RANZCP

Submission by Child and Adolescent Fellows (QLD Faculty) with a particular interest in child protection .

Royal Australian and New Zealand College of Psychiatrists
Queensland Branch

Queensland Child Protection Commission of Inquiry

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Introduction

Child Psychiatrists in Queensland have always worked with children in the care system because these children can present with significant psychological difficulties. Historically this population of children has been difficult to work with. A not unusual scenario was the child in care presented for psychiatric review in company with a youth worker, who has just met them. This person had no capacity to give the child's history or support any recommendations being carried out. Sometimes there was an expectation that children with complex problems might be "fixed" without anything happening in their care environment occurring to support this. The difficulty in influencing areas of children's lives that could support recovery led at times to a level of hopelessness in those trying to help these children. This was amplified by the fact that a significant proportion of them were identified as having conduct disorder, a condition that can be difficult to treat. For many other children in this cohort there was no diagnosis identifiable despite their very real psychological difficulties. In a mental health system that relies on diagnosis for resource allocation, they were sometimes denied service.

In the last six years some of us have had the opportunity to work intensively with this population of children in collaboration with interagency care teams, within the Evolve Therapeutic Teams and as part of the Evolve Interagency Service. This has coincided with an increase in our understanding of the neurobiology of the developing brain and the impacts of trauma and disrupted attachment on it. There was a realisation that our longstanding clinical observation that, children's development can be delayed or distorted by adverse experiences, can now be illustrated by neuro-imaging and by biochemical markers. In simple terms these children's brains can be damaged by neglect and abuse and we can now see this damage. This has drawn child psychiatry back to its roots in attachment theory. The integration of some of this thinking with a neurobiological framework offers hope for effectively preventing and treating psychological harms done to children in the family environment. The importance of human relationships, adults collaborating to ensure consistent positive relationships for children across their care environments are becoming more evident and there is emerging international evidence that treatment for these children needs to involve interagency collaboration and be multimodal eg involve work with the child, carer and school (Vostanis, 2010).

In the Evolve System we see this in action everyday. We see the commitment these children elicit from those that work with them: carers, child safety officers, teachers, therapists and we see how well these children respond when we are able to stabilise the system they live in and offer them boundaried and nurturing care from consistent adults. We also see children's progress stall or go backwards when we don't get it right and we see the systemic barriers that prevent us from meeting their needs. There are changes we can make to the way we work together to ensure we get it right more often. We can get more out of the resources we have available if we assess children properly, make plans on the basis of what they need and carry them through ensuring that their well being is our primary focus. There needs to be meaningful collaboration at every step.

In making a submission about the needs of children in care it is worthwhile identifying some of the principles many psychiatrists working in this area draw on in thinking about the needs of children in care. It can be easy to assume that all professionals working in the area share these principles and they are certainly becoming more of a consensus. In

practice there are a wide variety of schema for thinking about this group of children and it is worthwhile making clear the assumptions underlying any recommendations to be made in this submission.

A Child Psychiatrist's Framework for Understanding Children in Care.

1. Children need safe consistent and relatively thoughtful, available attachment figures to thrive.

This is particularly crucial for babies. Without this care babies are psychologically harmed. It is not enough to meet children's more obvious needs a consistent figure needs to be emotionally available and keep them in mind (Zeanah, Shauffer, & Dozier, 2011). They also need to be offered inclusion in families and communities. If parents can't provide this for them the care system needs to do so. Older models of care don't prioritise this. Historically care providers have sometimes been discouraged from supporting children to attach, as it was feared this would rob them and their parents of family connectivity. Family connectedness remains very important but needs to be provided in such a way that children's needs for safe, nurturing stable placements are not jeopardised. There are many ways children can retain a family connection and identity that do not put other needs at risk.

2. Overwhelming adversity doesn't make children tough and resilient.

Cumulative harm is the process whereby children become increasingly vulnerable with repeated harms and cope less well with each loss or trauma. Bromfield and Miller (2012) provides a useful overview. There are two main avenues for children to be cumulatively harmed. Sometimes we leave them with or repeatedly reunify them with parents who harm them. Sometimes we take children into a care system that can't always meet their needs for care and may expose them to repeated placement breakdown and other harms.

Permanency Planning is therefore very important. This involves identifying and appropriately resourcing and supporting parents who can develop the capacity to provide care for their children. This avoids children being exposed to cumulative harm in care. It remains important to quickly identify and remove children whose parents pose an ongoing risk to them when it is clear that this risk is not likely to change. This should allow placement in long-term stable well-resourced foster care or adoption.

An important challenge is identifying the two groups and managing the risk in the cohort who fall in between the two extremes. This makes the need for expert and intensive assessments clear and it may be that in some cases this needs an interagency approach including other professionals other than child protection officers. Psychiatric assessments for both parents and children to determine their individual needs, capacities and the fit between them may be necessary where there are concerns about psychological health.

3. Both complex trauma, by which we mean repeated trauma (usually abuse or neglect) in the context of close relationships **and disrupted attachment do significant harm** to children. There is now an international literature documenting the way these children present clinically and the neurobiological indicators of damage in this population of children. Delima and Vimpanij (2011) offer a useful summary of findings. Typically this group of children can have difficulty across a broad range of areas. This includes, but isn't limited to, difficulties with learning, communication, social skills, developing close

relationships and managing feelings. All of which can impact on their functioning at home, school and other settings (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Although there are clear patterns in this population each child needs their needs considering individually and they can surprise us with unexpected resilience or marked vulnerability.

4. A developmental perspective is important in thinking about the needs of children as neither children nor adolescents are mini adults and they have different needs and potentials. A developmental perspective changes the way we think about decisions for children. For example, we now see permanency planning for babies as urgent because we are aware that there is a small window for them to have the best opportunity to attach to a primary carer and that subsequent removal from this carer compromises their development and must only be done with careful consideration. New neuro-developmental perspectives on adolescence suggest that adolescence for some children continues until the early twenties, that it is a period of significant neurological remodelling and as such a period that provides hope for intervention. The policy implications of this are profound; it gives weight to funding appropriately targeted interventions for adolescents. It also means that we have to be more thoughtful about transitioning children out of the child protection system and other supports at eighteen. Some children experience impulsivity and emotional turmoil, during this developmental phase and we are aware their brains may not function like those of adults, until their early twenties.

5. Decisions about care environments need to match the specific needs of individual children with the care environment. There is a subgroup of children with special needs, either acquired via trauma and loss or pre-existing who need better than usual care. For traumatised children or children with disorganised attachment we now recommend reparative care. This is care that helps them recover and heal.
Provision of care like this requires a capacity for patience and thoughtfulness not everyone possesses. Not every foster carer can provide it. Some biological parents make great gains in addressing their own difficulties and develop the capacity to parent some of their children appropriately, without being able to meet the needs of older children who are recovering from prior trauma. Decisions about placement, contact and reunification should be based on a thorough assessment of the child's needs and the capacity of the parental figure to meet them. The question is not can this person be a good enough parent but can they parent **this child?** Could they do it with an appropriate support network? Can we realistically provide what they need?

6. Consistent long-term relationships and minimal transitions in care are important for all children. For children who don't live in the care of their parents it becomes crucial that those who are responsible for their care, particularly foster carers and child safety officers but also teachers, therapists, youth workers are consistent figures in their lives and that when change occurs it is where possible planned and sensitively managed. Without this we produce a population of transient children who no-one holds in mind in any meaningful way. To ensure these children are held in mind we need to develop a stable workforce across the sector and reduce the turnover we face, in both organisations and individuals within organisations.

6. Collaborative care

Among the therapeutic models of care that show promise for abused and neglected children are

- Multidimensional Treatment Foster Care (Westermark, Hansson, & Olsson, 2011); (Henggler & Schoenwald, 2011)
- SACCS Recovery Program (2011)

http://saccs.co.uk/recovery/outcome-5-longitudinal-study

- (Zeigler, 2011)

http://www.jaspermountain.org/brochures_reports.html

- Take Two in Victoria

They are all accumulating evidence that they can make differences in the lives of children in care with severe psychological difficulty. (Of these to date only MTFC has shown independently reproducible benefits but the others, like the Evolve Program, can provide internal outcome data that shows marked improvement in functioning).

These programs have in common control over the model and quality of care children are offered at home, at school and in therapy, offering a cohesive integrated therapeutic model. Some of them have the capacity to step children through an integrated model from intensive services like therapeutic residentials to foster care, supporting transitions and maintaining relationships. Our rather fragmented care system in Queensland has not made this possible. However, there has been preliminary success using the Evolve Interagency Program to build collaborative care and there is potential to build on this.

It is important that crucial decisions made by all the agencies involved in the care of these children (this would include decisions to exclude children from school, offer a particular therapeutic program, changing placements and other child protection case planning) should where possible be on the basis of consultation and where expert advice has been requested from services such as Evolve or from private practitioners it should be incorporated into the decision making process. It may be discounted in the face of other information or advice but it should be considered.

Agencies that work with this population of children need to have enough longevity to build a skill base, a consistent work force, collaborative partnerships with other agencies and a realistic understanding of the resources needed to sustain good practice. The system in place where the Department of Child Safety brokers services from foster care agencies, residential services, private practitioners often on the basis of competitive tendering and short term contracts does not lend itself to the cohesive integrated system of care needed. There appears to be quite a high rate of turn over of agencies.

A final advantage of collaboration across agencies is that the very difficult conundrum of how to protect children is shared across the community. Decision-making has multiple inputs although a single agency The Department of Child Safety retains specific expertise in child protection and retains legislative authority. This, authority, if it is operationalised via a consistent relationship with a child safety officer who knows the child well and combined with the provision of a consistent caregiver, provides a safeguard to the child falling between the cracks. There has historically been a tendency when we hear of children being harmed to deal with our distress by scapegoating those we delegate responsibility to. It is however a whole of community responsibility to keep children in mind and find the appropriate resources to care for them. A rational debate promoting realistic accountability across agencies and focusing on solutions rather than blame is needed.

7. A culture that fosters the development of **clear standards of professionalism and expertise** across the sector and integrates expert opinion into decision making about children in care should be developed and sustained. This includes

- child protection
- the foster care and residential care sectors
- education
- therapeutic care including mental health private practitioners
- practitioners who do parenting capacity assessments or provide therapeutic services to parents
- reunification services

We should be moving towards ensuring that all people employed to work with these children are appropriately trained and accredited, and have ongoing professional development and reflective supervision. We need opportunities to support the development of specialised skills in working with children in care within our professional groups. We need to have clear expectations about what special skills or credentials are necessary to complete a particular task. We need clarity around what professional standards are expected in relationship to particular tasks. For example parental capacity assessments appear to vary markedly in quality and yet this is a crucial document for making good decisions for children. There is an international literature which makes recommendations about the process (White, 2005).

8. In considering resource utilisation in child protection a whole of government approach considering the cost of abuse and neglect across the lifespan needs to be taken.

Resources saved in child protection may simply shift costs to other areas such as health, education, the forensic system,result in lost productivity and intergenerational transmission of ongoing childhood abuse and neglect (Scott J, 2010; Taylor et al., 2008). In thinking about where to put resources in our society it makes perfect sense to avoid children being harmed in the first place rather than undertaking the very expensive work of patching them up afterwards. Obviously addressing the social and cultural antecedents of child abuse and neglect is important especially in looking at the needs of indigenous children. A whole range of interventions that prevent damage being done to children and intervene early with psychological problems before they become entrenched can be identified. These provide a cost effective approach and reduce the need for resource intensive interventions in more damaged children. (RANZCP, 2008, 2011, 2012) documents have provided useful overviews of these interventions. From the perspective of psychiatrist working with children in care it is worth adding that when intervening with vulnerable populations attachment informed parenting interventions are recommended although the evidence base is promising rather than established.

However, there remains a need for tertiary intervention services with those children who have experienced significant harms. The size of this group of children may reduce over time but it is unlikely that they will disappear completely. Currently we have large numbers of these children in our system and it is neither ethically excusable nor sensible from a resourcing perspective not to intervene intensively with them.

All work with children and adolescents is early intervention and even the most expensive tertiary interventions in this population can lead to cost savings in the adult health and forensic systems and make intergenerational change possible. Without intervention this group of children are likely to suffer significant

physical and psychological health problems, are more likely to be involved in the forensic system, utilising significant resources throughout their lifespan. They are also less likely to complete education many of them being excluded even from meaningful primary education, engage in the work force or to be able to parent effectively.

There is a "dose effect " to take into consideration with these children. We would not expect children who have suffered severe physical trauma to recover without intensive rehabilitation. Children who have experienced serious and repeated psychological harm also need intensive treatment and as previously described there is emerging evidence that treatment that works is multimodal eg therapy with the child, needs to be supplemented by interventions to ensure therapeutically informed responses by carers and schools. The work is also collaborative (Vostanis, 2010). For this subgroup, less resource intensive interventions are unlikely to have positive outcomes.

Evolve Therapeutic Services are referred children with extreme psychological need. It is notable that these children are often referred as **large sibship groups from families who have an intergenerational history of disrupted attachment, complex trauma and child protection concerns.** Obviously the resources used by these families across child protection, education, health, and forensic services are significant. An interagency approach to assessing and meeting the needs of both the adults and children in these families might make it possible for us to change the cycle. From a purely therapeutic perspective these families are typically difficult to intervene with in terms of supporting their children to reunify. However, we have had considerable success in stabilising the placements of these children, keeping them in school in such a way that they make both academic and social gains and engaging them therapeutically. Supporting these children to process their traumatic experiences of abandonment and abuse and to develop the capacity to reflect about their familial patterns and future relationships, supporting them to use their experiences of good care to learn how to think about the feelings of others and to have healthy relationships is our best hope of preventing the cycle continuing into the next generation. Good care alone is generally not sufficient to support this shift in children with complex and extreme difficulties and needs to be twinned with intensive therapeutic support.

Response to specific questions of the Commission into Child Protection

1.THERAPEUTIC DIRECTIONS

In reviewing the success with which the Forde and CMC enquiries have been implemented we have chosen to focus on

CMC recommendation 7.5
"That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated."

This is the recommendation that led to the development of the Evolve Therapeutic Service and about which psychiatrists are best qualified to comment. In the interest of providing a timely submission further comment is deferred although there are many recommendations from the CMC enquiry that have significant implications for the psychological well being of children in care which we would be happy to provide further feedback. In summary many gains have been made since the CMC enquiry and there remains much work to do.

RECOMMENDATION ONE
THAT THE EVOLVE THERAPEUTIC PROGRAMME CONTINUES

We recommend that ETS continue to provide therapeutic intervention for children in care who need expert intensive trauma and attachment informed care and require the involvement (at least initially) of intensive interagency collaboration. This is a group of children whose needs are not met elsewhere and who are unlikely to benefit from a less intensive service.

We are aware that you will have access to the ETS 2011 Evaluation Report, which reviews the available qualitative data and provides case studies to illustrate the ETS programs capacity to support children back towards a healthy developmental trajectory. This material has been canvassed in the Inquiry to date in some depth and we will not it reiterate here. As discussed previously tertiary programs for children with severe psychological difficulties remain necessary and are an efficient use of resources if a broad perspective is taken.

The value of the ETS program itself needs to be considered in terms of its broader impact. It has been a crucible for the development of a workforce with specialised skills and for trialling, evaluating and adapting interventions in the area of disrupted attachment and complex trauma.
There is now a wider subgroup of psychiatrists and other clinicians who have built expertise in this particular model.

Evolve Therapeutic Services as a system support capacity for skill development in the broader mental health system, through our supervision and peer engagement with other psychiatrists and mental health workers. This is very much a reciprocal process as we draw on and consolidate the considerable expertise there is amongst the broader child and adolescent psychiatry workforce.

Our Professional Development staff and other clinicians provide formal training for carers, child protection, education, residential staff and others. It could be argued moreover, that the influence of Evolve travels further than the children directly treated and those directly offered training The carers, teachers, residential care workers, child safety officers, youth justice case workers, police etc. who have engaged in stakeholder teams or other liaison relationships gain valuable skills and knowledge which they utilise with other children. Each child receives regular frequent contact by their therapist not only with them but also with their carer, the child, the school, residential facility, biological parent or others in addition to the work with the whole care team.

SERVICE GAPS

It appears useful, in responding to a question about implementation of recommendation 7.5, to take the opportunity to identify service Gaps for ETS and the broader therapeutic care sector and make some recommendations for addressing these, recognising that a long-term, 5-10, year plan is needed. We acknowledge that in the current climate planning service expansion is difficult. However, we need to provide a map for the medium term which acknowledges the resources needed to meet the needs of this population of children and stem the escalating cost of treating them "down stream" either as children who have experienced avoidable cumulative harm and as adults who received no reparative care following this harm.

RECOMMENDATION TWO
THAT APPROPRIATE CLINICAL LEADERSHIP BE PROVIDED WITHIN THE EVOLVE THERAPEUTIC SERVICES PROGRAMME
A. Each Full time Evolve Psychiatrist should supervise the work of no more than ten clinicians. The provision of meaningful clinical leadership to Evolve teams with higher ratios is not sustainable.

- Clinical work with children in care with complex and extreme needs is work that has an emerging but not deep evidence base and few clear cut clinical guidelines or practice parameters. Therapeutic interventions therefore have to be individually crafted often from first principles and carefully monitored and adapted. This is a population of children with significant disability and who not infrequently are at significant risk of harming themselves or others or of deteriorating, without good care. It is therefore a population of children who will are arguably best provided with the expertise provided by a multidisciplinary team led by a psychiatrist. This gives the teams leadership from a specialty that integrates expertise on the
- developmental neurobiology and the impacts of trauma and neglect,
- psychopharmacology :ensuring children are neither medicated unnecessarily nor have helpful medications withheld. Ensuring there is some consensus statewide about such treatments.
- the diagnosis of mental disorders and ensuring this is done consistently across the state
- psychosocial interventions in complex circumstances where initial treatments have been ineffective or there is the evidence base is not yet clear . Critically assessing the clinical rationale and available evidence for treatments.
- Integrating a psychiatric framework with that of mental health colleagues from other disciplines and the wider care team should ensure that assessments are thorough and treatments tightly planned and efficient, and that all care (mental health, physical health, parenting, child protection, education etc. is integrated and holistic).

- supporting appropriate program development and evaluation and professional development for teams and stakeholders at a local and statewide level.
- Given the potential influence ETS has over the whole service sector, ensuring expert input into best practice, efficient interventions are crucial. There needs to be enough psychiatry time to ensure a genuine influence over the quality of care.
- have a role in building liaison relationships with Senior staff in other agencies, paediatricians, CYMHS psychiatrists, Child Protection etc. this is one of the most useful interventions involved as where there is capacity to engage in this there been built a shared framework for understanding the needs of these children and avenues for acting cooperatively to meet them, which makes it much easier to produce the circumstances in which children can make therapeutic gains.
- The breadth of role for psychiatrists recommended above is based on RANZCP expectations, which are modelled on the CansMEDS framework (Cornwall, 2009; Frank, 2005).

B. Planning for ongoing development of subspecialty expertise in complex trauma and neglect by providing a senior registrar position. Ideally this should be a statewide position.

C. A Clinical Director position for Evolve Therapeutic Service should be developed to ensure ongoing statewide clinical leadership and clinically informed liaison with Senior Decision makers in other agencies.

n the current structure of the ETS program statewide planning and liaison can be time consuming and difficult as psychiatrists have little formal access to senior child protection staff on a statewide level. Recommendations made by the leadership group in Evolve, which is made up of psychiatrists and team leaders have little formal influence, some important decisions about the statewide program historically being made at a project officer level without consultation.

For this reason we would recommend that a fulltime statewide Clinical Director position be developed. This Senior Psychiatrist would work closely with the ETS psychiatrists and have a circumscribed clinical role to ensure they continue to understand the clinical challenges faced. At least 0.5 FTE of their role would need to be clinical leadership of the statewide program ensuring integrity of therapeutic approach and that professional development and service and intervention evaluation is clinically informed. Crucially they would develop strong liaison relationships with Senior Child Protection and Education Staff and provide expert advice on the psychological needs of children in care. They would also develop strong links with Directors of Child and Youth Mental health, Paediatrics and Adult Mental Health to support the development of a cohesive, integrated approach to children in care within the health service.

Clinical leadership at a statewide level will be crucial to the provision of a cohesive tertiary level program given that local area hospital networks will in future manage each Evolve Team.

RECOMMENDATION THREE
THAT THERE IS ONGOING EVALUATION OF THE PROGRAMME AND THE INTERVENTIONS PROVIDED

Building a better understanding of the common difficulties experienced by and the interventions that are useful in this population of children is crucial. A partnership between a University and Evolve may well be a useful place to start. Evolve has had funding for research officers and this has made the collection and synthesis of data about program outcomes possible. It has not been as efficient and productive as it has the potential to be for a number of reasons. There has been a lack of centralised leadership for this team and some of the direction has come from the interagency project officers/ project managers group whose positions are not recruited on the basis of clinical or research expertise. The development of a Senior SERC position, which was until recently filled by a senior clinician with a research PhD, has improved the quality of the output of this team considerably but this work continues to be directed by the project officers group.

In the longer term the development of professorial position in child psychiatry focusing on children with disrupted attachment and complex trauma could be very useful in providing direction and leadership. In the short to medium term linkages with existing professorial positions interstate would enhance capacity to make meaningful evaluations.

Also valuable would be a position resourcing the child psychiatrists and professional development coordinators in exploring available literature to use in ongoing development of therapeutic program and training, in supporting clinicians with smaller projects within ETS teams, ie case series, audits and evaluation of interventions leading to publication and sharing of the services findings and in fostering the development of an auditing and evaluation culture. These evaluators should eventually develop larger projects across the state drawing on ETS and CYMHS populations. Evaluation to be led by clinical and academic staff with backgrounds in mental health rather than project officers and to be linked to performance indicators such as stabilisation of placement, engagement in schooling that have relevance to children's quality of life.

RECOMMENDATION FOUR
THAT THE EVOLVE MODEL BE UTILISED TO PROVIDE CARE FOR OTHER POPULATIONS
A. UNDER FIVES
B. CHILDREN WHO ARE UNDER CHILD PROTECTION ORDERS BUT REMAINING WITH THEIR PARENTS
C.CHILDREN WHO ARE BEING REUNIFIED
D. STEP DOWN CAPACITY FOR ETS CHILDREN WHO HAVE ONGOING THERAPEUTIC(LESS INTENSIVE) NEED AND CAN'T TRANSITION TO ANOTHER SERVICE.

These Clinical Programs could continue to utilise the ETS model ie

- intensive support for children with complex and extreme needs
- provided by a multidisciplinary team led by a psychiatrist,
- drawing on the emerging evidence base available and current best practice
- integrating this with knowledge of local systems and resources to develop individualised plans.
- support is embedded in an interagency process to provide cohesive, collaborative care
- structures are placed within a statewide evaluation program to capture the

evidence about what difficulties these children face and the interventions which are helpful to them
- sharing skills across the sector via formal training, professional links and supervision networks and via exposure to the work through interagency collaboration.

In this way the work done with these children can build capacity in other services.
Work with the biological parents in these primarily therapeutic program would necessarily need to incorporate the capacity to identify the specific needs of the child, the parent's current capacity to meet these needs, whether this capacity is likely to improve with support . This might then inform child protection planning about the capacity and progress of the parent. This group of parents, whose children have significant psychological difficulties will need parenting assessments either by part of the Evolve Service or in partnership with a specialist service appropriately resourced to provide assessments in this complex group. Many of these parents will require psychiatric input into their assessments to evaluate the impact of their own prejudicial histories or comorbid mental health problems on their parenting.

1. Early Years program

ETS and CYMHS are theoretically set up to provide care to children from 0-18. However the 0-5 group are infrequently referred. In the Evolve population this is probably explained by the fact that although babies and very small children can present at the extreme and complex end of the spectrum we as adults find the signals that very young children are distressed or not functioning difficult to read. This is unfortunate because this early period of life is one in which there is much neurodevelopment and capacity for recovery. It is also a period when templates for attachment are laid down.

For children in foster care engagement with a service like ETS or CYMHS is the opportunity for foster carers to learn to read the signals disturbed babies and children send and respond providing attuned reparative care, supporting the child to attach healthily to them and reducing their chances of multiple broken placements and cumulative harm in care. Even when babies and small children will eventually return to biological parents they must have foster care that supports them to make attachments to their current primary carer (the foster carer) because without having an available attachment figure in their home they will suffer psychological harm (Zeanah et al., 2011).

If ETS provided a parallel program for children in the care of biological parents then this would be the opportunity for a multidisciplinary team to provide a thorough assessment of the child's specific needs and their parent's capacity to meet these needs. Where there are deficits in parenting capacity this team could provide a plan either identifying the areas where the parent can be supported to meet the child's needs, what difficulties they are facing that can be remediated and what support they need. Such an assessment is likely to rely on the team psychiatrists experience in adult mental health and might draw on information from treating teams in adult mental health or drug and alcohol.
ETS would where possible support the parent in attuning to their child's needs via psycho-education, modeling, and intensive in situ support of time spent with their children etc. Keeping the developmental needs of the child uppermost the ETS team could advise Department of Child Safety about progress made and whether it was timely enough to meet the child's needs. There would be parallel permanency planning in case change does not occur.

The team might identify early, risks that are unlikely to change and advise accordingly so that permanency planning can be implemented.

It remains important that if children are to need permanent placement that they are placed as early as possible to allow them to avoid cumulative harm and develop healthy attachments.

The training Evolve provides to child protection staff about the developmental needs of children and the impact of abuse and trauma could be expanded and support their capacity to identify and refer young children early. We could also support them in thinking about the risk factors that might help them consider removal and permanency planning earlier in some cases. Evolve Consultant Psychiatrists could provide a useful consultation-liaison service to help CSOs think about particular cases.

It is also important to think about ETS place within mental health acknowledging that our infant mental health programs, CYMHs, perinatal psychiatry and adult mental health services are all involved in the care of these children and their mothers and that there needs to be collaboration and a sharing of expertise across mental health. An Evolve Clinical Director could support this planning.

2. Children on supervision orders with parental agreement or who are being reunified are another population that ETS or a similar program might usefully work with.

3. Flexibility to continue to see a subgroup of children in the longer term if they have significant needs that can't be met elsewhere and a strong therapeutic alliance with therapists should be considered.
This might reduce therapist burn out and increase caseloads.

Other Service GAPS
Children with significant disability not captured by current diagnoses
Children in care often suffer significant disability and distress as a consequence of their prejudicial childhood histories without meeting criteria for a formal disorder. We would suggest that this is to some extent a failure of the DSM and ICD to describe and capture this population in order to support ongoing research and enhance service delivery. There is a literature about this shortfall (D'Andrea et al., 2012), and attempts have been made to advocate for change. Diagnoses such as PTSD and Reactive Attachment Disorder have very restrictive criteria describing only a small subgroup of children who have symptoms secondary to trauma or disrupted attachment and many children with significant psychological difficulties do not meet them.

Funding and service provision is often offered on the basis of diagnosis rather than need (access to psychotherapy via medicare, ascertainment for education funding, disability support funding, treatment in some CYMHS). Diagnosis alone is not a useful indicator of disability or need. There are therefore difficulties for children in care in accessing services. Services specifically for this population of children irrespective of diagnoses such as ETS and education funding ESP have been helpful in bridging the gap.

There are children however whose therapeutic needs do not get met. There is a need for flexible, accessible, trauma and attachment informed psychotherapy services which can follow children and support their carers long term if necessary, discharge them and then allow them re-entry when they need support negotiating a particularly difficult developmental stage or when they face one of the serial losses this population of children experience and deteriorate.

Some of the children in the ETS system make great gains for instance ceasing aggression, allowing carers to provide support, settling into placements or schooling and achieving well. They get to a stage where they no longer need intensive support and frequent interagency meetings. However, in terms of supporting them to build the reflective function and resilience they need to develop into healthy adults and perhaps parents some of them they may need ongoing psychotherapy and their carers may need some support. There are few appropriate services to step them down to.

One options for providing for these children includes increasing the capacity of child and youth mental health services that is, resourcing them to see more children and using the ETS system to support specific professional development in trauma and disrupted attachment and support the development of structures to improve collaborative interagency practice.

Disengaged youth

There is a subgroup of children typically

- involved with a dissocial peer group and with the justice system, due to offending behavior
- intermittently homeless or running away from residential care
- often using substances, particularly volatile substances.

They are group ETS and the therapeutic residential care sector struggle to engage and help. Evolve therapeutic services has success with adolescents in these circumstances when they are intensively supported by a strong cohesive stakeholder group and they have an alliance somewhere eg with a youth justice worker, we can work through to engage them in a support network and eventually with us. However, many of these children don't have that and it is not uncommon for our clinicians to spend a lot of time chasing them without engaging them or supporting a stakeholder team that has little influence and limited consistent contact with them. This isn't a good use of resources.
It is timely given the number of these children being referred to consider another model for this cohort. The Evolve Service might be more useful to these children if it were one of a in a wider continuum of options that might include

- identifying drug and alcohol issues and engaging them with services that have specific expertise
- Offering mental health consultation to their support systems, stabilising them and then offering more intensive therapeutic work when they can be engaged. Using flexible services such as a drop in centres staffed by youth workers to engage them
- considering options for detoxification programs
- offering further support within youth detention,
- Considering the use of secure therapeutic residential care facilities so that children can be contained and kept safe whilst therapeutic work continues.

It may be timely to develop a reference group to progress this exploration and there

would be significant interest from Faculty of Child and Adolescent Psychiatry in engaging in such a process.

Provision of continuity, across the therapeutic care sector.

Children in care face multiple transitions in life. Just as we advocate for them to avoid cumulative harms by promoting stability of placement, educational links and stable relationships with child protection workers it is best practice that they have continuity in therapeutic relationships and frameworks. We should be able to offer some continuity of approach about best practice care for these children and be able to communicate appropriately across the sector. Links between CYMHS, DSQ, Paediatrics, and the NGO sector and with Adult Mental Health and Drug and Alcohol services should be actively promoted and supported. This would ensure transitions are as well managed as possible and that people can have an expectation of some continuity of approach. We would recommend that this is informed by best practice in appropriate assessment and treatment of complex trauma and disrupted attachment and is developmentally informed. The professional development opportunities offered by ETS professional development staff and other clinicians have made significant inroads into supporting this continuity. Within districts there is a potential for appropriately funded Evolve Team Psychiatrists to engage in further liaison with other specialists to support this consistency. At a Statewide level an ETS Clinical Director could build these links.

Provision of continuity, across the wider child protection system: Child protection services, foster carer assessment recruitment and support, residential agencies, parenting capacity or social assessors, reunification services.

The child protection sector uses a broad range of services. The use of the NGO sector, multiple small providers and short-term contracts does not promote the development of a consistent sector wide approach. Training provided is not always consistently applied across the sector and training varies. ETS as a preferred training provider could support a consistency of approach across the whole sector

A Clinical Director and Program manager for the statewide services could provide advice and consistent links between ETS and other services to promote cohesion.

ETS could also offer advice what child protection services should be asking for in a parenting assessment or reunification process, how to evaluate what is offered. Experience to date is that the quality of theses services is very variable.

An expanded ETS appropriately resourced to do parenting assessments and reunification Work might promote an integrated approach to care and provide models of best practice.

Further work could also be done in proposing standards and in credentialing services.

2. Whether the current use of available resources across the child protection system is adequate and whether resources could be used more efficiently.

As previously discussed child protection funding: preventing harms occurring to children or supporting their recovery when harms have occurred is money well spent given the social costs of not doing so. Reparative care for children can be very expensive and there certainly exists significant unmet need, suggesting an inadequacy of resourcing.
However there are multiple potential efficiencies possible to improve the use of current resources.
They can be thought of under the following headings

A. Reducing the cost of cumulative harm
The impact of cumulative harm on children is such that their need for support and resources escalates when these harms occurs and thus there are significant resources wasted in the child protection system as a consequence of cumulative harm. We can reduce these harms and their subsequent costs by improving the consistency of care relationships offered to children, minimising unnecessary losses and transitions and avoiding re-traumatising them by appropriately assessing and supporting children and parents prior to and during contact arrangements and reunification processes.

B. Ensuring decisions are made on the basis of good individual case knowledge and expertise. We need to focus on developing expertise in Queensland in child protection and in the sequelae of abuse and neglect. Ensuring that we build expertise within our institutions and that where we outsource requests for expertise eg. in assessments of our children or parenting assessments the advice meets appropriate standards and is integrated in planning.

C. Avoiding duplication of services or lack of integration.
The following recommendations stem from these principles.

Recommendation one: that all children in care have a comprehensive assessment at entry, drawing on input from an interagency care team and relevant expertise and that care plans draw on these. This should put the individual needs of the child at the centre of the case plan. Where expertise is sought and advice not followed the rationale for this should be discussed in case planning.
Where there is no formal care team or specific need for expert consultation this might be a relatively informal process of the CSO contacting carer, school, paediatrician and other care providers for information and advice.
Rather than repeatedly assessing children it is advisable to do it well and ensure that the assessment is utilised in case planning. Unless there is a clear rationale for a second opinion or there are new factors to integrate, the practice of having multiple practitioners provide opinions on complex cases without providing them with the opportunity to thoroughly assess children or putting them in touch with treating practitioners should be avoided.
Where advice from professionals involved in the child's care is significantly at odds with decisions being made by child protection services then there may be a place for a formal

process for decisions to be reviewed by senior child protection staff or an independent body.

Recommendation two: that permanency planning is in place for all children and parallel planning available should the primary plan not be possible. This should reduce the cost of cumulative harm.

Recommendation three: that placements are assessed on the basis of their "goodness of fit" for a particular child. Sometimes the best available placement isn't ideal. In this case areas that are concerning are identified, supported and monitored in the case plan. That we improve the quality of assessment and support offered to placements and ensures it is consistent across the state. This principle is applicable to state care as well as returning children to parents
This means we have to have a clear idea of what is expected in a good parenting capacity assessment, foster carer assessment, reunification service, foster carers support service and develop best practice models for these tasks. The ETS service could have a role here in developing and providing best practice programs and or offering recommendations and training to other organisations in these areas.

Recommendation four: that all agencies involved with children in care work from a common framework:
This should integrate an understanding of

- the developmental needs of children
- the impact of trauma and disrupted attachment
- cumulative harm
- reparative care and consistency of relationships
- the importance of meeting children's need to know and develop their own narrative and cultural identity
- collaborative care
- the concept of felt safety in helping children recover.

There needs to be a continuity of approach promoted across the sector as described above. There are significant resources wasted because services come from different frames and take time to come to a consistency of approach. All services should be drawing on the model the current evidence base and best practice recommends.

Recommendation five: That services across the sector integrate regular professional development and reflective supervision into their models of service delivery. The former should ideally be provided by a preferred training provider and should be in keeping with the principles described in recommendation three.
ETS could provide training directly or consultancy to other training organisations. Extra resources would be needed and at least one statewide senior position to integrate the work of regional professional development co-ordinators. Well-trained and supported staff are better equipped to make appropriate decisions about the care needs of children and avoid wasting resources.

Recommendation six: that continuity of care is an abiding principle within the child protection system. In order to make this possible there needs to be a

culture supporting stability of workforce across and within organisations. Lack of continuity contributes to cumulative harm, deteriorations in children's health and wasted resources.

The use of NGOs on short-term contracts, using competitive tendering and a casual workforce makes provision of continuity difficult. A solution might be long-term contracts with NGOS or use of the Public Sector, avoiding turn over of organisations such as residentials, training programs, and therapeutic agencies. This gives them time to develop and consolidate their model of service, skill-base, interagency relationships and to foster long-term relationships with children. It avoids tendering processes that encourage services to underestimate the true cost of good care in order to achieve a successful tender.

Flexible funding models need considering. This would mean that even if a child moves carers they can if necessary retain contact with youth workers and carer support workers etc. who know them well. Flexible funding would also address the problem of duplication of services, when children are referred to two intensive services wrap around rather than one service, which is augmented by extra supports as, needed.

Within organisations workforce stability also needs prioritising. This should reduce the turn over of CSOs, Carers, Therapists, Youth Workers, Carer Support workers in a child's life. Factors important across all sectors in promoting stability include: appropriate working conditions and reasonable renumeration, adequate training, ongoing professional development and reflective supervision. For the child protection workforce this might involve reprofessionalisation of the sector, manageable case loads, meaningful involvement in children's direct casework, and the development of a cohort of senior staff with the experience and qualifications to provide support and supervision. The Senior Practitioner roles already in existence meet some of this need but are overstretched. The Australian Association of Social Work submission (Healy, 2012) provides a useful frame for further consideration of these needs.

Recommendation Seven: The development of a cohesive continuum of placement options for children is needed urgently. Children need to have placements available that can meet their needs. For some children this means highly resourced placements such as a therapeutic residential. For most children family based placements are the best choice but this isn't sustainable for all. Children need to be able to access intensive care in a timely way rather than experiencing multiple placement breakdowns. They should then transition to more traditional care as soon as they are ready to manage it. There needs to be some continuity of both relationships and model of care and the capacity to move children fairly flexibly between placement types depending on how well they cope.

- resource intensive placements may prevent children overwhelming less well resourced placements being exposed to multiple breakdowns and subsequent cumulative harm.
- Family based placements are preferable, especially for younger children, and no child should be placed lightly in residential care. However, some children's need and their confronting behaviors overwhelm family resources and they may receive more continuity of care, attunement and reparative experience from a small group of committed, well trained, therapeutically supported residential care workers. This provides a basis for them to start to recover and move onto a family based placement.

- There is a subgroup of children whose aggression; absconding or sexualised behavior makes them poor candidates for the current model of therapeutic residentials. They have until recently been managed in individual placements, in the hope of stabilising them and supporting their transition to less intensive placements. These placements have been defunded. Co-tenanting these children safely and creating environments in which they can heal is challenging. They will need highly skilled staff who are well supported. They will also need high staff: child ratios and appropriate physical environments. Creating these placements is a matter of some urgency as children are already being moved out of individual placements before an appropriate alternative model has been identified.
- Sadly as a consequence of the difficulty faced recruiting carers and the challenging care needs of some children we currently have a number of young children across the state in residential care. Our current models of care do not meet their needs. If attempts to recruit and intensively resource foster carers continue to fail temporary therapeutic residential care specifically for these children must be made available.

Recommendation Eight
That contact with parents is managed in such a way that children's functioning at school and in placements isn't compromised. This might involve parent's being supported with preparatory psychological education and skills training and with specialised supervision and support during contact. It should involve contact being suspended if the child isn't coping well, until such time as the child has enough resilience to manage the contact better and the parent has capacity to support them.
There is a subgroup of children whose contact with parents is unpredictable, unstable or frightening. This can be because the parent has an underlying probable, which causes them to behave erratically. In some circumstances the parent is functioning well but they have previously been involved in the child being seriously traumatised. The child is traumatically re-triggered by contact and this impacts on their recovery. Currently it can be difficult to change contact arrangements to ensure that they prioritise the psychological needs of the child. There is also a dearth of appropriate supports for children and parents to ensure that they have the best chance of contact being positive. Child Safety CSSOs tend to supervise contact. They do not have the necessary training to manage contacts for this subgroup of children. Resources are therefore wasted because the child's recovery is repeatedly derailed by poorly managed contacts. Training for CSSOs in supporting contact better would help but some families need trained mental health support to ensure this process is managed well.

Recommendation Nine
That we reunify children under conditions that are likely to succeed. This means appropriate assessment, preparation and ongoing support including:
a. appropriate parenting capacity assessments which identify areas of vulnerability for the reunification, plan to address these vulnerabilities and monitor progress before initiating reunification
b. parents are provided with education and support in understanding the needs of their child and meeting them
c. parents are supported with a process focused on repairing their relationship with their child and ensuring the child feels safe in their care. This felt safety being crucial to the

mental health of children who have been traumatised.
d. Reunification services have appropriate expertise in understanding the impact of trauma and disrupted attachment, in reparative parenting techniques and in assessing parental capacity to meet children's needs.
e. That reunification services are funded for long enough to ensure an appropriate assessment and preparation phase, a graduated transition to resuming parenting and a period post reunification to monitor progress and support the family in consolidating the gains they have made before the service withdraws.
When reunifications fail after children have been abused or neglected again, the harm done is difficult and costly to repair. We can't always predict these failures but we can assess thoroughly, address risks proactively, stage reunifications so that we can see how families are coping and appropriately resource them to give them the best chance.

Recommendation Ten
That we appropriately support and resource the parents of children with disabilities to care for them. Children with disabilities are more likely to end up in care either as a consequence of abuse and neglect related to the stress of caring for them or because parents relinquish care because they can access support no other way. Appropriate support might prevent these children entering the child protection system. An appropriately resourced disability sector might free up significant resources for child protection.

3.The adequacy of any government response and action taken by government to allegations of child sexual abuse in youth detention centres.

Our forensic colleagues, who we understand are providing their own submission, best address this question.

4.The transition of children through, and exiting the child protection system

Transitions need to be well planned and scaffolded and kept to a minimum. Transitions can cause harm and children should not be subjected to them without good reason. Most healthy eighteen year olds remain supported to some extent by caring adults; adolescence is drawn out process in modern society because of social and cultural drivers. Neurobiological evidence reinforces the functionality of this approach given that changes typical of adolescence continue until the early twenties. As previously described this reveals adolescence as a period of marked developmental change, a period of vulnerability but also of great potential for recovery.
Some children in care reach eighteen with significant social and emotional developmental delays as a consequence of their prejudicial histories and are less well equipped for independent living than their peers. Many of these children have significant problems in functioning but don't meet criteria for a diagnosis that would make funding available to them.
Thought needs to be given to providing ongoing support to young people post eighteen, supporting ongoing connection with carers they have built attachments to.

Recommendation One
That intensive planning for transition starts at sixteen and that funders make decisions about what resources and supports will be available at this stage so that meaningful transition planning can begin.

Recommendation Two
That rather than all resources and relationships withdrawing at eighteen we stagger this reduction of services until twenty. Child protection services might be able to continue in a quasi-parental support role.

Recommendation Three
Flexible funding is made available to ensure children can remain in long-term foster carer's homes or engaged with familiar residential workers until they are well established.

Recommendation Four
That resourcing is provided on need not diagnosis and that we appropriately assess adolescents with high needs at sixteen to identify areas they will need to develop independent living skills in or ongoing support with. Occupational therapy input would be helpful.

5. Any reforms to ensure that Queensland's child protection system achieves the best possible outcomes to protect children and support families

Recommendation One
That child protection is important enough to need it's own minister and director. That there be an expectation that the department should be staffed throughout it's hierarchy ideally by people who have experience and expertise in child protection or at least significant experience in working with children.

Further Recommendations
Other recommendations can be found elsewhere in this submission. Because of the focus on therapeutic intervention and because good care has been framed as important in considering efficient use of resources recommendations pertaining to both areas have already been made above.

6.Strategies to reduce the over-representation of Aboriginal and Torres Strait Islander children at all stages of the child protection system, particularly out-of-home care

Indigenous children

Aboriginal and Torres Strait Islander children are over-represented in child protection and out-of-home care services compared to other Australian children and have been since the first data collection in 1990 (Australian Institute of Health and Welfare [AIHW], 2011). According to published data for period between 1 July 2010 and 30 June 2011, for every 1000 Aboriginal and Torres Strait Island children in Australia, 34.6 had child protection records of substantiated harm or risk of harm from abuse or neglect. The number for other Australian children was 4.5 in 1000, which means that ATSI children are 7.5 times more likely than non-Indigenous children to be subject of substantiated reports of harm/risk of harm.

Aboriginal and Torres Strait Island children in out-of-home care in Queensland (2850) make up more than 33% of all children in out-of-home care (8572).

Reasons for this disproportion are complex. Essentially different child-rearing practices (cultural differences) are complicated by erosion of traditional cultural values of displaced Aboriginal people, legacy of past policies of forced removal and cultural assimilation of children, intergenerational effects of forced removals are further complicated by socio-cultural problems experienced by Indigenous families and communities (e.g. alcohol and drug abuse, gambling).

Proportion of ATSI children in the Evolve population differs from service to service, with the highest in the North and Far North Qld teams (reaching up to 50%).
These children, and especially the adolescents, are usually very difficult to engage with services. They are often in overcrowded placements (due to scarcity of ATSI foster carers), or placed with non-indigenous carers or in residential care, often at young age. They are likely to use alcohol, inhalants and other substances even at the age of 10 or 11. Many engage in criminal behaviours and then become incarcerated in Youth detention Centers, where some wish to remain, as the safety, containment and structure they experience in custody is lacking in their lives in the community.

Difficulty in engaging both, the children and the foster carers (who are often overworked and tired, therefore unavailable) means significant limitation to therapy. Due to extreme behaviours those children are more likely to be frequently suspended from school, which further complicates their already compromised academic progress as well as causing further disruption to placements.
Availability of culturally-appropriate carers and in particular specialised carers is extremely limited. Poor preparation of carers and youth workers for work with traumatised children is common and poses risks for both, the children and the carers.
Multiple placement break-downs experienced by this population of children are particularly traumatising.
Experience of geographical isolation with extremely limited access to support services is common for families of children in care can cause breakdown of contact between the family of origin and their child in care.

Good understanding of traditional child-rearing practices of Aboriginal and Torres Strait Island people is needed to facilitate development of appropriate support for indigenous families in caring for children at risk, especially when removal of a child (children) is likely and also when children are being reunited with their families. Prevention of trauma and neglect needs to be made more of a priority in indigenous communities with particularly high percentage of families at risk. Currently very limited supports for families are available, especially in remote locations.

Good understanding of traditional child-rearing practices, availability of supports for the biological families to promote connection with their removed children and support for children in maintaining contact with their families of origin and developing a cohort of potential foster carers who understand both, the developmental and the cultural needs of the children in care would greatly assist in reducing transgenerational transmission of trauma and preparing young people to become more aware parents themselves.

Recommendation one : That the underlying historical antecedents and social determinants of this overrepresentation be acknowledged and integrated into any response. Particularly important is the principle of self-determination and appropriate consultation with indigenous communities in considering solutions

- This dilemma has unfolded over generations and we need to have a long term view and consistent programs that are re-evaluated and adjusted.
- Consistency of care providers is important with organisations needing to stay in communities consistently for the long term to build trust and develop meaningful cultural competence..
- Community connectedness and well-being are necessary to parent effectively. The health of aboriginal communities and the connectedness of indigenous people to the wider community need to be considered. Wider issues such as self-determination, loss of country and culture, loss of identity, unemployment need to be remedied if we are to stem the tide of children being taken into child protection.
- There is some consensus across the relevant professional bodies; both the AASW submission (Healy, 2012) and The RANZCP Position Statement on the Stolen Generation (RANZCP, 2011) acknowledge that indigenous people need to be consulted and supported to generate and carry out projects to build community health and develop programs.

Recommendation Two
That we should identify and trial programs to support indigenous families, who are struggling with parenting, to successfully meet the needs of their children.

Recommendation Three
That we continue to attempt to identify, train and support indigenous foster carers, focusing on supporting them to provide sustainable care and avoiding straining them by placing large numbers of children in their care.

Recommendation Three
It is important to ensure that in an attempt to remedy historical injustices we

do not create another by leaving indigenous children in situations where they are being harmed. This could occur in an attempt to protect them from disconnection with their families, communities and culture. Children's need for safety and healthy protective attachments and their need for connectedness to family, culture and land both need honoring. There is a need for further research into the characteristics of healthy attachment and child rearing in different indigenous settings. Improving capacity for cultural assessment and consultation would help in ensuring this balance is appropriately assessed and culturally appropriate options fully considered.

- There is an important place for child centered, individualised cultural consultation to help us work together to evaluate individual needs of children. Cultural assessments done for individual children taking into account their specific cultural needs and supporting care teams to integrate these with their attachment and other needs are needed. Care Teams need cultural consultation that can support an understanding of the different ways in which healthy attachment manifests in the multiple different settings indigenous children live and find ways to promote it. This acknowledges that consistent attachments and protection from harm are universal needs for children though they may be offered differently in different cultural settings. This level of cultural consultation is not readily available. Resourcing limitations and role definition restrict the Recognised Entity in filling this role. Expansion of roles such as the indigenous program coordinators, found in some ETS teams, who do provide cultural assessment, might prove helpful.

- There should be exploration of avenues to support the training of indigenous mental health and child protection professionals and development of professional networks which can provide cultural consultation informed by training in the developmental needs of children, their attachment needs and the sequelae of trauma and the ways in which these may be influenced and shaped by cultural expectations and experiences.

7. legislative reforms

Recommendation One.
That Legislation support best practice principle of care and prioritise the best interest of the child. These principles including an understanding of

- the developmental needs of children
- the impact of trauma and disrupted attachment
- cumulative harm (including the need for permanency and parallel planning)
- reparative care and consistency of relationships
- the importance of meeting children's need to know and develop their own narrative and cultural identity
- collaborative care
- the concept of felt safety in helping children recover.

Recommendation Two
That parental responsibility for providing adequate care be enshrined in legislation and there is an expectation that parents who wish to retain or regain custody of children, where there are child protection concerns, are expected to illustrate capacity

to meet the child's needs.

For children who have particular needs for example as a consequence of their stage of development or as a consequence of prior neglect or trauma, parenting capacity should to be conceptualised as being capacity to meet that child's needs.

Child Safety care plans therefore need to be very specific, identify the specific needs of children and provide the parent with incremental opportunities to illustrate capacity. This needs to be incremental to avoid parents becoming overwhelmed or children being further exposed to risk. Appropriate supports need to be offered to parents to help them build capacity. However, the failure of the state to provide appropriate support should not be a rationale for orders being rejected. The best interest of the child, not fairness needs to be the guiding principle when issues of parental contact and custody are heard.

Recommendation Three:
That the developmental needs of children are taken into account.
There is some urgency in assessing the capacity of parents of infants and other very young children. These children have a window in which to develop attachments to primary carers. For this group parenting capacity assessments should be done early. This will allow the identification of that small group of parents whose capacity to care appropriately for their child is very unlikely to improve in time for their child even with intensive support. Children whose parents clearly do not have capacity or whose parents can't gain capacity even with intensive support should be provided with permanent alternative care.

Notification processes for vulnerable pregnant mothers were implemented following the CMC enquiry. The concept of removing children at birth is a painful and contentious one. Appropriate assessment and clear justification for such a potentially tragic intervention needs to be illustrated. However, there is a small group of parents whose functioning is so impaired and or whose history with previous children is so suggestive of significant ongoing risk to subsequent children that removal is justified.

Because children have time limited developmental windows court processes need to be timely.

Recommendation Four
That the children's court system and other courts where children's cases are likely to be heard, are acculturated with an expectation that the best needs of the child are prioritised.
That magistrates are supported to have a sophisticated understanding of what this means and what best practice care of traumatised children involves.

This would involve training and ongoing professional development. Evolve Therapeutic Services could provide this and because ETS professional development co-ordinators are linked to therapeutic teams and psychiatrists, they are well placed to align training with current psychiatric thinking and therapeutic directions.

8. Any reforms to improve the current oversight, monitoring and complaints mechanisms of the child protection system.

In the absence of specific expertise or experience in this area comment is reserved except to note that it is vital that children who have been abused feel that adults are listening to them and able to keep them safe. Accessible monitoring and complaints mechanisms for children and their advocates are very important. It is also important that the approach of these agencies is transparent and solution focused, not punitive. The systems around children in care can be vulnerable to a culture of blame, which can make it difficult for those involved to be open and transparent in looking for solutions. A punitive culture can also be fatiguing for those who work in it, and promote burn out.

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