Submission to the Queensland Child Protection Commission of Inquiry

Child protection system and processes

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ACT for Kids is a charity providing therapy and services to prevent and treat child abuse and neglect across Queensland. Established in 1988 as The Abused Child Trust, we have worked in child protection for almost 25 years offering both government and philanthropically funded programs. We work across the whole child protection continuum, from primary services in education and advocacy, to secondary early intervention and family support services, through to intensive therapy for children who have experienced trauma from abuse and neglect.

ACT for Kids has observed and been part of significant changes in Queensland's child protection sector and we welcome the opportunity to provide input and help shape the sector to deliver better outcomes for Queensland's children and families.

This submission offers a number of recommendations to ensure the child protection system is effective in safeguarding children and young people and responding to risks of harm (in response to Inquiry Terms of Reference item 3c). These include that:

- referral pathways for early intervention services need to be opened to remove barriers to support and eliminate unnecessary notifications to the department by people trying to access help
- service footprints are expanded to meet the need for both secondary and tertiary services to reduce geographic disadvantage
- mandatory reporting be expanded to include all professional roles working with children and training provided to those workers so they understand and are equipped for the responsibility
- staff recruitment, retention and training and qualifications be reviewed and a practical strategy implemented to ensure the best practitioners are working and supported on the front line
- the Queensland Government and child protection sector push harder for progress on the national framework.

ACT for Kids has also prepared separate submissions focussing on the critical need for investment in early intervention and issues in remote Indigenous communities that hamper families and the child protection sector. These topics and recommendations are not included in this submission.

Removing barriers

A combination of restricted access to services and misunderstanding about child protection, the department's role and the options available to families has created a system overburdened with unnecessary notifications and a community unable to support its most vulnerable. Our recommendations for early intervention are detailed in a separate submission; however the need to open referral pathways beyond Child Safety Services and expand service footprints also applies to tertiary services.

ACT for Kids' Intensive Therapy Service in Brisbane and Townsville provides multidisciplinary therapy to children who have experienced trauma from abuse and neglect. Their developmental delays mean they are at risk of misdiagnosis (often for autism or ADHD) and may not receive appropriate treatment and support. Figure 1 indicates the types of developmental problems children referred to these services have. Our assessments also show that children have more than one impairment.

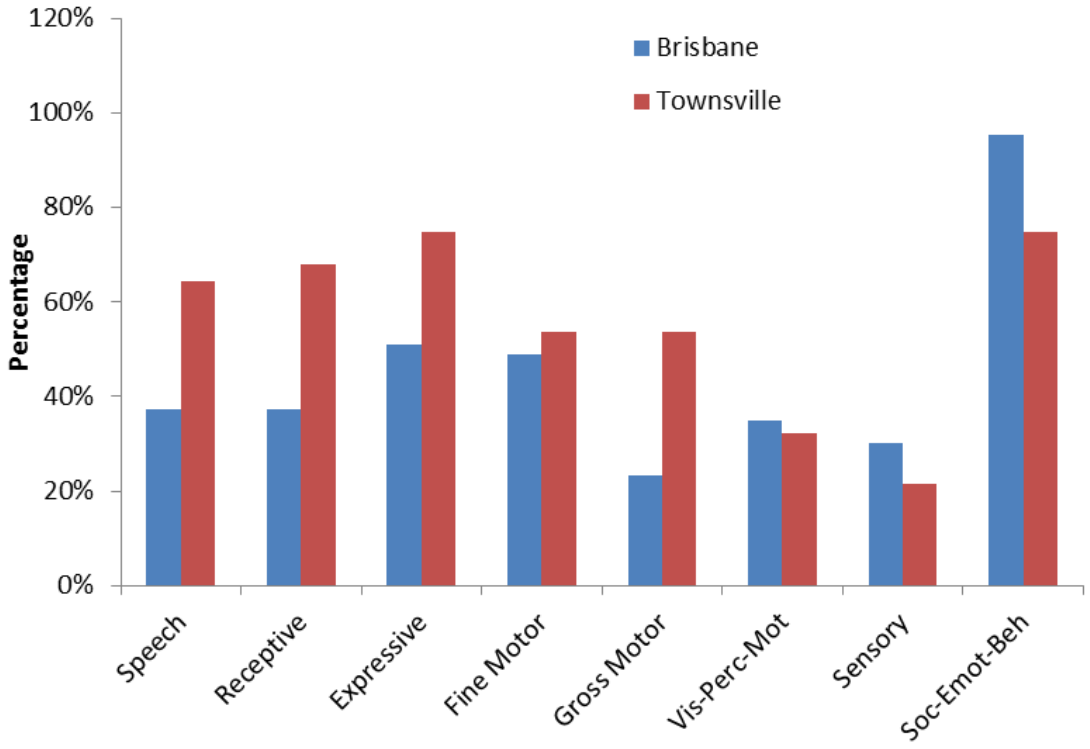

Figure 1. *The types of developmental delays children referred to the Intensive Therapy Services suffer. Numbers do not add to 100% as almost all children have more than one delay and multiple delays are common, for example speech impairments are often coupled with expressive and receptive language impairments and every child suffered social, emotional and behavioural impairments(n=71).*

Our team of psychologists, speech therapists, occupational therapists and early education specialists work together to ensure children are supported to overcome their experiences and have the best chance of a happy, productive future. These services are intensive but without them many children fail to flourish through no fault of their own (see case studies A and D).

The need for this support outweighs supply and the evidence is that they are effective for children who have suffered multiple developmental impacts through trauma from abuse and neglect. Figure 2 indicates the percentage of the children whose delays are depicted in Figure 1 improved across different developmental areas after working for with our therapists for a year.

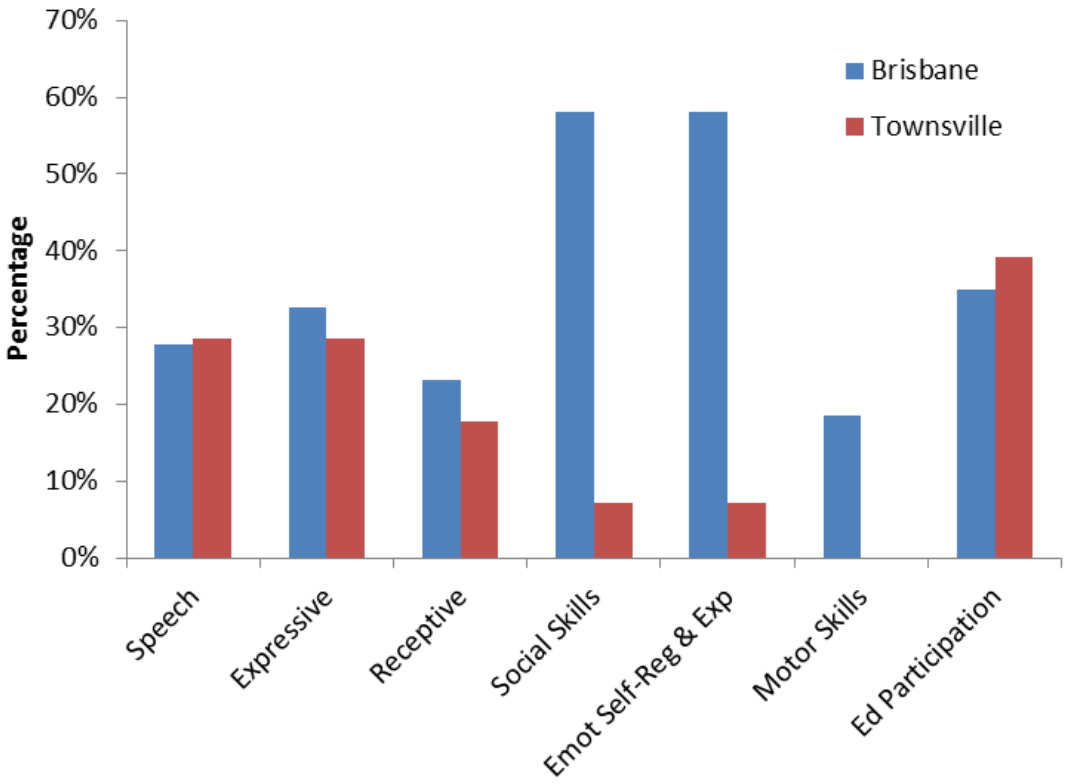

Figure 2. *Improvements made by children receiving services from the Intensive Therapy Programs. Children made improvements in more than one area, thus percentages do not add to 100 (n=71). Children in Brisbane improved across all areas and all children had significantly improved participation in their various education programs.*

Our Townsville multidisciplinary team significantly improved the lives of the children they worked with. Figure 3 shows ratings of children's functioning across a range of areas made by 85 parents and carers using the Strengths and Difficulties Scale – Parent Version. The carers reported noticeable improvements in their children's behaviour, hyperactivity, emotions, coping and social skills after working with our multidisclipinary team. Scores on the scales should reduce if improvements have been made, except for the prosocial skills score, which should increase. The total score reflects overall functioning and should reduce if positive improvements have been made.

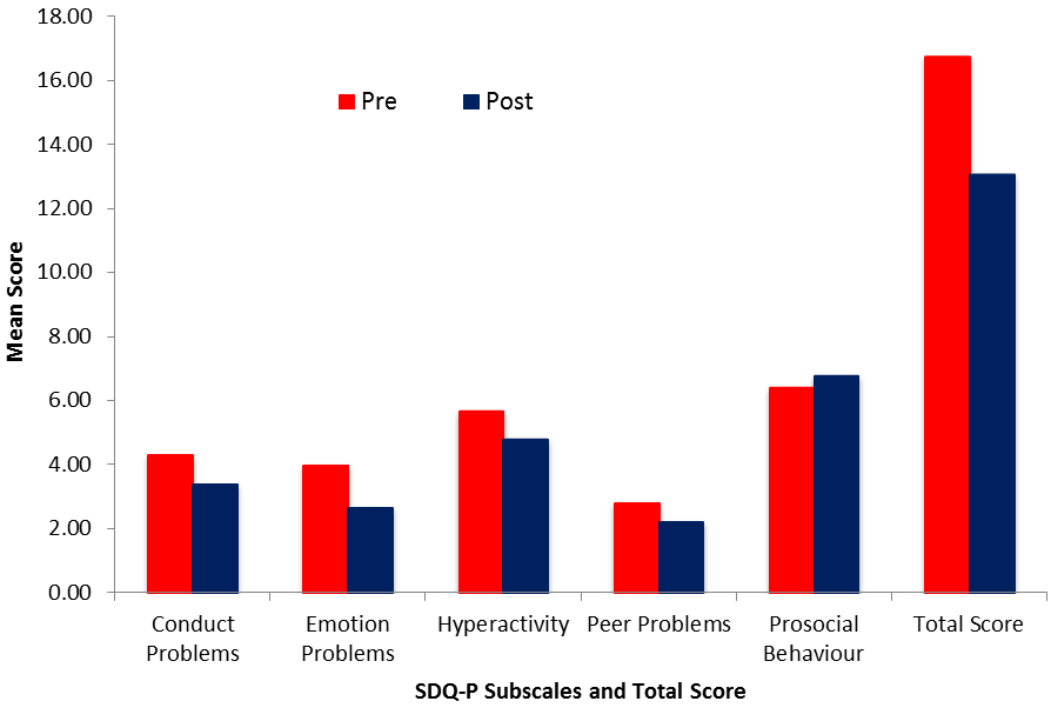

Figure 3. *Pre and post engagement scores on the Strengths and Difficulties Questionnaire – Parent Version for children referred to ACT for Kids Townsville Intensive Therapy Program (n=85). Results indicate statistically significant improvements for conduct problems, emotion problems, hyperactivity, peer problems and the total score.*

Given the evidence of the effectiveness of both secondary and tertiary services for assisting children we believe that:

- increasing the capacity and availability (both geographic and options for referrals) of secondary and tertiary services, based on service providers' identified gaps, would reduce the long term economic burden of child abuse and neglect on governments and communities and acknowledge that not all children effected by abuse are captured by the child protection system – why should they continue to suffer?
- once these barriers to support are reduced the community needs to be informed about what services are available and how to access them.

In addition, informing people about the role of the department, and that it is no longer a gatekeeper to support services, will greatly reduce unnecessary notifications from people desperate to access support, and the subsequent cost of investigations and processing for Child Safety Services. The availability and readiness of support will remove the fear of asking for help and empower families and communities to protect their children and young people.

Mandatory reporting

Every child and young person has the right to a life that is free from abuse and neglect, or risk of harm. The measure of a society is how well it protects its most vulnerable members. Anyone who suspects child abuse or neglect has a moral responsibility to report it, whether they are mandated to or not. However this only happens in an empowered, informed and caring community; mandatory reporting is a necessary rule to reduce risks to children's safety and wellbeing going unaddressed.

Mandatory reporting requirements differ in every state and territory. In Queensland, doctors, nurses, statutory child protection officers, residential facilities staff and police are mandated to report if a child has been harmed, or they believe is at risk of harm, to the Department of Communities, Child Safety and Disability Services. Teachers and non-teaching education staff are required to report suspicions of child sexual abuse by a school employee to the principal who must report it to the department and police.

This is not enough. There are many roles that have close and regular contact with children and young people; often they are better placed to notice ongoing problems or changes in behaviour than the professionals currently mandated to report concerns. Recommendations:

- Mandatory reporting should be expanded to include any role working with children, including but not limited to child care and allied health. Teachers' reporting should be expanded to include all forms of child abuse and neglect.
- Everyone in roles captured by mandatory reporting laws should receive thorough training and education covering, at a minimum:
    - their responsibilities
    - what constitutes child abuse and neglect and should be reported
    - what constitutes issues that a family should be offered help with through appropriate referrals to secondary services
    - how to report their suspicions
    - how the child protection system works
    - the levels of anonymity and protection afforded to them when reporting.

Best people doing challenging work

It is well known across the sector that Child Safety Officers are overwhelmed and under resourced. The symptoms are obvious through slow response times, inadequate investigations in some cases, slow referrals and staff burnout and turnover. It's challenging work and despite previous inquiry recommendations and trialled strategies, recruitment and retention of well qualified and expert staff is still an issue (see case study E).

There are some skills shortages and limited talent pools across the sector, particularly for qualified Indigenous community service workers. The reasons include a lack of encouragement and engagement into tertiary study for Indigenous people, and lack of practical support to see them gain relevant employment. Our Indigenous Workforce Strategy cadetship program in Cairns was created to address our own need for talent in the region. Since 2009 we have helped more than 40 cadets graduate with a Cert III or Cert IV in Community Services Work and practical experience through various community service agencies.

ACT for Kids has also partnered with James Cook University in Townsville to develop coursework specifically on child abuse and neglect and to provide student placements within our North Queensland programs to ensure that graduates are learning current best practice and are better equipped for this specialist work. These are just our own examples of what can be done at a grassroots level to improve the quality of education and training available to build the child protection work force, though there is more to be done.

- Retention of skilled Child Safety Officers is critical to ensure stability and case plan progress for children and young people.
- University and TAFE courses need to be informed by current best practice and provide practical skills to ensure graduates are well equipped to work in child protection.
- CSO training and professional development should include attachment, child development and trauma informed practice and assessment.
- The government and child protection sector as a whole need to work on attracting Indigenous staff. Creative and supportive approaches to formal training and qualifications will greatly increase the talent pool.
- Child Safety Officers working in communities with high Indigenous populations must have appropriate cultural training and wherever possible, experience working in community.
- Learn from others – Prof Eileen Munro has done extensive research into what is required to build and maintain a truly effective child protection workforce, many of those recommendations apply to Queensland.

National framework

Child abuse and neglect does not discriminate by state or territory, all Australian children deserve equal care and protection; however there is currently no overarching federal legislation covering child protection. Each state and territory has their own child protection legislation and governing body. In 2009 the Council of Australian Governments (COAG) endorsed the *National Framework for Protecting Australia's Children 2009–2020*, demonstrating their commitment to achieving a substantial, sustained reduction in child abuse and neglect in Australia. The framework recognises that protecting children is a shared responsibility and emphasises the importance of early prevention and intervention programs.

Despite this, different definitions and measures are still used in practice and for reporting across state jurisdictions, so comparisons and national figures compare apples with oranges. Differences in mandatory reporting laws also exist and there is inconsistent practice and frequent miscommunication. It is easy for children to get lost in the system across borders. Recommendations:

- National coordination and cooperation is needed to ensure knowledge and best practice are shared and to raise the standards consistently to the highest achieving strategies and programs across the country.
- A cohesive national research focus on child abuse and neglect and a national incidence study will provide a real picture of the issue and what is working across Australia.
- The Queensland Government needs to use the momentum, knowledge and recommendations from this inquiry to exercise influence to push for faster action and more progress in establishing consistent child protection legislation, practice, monitoring and reporting.
- National practice development and reporting must focus on outcomes for children and families – short and long term – not just outputs.

Case study A for the QCPCI

1. **What are the key issues this example covers?**

- Effectiveness of case management model and multidisciplinary therapy

2. **Describe the child/young person/family characteristics and particular needs or issues.**

- Young indigenous male referred to ACT for Kids in 2010, aged five years. At the time of referral he was in the long term care of the then Department of Communities, Child Safety Services, due to past experiences of harm, neglect and trauma.
- He was placed in a stable and supportive foster care family with his older biological brother, and has resided in this placement since approximately 18 months of age.
- The initial referral noted behavioural difficulties including aggression, hyperactivity and inattention, and significant developmental delays in speech and language.
- Ongoing concerns raised by carers and teacher included sensory difficulties, excessive and restrictive preoccupations, inflexible adherence to routines, bilateral integration difficulties, visual-motor integration difficulties, a lack of awareness and understanding of reciprocal social interactions, and extreme dissociative type symptomology resulting in unconscious states for significant periods of time.
- He was previously diagnosed with Microencephaly, Foetal Alcohol Syndrome (FAS) and Attention-Deficit/Hyperactivity Disorder (ADHD), for which he is medicated.

3. **Who are the main parties involved in the case?**

- Department of Communities, Child Safety Services
- ACT for Kids
- Foster carers
- School

4. **What happened?**

- At the time of referral he was primarily non-verbal, would display emotional and behavioural outbursts, allow only limited parallel play to occur, was isolated in terms of age related peers, was experiencing significant sleep disturbances, exhibiting notable anxieties and difficulties coping with unexpected changes, was extremely sensitive to touch, was experiencing episodes of unconsciousness related to dissociation, as well as difficulties with balance, coordination and motor skills.
- His treatment required an ecological approach including scaffolding of multidisciplinary support to target his complex needs. We used extensive trauma-informed assessments and multidisciplinary therapy from an occupational therapist, speech and language pathologist, educational support teacher, senior psychologist and support from the

team's Health Nurse.

- Under this case management model, he was also referred to a treating paediatrician to undergo an Electroencephalography exam (EEG) to investigate possible health concerns.
- He is now seven years old and has been receiving long-term multidisciplinary support since the time of the initial referral. Regular reviews indicate notable progress in multiple areas including a significant increase in language and reciprocal communication skills, improvements in sleep, reduction in anxiety, sensitisation to touch, ability to engage in imaginative and interactive play, increased inclusion with same aged peers, increased ability to cope with unexpected changes, age appropriate balance, coordination and motor skills, and no further episodes of extreme dissociation.
- Support and consultation for both the carers and school were also provided. The stability and security of attachment that carers were willing and able to provide, in conjunction with the willingness of the school to modify curriculum and teaching approaches to assist in the integration of this young person, have also been significant determining factors in the young persons progress and expected long-term prognosis.

Case study D for the QCPCI

Formerly known as Abused Child Trust

1. **What are the key issues this example covers?**

- Collaborative service delivery – education, carers, child safety, multidisciplinary intervention
- Access to education and health services – utilising a trauma informed approach

2. **Describe the child/young person/family characteristics and particular needs or issues.**

- Grade three school boy, referred to ACT for Kids by Child Safety Services after being removed from the care of his mother in 2009.
- He was considered to have experienced physical harm, neglect and risk of emotional and sexual harm.
- When entering foster care he didn't speak to adults, although he openly communicated with children.
- He had not attended school or early education until entering foster care at 6.5 years of age.
- He was also displaying some problematic sexual behaviours that placed other children and animals at risk of harm.
- In his favour, he has had one stable placement since first entering foster care, consistent school engagement and supportive teachers.

3. **Who are the main parties involved in the case?**

- ACT for Kids
- Child Safety Services
- Carers
- School
- Paediatrician
- Occupational therapist
- Teacher
- Speech language therapist

4. **What happened?**

- He started work with ACT for Kids' Speech and Language Pathologist, Occupational Therapist, and Educational Support Teacher.
- After these early therapies, he has engaged with ACT for Kids Sexual Abuse Counselling Service Psychologist since February 2011 with a total of 30 individual sessions.
- Sessions generally occurred at the school on a weekly basis. Focus of psychological therapy included protective behaviour education (feelings recognition, ok/not ok touches, and private parts), emotion regulation development including anger and anxiety management, and social skills development.
- Trauma and behavioural assessments were completed initially to guide treatment. A cognitive assessment (WISC-IV) was also completed in 2012 to assess his general cognitive

abilities to better inform treatment and recommendations for his needs. A complete psychological report resulted from this assessment that included his previous multidisciplinary assessment results (speech, occupational therapy, education).

- Regular reviews and support were also provided to his classroom teachers and his carer including education on protective behaviours, trauma symptoms, anxiety and anger management, problem solving behavioural difficulties, and self-care.
- Some improvements in his behavioural and emotional wellbeing have been noted, but there have continued to be ongoing difficulties in his day to day functioning. He has demonstrated diverse improvements in his wellbeing in the last 12 months, as reported by his teachers and carer, and observed by all his therapists at ACT for Kids. Specifically, he now displays a greater range of emotions, uses greater speech content and spontaneous speech, he can ask questions and can inform others how he is feeling, minimal problematic sexual behaviours in times of stress, reduction in nightmares, and reduced humming.
- While he has demonstrated good knowledge and retention of protective behaviour information and social skills expectations, he continues to have observed and reported difficulties in the application of this knowledge. For instance, he is observed to provide limited social interaction or reciprocity with others without prompting, is reported to get distracted in class with limited learning or completion of tasks at times, has ongoing difficulty with emotion regulation, and high sensory seeking behaviours. In addition, high levels of supervision are still required for him in home and in public.
- Early on in treatment his wellbeing was influenced by contact visits with his mother, which when occurring frequently and consistently would result in some improved behaviours, but more often were inconsistent and resulted in behavioural disruptions or regression. However, he has not had any contact with his mother in several months since her whereabouts became unknown; it is difficult to determine how or if this continues to impact his day to day functioning.
- He presents with a complex array of needs and it is likely that his progress will be gradual and involve ongoing attention in all the above areas. We have made some progress in reducing small aspects of his trauma responses and sexualised behaviours, as well as some improvements in his educational and social skill development.
- We have stopped work with him for now. Future therapy will likely be needed, but in light of the intervention provided to him over the last two years we recommend it's likely to be staged rather than ongoing and continuous.

1. What are the critical factors that contributed to the positive processes or outcomes?

- Length of the intervention – over two years, staged with different disciplines working together.
- Effective partnership with Child Safety Services.
- Taking a trauma informed approach to assessment and support for this young person's significant challenges.

Case study E for the QCPCI

1. **What are the key issues this example covers?**

- Effects of multiple changes of Child Safety Officers – need for retention of skilled CSOs

2. **Describe the child/young person/family characteristics and particular needs or issues.**

- Two children aged six and seven in foster care, removed on account of history of domestic violence, parental mental health/substance misuse, waiting for decisions to be made regarding permanency planning/reunification to either Mum or Dad.

3. **Who are the main parties involved in the case?**

- Department of Communities, Child Safety and Disability Services
- ACT for Kids
- Education Qld
- Uniting Care Community Foster and Kinship Care

4. **What happened?**

- This family/case was managed by four Child Safety Officers (CSO) and three Team leaders in 12 months, all with varying skills and approaches with parents and children.
- Parents have a sense of professional revolving door, "starting again", fear that information/progress will be lost in the CSO change.
- Children confused about the role of the CSO, reliability and trust.
- The current CSO was reluctant to engage with parents due to verbal abuse/case load fatigue and skills gaps (she is a 24 year old female, new graduate, and lacks skill and experience engaging with male client who intimidates).
- ACT for Kids therapist acting out of role by mediating the CSO/family relationship. Therapy became a secure base for the children.
- Parents required longer term therapy and practical parenting support and assistance.
- Constraints to gain access to long term therapy and receive specialist/ trauma informed practical parenting service.

5. **What are the critical factors that contributed to the poor processes or outcomes?**

- The CSO endings/handovers of the case were not conducted in transparent or constructive ways. The children/parents were informed by the CSO of departure at late notice; thus not giving time to discuss/plan with parents/children handover of information with in-coming CSO.

- The family would experience a gap in service from Child Safety, waiting for re-allocation of the case and would be unsure what information had been shared as the handover had been done behind closed doors.
- The new CSO would not address family experience of history or CSOs and worked with the Case Plan without establishing a working relationship with family.
- The cycle would be repeated.