**Submission No** 9

# INQUIRY INTO CHILD PROTECTION

**Name**: Name suppressed

**Date received**: 2 June 2016

LEGISLATIVE COUNCIL
Inquiry into child protection
GENERAL PURPOSE STANDING COMMITTEE – NO 2

Submission in response to Legislative Council 'Inquiry into child protection'

From:

Legislative Council – General Purpose Standing Committee – No 2

To whom it may concern

I would like to submit the following concerns and information for your consideration in relation to the 'Legislative Council – Inquiry into child protection – General Purpose Standing Committee – No 2'.
While not comprehensive, by any means, I hope they can be put with a growing body of knowledge which may go towards influencing some positive change in the sector.

I am making this submission as a private citizen. I would like to acknowledge that I have worked in the field of child protection or associated fields (domestic violence, youth work, disability services) for some 35 years, including 10 years on the After Hours Crisis Response Team with FACS. I have spent the last 2 years in a different FACS role and have had the opportunity to observe somewhat from the periphery the continued decline of the culture of NSW FACS and the deterioration of the volume and nature of services and supports offered to the vulnerable children, young people and families of NSW.

Clearly the current state of concern for our most vulnerable community members is not absolutely attributable to FACS per se; there are much wider social, economical and political factors exerting influence on the appalling state of child safety in this State. That being said there is also an enormous range of potential improvements that could be actioned within FACS which would go towards improving their service provision, the general culture of the Department and strong and positive outcomes for children, young people and families.

There are a great many people with both passion and integrity working within FACS. For the better part I believe they should be applauded for the job they do in the current climate. However the truth is that no amount of back patting or applause can make children and young people safe; the sector requires a shake up to ensure it can complete its appointed responsibilities to the vulnerable children, young people and families in this State.

I am concerned that some of the most important information won't be put forward to this inquiry as the holders of this information are so hard pressed in maintaining their day to day workload they will not be able to find the time to put pen to paper. I see this as a great shame.

I hope you, as a committee, are both compassionate and brave. Honesty is not always well received however it may pay to remind yourselves in this case the stakes are extremely high.

I wish you all the best in completing as task which may well have some of you questioning both your sanity and the wisdom of 'jumping into the pond'.

Regards

a) the capacity and effectiveness of systems, procedures and practices to notify, investigate and assess reports of children and young people at risk of harm:

Concerns re rate of abandoned calls/reports of risk of significant harm to Helpline

- Data regarding abandoned or terminated calls to Helpline is not readily available for general scrutiny via either the FACS statistics reports online or the FACS annual statistics report.
- Neither is the 'call wait' time listed in this data distribution. This is a significant factor given it appears the longer a call is waiting for a Caseworker response the more likely it is that the call will be abandoned.
- For some people it is an enormous challenge to report information relating to risk of harm to children and young people. This is especially true if these children and young people are family members or part of a close social group. There are no guarantees that the caller will make a second call to Helpline to report their concerns and hence many children's current level of real risk may remain unknown.
- Callers having to wait long periods to have their information taken are statistically more likely to abandon their call.

Concerns re 'triaging' of risk of harm reports by unqualified staff

- Helpline, where the majority risk of harm reports are initially received, has a process which has previously been called 'triaging' in which CSOs (Community Service Officers), who are not professional social workers and are generally not otherwise qualified, are the first point of contact with reporters. The CSO becomes the initial receiver of summary information from callers which is then distributed to queues to await reporter engagement with a caseworker to elicit the fuller story. This process can, and often does, result in callers hanging up as they feel they have given their 'story' once and they are unprepared to repeat the information. Research also shows clearly that retelling of traumatic events has its own inherent dangers.

Inadequate staffing (both numbers and experience levels) to respond to volume of calls received at Helpline to report risk of significant harm

- The volume of calls received at Helpline continues to rise and creates a situation where Caseworkers are 'under the pump' to process calls at speed. This often leads to situations where the time needed to encourage exchange of pertinent information is not taken and historical information is not taken into appropriate account in determining the current risk level of children and young people.
- This situation exists despite the bar to risk of harm having been raised to 'risk of significant harm' which was expected to reduce the volume of reports being made.
- Anecdotally the level of child protection experience of a Helpline Caseworker and Team Leader is on the lower scale. This is concerning given all other 'emergency' services appear to place their most experienced staff in any triaging positions, or at minimum provide significant experienced oversight and supervision to any 'triaging' tasks.
- The sheer volume of oversight and approvals required of Helpline Team Leaders impacts significantly on the quality of work they are able to perform.

Concerns in relation to 'Queue Management' of risk of harm reports

- Frequently, and at times of high call volume, reported information is summarised in the 'Contact' recording by Helpline Caseworkers.
- Often the Helpline Caseworker who has received and documented the initial information is not the Caseworker that will be prioritising the report for response. This procedure is known as 'queue management' or more specifically 'queue managed contact'.
- Information may sit for lengthy periods of time awaiting further action when 'queue managed'. There is often a significant backlog of these matters awaiting further assessment prior to being distributed to local CSCs for action.

- Records of reports are frequently queue managed prior to comprehensive child protection history searches being fully completed.
- Although these queue managed calls are provided with a token 'response time' this is often amended when the record is completed due to a range of reasons; not least of which is the unearthing of concerning historical child protection information.
- Queue management of reports at the Helpline is problematic in other areas. Not all the information received by the Helpline Caseworker that took the report is recorded. Some information may seem somewhat unimportant to the child protection concerns on first hearing by a Caseworker, especially an inexperienced Caseworker. However when viewed in conjunction with a child and family history information it may be identified as more pertinent than originally thought. If the receiving Caseworker completes both the full history check and the prioritisation tool there is a greater likelihood of the importance of 'loose' bits of information being recognised and contributing to appropriate prioritisation and distribution of reports; the queue managed system can not replicate this first hand knowledge transmission.
- The oversight and approval of contact reports, assessments and response (including use of the 'tools') is often completed by inexperienced practitioners (many of whom have never worked in child protection in the field and have little knowledge of the nuances that may point to a higher level of danger for a child or young person).

b) the adequacy and reliability of the safety, risk and risk assessment tools used at Community Service Centres

Concerns re the current prioritising tools being used by FACS to prioritise risk of significant harm reports that are to be transferred for attention at the local office (CSC) level having the 'bar' dramatically high in relation to identifying defining issues of concern as 'risk of significant harm'.

- This is especially obvious in relation to children and young people living with and/or being exposed to domestic violence.
- The importance placed on provision of concrete evidence to demonstrate risk is concerning given some callers to Helpline are not professionals or mandated reporters and hence often lack a grasp of the type of language used in the child protection field. What is common knowledge amongst child protection professionals is that the subtleties of situation are extremely important to read alongside the more concrete evidence to determine what risk is present in any given situation.
- Discounting concerns of people who are seeing children on a regular basis comes with enormous risks attached.
- There appears to be an over reliance on the suite of 'tools' versus professional knowledge and experienced analysis of the child protection concerns raised.

c) the amount and allocation of funding and resources to the Department of Family and Community Services for the employment of casework specialists, caseworkers and other frontline personnel and all other associated costs for the provision of services for children at risk of harm, and children in out of home care

Concerns for mismanagement of finite resources

- There is potential for employment of more caseworkers on 'normal' time without any bottom line financial cost. The use of Caseworkers in this way would appear more appropriate than for example the significant use of overtime at Helpline and on the After Hours Crisis Response Team. With adequate planning the money spent could potentially engage more CW hours i.e. the employment of more Caseworkers at same financial value. This is said while acknowledging that some After Hours Crisis Response Team overtime work is crisis driven and is therefore not predictable. And further there are periods of high call volume at Helpline that are best addressed with the use of overtime hours where staff are available.

Difficulty in employing, developing and maintaining experienced staff

- Concerns re limited level of completed field experience of 'casework specialists' or others in specialist roles such as JIRT or After Hours Crisis Response Team caseworkers.
- There is a significant lack of incentive for experienced caseworkers to remain in the FACS system (no incremental salary increases past a certain point).
- With the Departmental expectation of caseworkers changing from front line positions to management positions once some level of experience is obtained there is little acknowledgement of the value of experienced caseworkers in the field to mentor new entry caseworkers in child protection.
- Any acknowledgment of the importance of experience provided appears tokenistic and almost patronising. It would be difficult to imagine the giving of a plastic document wallet to any other worker that has completed 20yrs of service to an organisation.
- There is a significant loss of knowledge and information base with high turnovers within a workforce.
- The turnover within FACS has a direct flow on effect on vulnerable children, young people and families. It frequently means that these clients are required to re-tell traumatic histories and attempt to establish a trusting relationship with a new worker or workers.
- Client frustration with these type of changes often hinders progression of positive change.

The tightening purse

- The reticence of FACS to address even the most material resource issues within families is concerning. Brief interventions that respond to immediate issues may well alleviate current risk, reduce ongoing risk and moderate the chance of a child or young person entering care. Additionally such interventions often build a platform from which meaningful relationships can be built.
- The health, medical, dental and educational needs of children, both in OOHC and subject of ROSH reports, are often not ideally addressed. The Department frequently fails in it's obligation and responsibility to act as a 'good parent'.
- Appropriate and timely referral to mental health services is frequently delayed as FACS appear prepared to wait for a public health response rather than access services immediately in the private sector. For children and young people that have recent exposure to trauma it is rarely helpful to delay such engagement. The delays will often contribute to a child or young person being unwilling to engage with appropriate service providers.

d) the amount and allocation of funding and resources to non-government organisations for the employment of casework specialists, caseworkers and other frontline personnel and all other associated costs for the provision of services for children at risk of harm, and children in out of home care

- No comment provided.

e) the support, training, safety, monitoring and auditing of carers including foster carers and relative/kin carers

Impact of administrative tasks and excessive workload

- Caseworkers are being so heavily burdened with administrative tasks that they can not find adequate time to provide appropriate level support to foster/relative/kin carers.
- In many instances the sheer volume of tasks allocated to OOHC Caseworkers has meant that tasks associated with authorisation of carers have taken an secondary seat to more pressing immediate issues.

OOHC – private/NGO changeover

- The change of children in FACS OOHC to private/NGO OOHC sector has resulted in many more children being housed in motels with constant change of carer/staff to provide for their care and oversight.
- With the change of OOHC to the private/NGO sector training and monitoring of foster/relative/kin carers appears compromised in favour of financial and target meeting concerns.
- Risk of harm reporting from NGOs is not monitored adequately.
- There is little recognition that it is not generally in the best interest of an organisation to report risk of harm occurring within their agencies and hence open themselves for criticism or scrutiny by their funding body.

Concerns re allegations of risk to children and young people in OOHC

- Matters of allegations against carers are not consistently being treated as an urgent matters (whatever the FACS prioritisation tool may direct). As evidence there have been many situations in which foster carers have been subject to multiple reports as a 'person of interest' or 'person associated with causing risk' that have not been adequately investigated by FACS and further children in care have been put at risk when placed in their care.
- There appears to be an undue amount of importance attached to maintaining the status quo of relationships between agencies/NGOs and FACS when any investigation is completed regarding allegations against agency carers. This has previously led to a situation where a child was sexually assaulted by multiple workers in an NGO OOHC facility.

f) the structure of oversight and interaction in place between the Office of the Children's Guardian, Department of Family and Community Services, and non-government organisations regarding the provision of services for children and young people at risk of harm or in out of home care

- No comment provided

g) specific initiatives and outcomes for at risk Aboriginal and Torres Strait Islander children and young people

- The responses offered by FACS to at risk Aboriginal and Torres Straight Islander children, young people and families are often minimal or tokenistic initiatives that are poorly resourced.
- Some initiatives appear to be targeted more towards improving FACS general public profile than addressing real and relevant child protection concerns.
- The use of tokenistic 'cultural case planning' is problematic. Cultural plans need to be the result of robust consultation with the child/young person and communities; they need to be achievable and accessible. FACS continues to provide a less than adequate response to indigenous children both in assessing risk of harm from a culturally sensitive basis and providing culturally appropriate care arrangements when they determine the parents do not have the capacity to provide for their children's' safety and well-being.
- Community consultation frequently lacks a true level of transparency and integrity.

h) the amount and allocation of funding and resources to universal supports and to intensive, targeted prevention and early intervention programs to prevent and reduce risk of harm to children and young people, and

- Even when a child protection risk and safety assessment determines that a targeted early intervention may be suitable for the family to both address and mitigate identified risks issues there are frequently significant delays in families being referred to appropriate services. Additionally many clients then find lengthy delays and waiting lists prior to being able to access appropriate services.
- If families are referred to services and they do not feel draw into engagement at the initial referral point there are often limited on no alternative options offered.

i) any other related matter.

- the current culture and state of constant change within FACS has a significantly and negative influence and is definitely affecting morale of front line workers.
- the significant negative and dangerous impact of bullying and harassment of caseworkers within the workplace
- the current overly burdensome administration of system which is significantly reducing levels of motivation of front line staff
- the depressed level of professional optimism of frontline staff whilst completing their work
- the negative effect of repeated fluctuations in program directions, supporting policies and structures supporting systems
- statistical information relating to the organisation as a whole, and specifically in regards to children and young people within the system, is dated, simplistic and does not present a clear picture of the current state of either child protection services or out of home care services.

<u>Specific concerns relating to identifying 'persons of interest' in the CP system</u>

- I have significant concerns relating to the failure of reporting systems to identify 'persons of interest' or 'persons associated with causing risk' and categorised them as such in information directory systems.
- In support of not identifying a fear is frequently expressed in regards to no substantiation having been made at time of report or follow up assessment hence it being inherently 'unfair' for an 'allegation' to lead to this level of identification/categorization.
- Clearly this is not the case. Person of interest or 'POI' is used in many systems (notably policing) and can indicate a general interest due to information received, potential for further investigation in relation to a matter or simply an alleged physical presence in a situation. The term is significantly different from 'person causing harm' or 'person associated with causing risk' which require a substantiation of fact relating to a child protection concern.
- Such identification, categorisation and recording would allow for child protection history checks to show a much clearer picture of individuals over time thus allowing a more comprehensive and realistic assessment to be made when people apply to become authorised care givers to vulnerable children and young people or to otherwise work or professionally associate with children.
- If implemented nationwide this type of recording has the capacity to go some way towards breaking the stealthy and concealing actions of individuals that often relocate States to escape histories that would limit their interactions with vulnerable children and young people.