Responses to the Queensland Child Protection Commission of Inquiry Discussion Paper

March 2013

Dr Neil Carrington
CEO
07 3857 8866
neilc@actforkids.com.au

Dr Katrina Lines
Executive Director of Programs, Research and Education
07 3857 8866
katrinal@actforkids.com.au

This paper presents ACT for Kids' responses to selected questions posed in the Queensland Child Protection Commission of Inquiry Discussion Paper. We have confined our responses to questions for which we have knowledge and expertise and can contribute meaningfully to the debate.

CHAPTER 3. REDUCING DEMAND ON THE TERTIARY CHILD PROTECTION SYSTEM

Reduced demand on the tertiary child protection system will only occur once a number of conditions have been met across the primary, secondary and tertiary systems for a period of years:

- Early identification of at-risk families using a strengths-based approach
- Early assessment of children
- Well-resourced services that can meet the needs of children and families on many levels
- Highly visible and non-threatening pathways for children and families to learn about, be referred to and engage with services
- Provision of practical assistance to families
- Flexible and coordinated service delivery options
- Responsive tertiary system
- Culturally appropriate responses for Indigenous children and families

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

Experience through participating in two Action Network Teams and implementing and coordinating the South Gold Coast Helping Out Families Family Support Alliance have shown us that there are key elements to a successful secondary service system in a region.

Each region is unique in its differing demographics, cultures, service availability, cooperation levels, geographic challenges etc., thus, local solutions are always the 'best way' to get agencies to work together. If you prescribe a model, it won't work. The best model is a broad set of parameters and overarching aims within which regional networks can develop shared goals for child protection, language and governance structures.

Another key element is a coordination point and secretariat function. This needs to be specifically funded and a recognised part of the regional child protection model and preferably a non-government organisation. Without an organisation/individual funded and designated as coordinator the goals and agenda of the network will not be driven forward.

The coordinating body should be provided with information to assist them to develop a local approach. This could include information about:

- models that have worked in other areas,

- suggestions for strategic approaches,
- information about how to go about setting goals,
- information about how to develop outcome measures and evaluate outcomes, and
- a process for developing shared understanding about working together for child protection purposes.

One example of the type of information/training that could be provided is about developing a regional Program Logic for how service coordination will achieve the regional goals.

One of the tasks of the network/alliance should be to collect and analyse aggregate local data on child and family needs to allow the identification of service gaps. Locally developed solutions to address service gaps should be encouraged and may have to be funded. In regional and remote areas of Queensland, this will be a significant challenge.

Another task of the network/alliance will be to devise ways to obtain service user feedback for use in evaluating, monitoring and streamlining service delivery and coordination.

Networks/alliances will most likely choose to operate on multiple levels that encompass both operational and case management aspects and higher-level decision making across a region. Networks should have members with the ability to make high-level decisions and take action. Service gaps and issues would be escalated to the higher-level.

To operate successfully, be inclusive and create sector coordination and change, incentives for service participation will need to occur. This could occur through a requirement of participation written into service agreements or some other means of ensuring agencies prioritise the alliance.

Very small and/or remote communities, with few services, will be a special case of this kind of alliance. Our experience in remote Indigenous communities is that a reference group of key community members can be an effective decision-making group for child protection issues in the same way that an alliance of services can.

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

The best way to do this is through funding the coordination role so that there is a driver for goal achievement and joint decision-making. The funded organisation is responsible for facilitating regional goal setting, decision-making and coordinated service delivery pathways to obtain the best services for children in the region given the local level of funding.

Local level agreements about referral pathways, referral criteria etc. will also facilitate coordinated cost effective service delivery, reduce duplication of services and ensure children and families receive the right service for their identified needs and strengths.

Consent and confidentiality issues currently create barriers to services sharing information for effective service delivery and in some cases create risks for children because agencies hold relevant information about families but can't currently share it. Legislative changes to remove barriers to sharing information and protect community organisations from risk will be necessary for effective coordinated service delivery.

The local network/alliance could participate in managing and being responsible for regional funding budgets, especially around funding for services for identified gaps in the region. This would encourage cooperative problem-solving to make service sector changes; however, services competing for available funding will always create problems and perhaps even conflicts of interest.

Question 3. Which intake and referral model is best suited to Queensland?
In our opinion, option 2 is likely to transfer the existing bottleneck of reports and responsibility for the bottleneck from Child Safety Services to an NGO. The benefits of having one entry point for all assistance to children and families is outweighed by the likelihood that no real change would occur because the system would still not be resourced to handle the numbers of referrals, self-referrals and queries. The Discussion Paper (p. 42) states that more than 108,000 reports to Child Safety were expected in 2012. In any of these proposed changes to the system, the number of families who will require a service of some kind would be far greater than Child Safety alone receive now because many families who currently don't self-refer would be more likely to seek assistance. Evidence for this comes from the significant numbers of self-referrals directly to the Intensive Family Support services in the HOF Initiative.

Our experience with the HOFI Family Support Alliance is that it is under-staffed for the numbers of referrals it currently receives. We received more than 1500 referrals from the Referral Intake Service (RIS) in a one-year period and are funded for 2.5FTE workers to cold call or telephone all of these families, conduct needs identification, gain consent and make referrals. Our FSA service has a rolling waiting list of at least 100 families at any point in time. Many families won't receive a service as our prioritisation system means that families with less than high and complex needs always fall to the bottom of the list.

In addition, the referrals coming to the FSA from the RIS only constitute a fraction of the cases reported to Child Safety because there are many families reported who do not meet the Helping Out Families referral criteria. So those families with less than three previous Child Concern Reports, children older than three years of age and with no past history with Child Safety, currently receive no offers of services. We argue that it is these families who should be offered assistance in a true early intervention model.

We believe there is more evidence that Option 1, a dual referral pathway, if well resourced, and with support from an out-posted Child Safety Officer would deliver quicker and more efficient referrals for families. Evidence comes from Child FIRST in Victoria, the Tasmanian model and the Helping Out Families pilots.

The model should include:

- Legislated protection of the community intake service for transfer of risk of decision-making and information sharing about families.

- Adequate resourcing to allow for the employment of more staff would decrease the likely waiting lists and thus the time before families are contacted and therefore increase the engagement rates for intake (in HOF it's currently only about 25% – 35%).

- Self-referrals would come through the intake service rather than directly to the Intensive Family Support service (or any other specific service) as they do in the HOF sites.

- The intake service would undertake triaging via needs assessments for families to enable decisions about appropriate referrals. This process would also have to include some type of assessment for potential of cumulative harm. The out-posted Child Safety Officer would play a key role in this assessment by checking Child Safety history if necessary.

- The intake service would provide aggregate data on family needs and referral numbers to the local network/alliance to enable service planning and coordination.

- The community-based intake service should have access to a coordinated service directory outlining what government funded services are available to refer families to. This should include funded services across all levels of government.

- Availability of uniform criteria and decision-making aids and training for referrers so that they can be confident in choosing to refer to the community-based service rather than Child Safety Services. This would include the existing Child Protection Guide.

- A phone line for referrers to call to ask advice about where to refer.

- A funded marketing strategy, implementation plan and collateral for the intake service to assist referrers and families to identify where to go – regionally designed and delivered and coordinated through the local network/alliance.

- In Aboriginal and Torres Strait Island communities, the reference group could give cultural and family advice around appropriate referrals for families.

Question 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.

Uniform criteria and key concepts, along with a source of advice, information and tools to assist in decision-making would help referrers choose the appropriate referral pathway (community intake or Child Safety Services). The advice could come through a referral information line manned by the community intake service.

The Child Protection Guide trialled in the HOF sites was a start on this process; however, the education and information phase was not run for long enough and was only targeted at mandatory referrers in the government (Health, Education). Its use should be expanded to include workers in universal services such as day care centres and GP clinics to encourage early identification of children at risk. Ideally, in cases where the situation is not serious enough to warrant a referral to Child Safety the guide would also contain advice about how to talk to parents about seeking help and where to refer them for assistance.

Feedback given to our HOF team about the Guide was that if a referrer had multiple concerns the tool was not flexible enough to evaluate the best course of action based on all concerns, you had to go through the decision-making process separately for each concern.

Information would have to be presented in a number of different ways (as opposed to the guide which was only available online) to ensure culturally appropriate and understandable content. For example, instead of all written content, it could contain links to YouTube videos of scenarios and examples of referral situations and the key concepts. Being able to talk to someone about a case is also very important.

We see the mechanisms for assisting professionals (and perhaps the general public) to be the joint responsibility of Child Safety and the regional community-based intake service. Part of the marketing strategy for a community-based intake service should be to increase knowledge and understanding of child protection in the general public.

CHAPTER 4. INVESTIGATING AND ASSESSING CHILD PROTECTION REPORTS

Question 9. 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?

ACT for Kids believes that a differential response model should be adopted in Queensland and we support the model proposed in the Discussion Paper with one caveat. The 'assessment and support' process being trialled by the Department of Communities, Child Safety and Disability Services in which a Child Safety Officer conducts assessments with an NGO support service worker is not included in the proposed model. We believe this process has merit, particularly if there is to be the addition of the Signs of Safety, or some other strength-based assessment process. We would not recommend this for serious cases such as those outlined in the Olmstead County criteria for forensic investigations, however, it would be appropriate to ascertain differential pathways for community-based or family violence referrals.

In addition, we believe that in using any of these pathways with Aboriginal and Torres Strait Islander families, culturally appropriate methods must be used. These could include partnering with Aboriginal and Torres Strait Islander support services or reference group members in joint assessments and focussing on cultural and other strengths and including Aboriginal and Torres Strait Islander Child Safety workers in forensic investigations.

The effectiveness of this model and the ability to evaluate the effectiveness of it would be enhanced if all workers in the sector were trained in the use of the same strengths-based process for assessing risk and making decisions and all used the same outcome measures to assess success.

CHAPTER 5. WORKING WITH CHILDREN IN CARE

Question 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?

This should be determined on a case by case basis; however, timeframes should be put in place and known to all parties, specifically the parents. The New South Wales time frames seem reasonable. It would be helpful if there was some mechanism for assessing parents' capacity to change early in the intervention to minimise unnecessary waiting for positive change to occur before acting to create a stable environment for children.

As a Western society we underestimate the emphasis put on connection and identity by Indigenous people; 'adequate care' of children does not encompass this. So any decisions about more permanent and longer-term placements must take this into account for Aboriginal and Torres Strait Islander children.

Question 16. How could case workers be supported to implement the child placement principle in a more systematic way?

There has been much comment about the role of the Recognised Entity, whatever the eventual model; the most important role in terms of the child placement principle is to act as advocate and active participant in seeking culturally appropriate placement options for children during key decision-making processes. The goal of the advocacy is to get the best outcomes for the child taking into account their cultural and spiritual needs and connections.

We suggest that a specific process should be built around investigating all options for placing children in line with the child placement principle. This could be a collaborative process like the SCAN model. Each child's case should be examined by this team individually and decisions made about how the child placement principle is to be enacted. The Aboriginal and Torres Strait Islander partners in this process should have active involvement in finding solutions and advocating on behalf of the child.

CHAPTER 7. ADDRESSING THE OVER-REPRESENTATION OF ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Here we offer an overall response to this chapter of the Discussion Paper, in light of our experience and expertise working with Aboriginal and Torres Strait Islander families, particularly in the context of Remote Communities.

It is paramount that whatever policy decisions are made to reduce the over-representation of Aboriginal and Torres Strait Islander children in the child protection system that the historical and current experiences of Indigenous people through colonisation, child removal and social disadvantage are not repeated or perpetuated. Ongoing social disadvantage needs to be acknowledged as a major contributor to Indigenous children being considered at risk, particularly for neglect.

ACT for Kids' takes the position that the solutions to over-representation must be generated, at least in partnership with, and preferably by, Aboriginal and Torres Strait Islander agencies and communities. We believe that solutions should focus on some general principles including:

- Greater investment to solve the problem – obviously 15.9% of the budget is not going to make the situation better for children who are the subjects of notifications at more than five times the rate of non-Indigenous children, who are placed in out-of-home care more often and who stay there longer.

- Efficiencies and cost effectiveness will come from leveraging existing service infrastructure which may not necessarily be the same type of service in each region or community. Services that are well-resourced, trusted and utilised by the community are prime opportunities for developing child and family wellbeing services. This may include Aboriginal and Torres Strait Islander Medical Services, but it may also be the Indigenous child care centre, safe house or school. The best solution is the one that the community sanctions and the process of development (i.e. with or without whole of community approval) will decide whether the service is used or not.

- The means to determine whether or not a child is in need of protection must come from a strengths-based approach instead of a deficit approach that may be culturally questionable and perhaps contributing to over-representation.

- A recognition of the diversity of Indigenous child rearing practices and how these can include complex kinship systems and the dispersed responsibility for children within a community. Such practices, particularly around supervision of children extending beyond a child's parents, can be mistaken for neglect by Western observers when using deficit-based assessments. A contextualised, culturally appropriate method of assessment is required which looks more deeply at whether the needs of the child are being met.

- The capacity of Aboriginal and Torres Strait Islander communities and organisations needs to be strengthened and entrusted with the responsibility for the safety and wellbeing of Indigenous children.

- Genuine, equal partnerships will be needed to achieve the goal of reducing numbers of Aboriginal and Torres Strait Island children and young people in the child protection system. This includes partnerships between Indigenous organisations, Child Safety and other government departments and non-Indigenous organisations.

- Accreditation of Aboriginal and Torres Strait Islander agencies undertaking child protection functions should be based on the same standards as non-Indigenous services. Aboriginal and Torres Strait Islander Children have a right to the same standards of care and treatment as non-Indigenous children and young people. That said; the tools for assessing whether or not an organisation meets the standards should not depend on just having the required number of forms filled in and the right policies and procedures. The processes of accreditation are onerous and confusing enough for services with staff with high levels of education and English as their first language. English language based assessment is discriminatory for people with English as a second or third language and who may not have had the same education advantages as non-Indigenous Australians. Our experience is that achieving the standards of care for out-of-home services (safe houses) in remote Aboriginal communities is very achievable if you take the time to invest significantly in experiential learning and on the job mentoring for staff and cultural support and sanction for the service from key community leaders.

CHAPTER 8. WORKFORCE DEVELOPMENT

Question 26. Should child safety officers be required to hold tertiary qualifications in social work, psychology or human services?

One of the key tenets of job design, human resource management and recruitment is that the outcomes and tasks to be achieved by a role should guide what type of knowledge and qualifications staff will need. The question of what qualifications child safety officers should hold really hinges on what the role is designed to achieve. It also requires some understanding of the likely skills graduates will possess. For example, holding an undergraduate social work degree will mean that you will have had two placements in which you have had some experience working with clients in a supervised work setting, however, you may have no formal training in child development or assessment methods (depending on which university you attend). No undergraduate psychology degree and few human services degrees have a work placement as a core component. So having a psychology degree may mean you have no actual hands on experience working with children and families unless you have work experience or are actually registered as a psychologist. Similarly, a degree in education will guarantee that you can teach a class of children, but will not necessarily equip you to work with engage and assess parents who have a range of significant issues.

Cultural competency training, both specifically around working with Aboriginal and Torres Strait Islanders, and more broadly within socially and culturally diverse communities, should be a required component of becoming a child safety officer, either as part of tertiary education or in job-based training within the Department.

As female graduates in human services, social work and psychology degrees are overwhelmingly in the majority, the number of males in the child protection workforce is likely to continue to be very low if these degrees are the required qualification.

It seems that to be a successful child safety officer at present you need a very broad range of knowledge, skills, experience and personal qualities that are difficult to find, whatever the qualification. This is because the tasks and outcomes of the role are very broad and perhaps somewhat confused. We believe that the role of child safety officer needs careful review in light of the future directions of the tertiary service model. Job design principles should be employed to ascertain what qualifications, skills, experience and personal qualities will optimise achievement of job outcomes.

Question 27. 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 chid safety officers in the workforce? Or should this pathway be available to all workers.

Such a pathway would increase the diversity of the child safety officer workforce by providing opportunities to achieve qualifications and meaningful work for Aboriginal and Torres Strait Islander, culturally and linguistically diverse and male workers who might

otherwise be excluded from the role for a lack of appropriate qualifications. Any alternative model should incorporate (i) articulated pathways to gaining further higher education qualifications, (ii) mentoring and supervision to enable learning in the role; and (iii) support for academic components for learners from diverse backgrounds.

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

We believe that creating a less risk-averse culture would go a long way to supporting Child Safety staff. When the work culture is about avoiding risk and blame, workers are anxious and less able to work effectively with clients. This is exacerbated when the clients have complex needs. When the worker is focussed on avoiding making mistakes, their focus is on themselves, not on the child, where it should be.

One way to change the culture and support staff is to have separate supervision for client work and line management/role achievement. Case supervision would be based on evidence-based case management practice and:

- Be regular (at least fortnightly).
- Be one to one.
- Be prioritised.
- Be provided by a highly skilled and experienced case manager (NOT the line manager).
- Provide practical strategies to engage with difficult clients and communities.
- Provide mentoring and training around casework and practice frameworks and therapeutic evidence.
- Be provided from a child-centred framework.
- Be a safe, confidential place to discuss client outcomes.

Line management supervision would be based on engendering a performance culture in the workplace and:

- Be regular (at least fortnightly).
- Be provided by the line manager (NOT the case supervisor).
- Be focussed on achievement of performance goals such as caseloads, reporting, teamwork etc.
- Address compliance with policies and procedures (including risk management).
- Coach and address alignment with legislation, organisational goals etc.
- Be a safe place for a worker to give and receive feedback on performance, professional development needs etc.

Question 31. 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.

Targets on their own don't improve workplace diversity or increase the ability of Aboriginal and Torres Strait Islander people to successfully undertake the roles, training etc. targets are the 'bottom line', not what you would strive for in a culturally diverse,

effective, well-trained and efficient child protection workforce. You would aim for the top and put into place systems to ensure that the Indigenous people employed are supported to succeed to the best of their abilities.

Furthermore, effort must be made to address the existing barriers to Indigenous people working within the child protection sector, which include:

- Skills and qualifications – option for on the job training.
- To build in career pathways rather than Identified positions with no ability for career progression.
- Cultural safety in the workplace.
- Acknowledge the negative reputation of the Department within Indigenous communities due for example, to historical practices, leading to pressure not to be associated with child protection.
- Culturally appropriate practice, and respect of cultural knowledge within the sector will also increase the likelihood of attracting and retaining Indigenous staff.