UnitingCare Community Submission Queensland Child Protection Commission of Inquiry

October 2012

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UnitingCare Community in Queensland

About UnitingCare Community

1. UnitingCare Community is a leading provider of community services throughout Queensland, employing approximately 2,500 paid staff and 5,600 volunteers. It is a service group of UnitingCare Queensland which also delivers health and aged care services through its other service groups, UnitingCare Health and Blue Care. Our organisation is part of the UnitingCare Australia network which undertakes policy, research and advocacy work.

2. In the 2011/12 financial year, UnitingCare Community received $91m from the Department of Communities, Child Safety and Disability Services for a range of programs. Funding for out-of-home care programs totalled $26.6m and $16.7m related to family and youth support and Intervention programs. The balance of $47.7m was for adults with a disability, telephone and financial counselling, gambling and HACC programs.

3. Our organisation delivers the following child protection initiatives:
    - Self-funded and government funded counselling and crisis support services to adults, young people and children who have experienced abuse including clients who are or have been in state care
    - Early intervention family support services such as the Referral for Active Intervention and Helping Out Families programs.
    - Tertiary intervention programs such as Family Intervention Services
    - Out-of-home-care services including foster and kinship care programs and residential care services
    - Support to parents with a child with a disability including respite and foster care
    - Training and support to our staff and other organisations in the sector

Scope of this submission

4. This submission addresses 3 (c) and 6 of the terms of reference drawing on the direct experiences of our staff and illustrated by case studies. The areas covered are:
    - preventing entry into the child protection system
    - tertiary child protection services including out-of-home-care services, provision of services to children and young people in out-of-home-care, reunification and connection to family and support networks, as well as transition from care and post care support
    - regulation of care
    - workforce support and capacity building

5. This Inquiry is tackling complex and difficult issues which cannot be addressed by government or non-government intervention alone. The roles and responsibilities of parents, families, neighbours and communities are also significant in reducing the incidence of neglect and abuse. Community education should be undertaken, not just to better identify and refer child abuse, but to help build communities that can better support vulnerable families. These aspects should be part of the Inquiry's deliberations. UnitingCare Community is keen to work with all parties in helping develop a road map to improve the care and protection of vulnerable children.

6. While this submission highlights perceived deficiencies within the child protection system, there are many areas that are working well. In the interests of providing helpful examples, the case studies reflect instances where improvements can be made. Furthermore, there is significant goodwill and collaboration between the Department of Communities, Child Safety and Disability Services and other partners across government and non-government. These partnerships are critical to delivering the positive outcomes for children and young people that we are committed to achieving.

Preventing entry into the child protection system

Prevention and early intervention services

7. Early intervention can help avoid the development of serious problems later in life. The risk factors that increase a family's vulnerability are well documented, as are the models of effective service delivery. For a variety of reasons many families are hard to engage and also drop out of services before interventions can be completed. Non-stigmatising community-based services can help overcome these barriers.

Current UnitingCare Community involvement

8. UnitingCare Community has had considerable experience in working with 'hard-to-engage' families and supporting families in crisis. It provides a range of counselling and crisis support services which form an integral part of the primary, secondary and tertiary child protection system. These are outlined in Attachment A. In particular, our Referral for Active Intervention (RAI) and Helping out Families (HOF) programs have proved to be effective.

9. UnitingCare Community has three RAI programs in Southeast Queensland including services in Beenleigh, Eagleby, Nerang and Coomera, Kingaroy–South Burnett and Toowoomba. The largest of these programs can support 270 families per year and is now a component of the HOF initiative in the Beenleigh to Nerang region.

10. RAI services work with vulnerable children and young people (unborn to 18 years) and their families who have high and complex needs and are at risk of entering the statutory child protection system. The program uses a comprehensive case management approach which includes development of child and family plans and regular case reviews. Client participation is on a voluntary basis and services include advice and referral services, counselling, brokerage support, parenting groups and flexible, out-of-hours, home-based support for families. We participated in the 18 month and three year evaluation of the RAI programs which demonstrated the effectiveness of the programs.

11. Our HOF program opened in the Logan community in October 2010. It is the largest of the three programs operating in Southeast Queensland and includes both the Family Support Alliance (FSA) and Intensive Family Support (IFS) service components. The program aims to divert vulnerable children and young people from the statutory child protection system through to an earlier intervention. While it is still early days, recent data analysis undertaken by Child Safety has confirmed that these objectives are being achieved.

12. Over the last 12 months the program has provided a service to 3,622 individuals (822 families) and 1,397 of these individuals (330 families) were referred into the Intensive Family Support Service. A total of 28,016 hours of service provision was recorded during this same period.

Key issues for consideration

13. The vast majority of the families assisted by the HOF programs have highly complex needs and present with multiple problems as the case study below illustrates.

Helping Out Families (HOF) Case Study

The family consisted of a separated mother and eight children including a 10 year old child with a disability. Domestic violence was a persistent feature, and the father would remove the children without permission and also stalked the family. Excessive alcohol was involved, as was prescription medication abuse. The eldest boy displayed sexual behaviour as a result of being sexually abused by his father. This same child also involved his brother in criminal activities. The mother had no immediate family or friends and the main source of income was Centrelink benefits.

When HOF became involved with the family, the children were sleeping on mattresses on the floor, transport was a major problem but basic needs such as food and clothing were supplied. The child with a disability had a number of problems which were not being met and specialist services were limited. On the plus side the children were all in school, although behaviour problems and inadequate supervision of the children at home were reported.

During the mother's involvement with HOF she was diagnosed with cancer and the child with the disability required surgical procedures and post hospital care.

Case planning centred on safety planning and protective behaviour work, issues relating to the mother's and children's health, addressing the practical needs of the child with a disability and a referral to the local domestic violence service for therapeutic and legal support. HOF workers supported the mother in safe travel of the child to and from hospital appointments and liaised with the hospital to ensure the mother was able to carry out in-home rehabilitation activities. Specific needs around bedding, wheelchairs, physiotherapy equipment and an appropriate transport vehicle were addressed through sourcing a combination of government funding, HOF brokerage and in-home budgeting with the mother. By the time the HOF intervention was complete, the family was well connected to community supports, however their situation remained precarious.

14. The HOF initiative has enabled greater collaboration between government and non-government organisations, delivered more effective interventions for at-risk families and opened up community referral pathways. The case study above also shows how brokerage can be an effective tool for engaging families, alleviating short-term hardship and providing developmental opportunities and assessments for vulnerable children.

15. However, an area for improvement relates to the highly complex nature of almost all of the referrals from the Department's Regional Intake Service. Referrals received over the past 22 months do not reflect the full range of referral criteria outlined in the Service Agreement Specifications:

    A. Investigations and Assessment (I & A) where the outcome is:

    - *Unsubstantiated - child not in need of protection but the family is at high risk of entering the statutory system if they do not receive support or*
    - *Substantiated – child not in need of protection but high risk factors are present or*

    B. Child concern reports (CCRs) when one or more of the following is present:

    - *the subject child/ren is/are under 3 years old*
    - *history of multiple CCRs which may include domestic violence and family violence CCRs and or*
    - *previous statutory involvement (e.g. Notification).*

16. To date the HOF service has received a very limited number of *Investigations and Assessments* (Category A) referrals with the majority being *Child Concern Reports* (Category B). We are also concerned that very few children who are under three years of age have been referred, given the vulnerability of very young children.

17. Two examples of families referred to the HOF program appear below.

Child Protection History Family One

Previous child protection history includes eight Child Concern Reports, three Notifications that were not commenced, three Protective Advice Notifications, four Unsubstantiated Notifications and seven Substantiated Notifications (since 1995). The issues are usually around neglect, house being unhygienic and dangerous due to property damage, non-attendance at school, inadequate parental supervision.

Child Protection History Family Two

Previous child protection history includes 17 Notifications and 10 Child Concern Reports recorded between 1995 and 2012. Concerns have primarily related to sexual abuse due to the mother exposing children to known sexual offenders, neglect and mother's intellectual ability.

18. UnitingCare Community considers that the threshold for referring to the RAI and HOF programs is too high resulting in only highly complex cases being referred instead of families whom we regard as genuine early intervention cases. Most families referred to the HOF program present with multiple and complex problems developed over a number of generations. While the program is well placed to support these families, the needs of families who require low-to-medium levels of support remain unaddressed. As a result, early intervention services are not available to these families at a point when they would be

effective and the RAI and HOF programs are congested with referrals that have already had multiple notifications to Child Safety. By the time many families have been referred to the HOF (or RAI) programs there have already been years of reported child protection concerns and an intergenerational cycle of neglect, family violence, unemployment and substance abuse.

19. Another area for improvement is the extent to which information about clients can be shared between organisations in the best interests of the child but without the consent of the family. Amendments to the *Child Protection Act 1999* in 2010 have been interpreted conservatively with regards to information sharing, resulting in families not receiving help earlier.

20. Real improvements need to be delivered at a local level, however this should be in the context of a regional plan for vulnerable children which sets outcomes and targets and holds agencies more accountable. The Child Safety Directors established after the 2004 CMC Inquiry into Abuse of Children in Foster Care, provide a significant level of recurrent resources to help drive this across Queensland Government human service agencies. These resources need to be quarantined within departments to ensure they can help drive the next wave of child protection reforms. We consider there is room for increased involvement of Child Safety Directors in community service provision as currently they are too remote.

21. Over time investment in family support programs has occurred in a piecemeal fashion resulting in a lack of coherence in terms of program design, the types of services funded within locations and often the choice of provider. Various attempts have been made to formalise networks, such as the Area Network Teams which supported RAI initiatives, to improve access to services for vulnerable families. This involved government and non-government agencies. Our experience was that these meetings were delegated to lower level staff who did not have the authority to drive change within their organisation.

Children with a disability

22. While disability and child protection are seen as separate and independent, in reality there are overlaps between both systems. Some children and young people with a disability come to the attention of the child protection system for the same reasons as those without a disability. However many children with a disability enter the child protection system because their needs cannot be met in the disability system and their families reach a crisis point where Child Safety intervention is required.

23. Statutory child protection responses are built around children and young people who have been harmed or who are at risk of harm. The child protection system is not intended to intervene in the lives of families just because another system cannot meet their needs. There should be adequate services through the disability system to prevent unwarranted entry into statutory care.

24. An example of a child with a disability entering the child protection system is provided overleaf:

Case Study – Female child aged 12 years with a disability

The child had a number of diagnoses and had been variously labelled as having 'Autism', 'ADHD' and 'Conduct Disorder'. The mother contacted Child Safety in crisis needing help with parenting the child who was becoming stronger and increasingly more demanding. All options available from Disability Services had been exhausted.

Child Safety assessed that the mother was at risk, given her fragile state of mind and that she was not coping, and placed the child in out-of-home care. During this time, the child stayed alternate weeks in respite services that were approximately 60 kilometres apart. As a result, she could not continue to attend the same school and had no contact with her friends.

The constant change and not having contact with familiar things and people exacerbated the child's behaviour and she became more difficult to manage. UnitingCare Community was approached to develop a response to the child that was more predictable, that addressed her immediate and longer-term needs and ensured that her mother played a key role in her life. We developed a structured out-of-home placement in consultation with the mother to enable the child to return to her school and include the mother in her care.

25. In this case entry into the statutory child protection system could have been avoided if the required support and services through the disability system were available. This child was not being abused or neglected. The child and her mother simply could not get the timely supports they needed to remain as a family and deal with the extra demands of the child's disability. Access to intensive family support programs, rather than programs within the child protection system, is a better option to meet the needs of children with a disability.

Domestic and family violence

26. Similar issues also impact on women and children affected by domestic violence. There are too many situations where mothers who are able and willing to protect their children have them removed and placed in out-of-home care because they are responsible for 'failing to protect'. This is a punitive statutory intervention in circumstances where there are no identified concerns about a mother's parenting capacity, instead of a response that helps the family overcome these problems. This is well illustrated below.

Case study – Systems issues domestic violence and child protection

In 2010 a breastfed baby was removed from the mother's care on the grounds she had failed to protect her child, after the father had temporarily abducted the child. The mother had previously separated from her partner following severe domestic violence and had subsequently been stalked. The child remained in out-of-home care for over a year before a referral was made to a Family Intervention Service for reunification. After the completion of a two-month intervention by the service, no concerns about the mother's capacity to provide good quality care for her child were identified and reunification occurred. The child was two years of age at that time.

Recommendations

27. Develop a Vulnerable Children's Strategy which sets outcomes and targets at a regional level and identifies the key government and non-government agencies which need to drive the planning and implementation of the strategy.

28. Following this, and in consultation with the non-government sector, review the current funding allocations for prevention and early intervention in regions and reassign funding to more effectively deliver the interventions needed to improve outcomes for vulnerable children and families in each region.

29. Pilot a model which funds on the basis of achieving agreed outcomes for vulnerable children and their families, thus introducing greater flexibility and accountability in the delivery of services.

30. Expand funding allocated to RAI and HOF programs to enable them to deliver services to a larger percentage of *Investigation and Assessment* referrals where families will benefit from early intervention, while also continuing to respond to families with much more complex needs. A particular priority should also be *Child Concern Reports* relating to children under three years of age given their vulnerability.

31. Clarify the interpretation of the 2010 modifications to the information sharing provisions of the *Child Protection Act 1999* as the current interpretation limits the non-government sector's ability to share information across services in the best interests of children and their families.

32. Amend legislation to enable a range of options including shared care arrangements for parents with a child with a disability who is not abused or neglected.

33. Prevent or delay children with a disability from entering the child protection system by mandating that they have a specialist support plan and funds to implement it so they get the supports and services needed.

34. Increase the provision of specialist case work services for women and children affected by domestic violence, childhood sexual abuse, mental health issues and drug and alcohol abuse.

Tertiary child protection services

Out-of-home care services

35. The following are critical components of effective out-of-home care:
    - the quality of the placement
    - access to a sufficiently large pool of carers or placements to be able to place each child or young person in an appropriately matched placement
    - the right interventions tailored to the child's needs which have been comprehensively assessed
    - a sense of security, stability and continuity for the child

Current UnitingCare Community involvement

36. Currently, the out-of-home care system in Queensland comprises a combination of home-based and residential placement options including foster care, kinship care, residential care, therapeutic residential care and specific response care. UnitingCare Community provides the following forms of out-of-home care:
    - Three Foster and Kinship Care Services
    - Three Specialist Foster Care programs
    - Multiple Placement Support Services and packages
    - 17 Residential Care Services (from Cairns to Mt Isa to Brisbane and the Gold Coast)
    - Two Therapeutic Residential Care Services (Goodna and Townsville)
    - Specialist Disability Foster Care (Family Lives program)

37. Our organisation is licensed for 22 residential care services and 10 foster and kinship care programs. We employ approximately 354 staff of whom 12 per cent are Aboriginal or Torres Strait Islander. Currently 480 children are cared for, with 20 per cent in residential care facilities. Between 25 and 30 per cent are Aboriginal or Torres Strait Islander children.

Key issues for consideration

38. UnitingCare Community is unable to provide information on the outcomes for children and young people who have been through its out-of-home care services. Data collection and evaluation processes linked to Service Level Agreements currently report on outputs rather than outcomes for children and young people.

39. Children are in less than ideal placements due to the ongoing shortage and insufficient range of out-of-home care options. This may put them at an increased risk of further harm or an acceleration of their challenging behaviour as the case study below highlights.

Case study – Male young person age 14 years (Emergency Residential Care)

UnitingCare Community residential staff received a referral for an emergency placement of a 14 year old male young person who was living with foster carers. The carers had previously requested regular respite but following a recent incident had asked that Child Safety locate a respite placement immediately.

Based on information provided by the Child Safety team leader, it was determined that while there was a placement available in the emergency residential, there were risks associated with placing this young person in this facility. These included:

- he had moderate behavioural issues with no prior residential placement, whereas the emergency residential was funded for children with complex to extreme problems
- the behaviour of the current clients could expose this young person to situations that might frighten him or escalate his recent behaviour
- one resident was overtly sexual in her behaviour and aggressive to male residents.

The team leader advised against placing him in the emergency residential however there were no other options available and he was duly placed in this facility, where his behaviour deteriorated significantly.

40. Placement shortages can also have negative results for a young person who is new to out-of-home care and is placed in a residential care facility as the case study below highlights.

Case study – Female young person aged 14 years (Residential care)

This young woman came into care because of disruptive behaviour at home, stealing and because her family could not cope with her.

While placed in residential care she became involved with a group of peers with challenging behaviour and she absconded for lengthy periods and started using drugs. After an incident she was arrested by the police, immediately removed from the placement by Child Safety staff and moved back with her family as there were no other options available. This arrangement quickly deteriorated and she became homeless.

41. Placement shortages result in a mismatch between the child's needs and the options available and this contributes to placement breakdown, with negative impacts on the child, carers and our staff. Some children will end up staying in emergency placements for longer than desired. The following case study illustrates this:

Case study – Female young person age 14 years (Emergency residential care)

Initially this young woman was referred to the emergency residential with her sister. Shortly after, her sister was placed in a medium-to-long-term residential while she continued to stay at the emergency residential. By the end of her placement she had been there for a total of 194 days. (Young people should only be placed at the emergency residential for a maximum of 84 days).

The young person's behaviour deteriorated to such an extent that she became withdrawn, neglected herself and abused staff and neighbours regularly. Staff worked very hard with this young woman however they noted that her deterioration and feelings of abandonment and rejection increased the longer she stayed at the emergency residential. The young person was uncertain about her future and staff believed she was re-traumatised as a result of living there for more than six months.

For a range of reasons, our residential management team concluded that the young person's placement at the emergency residential was no longer safe for all concerned. When she left, Child Safety was unable to find a permanent placement for her and requested that she be dropped off at the Child Safety Service Centre with her belongings.

The young person eventually moved back with her mother, however this was short-lived and she came back into the residential on a number of occasions for brief periods.

42. Within the limits of current legislative provisions, information sharing should be as comprehensive as possible and should provide full honest disclosure of information relevant to the child or young person's care. Out-of-home care staff need to be informed about matters such as complex, challenging or high risk behaviours, previously identified risks to the child or young person, other people and any history of substance misuse or mental health issues. When making placement matching decisions, out-of-home care staff must consider the care and protection needs of other children and young people within a placement and the potential risks to members of a household or to residential care staff.

43. While the frank sharing of key information about a child or young person may mean a placement is refused, this exchange is vital. Professional relationships between departmental and our staff can be damaged from a loss of trust when there is a perception

that information isn't being shared or that information about a child or young person is being deliberately withheld in order to facilitate a placement. Information about risks and behavioural problems as well as advice about positive changes the young person has made are crucial. The following case study illustrates this:

Case study – Male child age 11 years (Residential care)

This child was a resident in a therapeutic residential for 18 months which was extended for a further two months. He came into the placement with no transition plan and our staff requested that Child Safety begin this process six months into his placement. This planning did occur but they were unable to locate appropriate carers.

Over eight months into the placement it was discovered that the Department's Placement Services Unit was using the initial referral information to recruit potential carers. This form was more than eight month's old and pre-dated the therapeutic residential placement. It did not identify the child's strengths, rather highlighted negative issues and was not supported by actual evidence during the placement. This form should have been updated to capture new information.

Child Safety staff agreed to update the referral so that it would be a true reflection of the child's current circumstances. Although not their responsibility, our staff often undertake this task to ensure the child is positively represented, to expedite transition planning and to ensure the placement matching process is based upon good quality up-to-date information.

44. Multiple examples can be cited where day-to-day decisions involving a young person in out-of-home care were delayed, resulting in children and young people missing out on normal events such as school camps, excursions and even sleepovers. These are activities which any child should take for granted. These children are made to feel different and may be the only person in their class not attending these events. Delegating these sorts of 'parental' decisions to the direct carers would mean decisions could be made immediately and the child's situation normalised.

Recommendations

45. Transfer the delegation for day-to-day parental decision making from Child Safety Services to the licensed care provider.

46. Transfer case management responsibility from Child Safety to capable non-government organisations with professional staff and staff development and supervision capability, to provide more comprehensive and timely responses to children and their families with the intent of delivering more certainty and stability for these children.

47. Develop a 'Placement Record' (similar to the 'Child Health Passport') which documents a child or young person's placement history, including their behaviour and psycho-social adjustment during these placements and the results of specialist assessments. This information should be made available to foster and residential care staff who have responsibility for the day-to-day care of the child.

48. Examine innovative ways to recruit foster carers using a variety of media including social media, to provide a significant pool of carers who have the flexibility to respond to children and young people.

Services to children and young people in out-of-home care

49. As reflected in the Statement of Standards, outlined in Sect. 122 of the *Child Protection Act 1999*, case planning for children and young people in out-of-home care must address their physical, emotional, social, developmental, cultural, education, training and employment, healthcare and disability needs.

Current UnitingCare Community involvement

50. Our organisation delivers a range of services targeting children and their families including sexual abuse counselling, therapeutic support whilst in placement, intensive services to facilitate reunification and support for grandparents who are the primary carers. **Attachment A** contains further details.

Key issues for consideration

51. A frequently identified factor in placement breakdown and the movement of children from one foster care placement to another is the complexity of children's needs, particularly when they first enter foster care. We have collaborated with Child Safety to develop a new approach in Far North Queensland, First Response, to address the needs of children and young people when they first enter care.

52. First Response foster care placements are viewed as 'assessment placements' where staff support specifically trained carers to use observation tools to identify the needs of a child who has entered care for the first time. Downey's Integrated Assessment Criteria (2012) is used and it focuses on areas including stress and emotional regulation, attachment and relationships, socialisation and behaviour, identity and self-awareness. For children who remain in the out-of-home care system the assessment results in a Wellbeing Plan and for those who return to their family a brief report is provided to Child Safety.

53. Since February 2012, 31 children have been assisted, of whom 22 have returned to family (either to parents or kinship carers). Two thirds of these families are Aboriginal and Torres Strait Islander. This model has been well received by the Indigenous community and strengthened relationships between our organisation and local Indigenous organisations. It has demonstrated that when children first come into care what they most need is a skilled professional who can begin immediate work to help the parents support the placement and work towards reunification.

54. This case study shows how an immediate professional response can support the child.

First Response Project Case Study: Baby Z

Baby Z entered the out-of-home care system for the first time after he sustained significant non-accidental injuries and was referred to the First Response Project where he was placed with a trained carer. His medical needs were significant and the carer attended additional training in infant resuscitation, seizure management and also received a physiotherapy plan and medication regime provided by the hospital.

The baby remained in care for five months during which First Response staff intensively supported the foster care placement and completion of observation tools, completed an assessment with the parents, supported their attendance at the baby's medical appointments and attended family contact with the baby and Child Safety.

A kinship assessment of his maternal grandmother was also completed. Following Baby Z being placed with his grandmother, our First Response staff and placement support workers supported the transition from out-of-home care placement to a kinship placement and kinship support workers continued the support. Baby Z's parents were referred to the UnitingCare Community Family Intervention Service which is currently working with them with a view to being reunified with their child. Feedback from the family has been positive highlighting the value of a family being supported instead of largely ignored during periods of significant difficulty in their lives.

55. This new program confirms what can be achieved when the child protection system undertakes both a thorough assessment of the child or young person's needs and is responsive to all aspects of the child's life – their parents, their carers and their needs - from the point of first entry into care. An evaluation will deliver findings in 2013.

56. Child Safety staff are responsible under the *Child Protection Act 1999* to facilitate the development of the child's case plan, monitor its implementation and review progress against the child's needs. However, the following case study is not an isolated example of problems in communication, case planning and coordination.

Case study – Indigenous male child aged 10 years (Residential care)

Due to her age and deteriorating health, the child's grandmother was no longer able to care for her grandchild. He came into out-of-home care because he was neglected and had started living with other people in the community.

An emergency placement was sought with UnitingCare Community. Information from Child Safety, the grandmother and the school indicated that the child could overreact to situations and become difficult to settle, had been excluded from school due to non-attendance and physical aggression. He had the characteristics of Foetal Alcohol Syndrome but no assessment had been sought, he was not misusing substances and was unknown to the police.

Residential staff informed the Department's Placement Services Unit that he did not fit the dynamics of the residential at that time because the other young people in the residential were older and had a number of behaviour problems. This young boy had only ever lived with his family. He was subsequently placed at the residential and Child Safety was asked to act quickly to locate a more suitable place for him to avoid placing him at further risk.

From the outset of the placement, the child was aggressive, disruptive and threatening towards staff and damaged property. He told staff that he was "sad and lonely" and just wanted to be with family and friends. He showed signs of suicidal ideation and within the first three days of placement, staff had to protect him from self-harm and follow emergency procedures, calling the police to transport him to hospital where he had to be sedated.

The child's behaviour further deteriorated and, in the absence of action by Child Safety, our staff contacted his grandmother and Aunty to identify possible kinship carers. These were passed on to Child Safety with a request to place the boy with family and to give them support and information on his behaviour. They continued to inform Child Safety about their concerns for his physical and psychological safety if he remained in a non-family placement.

Based on the information provided, several family members from the child's community were assessed and an Aunty was approved as a carer. After a number of weeks, she arrived and with support from UnitingCare Community staff was able to convince the child to return with her to their community. The child quickly became much calmer and he adjusted well.

57. As was the situation in this child's case, our staff have stepped in where they believe that the child or young person requires support. However, their efforts are limited by the current provisions within the Act whereby non-government organisations cannot share information about a child or young person with another agency, such as a school or counselling service.

58. Due to Child Safety staff workloads and high turnover, it is not uncommon for an officer to have minimal knowledge about a child's circumstances, behaviour and needs. This has resulted in instances where children have remained, to their detriment, in a placement well beyond the original agreement.

59. The outcomes from this lack of communication, case planning and/or casework include:
    - delayed or minimal assessment of the child or young person's and family's needs
    - lost opportunity to intervene with the goal of reunification
    - increased stress and trauma for the child or young person and family as it is unclear what is happening and when
    - less than optimal placement with no follow up support to mitigate possible risks to them
    - increased risk of further disconnection from family, community and prior support networks particularly when there is no active planning in relation to family contact
    - increased risk of further deterioration in challenging or high risk behaviour
    - increased likelihood the child or young person will remain in out-of-home care unnecessarily or for a much longer period than is necessary

60. Reunification and best practice case work and out-of-home care services could be achieved more efficiently if children and young people's needs were addressed in a more timely and comprehensive way (as demonstrated in the outcomes from the First Response project).
    - each child or young person should be assessed when first entering out-of-home care, across a range of factors, including their current health, education, social, developmental, emotional and psychological status
    - therapeutic and family support responses should be embedded across all forms of out-of-home care
    - intervention services should be commenced promptly to address any issues identified through this assessment that aren't addressed within the therapeutic care environment
    - each child or young person's assessment should be regularly reviewed, that is every 12 months and prior to reunification or placement in a permanent care option.

61. The majority of our out-of-home care services are funded for direct care positions, with a small percentage of funding for management positions. There is no capacity within current funding allocations and Service Level Agreements to employ any specialist or therapeutic workers within the team.

62. Due to funding limitations and legislative restrictions in relation to case management and information sharing, Child Safety Officers are relied on to organise required assessments and interventions and to facilitate family contact.

63. On occasions Departmental Officers, health care professionals, members of the judiciary and legal professionals, have not valued the input from carers and staff of residential services regarding a child's circumstances. In most cases, carers and staff have more direct knowledge about the children in their care and have stronger connections to them than departmental officers or professionals who have had sporadic or no prior contact. This case

study demonstrates some of the difficulties when case management resides with Child Safety staff.

Case study - Female young person aged 17 years (Residential care)

In the few months prior to her 17th birthday, this young woman's behaviour became increasingly difficult for staff in the residential to manage. Initially they were unsure whether this was due to her past trauma or to the emergence of mental health problems. Increasingly her behaviour started to impact on the other young people there.

UnitingCare Community staff made a number of requests to Child Safety to have her assessed but this did not happen until the School Principal also raised concerns and supported our request to have her referred to the Child and Youth Mental Health Service (CYMHS).

When the young women was first seen at CYMHS, the mental health worker advised that the young woman was not exhibiting behaviours that could be considered atypical of young people in care with abuse histories. Staff then insisted on a follow-up appointment with a mental health specialist which was scheduled for six weeks ahead. She was reassessed at a mental health hospital and UnitingCare Community was once again advised that her behaviour was normal for a teenager.

Three days later the young woman had a major psychotic episode which was very frightening for the other residents. It became necessary for an ambulance to be called and the paramedics convinced the young woman that she needed to be taken to hospital. She was subsequently detained under the Mental Health Act for a period of eight weeks in a different hospital. The hospital has since indicated that the young woman is most likely exhibiting early signs of schizophrenia.

The young woman later returned to the residential to complete her Grade 12 year via home schooling under the direction of residential care staff. However, the young woman wanted to attend her school formal at the end of the year and the School Principal was supportive of this request. In this situation this young woman's would have received a more timely intervention if case management responsibility rested with UnitingCare Community.

64. Current funding arrangements create silos. Funding is connected to particular Child Safety Service Centres rather than to the demand for services. An inability to work across regions means that resources can be under-utilised and some families in need may not be able to access a suitable service in a timely manner as illustrated below.

Case study – Service funding

Recently, a UnitingCare Community Family Intervention Service (FIS) in one region had an abundance of referrals, whereas a FIS in another region had insufficient to meet their target outputs. This was despite repeated attempts to obtain referrals from the Child Safety Service Centres within their region. Approval was sought to take on referrals that were waiting in the other FIS service. However, this was declined on the basis that the service was in another Child Safety Region. The difference in the number of referrals between the two FIS services in question may in part be attributed to the fact that RAI and HOF services exist in one region and not in the other.

65. The lack of funding in certain regions across the continuum of child protection services also means that either some families miss out on the help they need, or a service which is funded to provide tertiary level services has to accept clients with secondary level concerns, or vice

versa. For example, FIS has recently received referrals regarding families who are assessed as low-level risk and would have benefited from a less intensive family support than that required through FIS. These families are unable to access a RAI / HOF service because there is no such service in their region. Although they may not require the intensity of a FIS service, families are left with no choice but to seek help from that service.

66. Based upon our experiences with the Healing Opportunities, Prevention, Education, Sexual Abuse (HOPES) program, we have also identified a number of issues relevant to our work with sexually abused children and young people including the need for specialist assessment and intervention with this client group.

HOPES Case Study – seven year old sexually abused girl

HOPES received a referral from Child Safety which advised that a seven year old female child had been abused by her paternal grandfather. The abuse came to light when the child was involved in sexualised behaviour with her siblings at home. The family was referred for counselling and psycho-education for the parents. The latter focused on the impact of sexual abuse on the child, how to better care for the child, education on perpetrator grooming behaviour, privacy issues and personal boundaries.

The HOPES counsellor conducted an initial assessment with the parents which included a thorough developmental history of the child. The Trauma Symptom Checklist for Children was administered to ascertain a picture of the child's current psychological status in the different domains. This provided a baseline of the child's difficulties and assisted with case planning and directing the therapeutic intervention. To ascertain the level of sexualised behaviour the Child Sexual Behaviour Inventory was also administered. Test results were written up and stored with the child's therapeutic records for use within the court system if required at a later date.

All family members received individual and family sessions and the abused child and her parents were provided with protective behaviour information sessions. A protective behaviour quiz was administered pre and post these sessions enabling the counsellor to be aware of the child's current knowledge and where to focus the intervention.

67. The psychosexual development of some children can be affected by their early abuse trauma and a few children become adult perpetrators. The experiences of our counsellors who work with adult survivors of child sexual abuse confirm that many clients present for counselling with a range of mental health issues including depression, self-harming behaviour, suicide attempts, impaired ability to form healthy relationships, Borderline Personality Disorder, and Dissociative Identity Disorder. Early intervention counselling services for children and young people who have been sexually abused can prevent or minimise the emergence of such mental health problems later in life.

68. The HOPES program has received many referrals where there is a history of intergenerational sexual abuse. The role of the counsellor becomes extremely important in intervening in this pattern of behaviour in order to provide another pathway for the child or young person in developing healthy relationships. During the time HOPES has been in operation the waiting list has fluctuated from two referrals comprising four or more separate clients to 15 referrals comprising of 40 or more separate clients. Given the waiting list for the HOPES service and the fact that the general community is not able to access these services, we are concerned about their limited availability.

69. Despite the importance of this area of child protection practice, the HOPES program has encountered significant difficulties recruiting experienced, qualified staff at the salary levels UnitingCare Community is funded to provide.

Recommendations

70. When a child is removed from family, promptly assess the child's needs and concurrently work assertively with the family with a view to returning the child as soon as it is safe to do so.

71. Expand funding for specialist and innovative programs such as First Response to increase the likelihood that children will return to their family more quickly and/or have a positive placement experience.

72. Build into the funding model for out-of-home care services a 'wrap-around' therapeutic environment including capacity to employ specialist support and intervention workers. This should include residential services being able to employ family support workers to work with the parents of children in care.

73. Provide children when they enter care access to specialist professional counselling and assessment services that can identify each child's needs and plan to address these. These services should be integrated into the non-government sector's suite of services.

74. Transfer case management responsibility from Child Safety to capable non-government organisations with professional staff and staff development and supervision capability. Such an initiative would provide more comprehensive and timely responses to children and their families and deliver more certainty and stability for these children.

Reunification and connection to family and support networks

75. When a child or young person is removed from his or her parent's care, the primary goal is to work with them, their family and support networks to improve the family's capacity to parent and hopefully reunite the child with them. When reunification is not possible, a permanent, stable alternative care option is pursued. In either scenario, connection to family and support networks is critical to their ongoing well-being .Research demonstrates that children and young people who are in frequent contact with their parents in the earlier months of placement have a higher probability of being reunited with their families. Further, it is shown that at least one form of regular parental contact was positively associated with family reunification and reduced the length of time in out-of-home care.

Current UnitingCare Community involvement

76. UnitingCare Community established the first Intensive Family Service (IFS) in Queensland and went on to establish two more programs. These were based on the Homebuilders Family Preservation Model from the United States. An evaluation in 2001 showed that in 75 per cent of cases the child protection concerns were significantly reduced to the extent that the children and young people were still living with their families 12 months after the case was closed. At the request of Child Safety this program and others like it within UnitingCare Community, were later adapted to become the Family Intervention Services (FIS) model of service delivery. We now operate 10 such services across the state (Logan, Mt Gravatt,

Ipswich, Aspley, Sunshine Coast, Gladstone, Emerald, Rockhampton, Mackay and Far North Queensland).

77. FIS works with families where there has been a need for statutory intervention and to ensure the family has the capacity to safely care for their children. FIS teams also work with families where reunification is underway. The service may also be involved in helping Child Safety decide on the best permanent arrangements for the child or young person. The service is predominantly delivered in the home of the family and is a more intensive service than RAI or HOF. Due to the level of risk in these families, UnitingCare Community does not permit a 'waiting list' for this program in order to ensure that the responsibility for risk management during a referral 'waiting period' remains with Child Safety.

Key issues for consideration

78. Intervention timeframes with families are too often driven by the terms established in Service Agreements rather than according to family needs. For example FIS is only able to work with families for three months, with an extension on application. This is often inadequate given the profile of these families whose children were taken into care due to abuse or neglect. A more flexible arrangement is warranted to ensure services are not withdrawn prematurely before changes have been consolidated. The case study overleaf illustrates this point.

Case study – Family with four children referred to the Family Intervention Service

A sole parent father with four children between two and six years was referred to the local FIS service. There had been significant child protection history in the previous four years with respect to both parents. Following the mother leaving the household there had been increasingly serious concerns about children's safety e.g. children out on the roadway, fire setting, one child crashing the father's car, no parental supervision and home hygiene issues. Initially the family had been referred to a HOF service, however the level of need, concern, and crisis was deemed too high. The children were then subject to an Intervention with Parental Agreement (IPA) and referred to FIS.

By weeks 12/13 (usually the end of the FIS intervention), the father had made significant improvement in his parenting. The intervention was rolled over for a further six weeks but was then closed. At the time it was necessary for FIS to cease their intervention and the father said that he needed more time to practice the skills he had learned.

One of the recommendations made at the time was for Child Safety to remain involved with the family and monitor their progress over the short-term and involve additional support services when necessary. The Child Safety support moved from weekly visits to a fortnightly telephone call with the father and no further home visits took place to consolidate and progress changes to his parenting. To a large extent the father had to battle on in his parental role without the help that he clearly needed.

79. The issue identified above can in part be rectified by the availability of 'step-down' services for families but currently funding rules and service silos prevent this from occurring. Enabling these families to access less intensive services, such as RAI and HOF, for a period of time after the FIS intervention is complete would provide an additional level of support to ensure that positive changes are maintained. Currently FIS clients are precluded from accessing RAI and HOF services, where they exist, due to their child protection status. Furthermore, FIS programs are not able to refer these clients to other services due to information sharing restrictions within the Act as previously identified.

Staff comment

"The FIS model uses crisis as an opportunity for change. Its intensive, time-limited delivery can be very effective in motivating the beginnings of change, sometimes very significant change, for families. However, there will most often be a need for ongoing work including provision for lower intensity 'step down' home based services. Access to these services are presently precluded by referral criteria and service agreements".

80. UnitingCare Community considers that the current approach to tertiary child protection should give more weight to building family strengths and capabilities in an effort to enable more children to return home. When reunification is the goal the child and their family need to have sufficient time to undertake all of the tasks necessary to successfully achieve this. This includes time to understand the issues to be addressed, link with the required professionals or services and complete tasks defined in the case plan.

Staff comment

"At the present it appears that children remain in foster care for months or years before any reunification or other permanency plan is properly drawn up and implemented. Good assessments of children's needs, assessment of parental capacities, well trained and supported foster carers and timely decision-making that considers children's developmental timeframes should be the drivers of planning and action in children's best interests. We are also concerned that time-limited, home-based intensive services are not being put to best use. Where a referral is being made for reunification, all too often the referral is made at the last minute – only a matter of weeks before an order is due to expire. At this point, parents are likely to have little motivation to engage with the intervention service and valuable opportunities to build capacity and support children's wellbeing are lost."

81. Where reunification is no longer the goal, wherever possible the child should maintain connections with family, kin, and support networks. Many children and young people return to their families voluntarily, either when they leave care or by absconding from their placement. However there are currently no services in Queensland that support children in long-term care to maintain connection with family and community. Moreover, because of heavy workloads and staff turnover, Child Safety staff may not recognise this factor, nor prioritise maintaining connections with family when the case plan goal is not reunification.

82. When children and young people have not kept in touch with family and local support networks they may be at risk of further harm when they move back with family as:
    - they are traumatised when they return to the family due to their expectations and hopes for their family life do not match their experience
    - they do not have a realistic understanding of the dynamics in their family or the risks that may exist and as a consequence have not developed the emotional or physical resources to cope with their family's dysfunction.

83. UnitingCare Community believes that children and young people must be given an opportunity to participate in and be informed about decisions that impact upon their lives, particularly in relation to reunification. Such participation and communication will:
    - ensure that carers and service providers develop and maintain a trusting and open relationship with each child or young person in their care

- increase the likelihood that a child will commit to their case plan and its goals and will work in partnership with carers and service providers
- reduce the possibility of further emotional harm to a child or young person when their unrealistic expectations are not fulfilled or when changes to their case plan occur

Recommendations

84. Allow for greater flexibility in the timeframes Family Intervention Services can work with families to enable more successful reunification.

85. Increase the capacity of Referral for Active Intervention and Helping Out Families programs to operate as 'step down' services. This will require additional funding as outlined in paragraph 30.

86. Ensure that case planning for a child at the outset includes plans for leaving care. This will aid the young person's adjustment post-care.

87. Consistent with the legislative requirements, ensure that children and young people are regularly consulted and involved with decisions affecting their lives.

Transition from care and post-care support

88. Young people in the child protection system often have to make the transition into independence and adulthood in a much shorter period of time and with little or no pre- and post-care support compared with children who live with their parents. Research has confirmed the poor outcomes in general for young people leaving care.

Current UnitingCare Community involvement

89. UnitingCare Community provides transition and post-care support services to young people through planning with Child Safety staff, fulfilling its requirements as per the care plan and advocating to Child Safety for the young person.

90. UnitingCare Community is currently trialling two projects in relation to young people's transition from care.
    - In partnership with the CREATE Foundation, we are gathering feedback from young people in residential care services in Ipswich, Goodna, Toowoomba, Gold Coast and Brisbane about their experiences while in care and the system's capacity to meet their needs.
    - The second project involves six young people, across three different residential services who need a transition from care plan and who are likely to leave care within the next two years. The project involves UnitingCare Community taking a greater role than is usually the case in the transition from care co-ordination, case planning and implementation. This project shares the responsibility for transition from care with other community agencies rather than sole responsibility with Child Safety or indeed the young person.

91. UnitingCare Community provides a Peer Skills program (originally developed by Kids Help Line) which trains young people in support skills, help-seeking, communication and problem-solving strategies to prevent problems from escalating to more serious issues such as

bullying, depression and self-harm. We have been conducting this program since 2006 in high schools throughout Queensland and have adapted and delivered it to specific groups of vulnerable young people and even grandparents raising grandchildren. Workers using Peer Skills report that the program increases their capacity to connect with young people, to respond to the needs of young people and more effectively provide support.

92. Peer Skills activities also increase positive networking for young people across social groups fostering a climate of acceptance, care and respect in which difference and diversity are celebrated and resilience, confidence and the ability to contribute to the lives of others are increased.

Key issues for consideration

93. Too often transition from care planning does not start until the young person is 17 years of age. This gives staff only weeks or months to work with the young person to identify his or her needs during the transition period, develop a transition from care plan, source required services and funding, introduce the young person to a new home and service providers and identify post-care supports.

Case study - Male young person aged 15 years

This young man was 15 years old when initially placed with UnitingCare Community and remained with us for three years. At 16 he was diagnosed as having a low-to-average intellect, coupled with features of Asperger's syndrome and post traumatic stress disorder. Given his diagnosis and his strong attachments to the residential staff, we advocated for transition planning to occur as early as possible before his 18th birthday.

Discussions went back and forth about potential placement options over a period of months. Shortly before his 18th birthday Child Safety decided a co-tenant option with Disability Services was best. A suitable young man was identified with whom he could share, however difficulties arose when it was discovered that the two young men had different support workers through Disability Services and the arrangement required the young people to have the same support worker. Eventually this occurred, however this long process delayed confirmation of the living arrangements for the young man.

The service that took over the young man's care after he left UnitingCare Community's residential did not follow through with the behaviour management approaches recommended and his behaviour deteriorated quickly. In addition, the young man had a considerable amount of money that he had saved during his placement with UnitingCare Community. Child Safety was advised that he was likely to mismanage his money if not appropriately supported to budget and the Public Trust agreed to oversee his finances. While this was being set up the young man spent a substantial amount of his savings.

Months later, UnitingCare Community was advised that this young man had stopped attending all his community-based activities and that he had moved in with his father who was a known sex offender. Better advanced planning would have increased this young man's chances of having more positive outcomes once he had left care.

94. While the Act currently enables Child Safety to support young people even after they turn 18 years of age, transition from care and post-care support is often not given sufficient priority by Child Safety staff. High workloads and frequent staff turnover of a young person's case worker are contributing factors. In addition, provision of post-care support is not common as services to these young people are delivered via a support service case which is

not counted in the overall workload of Child Safety Service Centres. There is therefore minimal incentive for a Child Safety worker to do this work.

95. Due to their concern for the young person in their care, UnitingCare Community staff will at times become involved in transition from care and post-care support. However, they are limited in their ability to manage these activities as under current legislation they do not have primary case management responsibility for the young person and are prohibited from sharing information about the young person with other service providers (refer to recommendation in paragraph 31).

96. Due to these legislative provisions, young people may not receive required services or supports may be significantly delayed because Child Safety has not acted and our staff are not able to:
    - initiate or manage transition from care planning for the young people in their care even when these activities are not being undertaken by relevant Child Safety staff
    - refer young people to other services, including other UnitingCare Community services such as the Peer Skills Program, the music therapy program or counselling services, without such referrals being facilitated by Child Safety staff.

97. Proactive timely transition from care and post-care support planning is even more critical when the child or young person has a disability that will have long-term impacts on their functioning and when the young person has limited or no family support. Significant planning and service co-ordination is required to ensure that appropriate well targeted supports are in place prior to the young person turns leaving their placement or transitioning from statutory care at 18 years of age.

98. Current policies and procedures within government departments can create significant barriers to an effective transition from out-of-home care. For example, prior to allocating suitable housing, Housing Services in the Department of Housing and Public Works requires confirmation from Disability Services within the Department of Communities, Child Safety and Disability Services, about the funding their agency will provide the young person. However, Disability Services is not able to confirm their funding until the young person turns18 years.

99. As a result, while the respective departmental and agency staff may be working together to plan the young person's transition from care, confirmation of disability funding and housing allocations cannot be obtained until the young person turns 18. This impedes assisting the young person in their transition.

100. Transition points are crucial for children and young people with a disability in the child protection system. At the very least there is a need to examine how to effectively transition young people with a disability who are approaching 18 years of age out of care and into something sustainable for their future. For many young people with a disability this involves social housing, an alternate decision-maker, a financial administrator and an advocate for the young person.

101. Relationship and communication issues between government departments could hinder planning processes for young people with disabilities.

Staff comment

"One form of transition which should in fact be much easier than most is the move for a young person from Child Safety through to Disability Services. However, the process around this is definitely not clear and even though these services are part of the same government agency, the relationship and communication they have is very distant from one another."

102. Similarly, planning for a young person's transition from care and post-care support will be more complicated when they have additional needs that may require support from multiple services. This includes young people who have mental health, chronic health and substance misuse issues.

Recommendations

103. Amend the legislation to enable the provision of post-care support to young people who have been in care to the age of 21 years, including the provision of financial assistance.

104. Fund non-government organisations to provide post-care support to young people after they leave care including assistance with accommodation, education, training, health care and obtaining a driver's licence.

105. Provide case management post-care for young people with a disability and those with mental health problems to help them transition more effectively to adulthood and importantly to avoid their exploitation.

106. Consider waiving TAFE College fees for young people who have been in care.

Regulation of care

107. In Queensland, care services are regulated under legislation to ensure that the individuals providing care are suitable and the standard of care provided complies with the statement of standards in section 122 of the Act. The regulation of care provisions include the initial assessment and review of all approved foster carers and kinship carers and the initial granting and renewal of licences for residential care services.

Current UnitingCare Community involvement

108. UnitingCare Community is licensed for 22 residential care services under 11 licences and 10 foster and kinship care programs under six licences across its child protection and disability placement programs. These 17 licences include a mix of new and renewed licence types. Whilst the licensing process is a demanding one, our organisation has improved our quality management approach and hones its internal processes.

Key issues for consideration

109. In terms of the process to grant or renew a licence, our Quality and Standards team reports that the information required is often repetitive and has either been previously provided in another application or is information Child Safety already holds. Table 1 below demonstrates the types of documents required at each stage and the repetition.

Table 1 - Documents required by Child Safety or Independent External Assessors

Evidence type	Type of application required for		Stage evidence requested		
	New	Renew	LCS1 form	IEA request form	Panel-appendices
Director and Nominee Suitability and Blue Card details	Y	Y	Y	Y	Y
Proof of Director and Nominee Suitability and Blue Card	Y	-	Y	-	-
Service staff suitability and Blue Card details	Y	Y	Y	Y	Y
Carer names and status of approval	Y	Y	Y	-	Y
Public liability certificate	Y	Y	Y	-	-
Certificate of incorporation	Y	-	Y	-	-
Self Assessment Workbook (SAWB) *	Y	-	Y	-	-
Duplicate documentation from (Dept)	Y	-	Y	-	-
Process Documentation (PD) log	-	Y	Y	-	-
Process Documentation **	Y	Y	Y	-	-
For residential-lease and permission for use of building as a residential facility	Y	Y	Y***	-	-
For residential-compliance with Local Government Authority building and occupancy requirements such as copy of the classification certificate	Y	Y	Y***	-	-

*Similar information provided in duplicate document of and PD log. UnitingCare Community use same format.

** Process documentation (all previously submitted and approved PDs) requested by new Community Resource Officer

*** Information completed for services providing residential/non family based out-of-home care regarding housing requirements is also issued at time of premise being attached to a licence (LCS4, Part C) or when premise addressed is changed due to moving premises. This information still has to be provided again at licensing point, regardless if same evidence was given to Region in past 1, 6, 12 or 18 months as part of LCS4 process.

110. Our organisation recently estimated the costs associated with undergoing licence renewal using an endorsed business calculator tool (a renewal is less time consuming and complicated than applying for a new licence). The calculator identified that to put one site through a licence renewal process costs $10,635. This figure underestimates the true cost as only labour costs were calculated.

111. The siloed approach to licensing does not recognise organisations that have consistent processes across their out-of-home care programs, stable governance and a consistent management membership. As a result, there is no capacity to create efficiencies during the application process including those such as “ask once, use often”. Across UnitingCare Community, 18 separate licensing applications must be completed to comply with the

current licensing requirement which states that separate applications must be completed for each Child Safety region and out-of-home care program type.

112. As part of the regulation of care, the *Child Protection Regulation 2011* requires the Chief Executive to obtain certain information about a care service from an independent source in the form of an Independent External Assessment (IEA). There are some problems with the current approach as it:
    - places too heavy an emphasis on service process rather than client outcomes. There are no interviews conducted with children or young people to hear about their experience of the services delivered. Other contemporary models of Quality Management such as disability certification, engage with service users to validate whether the service's processes match with the client's experience. While organisations need to be mindful of over surveying children and young people in care, the opportunity for them to engage with the IEA provider should be explored as a measure of assessment to ensure whether the service is complying with the Statement of Standards
    - has created a system where processes are driven by compliance demonstrated through documentation with significantly less consideration of outcomes achieved and continuous improvement
    - is problematic as services can receive "non-conformances" for items that are Child Safety responsibilities. For example, services are required to have case plans on file. If the service does not have this it must show evidence of requests to Child Safety. The onus falls on the service rather than making Child Safety accountable

113. There is significant variation across Child Safety Service Centres, with staff requesting different evidence or paperwork, the level of training and experience in auditing and even knowledge of the Standards. This adds to the cost of meeting compliance requirements.

114. Our organisation has several residential care services where the building is provided by Child Safety and the building is a QBuild property. In the past, there have been difficulties associated with Child Safety not finalising or returning the necessary paperwork required to comply with licensing. Where a QBuild property is being leased by an organisation, full responsibility for compliance with Local Government Authority regulations should fall on Child Safety and not form part of a services licensing process.

115. Other issues in relation to the regulation of care include:
    - the impacts on organisations of mandatory training requirements including the costs of this training and its limited portability across organisations
    - the current limitations in the regulation of care services. It is unclear why services such as the Family Intervention Services, Referral for Active Intervention, Helping Out Families, and Placement Support services are not in scope
    - the lack of obligation of carer services provided directly by Child Safety to comply with the regulations placed upon non-government organisations including the requirement for independent assessment and monitoring.

Recommendations

116. Improve the licence application process through the use of:
    - an 'ask once, use often' approach be applied in relation to documentation
    - greater streamlining so that the legislation allows one licence per organisation as opposed to regionally based licences. This would result in a significant reduction in administrative and human resources required to both complete the prescribed application paperwork and undergo the independent external assessment process

117. Reassess the frequency of monitoring visits and ensure licensing reassessments are conducted by a consistent team of Child Safety staff who are competent in undertaking audits and thoroughly understand the Standards.

118. Include in the Independent External Assessment the results of consultation with children and young people to ensure compliance with the Statement of Standards.

119. Ensure, where a QBuild property is being leased by an organisation, full responsibility for compliance with Local Government Authority regulations falls on Child Safety and does not form part of understanding of the Standards.

Workforce support and capacity building

120. To provide high quality services to children, young people and families, staff from relevant non-government and government organisations across the child protection system require:
    - the appropriate minimum qualifications, knowledge and skills
    - a shared understanding of relevant issues, definitions, theories and child protection practice frameworks
    - access to systems and resources that allow them to complete their duties and meet identified personal, professional and organisational requirements
    - access to relevant ongoing professional development, educational and training opportunities
    - opportunities to network with peers, colleagues and other professionals from across the sector including participation in joint training
    - access to scheduled regular professional supervision and debriefing
    - opportunities to undertake evaluation and research, if desired

Current UnitingCare Community involvement

121. UnitingCare Community has a commitment to professional development and training. In 2003 it became a Registered Training Organisation recognised under the Australian Quality Training Framework by the Training Recognition Council. We deliver a wide range of training to our staff and other organisations.

122. In recognition of the stressful nature of child protection, our staff and those from other organisations can access an Employee Assistance Program (EAP) and/or the organisation's own RISE (Resilience, Information, Support, Empowerment) program. The latter program provides proactive employee assistance offering debriefing, assessment, intervention and referral for employees experiencing workplace or other life difficulties.

123. Where appropriate, professional staff members, registered psychologists and intern psychologists under supervision are also available to offer a crisis response following a critical incident at a residential.

Key issues for consideration

124. Given the significant over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system, government and non-government agencies should be encouraged to employ a percentage of Aboriginal and Torres Strait Islander staff that adequately reflects the cultural demographics of their clients and ensure that their staff have a sufficient level of cultural competency. Currently, approximately 12 per cent of UnitingCare Community's out-of-home care staff identify as Aboriginal or Torres Strait Islander. However, these staff do not have the capacity to work with all of the Aboriginal and Torres Strait Islander children and young people in UnitingCare Community's out-of-home care services across the state.

125. Staff recruitment and retention is an ongoing challenge for our organisation given the nature of the work, the professional qualifications we require in particular roles and the salaries that can be offered within the funding allocated. This is especially the case in rural Queensland where our organisation is funded to provide a single worker in some communities which means they do challenging and complex work in isolation. At present the mining boom in the Central Queensland region has had a direct impact on staff and their clients due to increased rental and living costs.

126. It is of real concern that children in care can be cared for by staff without professional qualifications. There is a need for the community services sector to become 'professionalised' in the similar way to the child care and domestic violence sectors. In order to attract qualified staff, non-government sector wages need to achieve parity with government salaries. Without pay equity this sector will continue to have difficulty filling professional positions, particularly at the more senior levels (e.g., program manager, senior practitioner and team leader).

127. We believe that consideration should be given to the development of a workforce education strategy for the child protection and family services sector which entails new collaborations between government and the non-government sector. Such a strategy should include the delivery of joint training to both sectors to foster the development of shared practice frameworks and greater collaboration on the coalface of service delivery.

Recommendations

128. Develop a workforce education strategy for the child protection and family services sector that delivers new collaborations between government and the non-government sector involving the delivery of joint training and the development of shared practice frameworks.

129. Establish mandatory qualifications for staff working with children and young people in out-of-home care. This will involve developing compliance timeframes as well as provision of adequate funding to the non-government sector to employ suitably qualified staff and to enable current staff to up-skill.

130. Increase funding to the non-government sector to enable greater wage parity between government and non-government child protection staff which is critical to attracting and retaining experienced, qualified staff.

131. Implement appropriate models of staff supervision, debriefing and performance planning across the child protection service system. Consideration could be given to the use of programs such as RISE to support and debrief staff.

Attachment A

Overview of UnitingCare Community programs which support vulnerable children and families

Since 1964, UnitingCare Community has provided a 24-hour Lifeline telephone counselling service.

- During the 1970s, face-to-face counselling commenced for issues such as separation and divorce, grief and loss, domestic violence, depression, anxiety, parenting and behavioural issues for children and young people
- Financial counselling was introduced in the 1980s and recently this service expanded to include the Financial First Aid Line
- In 2002, our organisation began school-based counselling at a number of schools in the Logan area and this was later expanded to the Wynnum and Redlands area in 2008. Many of the children who receive these services have experienced neglect or some form of family violence
- For the past seven years, we have been delivering sexual abuse counselling services to children and young people (to 18 years) who have been referred by Child Safety in the metro south region (HOPES program) and the metro north region (Specialist Child and Family Program)
- UnitingCare Community also has a number of youth development programs scattered throughout the state which focus on the development of resilience and interpersonal skills amongst at-risk young people who have experienced family violence, neglect, intergenerational unemployment, exclusion from school and/or social isolation

UnitingCare Community also provides a suite of crisis support services.

- The organisation is funded to provide a number of domestic violence refuges and homelessness accommodation services for women and children in Southeast Queensland as well as a safe house in Cherbourg and a youth shelter in Townsville
- Through its Seniors Enquiry Line, our organisation runs the unique Time for Grandparents (TFG) program which provides support to grandparents who have the full-time care of their grandchildren
- We have also undertaken a considerable amount of community recovery work in the past few years, using both paid staff and volunteers trained in Psychological First Aid, to provide support to families in crisis as a result of natural disasters. Our community recovery workers encourage parents to talk with their children in a safe manner about what has occurred during the disaster and to ensure that they do not direct any of their own stress or frustration towards their children

Our organisation provides a range of post-separation services that focus on family relationships and post-separation parenting within the family law system.

- The organisation is funded to auspice three Family Relationship Centres (FRCs) in Bundaberg, Logan and the Sunshine Coast which are a key component of the 2006 Family Law Reforms. Family Relationship Centres provide information, referrals and dispute resolution services. As part of these services FRCs are required to undertake a rigorous safety assessment with all clients particularly around family and domestic violence and child safety

- The Bundaberg Family Relationship Centre has developed specific resources for Aboriginal and Torres Strait Islander clients and provides a flexible service to this group
- Post-Separation Co-operative Parenting programs are located in Mackay, Wide-Bay Burnett, Caboolture and Ipswich. This program aims to assist highly conflicted separated parents to manage their conflict in the best interests of their children
- Our organisation provides a specific program that supports the wellbeing of children and young people from separated or separating families who are experiencing issues with difficult family relationships. The Supporting Children After Separation Program (SCASP) is located in Bundaberg, Ipswich, Caboolture, Chermside and Logan with outreach to Maroochydore

Place-based initiatives are one of the key ways that prevention and early intervention services can assist communities to raise children. UnitingCare Community currently operates two federally funded Communities for Children (CfC) – one in the Northern Gold Coast and the other in the Sunshine Coast and Gympie regions. These services foster social networks and peer support while also providing access to more specific or intensive services.

Communities for Children is a 'soft-entry' approach with activities that engage families and children in universal ways in every day contexts. The initiative is aimed at increasing child safety and wellbeing by addressing known risk factors that impact on the parenting capacity of families, enhancing parenting skills and building stronger and more sustainable families and communities.

Services for Children and Young People in Out-of-home Care

UnitingCare Community provides a suite of counselling services that support children in care, their parents and/or their grandparents.

- Our Healing Opportunities, Prevention, Education, Sexual Abuse (HOPES) Counselling Service provides counselling to children and young children 0 –18 years who have experienced sexual abuse, children 13 years and younger who are displaying early sexualised behaviours and non-offending parents and/or carers. Protective behaviour sessions are also provided by the service. The program which can only accept referrals from Child Safety has been operating for seven years in the Logan catchment and three years in the Gold Coast region. All staff are registered Psychologists who keep abreast of current research and therapeutic interventions. The complexity of the cases requires that staff receive regular supervision and debriefing.
- The Systemic Counselling for Optimal Placement Experience (SCOPE) program is a counselling program available to children and young people in care in the Ipswich region. It aims to increase the stability of out-of-home care placements and supports families where ongoing intervention by Child Safety is required. Reducing emotional distress, improving relationships and learning new coping and problem solving skills is the focus of the program with the aim of reducing future vulnerability to adverse mental health and social problems. Foster and kinship carers learn new ways to support the child or young person in their care and receive counselling support when their confidence in the caring role is undermined. Parents may also receive therapeutic help for up to one month to mitigate their disruptive conduct towards a child or young person's placement. Joint work may be undertaken with other services such as Family Intervention Services (FIS).

- Our Next Steps program operating in the Redlands is funded by Child Safety to deliver group counselling for women who have had or are at risk of having, their children removed from their care as a result of domestic violence. The women who attend these groups usually have substance abuse and mental health issues as well as complex trauma histories which will often include child sexual abuse. Where possible, these women are referred to additional services for individual counselling as almost all of them need a combination of counselling and family support case work.
- Since 2005, our organisation's statewide Time for Grandparents (TFG) Service has supported grandparents when they are the primary carers of children. TFG provides weekend grand-family camps where grandparents can identify goals and strategies to address stress, self-care and parenting issues. It also provides grandchildren with a wide range of recreational activities across Queensland. Specific activities and camps are provided for Aboriginal and Torres Strait Islander families (approximately 23 per cent of families) as well as for families from culturally and linguistically diverse communities. This unique program provides a valuable support role to the members of the Stolen Generation and assists them to keep their grandchildren from entering State care.
- The Family Lives (Annerley) Service receives funding from the state government to provide a range of family based supports for children and young people who have a disability, their families and carers A major service focus is the Shared Care Program which supports children and young people with a disability who are no longer able to live with their own families. In this service there is a strong focus on maintaining and strengthening contact with natural parents so they can maintain a parenting role while Family Lives provides the required support to their child.