Queensland Child Protection Commission of Inquiry

Comments on Discussion paper Feb 2013.

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Comment:

In the commissioner's overview (xiii-xiv) there is mention of the increasing demand on the child protection system and a number of reasons are given. There is however no mention of the impact of a number of societal factors which may be impacting on the increasing number of children at potential risk e.g. increasing complexity of family need with combinations of mental health, substance abuse and domestic violence on a background of generational abuse and dysfunction with a lack of family support.

Chapter two:

Comment: Page 12 Fig 2;

This diagram is incorrect: Intake leads to either a CPN or a CCR. A CPN does not lead to a CCR.

Page 13: When considering the number of reports being made to the Department, it would be helpful to see how many reports are repeat reports for families already known to the department and may relate to an issue that is not being resolved or rectified.

A number of tables refer to absolute numbers. It may be helpful to see the data based on population as interpretation is otherwise limited.

In relation to figure 6, page 27: There seems to be an interpretation that in 2012 there were 2149 IPAs and 8814 CPOs. It needs to be remembered that many of the CPOs will be long term i.e. there have not been 8814 new CPO's. The table would be more meaningful if it compared IPAs to new CPO's, but also there needs to be information about what had led to the CPO eg had IPA already been tried (and how often) before CPO applied for.

Chapter 3:

Question 1:

Planning secondary services:

For government agencies there needs to be clear governance structures setting expectations around service provision as well as defining the workforce skills and expectations and ensuring those expectations are met. There needs to be interagency (both government and NGO) collaboration and all levels, from executive to local level.

Many of the families who come to the attention of the Department, move in and out of the secondary and tertiary sectors and any model of care must be able to keep these at risk families within a support structure while they transition. Many of these families have long standing issues and traditionally improve while support is intensive and slip down again when supports are removed. There needs to be an understanding that supports have to remain, although less intensive at times, ramping up again when family circumstances require it. Hopefully, we will then stop seeing families following the roller coaster ride in and out of the tertiary child protection system.

Question 2:

Delivery of secondary services in most cost effective way.

Challenges in utilisation of secondary services includes: knowing what services are available; knowing the referral pathways to those services; having lack of knowledge of what other services may be being utilised by a client or have previously utilised and what duplication might occur. It would be helpful to have a lead NGO in an area responsible for the identification of other service providers. The lead NGO would case-manage families and be the 'one stop 'referral centre. They would then assess what would be the best fit for the family from the services they know in the local area, making appropriate referrals to other NGOs and government agencies. Brokerage funds would allow utilisation of private services that might be needed in a timely way e.g. psychology services; therapy services etc.

Question 3:

Which intake and referral model is best suited to Qld?

Option 1: Community based via dual referral pathway. It would be helpful for mandated reporters to be able to discharge their duty by having both options i.e. report to the Department or refer to support services via an NGO with responsibility to further assess the child protection risks for that family.

The reference to expanded information sharing needs to be explored further, as there needs to be consideration of the fundamental principle of the privacy of medical

information. This would not be handed freely to NGOs and consideration needs to be given to the practical aspects of this proposal.

The referral pathway must be one that has the capacity to act immediately at times of immediate and significant risk, 24 hours a day and must be one that can meet the statutory requirements.

Option 2 appears to be a privatised version of what exists now with RIS. If this was to occur the agency taking on this function would have to take on the responsibility for protecting children that is currently held by the state. Apart from the question as to whether an NGO would want to take that on, the question remains as to whether the government should pass on this responsibility to others. If an NGO was to take this on, how would they be accountable for outcomes?

In the past there have been cases where child safety have referred cases to ongoing follow-up by NGOs, where outcomes have been poor, with significant harm occurring. In these cases, accountability often becomes blurred.

The NGO sector would need to be able to provide timely decision making to meet the needs of cases where there needs to be immediate intervention. There would also need to be clarification about information sharing provisions with an NGO.

If in the end the NGO looks and feels like the current RIS, then it is questionable as to what is gained.

The current RIS is frequently overwhelmed, and regularly fails to meet the goal of providing outcomes within 5 days. The proposal mentions that this new take service will not only screen reports, but will refer on and have capacity to follow up on the referrals. This could only be done with increase in resources.

At the present time, professional government reporters have a process whereby they can challenge an outcome if there is concern that a child is at risk and no action is being taken. Ultimately, there is a clear governance structure of accountability. What process would be available and what accountability would there be when dealing with an NGO if there needs to be a rapid response to the concerns raised?

<u>Questions 4:</u>

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

The following will assist:

The reporting guide has been helpful but is just that – a guide.

Education and professional development and experience.

Consultation and mentoring.

Uniform criteria are something that needs to be defined after consultation, with appreciation of the different perspectives and backgrounds of those using the criteria. The reporting tool has been well received by Health staff using it, but it needs to be appreciated that the tool was modified after substantial multiagency consultation to be sure the pathways the tool utilised were compatible with the environment in which it was being used. If the idea of Uniform criteria is that Health staff need to think and assess risk the same way that Child Safety does, then this may well lead to detrimental outcomes. There is significant advantage to having various professionals see a case though different eyes and bring their different perceptive.

Chapter 4:

Question 5:

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

The fundamental advantage of SCAN is having senior, highly experienced representatives of key government departments coming together to review children at risk and their families. Having this combined expertise, coming from different perspectives, to oversee a case, provides opportunity for optimal assessment and service pathways. All core members need to have equal value in this process. This combined expertise should be called upon at various times along the trajectory for a child within the child protection system when complex planning may be needed e.g. intake, assessment, ongoing intervention, during foster care, reunification, post care etc. It again needs to be acknowledged that many families known to child protection will move in and out of the tertiary system. At the moment, there is no capacity to utilise the expertise of SCAN until the family have again entered the tertiary system. It is often the case that those working with the family can see the slide and earlier referral to assist case management may be of benefit.

Comment:

Page 80: There is discussion about the removal of the category of “likelihood of significant emotional harm” resulting in 31% reduction in substantiated cases of emotional abuse. This concept is reflected in some of the media reporting of the direction of the Commission around too many children entering the child protection system because of abuse and neglect. There is a potential inference that one must wait for actual harm before intervention occurs.

There is a substantial body of literature which shows that significant emotional harm and neglect leads to worse long term outcomes than physical abuse. Once the harm has occurred, the damage is done and so waiting for demonstrable harm can be seen as too

late. The challenge is defining what represents 'significant risk'. In potentially dismissing the category of 'risk of significant emotional harm and neglect', there needs to be a clear image of what families are being captured under this heading. Families include those with young children (pre school) with parents with substantial substance abuse issues, parents intoxicated while caring for dependent children, mental health issues and violence associated with the above. Houses unfit for habitation and children being exposed to drug users and offenders coming and going from the house, exposing the children to risk of sexual abuse. This is not an uncommon scenario where CS might become involved and need to intervene to meet the children's needs. To eliminate or dismiss the significance of this category of abuse may well decrease the substantiation rate, but I'm not sure how that improves the child protection system. Waiting for demonstrated harm in this environment is clearly too late. These cases are not uncommon.

Question 6:

How could we improve our response to frequently encountered families?

Do a thorough assessment of the family's needs and capacity to change. Make concrete measurable and meaningful goals and timelines that need to be met.

Use well-coordinated supports which are case managed and reviewed as to family's ability to change.

Decide if the family issues can be remediated and if not, look at permanency placement.

If supports are effective, provide ongoing support over a considerable period of time e.g. until children at school.

Utilise the SCAN team process at critical decision and planning points along the family and child's involvement.

Develop a smooth interface between secondary and tertiary systems, so family don't have to, again, hit rock bottom before supports are provided.

Question 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?

Individuals have the right to make decision about themselves- unless they are breaking the law.

Within the child protection system, need to identify:

- What is necessary for the safety and wellbeing of the child
- Actions and engagement by parents in specific interventions need to be linked with the above.
- A clear case plan with measurable goals should be developed with understanding that if the goals are not met, intervention including CPO will follow.
- Achievement of these goals needs to be more than just attendance.
- Support to continue to engage in the support services needs to be medium to long term
- If need be this could be supported by a PSO but this rarely happens now and appears ineffective.
- Expertise within the SCAN team can help inform the effectiveness of engagement in the case plan.

Question 8:

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

- Use them how they were intended i.e. a tool.
- Give consideration of including educational neglect.
- It may be beneficial to review the pathways of the SDM at a multiagency level to ensure they adequately reflect the Qld child protection system.

Question 9:

Should the department have access to another response to notifications other than an investigation ad assessment?

To raise a notification, intake has assessed that there is a likelihood that the child is in need of protection. To outsource the assessment of this to an NGO would carry with it the responsibility by that NGO of ensuring the child protective needs are met. What would this accountability look like? When meeting with the family the NGO would be required to make full disclosure as to how they have heard about the family, why they are there and what the outcomes might by. Over time, the NGO may well become known as an agent of the Department.

A differential response for those families who have not been deemed a notification may be very helpful and prevent families entering the tertiary system.

Comment:

Page 98; talks of a separate entity managing legal proceedings. This would be an excellent idea. It would also be good if there was an opportunity to link with the judiciary in ongoing professional development activities.

Chapter 5:

Comment page 102. There is reference again to Fig 6 saying that IPAs are not used as much as orders. As I have mentioned before, the data does not show that. While it may be true correct data is needed. It is more my experience that at least one attempt, and not uncommonly multiple attempts, at IPA occur before a CPO is taken.

Comment is made about directive and supervision orders – these seemed to be used less and do not seem to be seen as effective.

The issue about reunification is age dependent and there is not a one plan for all. There needs to be thorough assessment about what is in the child's best interest when these decisions are made. Especially for younger children the re-unification needs to be attachment informed. Decisions about re-unification may also benefit from SCAN team input.

Question 10:

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

This will depend on:

- The nature of the harm and risk of ongoing harm
- Age of the child
- Detailed and thorough assessment of what is required to change to ensure that the child's needs are met.
- Assessment of capacity to change and work towards meeting those goals with intensive support.
- When it is clear this is not going to happen, and the risk of harm remains significant, long term stable placement should be sought.

Question 11:

Should the CPA…..prescribe services to be provided to a family… before moving to longer-term alternative placements?

It is difficult to know what this would look like. What are the implications if the services are not available? Who holds the responsibility? Who defines what those services should be? What are the implications if the public system cannot accommodate the request? Is child safety required to pay for private services? What if they are not available privately?

Comment:

Page 107. There is comment about figure 15 saying that the graph indicates that placement instability seems to worsen the longer a child is in care. There seems to be an implication that the instability of placement is due to being in care longer. This is a simplistic interpretation of a very complex matter and may reflect that those children who have been in care longer have been exposed to worse abuse.

Question 12: no comment.

Question 13:

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

Yes-especially for the younger children after there has been thorough assessment. This may stop the cycle of re-traumatisation and enable the establishment of positive emotional attachments which may allow the child to develop relationships with family at a later date.

Question 14:

What are the potential benefits or disadvantages of the proposed multidisciplinary case work team approach?

There are a number of problems with this proposal. Over time workers who have come from different professional streams, begin to lose their profession specific attributes. Moving nurses into the role of child safety investigation is a fundamental shift from their usual role i.e. from a health professional to a statutory investigation officer. If their role is to advise on health issues and not actually investigate, on what basis do they give this advice? If they are asked to do an assessment, where does that leave their professional standing in the mind of the family when they are interacting with them under the authority of child safety? How does the nurse maintain expertise across all areas of child health: infants; developmental behaviours; adolescence; psychiatry; etc i.e. across all age ranges and all disciplines?

The current system allows for close relationships between Queensland Health and Child Safety through the well-established positions of CPLO (Chid protection liaison officers – mainly nurses and some social workers) and CPAs (predominantly Paediatricians). These

positions provide support to Child Safety staff, information sharing and co-ordination of services. It allows for staff to be closely linked but to maintain their separate identities. Families will commonly be more accepting of health professionals than child safety.

The system as outlined in Fig 17 is not workable from a health perspective. It would be better to further enhance the current roles of CPLO, CPA and SCAN.

Questions 15, 16 and 17: No comment.

Chapter 6:

It needs to be considered that children will leave care at different times e.g. after 12 months or after 18 years. Issues will be different. If returning home after a short term order, it is essential that parents are given clear plans about any ongoing health needs for the child and appropriate transitions occur if moving to a different geographical area.

While the chapter seems to refer predominantly to children leaving long term care, there needs to be more focus on meeting the needs of children WHILE THEY ARE IN CARE. If this is done appropriately, then transition from care can be more easily planned. Why prioritise these children after they are in care and not while they are in care? Why should there be a need for an exit health check if their health needs have been adequately met while in care?

Question 18, 19 and 20: no comment.

Chapter 7: no comment.

Chapter 8:

Comment: page 199. Re multidisciplinary workforce. See response to question 14.

The role of Child Safety is around psychosocial assessment of risk and protective factors around a child or children at risk. The skills needed to do this (and therefore the qualifications needed) should be separated from what is a very different question about how to liaise with expertise from other disciplines. As mentioned above, this utilisation of health expertise can occur via CPLOs and CPAs and SCAN teams. Over time nurses recruited to work alongside CSOs in assessment are likely to 'morph' into a generic CSO.

Comment:

Page 206 : paragraph starting with 'The commission has also…' This paragraph seems to have confused ICM meetings (related to SCAN) with ICMS information systems.

Question 26 and 27; no comment

Question 28:

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

Education about the role of other professionals in assessing harm and risk of harm and how to access that expertise.

Question 29:

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?

Simplify processes which would lead to increased efficiency which would release workers for other duties.

Question 30:

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

Mentoring with more hands on support from experienced staff.

Question 31: no comment

Chapter 9:

Question 32 and 33; 35 and 36: no comment

Question 34:

External oversight mechanisms?

Child death reviews should be extended to serious case reviews.

Chapter 10:

Question 37 and 38; no comment

Question 39:

What sort of expert evidence should children's court have access to and in what kinds of decisions should the court be seeking advice?

When child protection matters have a significant component of medically based information it is important that high quality forensic medical opinion is provided to the court. Development of a children's forensic service linked to the current child protection services

at the RCH and MCH and with the future Queensland Children's Hospital would give a 'port of call' of second opinion or review work if required.

Question 40-45: no comment.

Chapter 11:

Question 46:

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

A better coordinated use of both government and NGO services would be expected to lead to more effective and efficient service provision. If case work is done effectively and children's needs are met, either with their family or in stable long term placement, the long term costs of expensive OOHC options would be reduced. Furthermore, young people who are healthy, both mentally and physically, will go on to productive adults who will need less government support long term from across many sectors including health and the judicial system. Increased investment early on the child protection pathway for families and children is not only essential for the child as an individual, but for society as a whole, with elimination of the ongoing cycle of abuse.

Chapter 12:

Question 47: no comment