Paul O'Halloran MP
Chair
Parliamentary Select Committee on Child Protection

26.11.2010

Dear Sir,

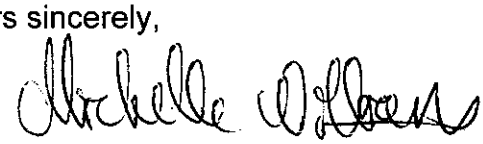
Parliamentary Select Committee on Child Protection

Thank you for the extension for submission to the Committee and the opportunity to make comment on our experience of Tasmania's child protection system.

We understand that there is a whole of government response to the Committee. None of the authors of this submission were asked for comment through the Departmental process. Our interest was raised in response to an advertisement of the Committee's terms of reference in The Mercury newspaper. The authors of this submission are a group of current practitioners in health with extensive experience and expertise in the detection and management of children who are at risk. We have a strong professional interest in the inquiry being undertaken. We have therefore made a decision to represent our concerns and some recommendations for improvement as individuals with expertise, interest and commitment to the protection and management of children at risk in Tasmania.

We have limited our responses to three of the terms of reference, sections (a), (b) and (d) those areas that we consider we have considerable knowledge and experience to contribute.

Yours sincerely,



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To enquire into and report upon the adequacy of Tasmania's child protection systems, including:

(a) *early identification, intervention and prevention strategies currently in place within all relevant agencies including the Department of Health and Human Services (including Family Support and Child Protection Services),the Office of the Commissioner for Children, Department of Education, Department of Justice, Tasmania Police and the non-government sector including Gateway service providers and including comparison with child protection regimes in other Australian jurisdictions*

Recommendations:

- **Need for improved capacity across health and education services to identify children at risk, particularly infants.**

- **Provision of more residential and therapeutic options for children under 18 years and those needing intensive support (eg post hospital discharge, home not safe; teenagers with attachment disorder and complex trauma).**

- **Consideration of the needs of young people who have been wards of the State and who have very limited support options when leaving care. These young people are over represented in hospital Emergency Departments presenting as homeless or with complex mental health and social issues, over representation in the prison system and within adult mental health services.**

Perinatal distress and depression affects 14% of women, producing long and short term consequences for parenting and families. Measures for early detection are important and non-identification of these mothers may exacerbate difficulties. (MJA 2002: 177: S101-105). Identification of highly at risk unborn babies for example a Perinatal Mental Health initiative is an important early intervention and prevention strategy. The senior clinician authors of this submission are supportive of upgrading of staffing and training of child and family health nurses; key front line staff who have daily contact with under 5 year olds in the community.

Other best practice initiatives world wide include:

- Early childhood nurse training to identify at risk infants and attachment disturbance.
- Nurse home visiting programmes to support and monitor at risk infants and their mothers.
- Early childhood nurses acting as care co- coordinators for highly at risk mother-baby dyads (model proposed by Prof. Dorothy Scott, Australian Centre for Child Protection, University of South Australia).
- Enhancing the capacity of community based services to refer to specialist intervention (eg: Child and Adolescent Mental Health Service, Child and Family Services) depending on level of risk to infant.

When high risk families and children at risk have come to the attention of health and child protection services, the senior clinicians group promote a system of child protection practice that recognises research in attachment theory and attachment therapy. This is particularly the case when considering both removal and reunification of children and families. Unfortunately, the experience of these clinicians indicates that this is not universally the case with Child Protection Services (CPS) at present. Decisions to remove at risk infants from their mother and place the infant with alternative carers need to be taken within a framework of understanding attachment and bonding. The first two years of life is a critical period of development of attachment patterns in order to avoid long term mental health and relationship problems In order to identify problem situations early and avoid repeated failed reunifications, a detailed, multidisciplinary assessment of parenting capacity is required. Such assessments assist in identifying and understanding those characteristics in a parent which predict a lack of response to intervention and continued high risk environment for infants and young children. These assessments are not universally available for CPS.

Lack of residential options and alternative care results in a failure to act appropriately for children at risk. It is the experience of these senior clinicians that on numerous occasions, young vulnerable children (10+) are not being offered an opportunity for a safer environment upon discharge from hospital. There are inadequate staff resources and inadequate supportive and therapeutic placement options, especially for young people (aged10+) who are apparently considered to be able to "self protect". Self protection and lack of alternatives are quoted as reasons for powerlessness of CPS to intervene to protect older children. Lack of resources should not by any standard be confused with the assessed needs of any child. The ethos of CPS and non-government organisations is that a hospital is a place of safety for children and young people. Whilst this may be true, hospitals are not an alternative accommodation facilities. Currently, a lack of resources impacts as a lack of action with regard to children at risk on acute care wards. A step down therapeutic supportive placement such as offered to adults (Richmond Fellowship model) would allow therapeutic support to young vulnerable people and afford them the opportunity to develop their potential.

Hospital clinicians have a particular investment in the management of alerts for babies deemed to be at high risk prior to birth (unborn alerts or UBA) and the CPS response to acting on information about these infants. It is a positive step that the unborn child is recognised as an identity for notification. This group however, is only one at risk group amongst under 5's. Evaluation, open analysis and auditing capacity for children subject to a UBA has not been integrated in to the CPS system and therefore there is little evidence to show that this provides an effective intervention over time.

(b) mechanisms currently in place and where improvements can be made to enhance the integration between all relevant agencies to ensure that the welfare of any identified child at risk is paramount and that all agencies work together to provide best practice care and service delivery

Recommend:

- **Requirement for all agencies to collaborate and enhance interagency cooperation to protect vulnerable children.**

- **Apply levels of staff qualifications, experience and ongoing professional development in recruitment to specialist child protection practice. Mandatory minimum training standards for Gateway and alliance services staff.**

- **Whole of government protocols across Tasmania, in particular the south of the State, which document minimum assessment and management procedures for child protection. Variability exists between the defined geographical areas in the south of the State, including response by CPS in the south east and south west.**

- **Improved liaison between child protection services, health, education and police.**

Best practice in managing children at risk promotes an environment of collaboration, coordination and communication to protect vulnerable children. It is the experience of clinicians in health that there is variability amongst qualified and experienced CPS workers to analyse information given to them by clinical staff. Examples include detailed reports tendered by suitably qualified specialist clinicians (including Child and Adolescent Psychiatrists and Consultant Paediatricians) being referred for opinion by another specialist. The same expert clinicians have experienced situations where child protection notifications made by them are queried by CPS intake workers. Querying the validity of a child specialist notifying to the Child Protection Service, indicates a lack of experience and awareness of the knowledge and skills of specialist medical staff and does little to enhance a culture of collaboration and partnership to protect vulnerable children. It is the recommendation of this group of experienced clinicians that there is a memorandum of understanding between CPS, Child and Adolescent Mental Health Service (CAMHS) and hospital based women's and children's services to ensure effective working relationships between agencies. It is our recommendation that identified senior health staff should be nominated as *expert* or *nominated referrers* to CPS. In order to avoid a delayed response for children at risk, expert notifications should be considered a priority, alerted to equally senior workers

within CPS, discussed between agencies as a matter of urgency and responded to as appropriate.

Senior clinicians in health and mental health have concern regarding potential loss of control of quality of service provision for families in need due to use of non-government organisations through Gateway and alliance. Referred families are being monitored by staff of unknown professional qualifications and training with no clear pathway for feedback to other agencies, supervision, support and accountability for these cases and workers. The Gateway initiative is positive in that there is a link with community based support for low risk cases. Concerned clinicians would like to see an external, open analysis built in to the system to indicate that this initiative works and that Gateway are in fact managing families who are clearly within the low risk referral criteria. Gateway must ensure that there are mechanisms in place for ongoing risk assessment, escalating concerns and intervening if the child's situation deteriorates. It is the experience of these clinicians that these mechanisms, if present, are not being utilised appropriately.

Of ongoing concern is the variability in practice across the south east (SE) and south west (SW) geographical areas of Hobart. It is the experience of this group of clinicians that SE utilises a more collaborative model with good liaison between agencies (police, hospital medical services etc). This recent improvement in communication has resulted in a greater level of understanding of impact and issues of risk and actual harm to children. The SW is seen to be far more fragmented in practice, with poor communication between CPS for the area and external stakeholders resulting in poorer outcomes for young people and their families.

There is major concern about internal decision making within CPS and lack of external consultation about children at risk. There is no formal system (as far as we are aware) to involve external experts to assist in decision making of the Court Action Advisory Group (CAAG). Despite this, the CAAG for SE has demonstrated a much more collaborative approach in this regard which has the obvious benefit of mutual information sharing and cooperative decision making for children at risk. A senior staff representative from women's and children's services in health regularly attends the SE CAAG by invitation. This is considered a most appropriate and useful initiative by both agencies. No such relationship exists with the SW. This group of experienced clinicians would like to see participation of relevant agencies and contribution to decision making in such meetings formalised.
Long discussed amongst this group of clinicians are the obvious and tangible benefits that an external panel of experts would provide for CPS. The expert panel's role would be to contribute to decision making on difficult cases, advise on intervention options, advise on evidence for submissions to Court and to provide a resource to support or replace the current CAAG system. Such a model has the potential to be very supportive of CPS workers, improve accountability in decision making and ideally provide access to resources for cases requiring specialist assessment or intervention. Similar frameworks existed prior to the 1997 Act and currently exist within mental health services, juvenile justice systems and child protection practice

worldwide. Best practice indicates that this type of collaboration supports the protection and assessment of children in need.

In response to the recommendation of the Report on Child Protection Services in Tasmania (2006)[1] the Department of Health and Human Services established a southern hospital Child Protection Liaison position (CPLO) in July 2007. This role has been met with some success in improving communication between agencies. This group of clinicians would like to see an upgrading of the CPLO role, allowing the incumbent CPS worker to act as a consultant, be allocated complex cases, and undertake CPS case work for hospital patients. Alternatively, co-located child protection workers who are based at the hospital and attend CPS meetings, undertaking their assessments and being part of the treating team where required, would be seen as a beneficial initiative to increase collaboration and protect children. This group of clinicians would also support upgraded CPLO positions being based with the Education Department in schools, another critical area where communication between agencies could be improved.

(d) other long term contributors to child abuse and neglect, such as poverty, drug and alcohol misuse and mental health issues

Recommendation:

- **Appropriate mandatory child protection qualifications to include social work qualifications for CPS staff.**
- **That alcohol and drug services and adolescent mental health services are adequately resourced and available state-wide.**
- **That CPS workers have increased powers for assessment of parents of children involved with CPS where alcohol, drug and mental health issues are impacting on the child's care.**

Tasmanian demographics predict that rates of child abuse and neglect will be higher than other states due to large proportion of children living in families experiencing social exclusion (higher than any state outside of indigenous populations). Social exclusion, poverty, drug and alcohol misuse also correlate with higher rates of physical and mental illnesses. Resourcing of child protection, health, mental health and drug and alcohol services needs to be matched to this demographic data.

Despite the Tasmanian Government response to recommendations in the Commissioner for Children's Report, October 2010, CPS workers are not necessarily qualified social workers. A range of qualifications exist amongst CPS workers, including some with specific qualifications including social work and psychology. Some workers have basic undergraduate degrees and other CPS workers do not have relevant tertiary qualifications at all. This group of

[1] Jacob, A and Fanning D, *Report on Child Protection Services within Tasmania*, Department of Health and Human Services, October, 2006.

clinicians includes social workers experienced in the management of children at risk and promotes the recruitment of experienced and qualified social workers at CPS with mandatory entry qualifications. This group would argue that child protection practice requires advanced/specialist training beyond basic undergraduate social work training and opportunities for further education and research should be actively promoted within health and CPS.

As a community we need to recognise that alcohol and drug problems frequently occur before the age of 18 years. Services for drug and alcohol are patchy and difficult to access particularly for adolescents.
It is worth noting that there are no inpatient detoxification facilities for under 18's in the State. Outpatient drug and alcohol services rely on voluntary engagement by the young person. This is problematic for many adolescents at risk who may be attempting to make life changing decisions without strong or effective family support. There are no inpatient adolescent mental health beds in this State, which leads to admission to general paediatric wards or inappropriate admission to adult psychiatric wards placing young people at further risk. Poor access to mental health care increases the risk posed to many young people in vulnerable situations.

CPS rarely considers they have the power to seek mental health, drug and alcohol or parenting assessment for parents of at risk children. Parental drug, alcohol or mental health issues are often of paramount importance in determining the safety of a child and assessments of parents where concerns have been raised is essential in determining safe placement options for children at risk. CPS workers should be able to mandate mental health, drug and alcohol or parenting assessments when a child is under an assessment order. CPS staff must have access to appropriately trained specialist staff to perform these complex assessments. Again, the existence of an expert review panel at CPS would facilitate objectively determining which families would require such assessments.

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