Queensland Health: Submission to the Queensland Child Protection Commission of Inquiry discussion paper: March 2013.

Chapter 3: Reducing the demand on the tertiary system

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

To achieve effective interagency collaborative practice requires a formalised approach that supports collaboration at multiple levels, across government and non-government agencies. This approach requires a sound governance structure with reporting responsibilities at the different levels, including agreed goals, planning to identify and respond to needs, and a lead agency to drive and support collaborative practice. A governance framework which focuses on key system outcomes would be of benefit.

Sufficient funding would be required at all levels to support this collaborative model. An independent authority to lead the approach may be required to reduce potential conflict and to reduce the risk of discussions or decisions being overridden a particular agency.

The following is a brief outline of the proposed three tier model:

- Tier 1. This tier would require senior representation from all government departments, both state and federal, and relevant peak bodies from the non-government (NGO) sector. Tier 1 would be tasked to coordinate strategic policy and planning of the child protection system, including any recommendations of the Queensland Child Protection Commission of Inquiry. This tier could be comprised of, and potentially utilise the existing resources of, the Child Safety Directors Network. Tier 1 would be required to develop, publish and report on, an annual strategic plan.

- Tier 2. This tier would be based at the regional level, and representation would be at the Regional Executive Director / Chief Executive level, across government agencies. Membership of tier 2 would also include relevant NGO and private sector agencies within the region. This tier would be responsible for the development of regional specific needs and responding to and managing local partnerships across agencies, and the identification of areas of need that require escalation to tier 1.

- Tier 3. This tier would target local service delivery, and representation would include Regional Director, Executive Directors of services and additional service providers unique to the location. Responsibilities of this tier are to oversight service delivery staff, address interagency barriers to service and identify emergent areas of need that require escalation to tier 2.

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

A function of the second tier mentioned previously would include the review of existing and new service applications to avoid duplication and address regional need.

Meeting the needs of vulnerable families, preventing harm to children and when necessary protecting children requires an approach that views changing family dynamics and need on a child protection continuum, rather than in discrete stages. Queensland Health supports the Department of Communities, Child Safety and Disability Services proposal to "review and re-purpose its suite of secondary and tertiary family support programs into one overarching child and family support program" (p. 47 discussion paper) and suggest the scope be broadened to include primary services.

Collaboration between agencies in the current system at the local and operational level for the common clients of multiple agencies could be enhanced by the development and implementation of a collaborative model. This model would lead case coordination/management role for these children and families. Such a model would need to be underpinned by:

- an appropriate level of commitment from relevant agencies (government and non-government) to the model
- agreed means for information sharing, through legislation and memorandums of understanding
- a shared framework for working together and outcomes
- a governance structure at the operational level.

The proposed three tier model could provide a mechanism to achieve more cost effective way to work with these families.

3. Which intake and referral model is best suited to Queensland?

The discussion paper proposes two possible options to address the current challenges of intake, and they are:

i. Introducing regional community-based intake (including a dual referral pathway); or

ii. Establishing a non-government intake and referral service through a single referral pathway.

Both of the proposed options have their benefits and limitations and include a need for legislative changes. Any change to the current intake and referral model need to be aligned with the growth in the secondary service system. It also would need to be supported with the establishment of clear escalation criteria to ensure that the safest and least most intrusive approach is adopted.

Option 1 is a community-based intake service that would be managed by a non-government agency, where professionals, such as health professionals, who have legislative or policy obligations to report concerns about children would be able to discharge these concerns through a referral to either the community based intake service or to Child Safety. This model is similar to models implemented in Victoria and Tasmania. This option is somewhat similar to the Helping Out Families model that is currently being trialled in South East Queensland.

Option 2 is a non-government intake and referral service, regionally based that would replace the role of the existing Child Safety Regional Intake Service. This option would seem to be a continuation of the current intake system, simply moved into the non-government sector. To avoid perceptions of bias there would be benefit in ensure there is separation between the regional intake and service delivery functions.

From a Queensland Health perspective any changes to the intake model are likely to require significant training of health professionals in regard to their mandatory reporting responsibilities.

4. 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?

Decisions regarding child abuse and neglect are complex and challenging to all professionals, including health professionals. Supporting staff to understand and meet their obligations in relation to child abuse and neglect requires continuous ongoing education and quality review of the resources used by staff to assist in decision making. No one tool can support staff, such as the Child Protection Guide. However a range of tools, including the child protection guide can assist professional reporters.

Since 2004, the Queensland Health has developed, and review second yearly, a range of resources that assist staff to meet their obligations in relation to child abuse and neglect. These resources include:

- A standardised report form, for use by all Queensland Health staff to report their reasonable suspicion of child abuse and neglect.
    - This form has undergone a statewide comprehensive review in 2007 and 2009, and recommendations from these reviews have been incorporated into a revised formed and the augmentation of education resources available for staff.
- A booklet to assist staff to complete the standardised report form. This booklet has been shared with Child Safety Intake services who have found it useful
- An education process for clinical staff that has two levels. At the first level, all clinical staff at induction into Hospital and Health Services receives introductory information regarding child abuse and neglect and their obligations. The second

level is specific to staff who work in services with families, children and young people and adults with primary responsibility for children, and requires staff to undergo annual self-assessment of child protection capability.

  - The statewide child safety education module, available to all staff, was developed in 2005 and is currently at the end of a review.
  - The annual Capability Self-Assessment tool has been reviewed amended and is currently at the end of a review in line with the child safety education module.

- Key positions have been established in Hospital and Health Services, including Child Protection Liaison Officers (CPLOs), Child Protection Advisors (CPAs) and Suspected Child Abuse and Neglect (SCAN) Team System core representatives.
  - All reports of a reasonable suspicion of child abuse and neglect made by Hospital and Health Service staff are forwarded to CPLOs, CPAs and SCAN core representatives. These reports are reviewed to determine if the matter reaches a threshold to refer the case to an interagency meeting – such as an Information Coordination Meeting or a SCAN team meeting. In many cases feedback is provided to the reporter on the quality of the information in the report, and the outcome of the report.
  - These key staff provide education to staff in Hospital and Health Services in regard to child abuse and neglect
  - Statewide training has been provided by the Department of Health to CPLOs, CPAs and SCAN core representatives through annual workshops.
- A 'Care and Treatment Order for a Child' information booklet and relevant forms and fact sheets have been developed and provided to Designated Medical Officers in Hospital and Health Services, to assist them in meeting their obligations in this role. This information has been reviewed and republished.
- A statewide Queensland Health Child Safety Unit intranet site has been established providing staff with access to a range of resources including the relevant forms, education module, fact sheets with specific information and key contacts. Some of this information is available on an internet site for registered nurses and doctors who do not work in the public health system.
- The Gold Coast Hospital and Health Service is participating in the trial of the Child Protection Guide (CPG) in South East Queensland. The CPG was developed by the Department of Communities Child Safety and Disability Services in consultation with Queensland Health and the Department of Education, Training and Employment. The CPG has been found to be a useful educative tool to assist decision making by health professional.

Queensland Health believes that to meet the needs of a large workforce, at different levels of skill and capability in relation to child abuse and neglect, requires a range of tools to support staff. However, such tools need to support, not replace, clinical judgement and expertise.

Queensland Health supports the view that there should be shared principles, criteria and concepts across the system. These principles, criteria and concepts should then be incorporated into resources that meet the needs of specific professional workforces.

Chapter 4: Investigating and assessing child protection reports

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

Whilst any interagency collaboration can be challenging, there is significant evidence of its benefit and the potential to more effectively address the problems of families with multiple and complex issues.

The multiagency framework that underpins SCAN should be encouraged and integrated into the entire child protection continuum from intake, to the investigation and assessment phase, to the case management response to children and families subject to any form of intervention by statutory services.

To achieve the full potential of this current resource, there needs to be a shift to:

- open the referral criteria
- determine more clearly the common aims for the children
- support the role of the coordinator
- seek the provision of an independent chair.

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

These families at times are known or linked to a range of services and agencies. Frequently encountered families require consideration in the context of their full history and not separate notifications. They require intensive support for long periods and at times struggle to develop skills required for adequate parenting without any support. Previous notifications need to be reviewed and the effect of cumulative stress and trauma on the child considered. The child's functional ability, emotional development and mental health also need to be tracked over time to determine level of harm or future risk of harm.

These families would benefit from:

- a multi-agency, coordinated assessment of both identified needs and risks
- an evaluation of what has already been offered, the outcomes and identification of the challenges to offered intervention
- a coordinated and targeted approach with a realistic objective that all that might be achieved is a difference in the next generation

- provision of a multiagency expert overview available through the Suspected Child Abuse and Neglect (SCAN) team system.

7. 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?

There are currently some provisions that can be used to compel or drive change, for example an Intervention with Parental Agreement (IPA). Families on an IPA are often assessed and referred to other agencies for intervention. Prior to the finalising of any interventions there needs to be an assessment of the parent's/family's comprehension of the issues and capacity to implement the changes over a sustained period of time.

These cases would benefit from multi-agency review, such as available through the Suspected Child Abuse and Neglect (SCAN) team system.

There is however a risk that compelling attendance may only results in attendance without any behavioural change or skill development. Notwithstanding this, attendance does at least provide some exposure to information and skills.

Chapter 5: Working with children in care

10 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?

A reunification plan with clear, reasonable and measurable goals should be developed collaboratively between support services and parents. Reunification efforts should cease when there is no significant improvement towards achieving these goals. This may be due to the parents' inability to make significant gains or their lack of engagement in the process. Reunification planning and goal monitoring requires a skilled workforce. Whilst child safety services would remain the 'case manager' of this process, collaborative input should be provided by all support services engaged with the family.

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

If the legislation was amended to include provisions prescribing services to family the following would need to be considered:

- availability of the service
- who decides the type of service that should be provided
- who decides the agency who should provide the service.

Through the current Suspected Child Abuse and Neglect (SCAN) team system the core member agency representative may be able to provide advice in these cases, as well as regional level teams that include government and non-government agencies.

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

The enhancement of placement stability by making both adoption and permanent placement options more readily available is preferred. Adoption should be an option when:

- intensive efforts at reunification have failed or are considered unable to achieve a positive outcome;
- adoption is deemed to be in the best interests of the child; and
- there is a family willing and able to adopt.

Appropriate financial assistance to support adoptive families should be made available.

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

Within the current child protection system there are two multi-disciplinary interagency teams that would be able to support a casework team approach. The Information Coordination Meeting and the Suspected Child Abuse and Neglect (SCAN) team system. Either of these teams could be expanded or enhanced to meet many of the proposed functions outlined in this section of the discussion paper. In these current teams, high level expertise from a range of sectors is available, including health, education, police, child safety and the Aboriginal and Torres Strait Islander Recognised Entity service.

The proposed multidisciplinary casework approach in the discussion paper has the following benefits:

- allows intensive casework and support to an increased number of children and young people
- has a capacity to provide intervention and support in a team context could increase staff satisfaction for professional s and potentially reduce staff turnover
- draws on the skills and perspectives of a range of professionals, thereby promoting more comprehensive assessment, intervention planning, monitoring and support to address the multiple and complex needs of children and their families
- a range of professionals working for one organisation reduces the likelihood of conflict within the multidisciplinary team due to differences in policies and goals between organisations
- an integrated team is able to enhance the continuity of care provided to families

- professional supervision and development is identified as essential for all disciplines within the multidisciplinary team.

This proposed approach has the following limitations:

- The caseload of the team would need to be capped to allow for an appropriate intensity of intervention. If caseloads grow unchecked, the focus would move to assessment and monitoring with little capacity for intervention and support.
- A key worker would still need to be identified to hold responsibility for overall coordination of the multidisciplinary effort.
- Skilled team leadership will be required to optimise collaborative assessment, care planning, therapeutic intervention and review by team members from different professional backgrounds.
- A multidisciplinary team under the leadership of a senior child protection practitioner may take on the single perspective of child protection investigation and casework, rather than the multidisciplinary perspective required to provide comprehensive intervention and support.
- The capacity to build trust and rapport essential to effective therapeutic intervention with families may be reduced for professionals employed by a statutory organisation.
- The capacity of existing Queensland Government departments to provide professional supervision by senior professionals across departmental boundaries is currently limited.

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

Queensland Health is of the view that the *Mental Health Act 2000* and the *Youth Justice Act 1992* and the facilities available to care for children who require care under these Acts (i.e. authorised mental health services and youth detention centres) are appropriate and sufficient to meet the needs of children and young people with behavioural problems. The *Mental Health Act 2000* sets out processes for a person to be assessed and authorises the person's detention for assessment. The purpose of involuntary assessment (which may involve detention in an authorised mental health facility for up to 72 hours) is to determine if the person requires treatment for mental illness. The *Youth Justice Act 1992* establishes the basis for the administration of juvenile justice and dealing with children who have or are alleged to have committed offences.

The primary aim in the provision of mental health care for young people is to ensure their safety whilst minimising the amount of disruption to their family, educational, social and community networks. A goal that is consistent with directions in contemporary mental health care for young people at both national and international levels. The primary focus of providing care for children and young people with behavioural problems should be through the support of parents / carers and their families.

Chapter 6: Young people leaving care

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

The discussion paper identifies options for Child Safety and Queensland Health in regard to health needs of young people exiting care. The options include:

- *'Child Safety are to with, with the young person's agreement, have an exit from health care check..."*
- *'Queensland Health are to provide free six monthly health checks for all young people leaving care until 25 years of age'*

Queensland Health acknowledges that the health needs of children and young people in out of home care is important, however this care should be regularly assessed and planned throughout the period of time that the child and young person is in out of home care. It is important that the child and young person is linked in with a primary health care provider, who is able to refer the child or young person to services as required or identified through annual health assessments that should occur whilst the child is in out of home care.

The provision of annual health checks for young people leaving care until 25 years of age should be provided through the primary health care system, with appropriate referrals to specialist services as required. In most cases this would be the young person's general practitioner who would be familiar with their care needs.

All children and young people who have a chronic illness will undergo transition to adult services dependent on their condition, and with consultation between the child and young person, their paediatric and adult service providers, including children and young people in out of home care.

Chapter 7: Addressing the over-representation of Aboriginal and Torres Strait Islander children

Queensland Health is supportive of the recommendation of the Aboriginal and Torres Strait Islander Child Protection Taskforce that the approach to protecting Aboriginal and Torres Strait Islander Children should change. In particular that it should start with a shared vision across government, mainstream agencies and Aboriginal and Torres Strait Islander agencies and that the vision should be underpinned by appropriate legislation, policy and practice support and a commitment to genuine and respectful partnership by all parties.

Queensland Health is supportive of these changes being developed in partnership with Aboriginal and Torres Strait Islander communities and a range of innovative approaches being piloted.

Queensland Health works in partnership with mainstream child protection services, and supports:

- An increased focus on developing a culturally competent and sensitive mainstream workforce with a deeper understanding, and respect of cultural and family practices as outlined in the Aboriginal and Torres Strait Islander Cultural Capability Framework, Queensland Health 2010-2033, Queensland Health 2010 and the whole-of-Government Making Tracks Policy and Accountability Framework, Queensland Health 2010
- An increased employment opportunities for Aboriginal and Torres Strait Islander staff in mainstream and Aboriginal and Torres Strait Islander specific services to ensure Aboriginal and Torres Strait Islander children and their families feel safer
- An increased focus on parental education, and promotion of family well-being before families reach crisis point, and whereby services can refer to preventive services without the need for notification to a statutory service
- The removal of any structural barriers in the child protection system contributing to Aboriginal and Torres Strait Islander children being over-represented in the Queensland child protection system, and Aboriginal and Torres Strait Islander people being under-represented as suitable for kinship out-of-home placements
- The establishment of clear exit points, so that families do not have unnecessarily prolonged involvement with statutory services
- That every child has the right to a statutory response when needed to keep them safe from harm.

21 What would be the most efficient and cost effective way to develop child and family wellbeing services across Queensland?

An efficient and cost-effective way would be for the Aboriginal and Torres Strait Islander child and family services to be delivered by not for profit/non-government Aboriginal and Torres Strait Islander services in partnership with community organisations and government. This partnership would need to ensure the identification of services to meet the need of the local community, and with all key stakeholders in the partnership acting to prevent duplication of services. This will require a degree of flexibility to harness any support capacity within local communities.

Queensland Health supports the development of a centralised peak body to take carriage of the direction of the Aboriginal and Torres Strait Islander child and family wellbeing services across Queensland. The peak body would be responsible for the liaison and facilitation of the coordination of different Aboriginal and Torres Strait Islander services and support them to work collaboratively together as well as with mainstream services.

22 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?

It would be appropriate for Aboriginal and Torres Strait Islander child and family wellbeing services to be connected to and/or delivered in partnership with existing service infrastructure such as Aboriginal and Torres Strait Islander Medical Services and Aboriginal and Torres Strait Islander Kinship/Foster Care organisations. This model will remove the impact of cultural bias in decision-making about protection and care including the cultural constructs that equate cultural differences in child-rearing practices with neglect or abuse. This model may require the review of current funding arrangements, and care needs to be taken to not overburden the existing organisations who are set up with a particular intent.

The model could provide a suite of child protection services and responses across the various levels (local, regional, state wide) in a more fluid and flexible manner, which may be accessed by Aboriginal or Torres Strait Islander children, young people and families as and when they are needed.

Queensland Health is supportive of a range of child and family well-being services being offered so that Aboriginal and Torres Strait Islander people are given a choice of provider because of concerns about privacy and family. This could be provided through Aboriginal and Torres Strait Islander Medical Services, newly established services or culturally appropriate mainstream services to give families choice. The expansion of child and family well-being services through Aboriginal and Torres Strait Islander Medical Services could provide early intervention and support to vulnerable Aboriginal and Torres Strait Islander families.

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

Queensland Health supports the development of a peak body with broad representation and mechanisms of engagement at all levels of governance. The peak body should be the mechanism for better integration between the programs delivered by Aboriginal and Torres Strait Islander agencies and for these agencies to be embedded in the broader child protection system.

The functions of this peak body would need to be developed over time.

It is important to acknowledge that Aboriginal and Torres Strait Islander families often choose to use mainstream services across the existing child and family wellbeing services, as

such the development and design of such services should not prevent access to mainstream services.

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

Queensland Health recognises that Aboriginal and Torres Strait Islander services are generally the best placed to provide culturally appropriate placements and facilitate the safe reunification of children and young people with their families or placement with kin. The delegation of certain child protection functions to Aboriginal and Torres Strait Islander services may strengthen the intent of the Child Placement Principles of the *Child Protection Act 1999*, which recognises the importance of the extended family, kinship arrangements, culture and community in the raising of Aboriginal and Torres Strait Islander children.

The delegation of statutory functions should not result in Aboriginal and Torres Strait Islander child and family agencies being the only service responsible for the interventions afforded to Aboriginal and Torres Strait Islander families and children at risk. To address potential disadvantages, as outlined in relation to non-government services on page 60 of the discussion paper, consideration needs to be given to ensure a framework is in place to monitor the application of statutory functions and provide oversight and review of services. Ideally, this monitoring function would link into current processes that relate to all non-government child and family services.

A phased approach changes and functions to Aboriginal and Torres Strait Islander agencies, including pilots or trials, would ensure and broad understanding of how different community structures manage the new functions and to assist in the identification of issues to be addressed in the implementation phase. There would need to be a rigorous review process from an independent body throughout a trial or pilot process.

25 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?

Queensland Health supports the development of a standardised process of accreditation to reflect legislative requirements and to provide oversight of the organisation's strategies, and the effectiveness and quality of services provided. All funded services should be required to provide reporting on progress of strategies, outcomes, service delivery practices and indications of interface with partners, government referrals and joint support provisions. An option could be the establishment of licencing provisions for relevant agencies. As part of

the licencing arrangement the agency must meet ongoing accreditation requirements as well as meeting certain reporting obligations in terms of both outputs and outcomes.

Chapter 8: Workforce development

Queensland Health requires clinical staff to undertake two levels of training to assist health professionals to understand their responsibilities in relation to child abuse and neglect. All clinical staff at induction to employment within Hospital and Health Services are required to receive introductory information in relation to child abuse and neglect. This information includes their legislative obligations (for registered nurses and doctors) and key contacts or resources within their Hospital and Health Services to support them. These resources include Child Protection Liaison Officers and Child Protection Advisors.

The next level of training is targeted to staff who provide services to children, young people and families, and staff who provide services to adults where these adults may have responsibility as a primary carer to children and young people. Staff within these services are required to undertake an annual capability self-assessment process, to assess their capability to identify actual or potential child abuse and neglect.

The Department of Health has facilitated annual workshops for Child Protection Liaison Officers and Child Protection Advisors and Suspected Child Abuse and Neglect (SCAN) core representatives, to provide an opportunity for professional development of health professionals in these positions.

Staff across all agencies require a range of child protection training that is specific to the organisation that they work within. There should however be opportunities for interagency training across the child protection services.

Whilst there are always opportunities for one agency, for example the Queensland Health, to provide training to staff from another agency, for example the Department of Communities Child Safety Services, this training should not replace or discourage the seeking of advice and expertise. An example of this is the role and expertise that all agencies provide in the interagency SCAN team forum. Specifically, the role of key positions in Hospital and Health Services, such as Child Protection Liaison Officers and Child Protection Advisors are a valuable resource of expertise across the child protection system.

Key staff in all agencies, including non-government agencies, should have the opportunity to share information and training in relation to child abuse and neglect. Specifically there should be training on agency specific legislation, policies, and protocols, particularly where these intersect with other departments and agencies

Regions and specific locations should be encouraged to develop and implement their own interagency training opportunities to respond to their specific needs.

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

The Queensland Health supports the view of the Commission that Child Safety staff should be supported through a range of strategies including mentoring and supervision.

Chapter 9: Oversight and complaints mechanisms

Currently the Child Protection Act 1999 requires Child Safety Services to review its involvement with a child where the child was known to the Department in the last three years prior to their death. Whilst cases involving child fatalities are heavily scrutinised through the Child Death Review Committee processes, there is no parallel system to allow similar scrutiny in cases that constitute a 'near-miss'. In significant cases, where a fatality did not occur, there are opportunities for learning's across the child protection system. The development of a serious case review process would enable these learning's to occur.

Within the Child Death Case Review process there is a mechanism for the recommendations of a review to be shared with the relevant Department of Communities, Child Safety and Disability Services region and Child Safety Service Centre/s. This Child Death Case Review process could be further enhanced by feedback, including actions undertaken in response to the recommendations of the Child Death Case Review Committees.

Chapter 10: Courts and Tribunals

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

Queensland Health suggests that in matters where the child or young person has medical concerns or needs, that advice should be sought from a suitably qualified medical officer.

Chapter 11: Funding for the child protection system?

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

Since 2004 there have been significant changes in the legislation in regard to information sharing. Information sharing has a significant impact on Hospital and Health Services as the requests for information between prescribed entities, such as requests from the Department of Communities Child Safety and Disability Services to Queensland Health, have increased substantially in number and at times the same request is duplicated. For example duplication occurs when the information is requested and provided by the Queensland Health SCAN core representative at a SCAN team meeting, and the same information is requested by a case worker in a Child Safety Service Centre.

Further work should be undertaken between key agencies at a strategic and operational level to achieve efficiencies in timely and effective information sharing. The discussion paper proposes the need for uniform criteria and key concepts in regard to reporting concerns of child abuse and neglect. Queensland Health proposes that similar principles, criteria and concepts are developed to address information sharing. These principles need to consider and be reflective of each agencies specific legislative and core business.

Chapter 12: Conclusion

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

As above in response to question 46