensitive to criticism.

Should a judge-led case management process be established for child protection proceedings? If so, what should be the key features of such a regime?

There is a criticality in having a timely process in child protection proceedings, particularly from the perspective of the interests of children. Further, having a less adversarial process than might otherwise ensue is a preferable way to go. Generally speaking, parents have a lot of emotional investment in the proceedings, and from my experience, if they have formed the view that they have been dealt with unfairly by the Department, the proceedings can end up as a mechanism for exploring their grievances rather than what is in the best interests of their children. Having a judge-led process would probably be an advantage in many matters, but not all. I think that such a process would likely also lead to a more consistent departmental standard for taking protective-order applications and there would likely be benefits in having the Children's Court judge have an increased role in developing the case management process over time.

I would have thought that there was already an obligation on the Department to fully disclose all relevant material to the parties and the court in child protection proceedings. If there is evidence to indicate that this has not always been the case then a legislative requirement to make this happen is appropriate. In short, the Department should be a 'model litigant' that has the highest standards.

Should the number of dedicated specialist Childrens Court magistrates be increased? If so, where should they be located?

My experiences as the Manager of Court Services for the Department have led me to be a supporter of having specialist Children's Court magistrates as I have observed the qualitative difference that they can make to the proceedings and the adjudication of the matters in dispute. Having more specialist magistrates will provide an improved environment and process for Children's Court proceedings. These new positions should be located where the data indicates they are needed.

What sort of expert advice should the Childrens Court have access to, and in what kinds of decisions should the court be seeking advice?

Given the highly decentralised population of Queensland, and the issues associated with recruitment of expert medical and human services specialists, it is likely that getting a high quality of expert advice and testimony across the state will be difficult. There are also legitimate questions to be raised about the independence of the advice if private practitioners are regularly employed by the Department to undertake expert assessments and provide advice. I am not inferring here that their advice would be biased or improper because of their relationships with the Department. Indeed, in my experience, independent professional assessors take great measures to ensure that their independence is maintained. However, from parents' perspectives, it is sometimes easy to conclude that independent advice, if arranged and paid for by the Department may be tainted or less than fully independent. Hence, in my view, having a separate organisation responsible for organising and undertaking an independent assessment, such as is done in Victoria, has many advantages and should therefore be part of the systemic response to ensure that the court is properly informed.

Should certain applications for child protection orders (such as those seeking guardianship or, at the very least, long-term guardianship until a child is 18) be elevated for consideration by a Childrens Court judge or a Justice of the Supreme Court of Queensland?

From my experience of litigation at all jurisdictional levels involving children there is a clear difference in the quality of the proceedings and deliberation of the issues. This is not to disrespect low courts in their determinations but merely to recognise that higher court judges bring particular qualities to the court process. I support long-term guardianship matters being determined by a Children's Court Judge or the Supreme Court because the nature and complexity of the issues that can abound and the application of appropriate principles and guidelines to ensure consistency of determinations. However, this could significantly raise the costs, particularly for those matters that are uncontroversial and uncontested, so I am of the view that there would need to be put in place measures to ensure there were checks on the proceedings to prevent these becoming financially prohibitive.

What, if any, changes should be made to the family group meeting process to ensure that it is an effective mechanism for encouraging

children, young people and families to participate in decision-making?

In order to ensure that these are fair to all parties there should always be a fully independent convenor. Further, the practice in Family Group meetings in Queensland is often at variance with the original New Zealand model which aimed at ensuring the broad family and community were involved in the process. For matters involving Indigenous children, in particular, there is a compelling case I believe for alterations to FGMs to ensure that there is proper community involvement in this important process. I agree with the Legal Aid submission to the Commission that these are critically important opportunities to engage families. If the process involves a power imbalance then it is likely to fail as a truly participatory process that can facilitate the commitment by families to work collaboratively in a case plan that is in the best interests of the children.

What, if any, changes should be made to court-ordered conferences to ensure that this is an effective mechanism for discussing possible settlement in child protection litigation?

Court ordered conferences, from my experience, can be a critically important mechanism for crystallizing the facts and issues in dispute and those in agreement, and for providing a venue where agreements can be reached about how to work in partnership to resolve matters. I must admit I was surprised by the Legal Aid submission indicating that there was not always full disclosure by the Department. I have already shared my views about the Department's obligation to be a model litigant and to provide full disclosure. If there is a perception that they are not then this certainly needs to be addressed with rules to ensure they meet the highest standards. The public should have an uncompromised confidence in the integrity of the Department and its officers when they are taking proceedings before a court that will have a material impact on a child and their family.

In my view it is unacceptable for departmental officers to go into a court-ordered conference without having received legal advice nor being legally represented. The same can be said for parents (and children) as it is grossly unfair that they not be legally represented in proceedings of these sorts that can have life-long impacts and implications for their family. I have already identified in this submission that my experience of working with Crown Law whilst I was managing the Department's legal matters at Court Services demonstrated the critical importance for departmental officers in having a full legal appraisal of the quality and merits of their case. To be frank, departmental officers can sometimes become over-involved in matters and find it hard to delineate what their professional views of a matter are, and what can be established on the facts of the matter to the satisfaction of a court. Given the seriousness of these matters there should be no impediments to the Department being fully legally briefed about their case, and to ensuring that a person with the proper delegations is present at the conference to ensure the matter can settle on the day.

What, if any, changes should be made to the compulsory conference process to ensure that it is an effective dispute resolution process in the Queensland Civil and Administrative Tribunal proceedings?

Similar to my responses above, the Department should be a model litigant. If there are departmental practices that are less than this standard they need to be changed. My worry here from reading the

Discussion Paper is that it appears that some departmental officers may not fully understand the importance of their actions being open to scrutiny by external accountability mechanisms and forums. If departmental actions are perceived by families and others as unfair then there is a real problem that needs to be fixed. There clearly needs to be checks and balances upon those who exercise the sorts of statutory authority and power that departmental officers must hold. It is imperative for the public to have full confidence in the Department as an institution of public authority and the active arm of the State. I am supportive of changes to the legislation to ensure that there is a duty of full disclosure upon the Department and also that it should be a model litigant.

Should the Childrens Court be empowered to deal with review applications about placement and contact instead of the Queensland Civil and Administrative Tribunal, and without reference to the tribunal where there are ongoing proceedings in the Childrens Court to which the review decision relates?

I remain unconvinced by the arguments raised for the Childrens Court to take on any responsibility for determining matters about case management related decision making by the Department. To my mind, this is a potentially dangerous path to tread because it opens up the prospect of proceedings becoming bogged down with disputes about day-to-day case decision making rather than attending to the central issues of the protective orders being sought. It would likely result in lengthy delays due to the already packed Court calendars. This would make the court process both longer and more costly.

It would also raise in my mind questions about the appropriateness of Childrens Court magistrates determining disputes about case management decision making without necessarily having at their disposal the sorts of expert advice required because they are structured differently to QCAT. I think it likely that there would be all sorts of decisions made and that this would involve costly appeals processes and likely render inoperative departmental decision making because it would fetter the necessary professional discretion to make sound assessments and decisions. I am of the view that we should let the departmental officers have the authority and discretion to make decisions about complex case management issues, but then hold them accountable and open to scrutiny by properly structured review processes. To my mind, there is no evidence to suggest that the Childrens Court could consistently do this role as it is presently configured.

What other changes do you think are needed to improve the effectiveness of the court and tribunal processes in child protection matters?

There is an argument of greater access to legal aid support for the appointment of independent representatives for children when Childrens Court matters become likely to go to a contested hearing. It is sometimes the case that the relationships between parents and the departmental officers can become deeply conflicted. This can be highly stressful for all. Independent children's representatives have often proved their worth in being able to facilitate an environment that is more conducive to solid working relationships between the key parties.

From my experience, any measures that can facilitate alternative dispute resolutions need to be embraced. Court hearings of contentious matters do not usually, in my observations, help people to resolve the matters at hand. Rather, they frequently just entrench viewpoints about being in the 'right' and make resolution less likely. In these sorts of outcomes the parties can carry over their disputes and unhappinesses into the subsequent ongoing relations, sometimes making an effective working relationship impossible to achieve. The damage that occurs here to people should not be underestimated and it should therefore, in my view, be avoided if at all possible. Hence, my preferences for alternative dispute resolution processes and an overall principle of reducing the adversarial nature of the proceedings.

Where in the child protection system can savings or efficiencies be identified?

It is a fact that the government has substantially increased resources to the Department since the CMC Inquiry – far more than most other portfolios. I remain unconvinced by those that suggest that with further resourcing the endemic problems identified in the Discussion Paper will be resolved. There are many work practices within the Department that are inefficient or ineffective and these need to be culled or wound back. Its responsibilities should be narrowed by transferring some to the community-based sector, and by tightening the definitions (and risk frameworks) to reset the bar at a higher point concerning the justification for intervention by the State into private family life.

Part of the test for taking statutory action to remove children should involve being able to be confident that the intervention will advance the health and wellbeing of the children and improve their life chances. At present, the prospects for many children in care appear to be decreased life chances as a result of coming into care. Surely it is more efficient and effective to prevent children coming into care by providing accessible early intervention and prevention services without the stigma and consequences that statutory interventions entail?

I have previously outlined to the Commissioner the need to reduce the demand side of the equation through changes to the system for receiving and assessing public concerns about children including revising mandatory reporting. The imperative here is that if we are unable to wind back the statutory investigation and assessment function we face the real risk of collapsing the system under its own weight, thereby rendering it incapable of protecting children and supporting families.

The Commissioner has publicly advocated undertaking an audit of children in care to ascertain who might be better placed at home. I support this move.

The critical change is to provide a stronger role for community-based agencies in the early intervention and prevention roles, although I accept that at present there is an urgent need to address the significant gaps in secondary services.

With regard to the over representation of Indigenous children and families there are no short cuts. As I have outlined in this submission and elsewhere, the increasing over representation can be located in the key issues of a longstanding economic and social disadvantage, the consequences of colonisation and the damage to community, culture and identity, and the compounding impacts of intergenerational transmission of trauma with its implications for mental health, alcohol and drug abuse, interpersonal and communal violence. A whole of system response is needed.

We simply have to do things differently on a number of fronts. The critical point, though, is to not make the mistake of transferring responsibility (and risk) to Indigenous communities and organisations, without giving them the resources to be able to do the job properly. Empowerment is required but without adequate resources it would be a cruel hoax.

What other changes might improve the effectiveness of Queensland's child protection system?

I have already made a statement to the Inquiry of approximately 10,000 words and given oral evidence. This submission to the matters raised in the Discussion Paper is already over 8,000 words. I appreciate the latitude given to me by Julia Duffy the Commission's Solicitor to have an extension till Monday 18 March to make this submission. Because I have had to spend the weekend working on this and now time is short, I have been unable to do a proper edit of my submission, so I apologise if there are errors or faults in my written expression. If the Commissioner wishes to clarify any of the points I have made in the submission I am available to assist.