REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO CHILD PROTECTION SERVICES

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At Sydney on

Tuesday 5 November 2002

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The Committee met 10.30 a.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. James Samios
The Hon. Ian West

GLENDA STUBBS, Office Manager, Link-up Aboriginal Corporation, P.O. Box 93, Lawson, and

WENDY HERMESTON, Senior Case Worker, Link-Up Aboriginal Corporation, P.O. Box 93, Lawson, affirmed and examined, and

LOUISE COE, Solicitor, Aboriginal Childrens Service, 18 George Street, Redfern, sworn and examined:

CHAIR: Have you received a summons issued under my name under the Parliamentary Evidence Act?

Ms STUBBS: Yes.

Ms HERMESTON: Yes.

Ms COE: Yes.

CHAIR: Are you familiar with the terms of reference of this inquiry?

Ms STUBBS: Yes.

Ms HERMESTON: Yes.

Ms COE: Yes.

CHAIR: In what capacity do you appear before this inquiry?

Ms STUBBS: As a co-author of the submission and by invitation.

Ms HERMESTON: As a co-author of the submission.

Ms STUBBS: As a co-author of the submission of Link-Up.

CHAIR: Do you want your submission to be included as part of your sworn evidence?

Ms STUBBS: Yes.

Ms HERMESTON: Yes.

Ms COE: Yes.

CHAIR: Do you wish to make an opening statement?

Ms STUBBS: We need to acknowledge the traditional owners of the land on which we are today, and to say thanks for allowing us to be here. I also want to acknowledge the struggle that Aboriginal families have had in keeping their families together in the past and at the present.

CHAIR: The Committee recognises that.

Ms HERMESTON: I want to acknowledge the large number of workers in the department who are very dedicated and committed to looking after and protecting children and looking after families.

CHAIR: You say that before we embark on the criticisms of the system. The committee has heard evidence from a few people who have taken that approach.

Ms STUBBS: We are here not about criticism but about making some positive changes towards self-determination of Aboriginal families.

CHAIR: The questions probably cover most of the areas, but Ms Coe do you want to saying anything further?

Ms COE: No, not at the moment.

CHAIR: Would you give the committee an overview of the responsibilities of your organisations as they apply to care and protection of children?

Ms HERMESTON: Link-Up New South Wales provides support to Aboriginal adults who are seeking family where they have been separated through government intervention—whether that is adoption, having been placed in institutions, foster care or out-of-home care. We see the end results of past policies. People who have been subjected to past policies and practices and are over 18 years of age come to us. We have had clients who, as soon as they turn 18, comes to us. Again, just to acknowledge that it is not in the past because they are dealing with the effects of today. We are here, hopefully, because we see those past effects to have input as to what those effects are to hopefully look for strategies to stop them happening in the future.

CHAIR: In the past the committee heard similar evidence to what you will give today from Link-Up in the adoption inquiry. Ms Coe, do you want to comment specifically about the role of the Redfern Childrens Service?

Ms COE: Yes. The Aboriginal Childrens Service is a community organisation which was started approximately 26 years ago. Initially it started because there were a lot of Aboriginal children going to court and being made State wards. We had field workers who would go to court and argue for an adjournment so that Aboriginal foster carers could be found. This has grown during the years so that we are now a private fostering agency and we look after children in care. There are children who are committed to the care of the principal officer of the Aboriginal Childrens Service through the courts and their committal-to-care orders. Under the old Act it was section 72 when they would be committed to the care of the principal officer, usually until the age of 16 years in which case we would take on the parental responsibility of that child, find a placement and monitor the placement.

At present we have officers in St Marys, Wagga Wagga in western New South Wales, Cowra and in Redfern. We have more than 300 children in our care. As I said, some are committal-to-care orders, other children are referral from the Department of Community Services [DOCS] and there a great majority in western New South Wales who are what we call voluntary placements. They are children where the family have come to us, rather than going through DOCS and going to the courts, and they would ask if there are particular issues if they could place their child in care. That is with the consent of the person who has guardianship over that child.

We normally place in family units and most of our placements are fairly long-term. When they are with families they are usually there for the long haul when the parents do not basically get their act together and are able to take over the care of the children.

CHAIR: When you say in "family units" do you mean kinship care or in a unit that is a family?

Ms COE: In what I suppose is referred to as kinship care now and mainly with maternal grandparents or aunties or uncles. We always look at the family first for the children. We are an organisation that is under the Aboriginal child placement principle that is basically the last resort of being notified when there is a child that is in need of placement. That is what we have been doing for 26 years. We have worked with the DOCS on a daily basis.

At the moment our responsibilities, so far as care and protection, are to notify—mandatory reporting. We do not do any investigation of any abuse in care. We do not do any removal, obviously. We would like to keep it that way. We do not want to be too closely associated with DOCS because of a mistrust of DOCS workers, particularly in rural areas. We try to work as a go-between. We do support services, the Department of Housing and things like that to help people. Although we get funding from DOCS, ATSIC and the Department of Family and Community Services, we try to maintain our independence.

CHAIR: We will come back to the issues raised by Link Up. In your submission you suggest that the effectiveness of the aboriginal child placement principle is confined to or limited by a number of factors. We note that you have included no real policy and practice specifications to support the principles, a lack of resources and also a lack of Aboriginal foster carers. How do we make the principle work? In view of what you have just said, would you like to expand on the statement about a lack of Aboriginal carers?

Ms STUBBS: It needs to be legislated. It needs to be put into practice. I spoke about a scale of 1 to 10. Someone will say, "Does anyone know of a Koori placement?" And the officer will say "No" and that is all that person will do to look for an Aboriginal placement, whereas another person in the same office will have community meetings and drive Aboriginal people barney to find a placement. There is a whole scale. It depends on the integrity and the morals of the GO.

Ms COE: I agree. Because we have offices throughout New South Wales and we are dealing with different areas of DOCS, there is a great disparity between what DOCS is willing and prepared to do, and what should be done. Ideally, we would like the Aboriginal children's placement service to at least be notified when an Aboriginal child comes into care, whether someone contacts the Hotline and someone from the Hotline then contacts us. A lot of Aboriginal children go into non-Aboriginal care, and we do not find out for a couple of years down the track.

I can think of one case in particular that went to a community services appeal tribunal, and it came down to which psychologist could be believed about whether bonding with the non-Aboriginal parent was more important than the child's Aboriginal identity. Psychologists without any particular training in Aboriginal issues or culture are saying that it is much more important for a child to maintain its bond with the parental figure rather than that child, who is Aboriginal, growing up knowing about its Aboriginality and being able to identify as Aboriginal. That is happening all the time.

We should at least know what children are coming into care. The Koori community is very close knit. You usually know who is Koori, who is not Koori and who is related to whom. But the problem with foster care and what flows on from that adoption is that the child can lose its heritage. The child is another Link Up child waiting to happen. The child does not know who its family is. In a lot of towns, particularly in western New South Wales, the communities are small. If the child is being raised by someone else not in the family group that child could easily marry its first or second cousin. It is a close-knit community.

The children need to know not only their life story but where they come from. Not enough emphasis is placed on the cultural identity of the child and maintaining that with the child's life story. You can draw the comparison with native title, the amount of money that has gone into researching families' claims that they maintained their ties going back 200 years. The whole connection to the land has to be maintained. But that is not being done with children. The child has an identity crisis. The child does not know not only who their family is but where their land is. It is a very important issue with Aboriginal people. We are perpetuating it.

Foster care is good in that it meets immediate housing needs, care needs and protection needs, but it does not look at the long-term: maintaining the cultural needs of the child. Even if the child is with another Koori family the child really needs to know who the parents are and who they were. They need to go back as far as possible so that the child can take some pride in who they are and know exactly who they are. That area needs to be addressed. The Aboriginal child placement principle is not enough. I spoke to one of the directors in DOCS, and it is not mandatory for them to contact us when a Koori child comes into care. But in light of all the children that are falling through the cracks, it should be mandatory. As Ms Stubbs said, they may make one phone call and that is it.

CHAIR: You said earlier that you have offices in St Marys, Wagga Wagga, Cowra and Redfern. We have spoken to groups of Aboriginal people on the North Coast. If you were notified about an Aboriginal child on the North Coast what steps would you take?

Ms COE: We do not have an office up there, but our workers from Redfern travel to the North Coast and the South Coast. They travel as far as Tweed Heads and then down to Batemans Bay.

Even though we have officers in Wagga Wagga and Cowra, they travel out to Broken Hill, Tibooburra and all over.

CHAIR: You the cover the whole State?

Ms COE: We cover the State as far as the children are concerned. Without boring you with too much detail on funding, DOCS currently funds one position in Redfern. That office is basically funded by ATSIC, which says that we are a regional organisation so they do not actually fund us to go up to the North Coast. We have to work that out ourselves.

CHAIR: You said that you get some Commonwealth funding?

Ms COE: That is right. We use that, too, to send officers up there.

CHAIR: You say there is a big variation between DOCS workers, individuals in the same office. Can you expand on that? Is it because there is a lack of training or information by DOCS to inform its workers, or is it prejudice? Is it overworked people thinking "Here is a family. That will solve the immediate problem."

Ms STUBBS: It is a combination. A lot of this is about integrity, about how people view it as important. A lot of people still have the idea that they are saving Aboriginal kids by placing them in white families: they have more things to offer and the family is richer.

Ms HERMESTON: Material things.

Ms STUBBS: I had a case where there was a white grandmother and that mum had Aboriginal children. They did a DNA test and found that she was not their grandmother, but my manager said, "Kinship care. Good!"

Ms HERMESTON: This is the whole issue, it is the department, but the department should not make a call on what is kinship and what is not. It should be community members and it should be community treatment. You can go the other way and say that they would not class a great aunt as kinship because it is not within that family.

Ms COE: It is back to the usual problem of applying Eurocentric definitions to Aboriginal people. What is family to the greater Australian may not be family to Aboriginal people. It is quite funny because you have kinship care, which basically means that DOCS does not have to compulsorily pay the foster care allowance if a child is in kinship care. On the one hand you have the Aboriginal child placement principle which says place with the family first, which is great. But if you are looking at it from the financial viewpoint, DOCS is saying, "That is great because now we have to assess it only as a non-parental allowance." Therefore they get less money because it is kinship care. The Aboriginal people are losing out. We recognise it is important to provide kinship care. The child's needs would be the same whether the child is with the grandparents or a stranger. I do not see why a financial distinction should be made for kinship care.

Ms HERMESTON: Less support.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is really a way of ripping you off.

Ms COE: Yes. It is a case of their saying, "Let's keep these Aboriginal child placement principles, but the grandparents will be assessed on their income and will not get the mandatory payments."

Ms STUBBS: It leaves the gap with counselling or therapy.

Ms COE: And support services. They are vital. No-one can tell me that any child who comes into care will not have psychological problems. They need their health assessed before coming into care. They say you have to give the foster parents all the information that is pertinent to that child. However, if that child is not comprehensively assessed, they are not fulfilling that obligation or providing that information. That is very important.

Mr WEST: In trying to mix the difficult issues of your association with DOCS and maintaining independence and those important issues of heritage and so on, have you thought about how you get the mix right in terms of training and educating the DOCS staff? I am trying to visualise what ideas you have in mixing those together.

Ms HERMESTON: I have a few ideas. It is difficult because in some ways we are still dealing with a fair amount of defensiveness on the part of the department. Last year when we sat around the table trying to discuss the proposed permanency planning bill, which we had and still have major problems with, we picked up a certain amount of defensiveness that encapsulates what is going on in the department in general. This has happened in the past and it is still happening today. There is that extra wall we need to get through, instead of being able to sit down, listen and have an equal partnership in working things out and allowing a lot of community input. There is defensiveness there, and that is the first thing to get over.

There are major opportunities. Last week DOCS legal officers were having a meeting and I spoke at that meeting. There should be more training, not just for new recruits but at a range of levels-we mention that in the training and morale section of the submission. We should have a systematic approach to training and education. We are also dealing with attitudes. That would be the ideal. The same applies to corrective services workers and a range of different people who work with members of the stolen generation. Is that what you are asking?

Mr WEST: Effectively. More will come out as we go through this.

CHAIR: All the issues overlap.

Ms STUBBS: You need to look outside the box. My friend Christine has given me ideas about looking outside the box to keep families together and so on. That is about different levels of integrity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not know as much about Aboriginal people and that situation as I should. However, we hear horrendous stories about kids sniffing glue. I presume that is the result of despair and having nothing to do. For as long as I have been an adult and thought about it-that is, about 30 years-people have supposedly been conducting programs to assist disadvantaged Aboriginals. There appears to have been an extraordinary lack of success in terms of the dollars invested-for example, infant mortality and life expectancy figures. What child support services or other services will break the cycle? If you were to look at one child who was sniffing glue and who came from a white middle-class family from central casting, you might ask what you could do for that child. You would be able to see where he might have come from. If they were going into a community with that problem, they would then ask what they would do for that family. They could take the broad view and fix the whole community rather than just one child. Obviously, at the average caseworker level that is not possible. This committee wants to fix the whole situation, or at least get the concepts together and try. What should we be doing to fix the community and to make it a good situation in which these children have equal opportunities?

Ms HERMESTON: I do not know how many hundreds of billions dollars are spent each year. I have heard the figure bandied about that some massive percentage-about 80 per cent-goes into the white bureaucracy. It does not trickle to where it is needed; it gets caught up in bureaucracies and government departments and does not get to where it is needed in terms of programs on the ground.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean 80 per cent is spent on overheads?

Ms HERMESTON: That is the figure I have heard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is extraordinary.

CHAIR: The Federal Government includes the cost of running the departments in the amount officially dedicated to Aboriginal people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely the bureaucrats do something?

Ms HERMESTON: Yes, but not enough is happening.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am taking the Australian Institute of Public Health figures, which were released recently.

Ms HERMESTON: It released a report last year.

Ms COE: In New South Wales, 28 per cent of children in care are Aboriginal, and 2 per cent of the funding goes to Aboriginal organisations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is in your submission.

Ms HERMESTON: That is all worked out.

Ms COE: I know that DOCS is trying to get services to tender for a program at the moment. It is based on a Victorian model of an intensive family support service. Someone in DOCS has decided that the model is fantastic and that we should do something like it in Sydney and the department is calling for tenders. I have read a long document produced by a consultant about the program's outcomes. It is too little. The program involves two workers in one organisation who work with no more than two families for no longer than six months. The pilot program went for two years. They may have helped about 15 families over those two years. There is also the six-month time limit. Intensive services are provided to the family and after six months that is it. If the family still needs help, there is no funding. The bureaucrats might think these programs are fantastic and that they should be implemented here, but we should keep in mind that Aboriginal communities are different in different States and towns. However, if the department goes ahead and the program fails, it can at least say it tried.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it another paternalistic model?

Ms COE: It is. Even if the department goes to the community and asks what is needed, by the time the program gets to the person making the funding decision it has been twisted and turned. If we wanted to tender for it we would have to be like another DOCS and take a bureaucratic approach. We deal with people on the ground and with crises as they occur. We are not threatened on a daily basis, nor do we cop abuse. DOCS offices all have security. We are in a terrace in Redfern and people who are unhappy with us can get us. We are on the ground, whereas the people making the decisions are in those offices.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Behind the fence.

Ms COE: Yes, and protected. If we had a model like that, people would ask why it was being done for one family and not for them.

CHAIR: If you were appointed as the Director-General of DOCS and had considerable power in this situation, what sort of support services or processes would you establish?

Ms COE: Initially, we need to do parental training. As Wendy and Glenda can tell you, we are dealing with stolen children going back four generations; these people do not have parenting skills. We need more preventative measures.

CHAIR: We very much agreed with that view in our interim report, which you may have seen. We referred to the entire community-Aboriginal and non-Aboriginal-and breaking the cycle of crisis, providing crisis intervention and doing enough. As a society, we need to turn the whole thing around and intervene at the beginning.

Ms STUBBS: For every dollar spent in the beginning, we will save it in the end when the children are not juvenile justice clients or in prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That 2 per cent to 28 per cent sounds like the kinship rip off gone crazy.

Ms COE: They are trying to do it even more. In the past the grandparents were getting the $350 a fortnight. Now it will be means tested. They are disadvantaging them more. The "Through Black Eyes" report said that the 28 per cent of children in care are there as a result of care issues not abuse issues. It is not that they have been sexually abused or whatever. Their problems are care issues, which come down to socioeconomics and lack of education and training.

CHAIR: Can you expand on that? Most of the evidence the committee has heard has related to child protection; in other words, with an understanding that abuse has occurred. We sometimes try to say "neglect and abuse". Are you saying that in many ways for Aboriginal children it is not abuse, whether that is defined as sexual or physical abuse, but more a matter of neglect or dysfunctional families? It is not a matter of allocating blame or saying that this person did this to this child; it is a more diffuse breakdown.

Ms COE: Because of what has happened with welfare agencies in the past, there is a basic mistrust of organisations such as DOCS. If a family were in crisis, it would not be likely to go to DOCS and ask for help, which it is obliged to give. If it were me, I would think that, if I asked for help, the next minute they would be knocking on the door and wanting to take my kids away.

CHAIR: When you talk about starting at the beginning with parent training, does an organisation like Families First, which has no connection with DOCS, fit in? Has it worked for Aboriginal communities?

Ms STUBBS: There is no specific Aboriginal parenting program.

CHAIR: In Families First?

Ms STUBBS: I do not know about that. That was raised last year at a child and family wellbeing conference. There is the three Ps. The crux is that we parent differently and we are judged on our parenting.

CHAIR: Is the Families First home visiting undertaken by paid or volunteer workers effective?

Ms STUBBS: That would be scary.

Ms COE: If they were not Aboriginal it would be scary. It would still appear that they were being checked out and judged. There will always be that difference.

CHAIR: Even if Families First in south west Sydney is absolutely committed to visiting every new mother and baby regardless of background or wealth?

Ms COE: There will be mistrust.

CHAIR: Even if it is universal?

Ms HERMESTON: It is still imposing on a family. It is an organisation making a decision to go into a family's home without any consultation or input from Aboriginal people.

CHAIR: How do we do the parent training then?

Ms HERMESTON: That relates to question No. 3. It is about preventative strategies, because most of the DOCS resources are directed at child protection, not at preventing abuse from happening in the first place. It will always be chasing its tail as a department while that goes on.

CHAIR: If home visiting is seen as intrusive or paternalistic, with white people coming in and telling Aboriginal people what to do, presumably you are saying Aboriginal people must do the parenting training, home visiting, et cetera.

Ms HERMESTON: Yes, get together, design and come up with programs, run the programs, and offer the support. It comes back to self-empowerment. Glenda has something in an article to read to the Committee.

Ms STUBBS: "We will measure the Government's commitment to self-determination by how well or poorly it supports and funds the implementation and entrenchment of the child placement principle in its ongoing practices and procedures."

Ms HERMESTON: That also applies to how well the Government commits to self-determination as measured against the programs that stop the child getting to the point of having to be placed in an Aboriginal family, or any other family for that matter.

The Hon. IAN WEST: That relates to overseeing crisis procedures. The Chair asked what input you have to Families First, the wellbeing conference not getting very far, home visiting being scary, and the level of access to the new parenting where the site.

Ms HERMESTON: For a lot of families, there is no access to the Internet.

Ms STUBBS: For Families First there was a pilot program at Penrith. There was talk about the fact that people were going into families' homes. I thought, "What about Cranebrook, for instance?" They can't even deliver the local paper there without fearing for their lives. How are volunteers, like my Mum, going to get on if we cannot even deliver the local gazette there because it is too risky? Do we expect little old Maude to go in and knock on the door and say, "How are you going? How are you coping?"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it that bad?

Ms STUBBS: At Cranebrook they cannot deliver the local paper. There are areas that are very risky.

Ms COE: There are some high-risk areas. Even ambulances cannot get in.

The Hon. AMANDA FAZIO: I have been to a fair few of the Families First home visiting programs and things like that, and they do make a concerted effort to try to match the volunteers with the families and make sure that they do not act intrusively. As you have such misapprehensions about the program working effectively and not creating a fear of authorities intruding on families, have you any suggestions on how, for example, service delivery to Aboriginal families might be developed, so that they do not miss out on the opportunities that exist under the Families First Program, so that they can actually get some benefit from it without reverting to the old days when welfare came in and sort of stomped all over people?

Ms STUBBS: I think you have touched on an important point: that past practices have left this fear. I think it will take time to overcome that.

Ms COE: I can think of one family from western New South Wales that is currently in the Children's Court because children had been removed. That family had someone coming into their home. You spoke about protection. The director had to remove that person. Because of what was going on in the home, it became too risky. So, it might have achieved something in the short term, but matters of domestic violence and so on still escalate. That worker had to be pulled, and now the children have been removed from the family.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Risky for the kids?

Ms COE: No. Too risky for the volunteer person going in.

CHAIR: Was that an Aboriginal person?

Ms COE: No. The volunteer was not an Aboriginal person.

CHAIR: Would it have helped if the person had been?

Ms COE: No, not really, because you will still have domestic violence issues. Quite often, at work we have to lock ourselves in and things like that. Domestic violence will still be there. It is not necessarily a long-term solution. It might be good in the short term, but there are other issues and other support services that need to be properly funded.

The Hon. IAN WEST: In that case study, what would you have done if you had the ability to whatever you thought fit?

Ms COE: The father or stepfather in that organisation would have had to have some sort of anger management course. There would have to be some counselling for the couple. And the mother should have had parenting training. What she was receiving was not parenting training. It was just like a support service—somebody to come in and take the kids to the park. Things like that are great, but she has about seven or eight children. and they are dependent on care because she does not have the parental skills. And there were drug and alcohol problems. So you need a wholistic approach. Usually, there are drug and alcohol problems associated with kids coming into care, so those problems need to be addressed. Our organisation is funded to look after the kids, but the natural parents then slip back into the alcohol syndrome, and things like that. They do not get the services, so the child is in long-term care, which is not in the best interests of the child. It is in the best interests of the child if the child is with the parents, if the parents can get their act together. So I think you need a whole range of services focusing on the issues. Home visiting is only a really small part of the problem.

The Hon. AMANDA FAZIO: So you think there needs to be proper case management for families that have a complex range of problems to deal with?

Ms COE: Usually the problems are complex. You have drug and alcohol problems, which lead to domestic violence, which leads to the children being neglected, which indicates a lack of parenting skills and so on. The range of problems is huge.

Ms HERMESTON: The drug and alcohol issues very often come from grief and loss, but quite often parents who remove themselves, where issues have not been properly dealt with, have not had the support. Our service can provided limited help. At the moment, we are again down to two caseworkers to deal with the whole of New South Wales—myself and one other worker. We have to be a presence in the community, get out and about and let people know that the service exists and what it can do, give workshops about stolen generations, and educate workers who are dealing with people, like DOCS and Health workers, or whatever. That is one issue.

The next, and most important, issue is doing the research work, trying to search for families. Perhaps equally important is the pre-reunion and post-reunion support for the person to deal with the issues. The issues that they have usually land them with drug and alcohol issues, because they are trying to drown out their pain. So the pain that leads them to drug and alcohol is the real underlying issue. They will have issues associated with abandonment and rejection, but quite often they will have cultural identity problems too. These are very powerful influences. Cultural identity issues, and being caught between two worlds, put you in a very lonely and desolate place. People feel very isolated when they are in that position and have no support. Suicide is a major issue as well.

Ms COE: I think grief management is very important, because that is an issue with many families.

Ms HERMESTON: Death is also because it is such a factor in everyday life, but so also is loss of relationships. Last week I was in South Australia at a reunion for a mother and daughter. The grief that is there, because they have lost all that time, is impossible to get over. You can never make up for it. So there are all these underlying issues. Everybody has issues that they have to deal with, and they carry the burden of those issues. These are extra issues on top of those which make it very difficult already. If you were put in those persons' issues, how would you deal with all those issues? How could you bring up your family?

Ms STUBBS: I am dealing with a perfect example of why siblings should be together today.

CHAIR: Can you tell us a bit about that, without going into specific details?

Ms HERMESTON: It happens pretty much in every reunion, particularly where the child has been adopted, because identity has been taken away. They do not know their name and they do not know their mob. There is a chance, if they have been fostered, that they will be able to keep their name, although it does get changed from time to time. But where the connection has not been kept with siblings, the family has no idea how to bring the child, which is now an adult, back into their life. So, quite often, their way of dealing with it is to just act normally. However, that does not recognise that the child that has been separated from them, even though an adult, might interpret that reaction as rejection or abandonment again. They become fearful of saying no to the family, or not doing what the family wants, such as, "Let's go here, let's go there," such as when a reunion is on, or, "Come back for Christmas." The family does not realise that individuals are grappling with major issues. "Here are these strangers who are supposed to be my family, and I am supposed to fit in with them, but I am not. I have grown up to have two completely different lives. How do I fit back in?"

The smallest thing, like setting up that particular reunion, can be a problem. The mother wanted it at a town away from the smaller town in which she was living, because she had never told a soul about this child. When she arranged that, the daughter was ready to say, "We're not having it," because she took that as rejection, as an indication that the mother did not want people to know about her. The brothers in the family both had drug and alcohol issues of their own that they were dealing with. How do they fit this sister back into their lives? What is their role in it? What are they supposed to do? Men have extra issues because quite often they are expected not to show any emotion or express any sentiments, and that compounds the problem. This is just the difficulty of trying to fit families back together again. It is a long-term process. It is very difficult to describe. In a way, it is like two magnets: they know they are supposed to be together, but there is a resistance because of all the issues going on.

CHAIR: You said at the beginning that Link-Up deals with such a range of people—parents, children who have been taken away, and people of all ages. You also mentioned that you get 18-year-olds coming to you. Can you give the Committee a picture of what the 18-year-olds are telling you about their out-of-home care experiences? I know it is asking you to generalise to a large extent, but obviously the Committee's inquiry needs to focus on the current system. So I am thinking particularly of the 18-year-olds who have just come out of foster care, or whatever. What sort of picture are they giving Link-Up of what things have been like for them?

Ms STUBBS: I think the picture is of divided loyalties. They feel, especially if they are in white placement, that they need to be loyal to their foster parents.

Ms HERMESTON: They feel obligated.

Ms STUBBS: Often, they are not encouraged to find their families. They have had some of their material needs met, but they have a big void and they want to find their families. But, if they do that, they could be rejected by their families.

CHAIR: Are you suggesting that most of them do not know who their families are, or have not had contact?

Ms STUBBS: That is adopted people.

CHAIR: What about fostered children?

Ms STUBBS: A lot of foster kids have not had much contact with their families.

Ms STUBBS: It depends on the DOs. I have a girl in my care who the court ordered should have access to her siblings. For 10 months she has not had access because it does not suit the foster carers: "No, you can't do it this weekend. No, we can't do it that weekend. No, she is going away for the whole of the school holidays."

CHAIR: We have a question, which we have not got to at all, but you have referred to it a couple of times in passing. It is about your picture of the Children's Court and the dealing that indigenous families have with the Children's Court. You have just mentioned a court order that was not working. Can you tell us a bit about the role of the Children's Court?

Ms STUBBS: We were going to pass that question to Louise.

Ms HERMESTON: Yes, she is in a better place to answer it than us. You asked about children who have come out of care recently. It is almost as though they are even more damaged than their parents. We recently had a reunion at the office involving a boy who was in a Christian rehab program. It was quite a full-on Christian rehab program where the word of the Lord gets you through and problems are dealt with in a specifically religious way. In some ways I think whatever gets him through and stops him from slashing his wrists is good, but in other ways you know that that is basically brainwashing that he will have to deal with before he gets back to who he really is and where he is from—which is what he needs to do to start healing.

CHAIR: Was this boy cared for by an Aboriginal family?

Ms HERMESTON: Now, he was in a white placement and institutions. The major issues they seem to have are cultural: they do not know whether they have the right to identify as Aboriginal. They do not know how to fit in with other Aboriginal people and face rejection from their people when they cannot. They cannot answer questions such as: Who are you and where are you from? This boy knew his name but he could not say where he was from. That is a major problem because it is usually the first question asked in the Aboriginal community. Most of our clients cannot answer that question until they find their families. That is a central issue. They have cultural issues that they are trying to deal with.

This boy was a very angry young man. He hid it well when he met his mother but he had a lot of bitterness and bile towards her. They went to court when he was 14 and he stood up and said, "I don't want to go with her". But he did not realise what had happened: How the mother had struggled even to get that hearing to allow the boys to comment on where they should go. His anger towards his mother that he had had throughout his life was incredible. It was amazing that he had not harmed himself severely or fatally or harmed someone else. Many of the lads and women who are in the system now who have been removed have this anger and alienation, which is what has landed them in the system. Alienation, isolation, anger, cultural identity and an overpowering sense of not belonging to anybody or to anything or having the right to identify or even exist—feeling invisible—are the issues that the younger ones seem to deal with.

After a reunion—on our way back from a country town in the car—one younger girl who is adopted finally revealed the reason why she wanted that reunion with her mother at that young age and was so urgent about trying to have it. That is when the warning bells go off for me: when someone urgently wants a reunion and cannot let the other person allow it to happen in their own time. It turned out that the girl wanted to have the reunion in order to hurt her adoptive father. A great number of our clients have been abused in care. I could not tell you what percentage, but it is a lot.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that girl abused in care or was she rebelling as a teenager?

Ms HERMESTON: It was a combination. She disclosed that she had been physically abused. She did not disclose sexual abuse but there had also been emotional abuse. But sexual abuse is an issue for a lot of our clients, particularly those in out-of-home care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is abuse very common in out-of-home care?

Ms HERMESTON: Yes, both in adoptive families and in out-of-home care. I know that you do not like my figures but I have heard that one in three of the general population is subject to sexual abuse of one form or another in the course of their lives—or one in three girls in the general population.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One in four was quoted in a recent article.

Ms HERMESTON: I would say it is more than that in our client population. It would be good to research it.

CHAIR: We have heard evidence from various areas about the level of generally unsatisfactory performances by carers, which includes abuse at the extreme end. To some extent it comes back to the availability of carers, their training and support.

Ms HERMESTON: That is it. They do not go through the same process as adoptive parents when they take children into their care. Prospective adoptive parents go through so much to reach that point of being able to adopt. First and foremost, we do not agree with adoption but at least they go through that process.

CHAIR: Presumably DOCS would say that there is a grave shortage of potential foster carers.

Ms STUBBS: There is.

CHAIR: They would also say that there is a grave shortage of potential Aboriginal foster carers.

Ms STUBBS: Even more so. When you hear about people being abused in care you think, "I don't want to be lumped with that lot".

Ms HERMESTON: That is why there needs to be a proactive stance about recruiting and supporting Aboriginal families so that once a child is placed with them DOCS do not react in crisis and look around desperately and say, "Glenda, can you take this six-week-old baby? No? Well, tick—that is the Aboriginal child placement principle taken care of."

CHAIR: I notice your first case study says exactly that.

Ms STUBBS: They are all true cases.

The Hon. AMANDA FAZIO: We heard evidence previously from people who came from the country—or perhaps it was evidence given during the mental health inquiry—about Aboriginal placement principles and what happens to children when their family breaks down for whatever reason. They made the comment that some Aboriginal families are having an enormous burden put on them. As you said, someone calls and says "I have a six-week-old baby who needs a placement", and they have such a strong personal commitment to keep that child within the Aboriginal community that they agree and are overburdened.

Ms STUBBS: It is a moral dilemma. It comes down to the fact that it is the department's job to keep families together but they have an obligation to support those families.

Ms HERMESTON: Glenda, do you want to tell them about what you are going through at the moment?

Ms STUBBS: Yes. I am in a moral dilemma. I have two siblings in my care and mum has had another baby. But I feel that without support from the department I will not be able to take the baby. You only have to look at me: I am not real young.

Ms HERMESTON: Glenda has five kids in her care plus her own children.

Ms STUBBS: My friend Christine—who will be licensed as an agency soon—gave me some ideas about how the department could support me. Nobody suggested any ideas; they simply said, "Can you take the baby? Let me know tomorrow." I said, "I can't do that". Christine gave me all these different ideas about doing this and that, respite, maybe the department could fund some of my pay so I do not have to work full time and so on. Nobody suggested that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is no care management plan, as it were.

Ms HERMESTON: No, and it is the child who will suffer in the long run.

CHAIR: You have five children in your care at the moment?

Ms STUBBS: Yes.

CHAIR: Plus your own children?

Ms STUBBS: I only have one. But I have cared for eight children for 10 years so six ain't nothing.

CHAIR: So your moral dilemma is that you strongly believe in siblings staying together.

Ms STUBBS: How can you link with an Aboriginal organisation that keeps kids together and say to the two children in my care, "I can't take your sibling"? How can you do that? How can you look at their little faces every day? How can you do this stuff and see the damage and not do it? There are all these excuses. They should have been embracing me and Christine and saying, "We'll support this", instead of putting barriers around me. Don't you think? It is about money crunching.

CHAIR: So you think DOCS is saying this is a problem and Glenda can solve it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I know this is a very white man thing to say—

Ms STUBBS: I will slap you up if you say too much white man stuff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there no contraception? It seems—and all the DOCS people have told us this—that as soon as you take a child away another one comes.

Ms STUBBS: They are trying to fill the need left when the child was removed. They think they will eventually have the chance to keep one baby. We do not condone child abuse—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If a mother is likely to have another child when one is taken away surely you would say, "Let's try to support this mother" or at least, "Please take the pill on Wednesday". It seems to be an incredible cycle: The ones who cannot cope keep producing children who are then taken away from them. It is almost absurd. At what point do you break the cycle and what is the best way to do that?

CHAIR: That brings us back to the issues we talked about earlier: broad family and community support.

Ms HERMESTON: That is right. Stopping the woman from having a child does not address the issues. Those issues will still be there for as long as the woman has a reproductive life. In this case the mother has a serious impediment to her looking after the children and the department must take care of that. However, if she falls pregnant again the same issues will arise because they have not been addressed. Why not address them now and realise that she needs psychiatric help and support to access her children and maintain a relationship with them? Restoration to the family wherever that is possible—wherever there is a chance—should be the aim every time.

Ms STUBBS: In this case it is not possible.

CHAIR: What about the traditional solution: Are there any grandmothers?

Ms STUBBS: No, it is not a usual case.

CHAIR: I have another question that is not on our list. We have talked to a few witnesses about some of the non-government organisations that are trialling new forms of small residential care facilities. I guess an easy parallel is with the group homes that operate for people with intellectual disabilities. Some people, particularly Aboriginal people, are very nervous about this idea because it sounds like a return to the old institutions. However, this is sometimes suggested as a solution to the problem that you are identifying. You have to have a paid professional carer or set of carers.

Ms STUBBS: That is going back to your dollars, Mister. That costs lots of money.

CHAIR: Would you support a move towards that in some cases?

Ms STUBBS: We are communal people; we like living together. Many Aboriginal families have eight, six or seven kids. That could be a real possibility.

CHAIR: Would residential care have to be located in the midst of an Aboriginal community?

Ms STUBBS: We are everywhere. Aboriginal people live everywhere.

CHAIR: Would you have to take special steps to maintain family contact?

Ms STUBBS: It depends on whether the parents are nearby.

Ms COE: DOCS also has a responsibility to fund access for the natural parents, which it does not like to advertise. Many natural parents do not realise that. They think, "My kids are in Lismore and I live in Sydney now, how do I get to see them?" DOCS has a responsibility to transport and accommodate parents. As to the group home idea, we would dearly like to have some small group home specialising in children with behavioural problems and things like that. Many of our nine- and 10-year-old boys are starting to act out because of what has happened to them. So there are many behavioural issues and the foster parent—whether it is the grandparent or someone unrelated—says, "No, can't handle them any more; take them". That is always the prerogative of the foster parent but it is no good for the child because there is no stability. Our problem is where do we place them? Everyone else is overburdened.

If the child is acting out sexually you cannot have him around young girls. So a lot of times they need one on one, but any homes that we are aware of, which are very few, they are mainly teenage boys. So nine and 10-year-olds need the service in place when they are seven and eight so that they are not hijacking planes at 10 years of age and things like that. Then nobody can take them because they are too young. They are not teenagers so they cannot go in that situation. We do not have qualified, trained carers who can deal with the behavioural issues of that child. It is not fair to the children and it is not fair to anyone.

Ms HERMESTON: In a culturally appropriate way.

Ms COE: Exactly. Sometimes we are looking for something like that where the kids can have their particular issues addressed without them being at risk to other children in the house.

CHAIR: But DOCS only allows that for adolescents over a certain age, does it not?

Ms COE: Yes. Most of the places we have looked at, it is boys going to high school and they might stay there. There is a girls' hostel on the north shore that is for girls in high school.

CHAIR: I know someone who is trying to set up a small service for children aged nine or 10 and is meeting the lot of resistance from DOCS with other sorts of arguments about the inappropriateness of children that young being removed from a family setting. So there are arguments on both sides.

Ms COE: If it is small it is still like a family setting. The thing is that they need individual specialised attention so if they are not going to get it in that time or wherever it is no good to them. They have particular issues that maybe it is too much of a burden for a normal person or a normal person with a house full of children already.

CHAIR: We need Louise to answer the question about the Children's Court because obviously it is an important institution in the experience of a lot of Aboriginal families. Perhaps you could talk a little about the Children's Court and the problems you see there and how we might address them.

Ms COE: Currently, what I am doing with the children's service—we only got funding this year for my position although I have been there for 5½ years—I am going to court in country towns, wherever it comes up, mainly in relation to children that are in our care or where the parents have asked us to be involved. I think a problem, a shortfall, with the Children's Court is that the natural parents do not fully understand what their rights and responsibilities are, what rights they have before the court. They often have problems getting access to legal representatives because Aboriginal legal services do not normally do care and protection, particularly in the country. They are only funded basically to do criminal matters and that is it. One of the problems is letting the natural parents know what their rights are.

I think the idea of a preliminary conference, which is what they have before it goes to hearing where they try to get issues together, is an excellent idea because it is in a round table. You are not in an imposing courtroom—particularly, the country courts are very imposing, more so than the Children's Court down here, because they are the Local Court so it is quite scary. So I think the preliminary conference idea is great but it is not always ordered in particular cases. I think magistrates, too, because they are not specialising in children's issues, are not fully aware of what their role is in relation to child protection matters. There are some orders which I am not sure—we would rather see children committed to the care of the Aboriginal Children's Service principal officer rather than individual foster parents which has happened and is happening, mainly because, what we are saying happens with the adoption, that is a follow on. People see foster care as a short course to adopting because after a number of years they can adopt.

Ms HERMESTON: Especially with the new permanency planning bill.

Ms COE: We cannot be seen as a community organisation that is assisting that adoption. We do not believe in adoption at all but we often have foster carers that, even if the court order is to us, they always have the option to vary the order. They go back to court and ask for the child to be put in their care. I have had to impose it on behalf of the Children's Service a few times because the foster parents have made it clear that their goal is to adopt a child.

Ms STUBBS: They would question their Aboriginality if they did that.

CHAIR: Are you talking about non-Aboriginal foster parents?

Ms COE: No. Sometimes it would be a mix. In one case I am thinking of the mother is non-Aboriginal and the father is Aboriginal. She had the main caring role but she wanted the order varied so that she could adopt the child. They were a couple in their 50s but they were living in a small town. That child then does not have any access to koori siblings or cousins or whatever in the family so that there is a high likelihood that that child would grow up marrying someone they are related to because there was no contact between the parties. When we finally tracked down the natural mother, who was in Mulawa, we went and saw her and she said, "I never thought". She never went to court when the child was placed in care. She thought she was never allowed to see that child. She had kept in contact with all her other children but she thought she was not allowed to see this little four-year-old.

CHAIR: Was the four-year-old the only child who had been subject to a court order?

Ms COE: That is right. The others were in out-of-home care but this was the only court order one. What happened was she said that she always thought the order was to the foster parents, not to us, so she did not feel comfortable about trying to contact the foster parent to have access. The most important thing is maintaining access for children in care. So that is something that with a variation to the court orders, which needs to be explored a bit more. Without getting too complicated, we even have to seek leave to make that application to vary and sometimes that leave is too easily granted. There has to be a significant change in circumstances, and I think some magistrates are too easy to say that there is a significant change in circumstances so that the matter could be varied. We are against any court orders which put children in the care of foster parents.

There is another example which is blowing up of two twin girls who were put in the care of foster parents. Aboriginal children's service just supervised and the mother was to have liberal access. The mother has never had access with the girls since they were eight months old because the foster parents took off. The foster parents changed the girls name to her surname. Now when we are trying to get access she says, "Speak to our lawyer" and the barrister is saying, "No, that is an old order and it doesn't apply under the new Act. You should not even be involved." He is telling the children's service that we should not be involved. So there is a natural mother who cannot even get access with her two girls.

CHAIR: Is one implication of what you are saying that some of the people in the court system could do with a bit of training?

Ms COE: I think so and I think training in Aboriginal issues and cultural issues. It is not just the court system but in DOCS as well because there is no Aboriginal training component in the DOCS training calendar at the moment.

Ms STUBBS: I think there is half a day out of three weeks, and if you are sick that day you miss out completely.

Ms COE: There is no ongoing training. Even if they came into organisations like the Aboriginal Children's Service and spent some time they would see what the issues are and they would learn a lot from that, and that goes with the court system as well.

The Hon. AMANDA FAZIO: Do you think that the Children's Court should have something like Aboriginal liaison officers who can be the contact point with families that are having to come into contact with the court?

Ms COE: At Bijura one of our workers used to go to court and he would be there for any child, whether it was a child in care or whatever, any koori kid who was going to either criminal court or whatever. You have the fact that they are all closed courts, in camera, so they would have to have the permission of the magistrate to be in there. This man went for years over there and sometimes there would be a magistrate who questioned his right to be there. So if you are going to have Aboriginal liaison officers it would have to be with the approval of the magistrate. I think someone who can support the family is going to court, a koori person, would be a great idea but as long as it is with the full support of the court system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Basically in kinship care if this anomaly of the 2 per cent and the 28 per cent were addressed you would get a big influx of funds, even within the existing framework, would you not?

Ms COE: Yes.

Ms HERMESTON: You just look at how underresourced our services are now. They have a worker to travel up to the North Coast and down to the South Coast and try to cover all that area.

Ms COE: An average of 30 cases per worker, whereas in DOCS it is about 10.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would be losing a lot of workers while they are in transit. You are paying for a worker who is not effective for half the time because they are travelling all the time.

Ms HERMESTON: Then you have the issue under the award of overtime and time in lieu. If everyone took their time in lieu you would have no-one in the office for a month at a time because everyone works excessive hours and they are there for the sense of the kids, not for the lack of pay or conditions.

The Hon. AMANDA FAZIO: Who is funding your service?

Ms COE: We have offices in Wagga Wagga, St Mary's and Cowra, and they are funded by DOCS— underfunded though. DOCS also funds one position in Redfern. In Redfern ATSIC funds a number of positions and then we have Department of Family and Community Services that gives us emergency welfare money which we dole out as food orders and then some emergency accommodation money which we used to prop up the shortfall from DOCS and ATSIC.

Ms HERMESTON: That is the major issue. Our service needs to have a community liaison and education person to go out and do exactly this, go and make sure it is put on the agenda for DOCS and other service departments, the training and ongoing and be right in there and proactive about making sure it is on the agenda. We need bringing them home councillors out of our service because we are struggling to provide ongoing quality counselling to people post reunion or pre their reunions when we are struggling to keep up with the case worker of locating families. We need assistance in policy development and making sure that when stuff like permanency planning comes up we have someone. This is a problem. We were sitting around with tables of DOCS lawyers last year trying to get their head around what that legislation is saying and what the implications are. We need somebody out there to be on top of this stuff. I should be at work right now trying to catch up with my casework but being here doing this role. I am sure it is similar in the other services and in Redfern as well. So that would be greatly appreciated.

CHAIR: We are trying to tease out what you believe are the areas of greatest priority for making improvements to the child protection system as they relate to Aboriginal people. We have had a lot of criticism from everybody about the DOCS data and information system and you have mentioned some of that. Do we need more Aboriginal workers in DOCS? You have talked about the need for more liaison workers and perhaps more funding and workers in organisations like your two. Do we need to put a huge amount of resources into improving out-of-home care arrangements for indigenous families and support for carers, or do we need to change all our priorities and go back to putting more money into prevention services?

Ms STUBBS: All of the above.

CHAIR: Should we have more Aboriginal people in DOCS? We know there are some and they say they make an effort, but should that be a big priority or is that too conflict ridden for the Aboriginal people themselves?

Ms STUBBS: Years ago I can remember no Aboriginal liaise. They seem to be making an effort but to be an Aboriginal DO would be a horrendous job. You have to live with the community. You have to be slagged off by the community.

Ms HERMESTON: And overloaded by DOCS. Any issue that comes up to do with Aboriginal people, bang.

CHAIR: It is your job.

Ms HERMESTON: Yes.

Ms STUBBS: If you are told about a huge percentage you have a huge load and you are supposed to be the know all and be all.

Ms HERMESTON: And unsupported and isolated, often working in isolation. So there are a whole lot of issues there.

CHAIR: But we still must have them.

Ms COE: I would suggest you have more of an equal partnership with people in DOCS and with community organisations because then there is a support mechanism for the workers. Whether they are Koori or not, if we felt we had an equal partnership with DOCS, that would go a long way towards dealing with relationships between parties.

CHAIR: But that does not rule out DOCS from continuing to make efforts to employ Aboriginal workers?

Ms COE: No, but I am saying that the ones who are employed will be less likely to leave and come to us if there was support within the community organisations as well.

The Hon. IAN WEST: Has anyone done any rough actuarial assessments as to what it would cost for all these issues you are suggesting?

Ms STUBBS: What cost can you put on keeping families together?

The Hon. IAN WEST: But leaving that aside.

Ms HERMESTON: You mean in terms of enhancing services that already exist?

The Hon. IAN WEST: In putting forward solutions such as equal partnerships, prevention and training, preventative and early intervention issues, which we all agree are important, has anyone done rough actuarial assessments as to how much more money would be needed?

Ms HERMESTON: A good start would be commensurate with the 28 per cent of Aboriginal kids in care would be 28 per cent of the actual funding. That would be a good start.

Ms COE: For Koori programs.

Ms HERMESTON: In terms of priorities, there are the child placement principles and placing siblings together. We also mention panels of review for some kind of access for Aboriginal communities, similar to the so-called sentencing model that is going on in the court system, a panel of review where Aboriginal children are concerned. This needs to be put to the community: should there be surveys and research of actual clients of DOCS where Aboriginal clients have an input into how DOCS can work better with Aboriginal communities, and looking at different models that are working here in Australia and overseas. In the United States they have the native child principle, and I can get you some information on that.

CHAIR: That would be helpful.

Ms STUBBS: It is in our submission under "Panel".

Ms HERMESTON: That needs to be put to the community because those are just our thoughts.

CHAIR: That would also involve perhaps changing the procedures of the Children's Court and some legislative changes.

Ms COE: More self-determination rather than paying lip-service to it at the beginning of the Act; to actually put it into practice and have Koori people having the power to make decisions in relation to their kids rather than it going to the Government.

Ms HERMESTON: Accountability and transparency of the department where responding to those suggestions and recommendations are concerned because there is not enough accountability back to the community in terms of decisions being made.

Ms STUBBS: There have been lots of good changes. If we hold hands and work together in partnership things can continue to change for the better for our kids.

CHAIR: You are in a position to know, given the number that you are caring for.

(The witnesses withdrew)

GWYNNYTH MURIEL LLEWELLYN, Academic, University of Sydney, East St, Lidcombe, affirmed and examined:

DAVID McCONNELL, ARC Post-Doctoral Research Fellow, University of Sydney, East St, Lidcombe

LINDA JANE ROGERS, Intellectual Disability Rights Service, 128 Chalmers Street, Surry Hills, and

MARGARET MARY SPENCER, Occupational Social Worker and Co-ordinator, Parent Access Program, Family Support Services Association, 357 Glebe Point Road, Glebe, sworn and examined:

CHAIR: Did you each receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act, 1901?

Professor LLEWELLYN: Yes.

Dr McCONNELL: Yes.

Ms ROGERS: Yes.

Ms SPENCER: Yes.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Professor LLEWELLYN: Yes.

Dr McCONNELL: Yes.

Ms ROGERS: Yes.

Ms SPENCER: Yes.

CHAIR: Do any of you have a written submission?

Professor LLEWELLYN: No, I did not do a written submission.

Ms SPENCER: I did put in a written submission.

CHAIR: We have grouped you together because we want to talk with you about families where one person has some sort of disability and where that is a major contributor to child protection issues. Do any of you wish to make an opening statement? Question one asks for a broad overview of your respective roles and expertise with regard to families headed by a parent with a disability, which may give you an opportunity to say something about the groups that you represent.

Professor LLEWELLYN: I am happy to answer the first question. There are some questions I do not wish to answer because they are not my areas of expertise. I am a sesquicentenary professor of occupation and leisure sciences at the University of Sydney and I also direct a research team called the Family Support and Services project. That research team has been doing research since the late 1980s around issues of family and disability, in particular, with parents who have a disability as well as with families where children have disabilities. I am also a ministerial appointee to the Children's Court Advisory Committee, to the New South Wales Commission for Children and Young People and also to the Enact Implementation Committee, so that may give you some background as to my expertise and the committees of which I am a member.

Dr McCONNELL: I am an occupational therapist by profession. Over the last 10 years I have worked as a researcher in the family and disability field. I am currently an ARC Post-Doctoral Research fellow, working in partnership with the Department of Community Services on a significant research program. I am based at the University of Sydney. I would like to say a few words. I am conscious of the fact that no family headed by a parent with a disability really has a voice at this table. I would like to submit a paper written by a father with intellectual disability, with my assistance, which I think you will find addresses the spirit of change entitled, "Look at me, listen to me. I have something important to say".

Document tabled.

CHAIR: Obviously, Committee members cannot read that now but do you want to tell us something about it?

Dr McCONNELL: I would like to set the scene a little. We know that these families are significantly overrepresented in the child protection system. Evidence of this is documented in a report entitled "Parents with a Disability in the New South Wales Children's Court", which was submitted as an attachment to my written submission. The report documents the findings of a study funded by the Law and Justice Foundation of New South Wales. I would briefly like to give you the example of parents with intellectual disability, the group whom I have had most experience working with.

Essentially, we know that their children feature in almost one in 10 Children's Court matters. They are removed at a younger age and they tend to be removed on mass, that is, more than one at a time. We know that these parents are roughly twice as likely to have had children removed previously. Further, these children are placed in out-of-home care more often than any other group. Indeed, our study findings suggest that as many as one in six children placed in foster or residential care by the court have a mother with an intellectual disability.

I would like to say up-front that my concern is not with the removal of children who are in need of care per se, and there will, of course, be children with parents with a disability who need to be removed to secure their safety and wellbeing. My concern is with the alarming and now substantial body of evidence demonstrating that these parents do experience discrimination all through this system, that the children may be removed unnecessarily and that the service system is really poorly equipped to accommodate their support needs. These families too often fall into the too-hard basket.

CHAIR: That brings us to some of our other questions. This panel obviously has overlapping but different expertise.

Ms ROGERS: I am Linda Rogers. I am appearing before the Committee in my capacity as Principal Solicitor of the Intellectual Disability Rights Services [IDRS]. IDRS is a community legal centre for people with intellectual disabilities. It is a statewide service in New South Wales. We provide legal advice and representation for people with intellectual disability. We also engage in community legal education, policy and law reform work. The solicitors of our service provide advice and representation to parents with intellectual disability in contact with the care and protection system. We participate in case conferences with the Department of Community Services [DOCS] and also represent clients in the Children’s Court. I understand that we are the only legal service in New South Wales that exists solely for people with intellectual disabilities. We have expertise in both care and protection matters and also specific issues that arise with parents with intellectual disability in contact with the system.

I have a couple of matters to raise at this stage. One is that as a result of the closure of institutions it is quite natural and expected that people with intellectual disabilities would become parents. I would suggest that a basic human right is that people be able to have children. The issue that arises and what we want to raise with the Committee is that many children of parents with intellectual disabilities are removed from their care when this does not necessarily have to be the case. Indeed, section 71(2) of the Children and Young Persons (Care and Protection) Act suggests that disability alone is not a reason to suggest that a person with an intellectual disability is not a capable parent.

The law provides in principle that disability alone should not be a consideration as to the parenting capacity of a person. It is enshrined in the legislation that it should not be suggested that a person is not able to care for their children. But in practice, it is almost the opposite that occurs. IDRS is very concerned about the overrepresentation of parents with intellectual disabilities in the care system. The anecdotal evidence from our service supports the fact of the overrepresentation. We are also concerned about the pre-emptive nature of the involvement of DOCS in these families. Indeed, with the removal of children once they are born in hospital without appropriate support being provided and an opportunity for parents to support a child at home.

We are also concerned about the lack of effective engagement by the DOCS with parents with intellectual disability and the blaming of parents in saying that they have not been willing to co-operate with the DOCS or with other disability service providers. We are also concerned that parents often do not understand what they are involved in, and the court proceedings, and are effectively excluded at times from Children's Court processes.

Ms SPENCER: I am appearing before the inquiry as the co-ordinator of the Parent Access program. The Parent Access program is a funded by the Department of Community Services and is auspiced by the Family Support Services Association of New South Wales. The Parent Access program was funded in 1993 to provide ongoing support to family support workers and other workers in non-government organisations in terms of improving access for parents with intellectual disabilities in generic services. In terms of the type of support that is given through the Parent Access program, the key areas are in training, information and resources, clinical supervision to workers and, in recent years, seen the need to base our practice on solid research and evidence we have formed formal links with the University of Sydney and the Family Services and Support project. As part of that formal link I am also a PhD candidate at the University of Sydney looking at developing an assessment model for looking at the support needs of parents with intellectual disability.

In relation to my work during the past nine years in this area there has been no increased funding in the Parent Access program. The program is funded to $45,000 per year to cover the State. As more and more services are aware of parents with intellectual disability and their needs, as we raise awareness, also comes with that are people looking for support and services. Not only within the non-government sector is the Parent Access program called upon to provide specialist support, but also to many departmental workers, particularly case workers who often feel that they have inadequate training to deal with the issues confronting them when working with a family where a parent may have a disability. In addition to the Department of Community Services similarly for Legal Aid lawyers. I do a lot of work with Legal Aid lawyers and because of the limitations with Legal Aid we are often called upon to help prepare cases involving parents with intellectual disability.

As David said, when we talk about parents with intellectual disability because we have a picture of people with intellectual disability as often being eternal children, we find it very difficult often as a community to come to terms with the fact of people with disabilities actually parenting and to actually understand that the adults about whom we are talking with intellectual disability are really people who, for all intents and purposes, are integrated members of the community but when having to take on the role of parenting, are requiring additional supports. It is often only when they become parents that their disability issues come to the fore and they are faced with discrimination that they may not have faced since earlier days when they were in school systems.

I want to pass around a picture of a mother with an intellectual disability and her two children that was taken on a recent access visit. These two children came into care in April. They have now been made wards of the State. They came into care because the mother who had another child said that her child was not thriving because she felt he had a disability himself. The department would not hear that. They said it was because of her intellectual disability that her baby was not thriving. The child then went into foster care. The foster parents said there is something definitely wrong with the child, and the child has now got treatment. However, despite the fact that the mother knew that herself about her baby, that child has been made a ward of the State, so have her two older children.

This picture was taken at a recent access visit. The children have not been placed in long-term foster care, despite the fact that they came into care in April. The little three-year-old girl in the photograph has been in six placements since April. The little boy is pictured with an older white-haired woman who is his maternal grandmother who is in her eighties and was left to care for him for six months because the department asked her to take him for a week as it could not find a placement. He is now with his schoolteacher because she could see the pressure that was on the maternal grandmother. It is helpful to look at those pictures and realise that until this access visit these children had not seen each other because of problems of access for three months. Those photographs put a human face to what we are talking about.

The Hon. AMANDA FAZIO: Was that mother trying to raise those children as a sole parent?

Ms SPENCER: Yes. Her eldest boy has a physically damaging condition, the same condition as her baby son. That is why when the baby was born she said, "He is very much like my eldest son. I know that this child has something wrong." The hospital staff would not take that on board. The department was very unhappy about her having another baby because it said, "She can cope with these two: She will not cope with the third." Often it is the case with many of our parents that they are treated in many ways as we treat, maybe, a pet. We are told we can keep one puppy but we cannot keep three, and that is what happens to their children.

We look at these photographs and realise that these kids love their mother. This is a mother who definitely cares for her children but was not coping. She wanted some practical support in the morning to get the kids off to school and was told that she was not eligible for that. They were not happy to provide it. It was a matter of practical support that this mother needed and as a result we now have three children in long-term foster care until the age of 18 years.

CHAIR: Was there an attempt made at least to put the three children together?

Ms SPENCER: No attempt was made to put the three children together, and my last contact with the Department of Community Services officer who is involved said that it will be at least twelve months before they will find a long-term foster placement for the eldest child because his condition is actually a degenerative condition and that affects his life expectancy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is assumed that they could not be restored to the mother? Has it been tried?

Ms SPENCER: This family could manage quite well if it were given practical support. It was seen that it was unrealistic to provide long-term support to a family. If this mother could not parent independently, as it was put in court, then it was seen that the children need to go into care.

The Hon. JAMES SAMIOS: What is practical support?

Ms SPENCER: Having a home-care service come in. The eldest boy has incontinence problems so just toileting him in the morning. When you are actually breast-feeding another baby, plus getting a toddler off to daycare, it is really difficult. She wanted to have someone come in the mornings to help get him organised for school ready for a bus. I could take an hour talking about this family but I do not want to do that but the pressure on this mother was quite incredible by anyone's standards. That is an opening statement to show a human face and that this is a family that love each other but will grow apart, and that is what we are talking about, because of lack of practical support.

The Hon. AMANDA FAZIO: Does the eldest boy who has the degenerative condition go to a special school?

Ms SPENCER: Yes.

CHAIR: Are we talking only about parents with intellectual disability? I know we can get hung up on definitions but are there other disabilities? Are we also talking about mental health and drug and alcohol issues? Do some of the issues about which you are talking apply to other people as well?

Professor LLEWELLYN: I want to suggest that we broaden it to include parents with psychiatric disabilities, although not necessarily parents with drug and alcohol substance abuse problems because that is a different issue. Certainly from my perspective most of the comments will apply to parents with intellectual disability. In relation to question two around overrepresentation, I would certainly want to make some points which cover more broadly parents with disabilities. Parents with physical and sensory disability are not generally disadvantaged in the system any more than any other parent is. They are probably not of such immediate concern.

Dr McCONNELL: Parents with psychiatric disabilities are certainly the most prominent group. Between parents with an intellectual disability and parents with a psychiatric disability we are talking about roughly one-third of cases that the DOCS takes to court. Parents with physical and sensory disabilities are not nearly so overrepresented.

The Hon. AMANDA FAZIO: When I had one of my children, in my room there was a blind lady—who had a blind husband—who had a baby. Everyone said it would be difficult for them to raise that child. Workers from the Royal Blind Society, I think it was, said it would be fine because it has the funding to provide the parents with every support they need to assist them to raise their child. Obviously, there are supports for some groups within the disability spectrum. Do you have any comments on why those supports are not there for other sectors?

Professor LLEWELLYN: Or perhaps the reasons why those supports are there for particular groups.

The Hon. AMANDA FAZIO: Yes.

Professor LLEWELLYN: It is fairly well known that in Australia there are quite extensive supports for people who are blind or visually impaired, so much so that, for example, the blind benefit or pension is not means tested. We have good historical reasons why people with blindness or physical impairment have a lot of support. Your comment is absolutely correct, there is a lot of support in parenting for people who are blind, as in many other areas; similarly in the deaf community. There are some very good reasons why there is not that support for people with psychiatric and intellectual disability. I would be happy to answer question No. 2.

CHAIR: Tomorrow we will hear from Dr Louise Newman from the New South Wales Institute of Psychiatry. We will explore some of these issues with her as well. Why are families overrepresented? Is it discrimination, prejudice, presumption? I note the language used about people being treated as children and the argument of children being like pets. We are talking mostly about a complex of issues in our society.

Professor LLEWELLYN: That is partly true. The document submitted by Dr McCONNELL to the inquiry goes into the statistics behind it, if you like. At the community level there are four points we have to keep clearly in mind. It probably helps to answer some of your questions. We have a child protection system that is still working to what is now a rather outmoded principle that the parent is the problem rather than: this is a family in which their circumstances need to be taken into account. That is seen to the extreme when you start to talk about parents with intellectual disability or parents with psychiatric disability. In a sense it reflects community attitudes. If I can put it like this very simply: we still have attitudes in the community that a person with a psychiatric disability is somehow mad. Parents with that sort of disability tend to be seen as mad and bad, if you are going to blame the parent for any problems when they have parenting difficulties.

For parents with intellectual disability there is a different community attitude, which is rather as Ms Spencer says, that somehow these people are eternal children. Therefore they are incapable of raising a child themselves. Again, if you are going to look to the parent as the problem rather than their situation you are going to say bad and incompetent. You get these general attitudes, which, not surprisingly, are reflected in workers as well as the general community. What is overlooked is that the conditions that are set up for people in our society who have an intellectual or a psychiatric disability are still very much substandard compared to the conditions for others.

They do not have as much access to education, they live in poorer socioeconomic circumstances, they have difficulty being employed, they live on benefits, they are in public housing. There is this complex of socioeconomic factors that are set around them so that when they become parents they are raising their children under more difficult circumstances, but we have a protection system that is still saying: you are the problem as an individual. That particular approach is not taken so much with parents with physical disability or sensory disability.

The Hon. AMANDA FAZIO: Is the bottom line that there is an underlying attitude that people with a psychiatric or intellectual disability have less rights to become parents?

Professor LLEWELLYN: Absolutely. I think that is correct.

Ms SPENCER: And they are historically based. Look at why people with a psychiatric or intellectual disability were segregated early in our history—eugenics. The other issue is that whereas parents with a sensory or physical disability have a voice, people with psychiatric or intellectual disability do not have a voice. If we are able to articulate and talk, we have power. If you do not have a voice or if you cannot understand the proceedings then you are disempowered. That is what we find. Many of our parents do not have a voice. People assume things about them that are not correct. They are strong assumptions.

CHAIR: We are dealing with a problem that is relatively new in that the number of people with intellectual or psychiatric disability having children, whereas until 20 years ago the number was very much smaller because of the pattern of locking people away and segregating the sexes.

Professor LLEWELLYN: That is not totally correct. There have always been parents with intellectual disability. The research literature, for example, goes back to the 1940s. There have always been women with intellectual disability having babies in societies where there is less focus on sophistication and industrialisation. Many of those people fitted into the community and were supported in the community. We have a phenomenon such as the six-hour retarded child. There are kids with an intellectual disability who are not noticed until they go to school. Clearly, if they do not behave like other children they become labelled. As they become adults they can move back into the community and not necessarily be seen at all.

It is partly true that deinstitutionalisation has added some measure of additional parents. But it is more that we have a more open view, perhaps, to understanding that there are people with a disability in the community. But many of the people we are talking about as parents would not necessarily always be IQ tested and labelled. They will be people with really quite severe learning disabilities, a lot of socioeconomic disadvantage, which we have already mentioned, and this creates some problems in terms of departmental responsibilities. If you are not labelled with a particular IQ then one department will not deal with you and another department labels you as being disabled and wants the other department to deal with you because that department does not want to deal with you. There are a lot of issues around this notion of disability that need to be explored.

CHAIR: Which is what we are looking at in our other inquiry.

Professor LLEWELLYN: Of course, you have heard this before.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that no more disabled people than before are having children and it is just out in the open, or are you saying that it is not known?

Professor LLEWELLYN: We do not know. All my colleagues worldwide are having difficulty establishing this. We make some assumptions based on deinstitutionalisation, normalisation, so on and so forth. But we do not have a lot of figures from earlier times. We did not always IQ test people in earlier times. We just do not have the figures, for example, on intellectual disability, similarly with psychiatric disability. I am sure that Professor Newman will speak to that tomorrow.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Spencer referred to eugenics and a case study in which the third child had a problem of muscular dystrophy. To my medical understanding that is hereditary, or the male is dominant, so it is one in two for the same parents. Normally you would deal with that by way of genetic counselling.

Professor LLEWELLYN: It could be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I presume that those children had the same parents, even though she was a single mother.

Ms SPENCER: Yes, they had the same father.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How would that be dealt with?

Professor LLEWELLYN: If I understand what you are asking, is it that parents with intellectual disability ought to have access to the same genetic counselling services, or?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is what is likely to happen, yes.

Professor LLEWELLYN: Yes, of course they should. It is not necessarily true that they would. We have to be clear that many, in fact the majority, of people with intellectual disability will have no genetic conditions at all. Intellectual disability occurs just as part of the normal spectrum of society. There is a group of people up that end who are the brighter people in our society and there is a group of people down this end who are less bright, and only at the very end of that spectrum do people generally have some genetic condition. This is very unfortunate where there is a genetic condition that is affecting the children, but that would be no more common for parents with intellectual disability than it would be in my family or your family.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but presumably your family or my family would have done an amniocentesis or something?

Professor LLEWELLYN: We may have chosen not to. Not everybody chooses to have genetic counselling.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but some have the choice.

Professor LLEWELLYN: Some have access to choices that other people do not have. That is absolutely correct.

CHAIR: We have probably covered why, in broad terms, these families are overrepresented. Should we say something separately about the factors that bring them into contact with the child protection system? There are really different questions. You said that we have people going through their normal lives without anyone particularly noticing them, but should we say something about the specific factors that bring them into contact with the system?

Dr McCONNELL: In 1954 as study in United Kingdom looked at the children and asked how the children of previously institutionalised women with intellectual disability were doing. The big question: Are these children going to be retarded? What is the outcome for these children? They found that 3 per cent of the kids could be labelled as mentally defective—they were the words used in 1954. The authors concluded that they hoped these findings would address the now and current inhuman practice of removing children from their caring mothers. When I went back and read through that study it made me think about how much has changed. Some 50 years on this is still the question that many people are asking.

CHAIR: That 3 per cent would be very little different from the norm?

Dr McCONNELL: Not a great deal. In terms of what issues bring them into contact with the care and protection system, it is the safety and well being of the children, the same as for any other families. My study and the work of my colleagues overseas has found that allegations of abuse were extremely rare in cases involving these parents. Much more common are concerns about adequate provision. Often there are concerns that the parents generally have poor parenting skills, or concerns about the home learning environment or the hygiene in the home. One of our colleagues in California refers to it as neglect by omission. We are not talking about wilful maltreatment, although the support needs should not be trivialised either. We are not talking about the cruel and uncaring parent that has been well mythologised in the media. Like a majority of parents that come into contact with the care and protection system, we are talking about a group of families who are really struggling under extremely difficult circumstances, circumstances that would make it difficult for any parent.

The Hon. AMANDA FAZIO: Your report said you would provide us with an attachment. Will the information gathered in that allow you to say with any degree of confidence that the interventions in these families are because of the situation you have described or are they the same as for the general population where there is no parent with an intellectual disability or psychiatric disability? Are these parents being watched more at the outset because there are presumptions that they are inadequate parents?

Professor LLEWELLYN: You have summed it up.

Ms SPENCER: Often parents demonstrating that they are not coping would lead to support being put in, which leads to the child protection system looking at whether the child can stay in the situation. There are different standards that apply because of what is seen as the situation being irremediable as quoted in Dr McCONNELL's report.

CHAIR: Who is doing the watching? Are we talking about neighbours, teachers or DOCS?

Ms SPENCER: It starts very much in the maternity ward. What we find, and there is a study that perhaps Dr LLewellyn and Dr McCONNELL might talk to, in terms of women with intellectual disability and antenatal care is that we know they have poor antenatal care. Often for these women they are not coming into contact with the antenatal system until very late into their pregnancies because of the fear of being forced to have a termination. Many of the parents we know have had terminations. That mother had three terminations before her son was born. Those terminations all happened because she was sent to hospital to have ultrasound testing and was then told she had to have an operation. She became pregnant and moved out of the area, so she had this child. The family doctor did the terminations without her realising what was happening. These stories are common.

CHAIR: They are misled or coerced.

Ms SPENCER: Yes. Many mothers will say that because of past experiences they are reluctant to have antenatal care until late in the pregnancy. Often sex education is not provided for people with intellectual disabilities in the school system, so many do not know that they are pregnant. We also know that there is a high level of abuse. Research suggests that we should assume that women with an intellectual disability have been sexually abused or sexually assaulted. It is very prevalent. Many of the women we know get pregnant as a result of sexual assault. Often they get very poor antenatal care, which then affects birth outcomes. David might like to talk about that. The scrutiny starts at that point.

We applaud the new provisions relating to pre-natal reporting, which means that support can be provided. However, that is often used to do the pre-emptive strike. We find that mothers are being notified to the department during pregnancy, but no support is being initiated because it is believed that we will remove at the maternity unit. I can provide many examples of that happening at the moment.

Dr McCONNELL: That is totally contrary to the spirit of section 25 of the new Act, which is about identifying vulnerable expectant mums early so that we can support them. We have seen several cases in which after notification little or no support has been provided. It is as though that section of the Act is there to help DOCS prepare for child removal rather than to help us prepare these women for motherhood.

The Hon. JAMES SAMIOS: What percentage of these pregnancies is the result of assault?

Ms SPENCER: We do not have figures on that.

The Hon. JAMES SAMIOS: Is it significant?

Ms SPENCER: It is quite a number.

Dr McCONNELL: Many of the women we know are single mums or in relationships and are choosing to have families and are absolutely thriving. We need to keep the broad spectrum in mind.

Ms SPENCER: It is very much a heterogeneous group. We do have the element that is the result of sexual assault and abusive relationships. We often refer to families headed by a parent or parents with an intellectual disability as the most vulnerable of our vulnerable families. The same socioeconomic factors that bring vulnerable families unstuck exist for parents with disabilities. However, often they do not have resources behind them or extended family resources to back them. Many of these families are what I sometimes refer to as our "successes of normalisation"; that is, they have gone through mainstream schooling and have not worn a disability label, and have not wanted to. Every time they have tried to push for their independence, they have been punished for it either by family members or the community. Being a parent is another time they face that.

Dr McCONNELL: About 60 per cent of the women involved in our studies over the past 10 years have reported sexual and physical abuse.

The Hon. JAMES SAMIOS: That is an enormous figure.

Dr McCONNELL: It is safer to assume that these women have been abused, than to assume otherwise.

PROFESSOR LLEWELLYN: That is well substantiated internationally.

CHAIR: What is the figure for the general population?

PROFESSOR LLEWELLYN: Nothing like that.

CHAIR: The committee has heard evidence mentioning one-quarter or one-third.

Ms SPENCER: We collect census data on family support each year. In 1988 we collected data specifically on parents with special learning needs. It indicated that 49 per cent of the parents with special learning needs reported having been sexually abused compared to 14 per cent of our other family support clients who come from the same disadvantaged community. It is a huge difference.

Dr McCONNELL: Referring back to birth outcomes, we have collected data and found that rates of poor birth outcomes in terms of low-birth-weight babies and premature births were four times higher than the NSW population average and twice the rate of that for Torres Strait Islander families. Questions need to be asked. In fact, we are undertaking a study in south-west Sydney to understand more about their access to pre-natal care. This is significant because when their children have developmental delays they are easily attributed to the parent's disability and lack of stimulation. That is a common concern in child protection worker affidavits. We collected data about the home environment, the stimulation responsiveness of mum, pregnancy history and birth outcomes. We found that, like most other studies, roughly one-third of these kids have a developmental delay of at least three months. However, we also found that the stimulation provided in the home did not explain that variation. In fact, when we controlled for poor birth outcomes, the kids were doing fine.

PROFESSOR LLEWELLYN: In other words, a group of these mothers are having such bad antenatal care and poor access to the care than other mothers have that their children are significantly disadvantaged from birth. As David said, we now have funding to examine that in a population-based study in south-west Sydney. We can provide the committee with the article detailing those figures. It is being published in the December issue of *Australian and New Zealand Journal of Public Health*. This is a public health issue. We can provide that extra data and it may be helpful.

CHAIR: The committee's interim report stresses the need for prevention and early intervention. Another inquiry is being conducted into early intervention for children with learning difficulties. The committee has paired the two and talked to people such as Victor Nossar about some of the things that are happening in south-west Sydney. Would you agree with the suggestion that the situation of families headed by parents with a disability illustrates perfectly the need to shift the system towards a focus on prevention and early intervention, or is it more complex than that?

Ms SPENCER: Clearly, parents with intellectual disabilities and their children fall between the gaps in the system. We need a whole-of-government approach and an early intervention and prevention approach. The difficulty is that we know these families need support, and with the right support they can do very well. However, to get that support now means they have to come into the child protection system. However, it is not a child protection issue; it is an early intervention issue. The question is whether these parents should be the responsibility of the Department of Ageing, Disability and Home Care. Yes, there is the element that their disability is creating the need for them to have more support. However, they often do not label themselves as having a disability. Do we put them into that category when the parenting function puts them under greater stress?

I agree that we need a good system which recognises the importance of early intervention and which gives it due place in the continuum of child protection in terms of money being quarantined. It always seems to go to the end of child protection and that is mentioned in the committee's interim report. About $28 million is allocated to early intervention or family support and $185 million is allocated to out-of-home care. The money always goes to that hard end. There should be early intervention.

To put a human face on this again, I was recently in a rural area and the parents there need support. To access that support, we need to go through a funding system within the department called the Family Initiatives Fund, which has funds that can be used at the department's discretion to access services for families at risk of having their children put in care. For that to happen, the family must be reported to the department. The dilemma is that this family has not been reported because there is no reason to do so. The biggest concern is for the father as he was a ward of the State and he does not want to go back into the system, but he needs support. How do we get that support without going into the child protection system? It would be much better if we could go into an early intervention system to get it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had many inquiries into many groups with many problems. The tendency seems to be a reluctance to use population-based data-everyone wants to catch each individual case and not keep a waiting list so that the numbers do not get out of control. Are you recommending that we should say that for a population there would be X children per 1,000 adults and, of them, 5 per cent would need greater support and that we should then budget on the basis that Y percent would need graded support and then grade that support according to intellectual, physically or psychiatrically disabled, and built that into a universal child support system? In that way there would be no stigma in saying that a person needs X or Y amount of support, which is slightly more than the mean.

PROFESSOR LLEWELLYN: In a sense, New South Wales has done that. We have Families First.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In some places.

PROFESSOR LLEWELLYN: That system does not refer to parents as the problem but to families needing support. That is the model we should be looking towards; that is, that there be a recognition that some families may need more support than others, but that that be provided within a total package, acknowledging that families need support to raise kids adequately and that some need more support than others. The resources for those families have to be quarantined so that they are not expended during a crises at the other end of the system. One of the difficulties with parents with psychiatric and intellectual disabilities is that they will need resources over a period but not necessarily intensively all the time. Unfortunately, people start to think, "On dear, she's talking about 24-hour support for everyone all the time and that is very expensive." That is not what we are talking about. If people are given support when they need it, there are periods when they do not need it. Parents with psychiatric disabilities experience periods during which they are perfectly well. However, when they are ill they obviously need support.

Similarly, we know that there are certain periods during which parents with intellectual disabilities experience greater stress. The same is true for families who have a child with a disability. When the child is transitioning from child care to school, the family needs extra support. The model needs to focus on family support and to recognise that different groups need different support. It should also recognise that that support must be different at different times. Unfortunately, Families First is only just to starting to consider tier three, which relates to families with extra support needs. We are behind in that sense. That is the group of families we are talking about, but Families First is yet to address how it provides that support to those families.

The Hon. JAMES SAMIOS: You are saying there should be a more inclusive approach, that the tendency is, because of bureaucracies, to be exclusive?

Professor LLEWELLYN: Yes. And to try to limit particular groups of families to particular systems, or to argue about which system should take responsibility. I think this State has been fairly successful, although I know all bureaucrats do not agree with me on this. Since about 1995 we have had a joint, collaborative effort across four departments to deal with early intervention for families that have kids with disabilities. Health, Education, DOCS and DADHC have got their act together and done it. Now, I not saying it is perfect, but they have done it. If they can do it around early intervention issues for families with kids with a disability, we ought to be able to have those departments saying: There are other families who have similar needs. How do we work together to ensure we are not working in silos, often with 20 workers involved in a family's life, but none of them collaborating or co-ordinating their efforts?

CHAIR: At this point we should be very brave and ask you what you think of our suggestion for a new department of child development?

Professor LLEWELLYN: I will be very quick, because you may not appreciate my comments. I have been around a very long time. No doubt some wish I would retire. I do not plan to just yet. I have seen new departments set up in this State. I have been involved in the disability service as it has moved from Health, to Education, to DOCS and everywhere, backwards and forwards. At a very practical level, a new department means new infrastructure. To be perfectly honest, I am very tired of seeing money going to bureaucratic infrastructure and not to families. I was doing some maths the other day on my way home to work out what DADHC has cost this State. If that money had been tied to individualised packages for the people served by DADHC, I would be a much happier person, and I can assure you that the families that we serve would be much happier families. We have a tonne of research evidence to back this up—not just in this State but internationally. With all due respect, we need to quarantine the resources, but we need to find ways to quarantine those resources without having another infrastructure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean that the cost of changing the infrastructure is so great?

Professor LLEWELLYN: I have watched restructure after restructure. I have seen letterheads having to be changed. Seriously, the cost of changing even a letterhead would provide the support for these mothers that Margaret talked about. What are we doing? It does not make sense. At a commonsense level, this is not what we should be doing.

CHAIR: Do you all agree?

Ms SPENCER: We need to quarantine early intervention and prevention. We need to make sure that that is given the importance that it deserves. However, on the question of setting up a new department, I would have the same concerns that Gwynneth would have. I wonder whether it is a question of how we look at governance within departments, making sure that they have in place robust systems to ensure that funding is not being siphoned off to the hard end of child protection all the time. That really is what needs to be called for within the department. I can see the spirit of the interim report. I think you have hit the nail on the head in that we really need to accord importance to the important issue, and that is at the preventative end. I do not know whether that will be done by setting up another department. In fact, it would be just another department that has to learn to talk to another department, and they will be competing for funds. I wonder whether we need to look at some different governance models within the department.

CHAIR: Our suggestion certainly has got people talking.

Dr McCONNELL: I absolutely agree with the points made by Gwynnyth and Margaret. But I would like to make another, obvious observation: that investing in prevention and early intervention will pay dividends for children and families. That is important. However, although you might expect to make a difference in terms of the number of kids entering care, do not be too optimistic about that. Some United States research shows that the number of kids entering care correlates very well with the amount of money put into child protection, but that the amount put into family preservation and early intervention makes very little difference at all. In other words, movements in the rates of child removal are largely dependent on the sheer capacity of the child protection system to remove kids.

The researcher is a person named Leroy Pelton. He observed that there will always be enough children living in poverty to fill the available stock of foster homes.

CHAIR: He is regarding poverty as the overriding cause, is he?

Dr McCONNELL: As a key factor, but also that having dual structures that do not effectively work with each other or communicate with each other is pointless. My point is: Let us invest in prevention and early intervention, but at the same time we need to do something about child protection in this State.

The Hon. IAN WEST: If we do not set up a new department, how do you deal with the issue of the lead agency quarantining prevention and early intervention money? When you are really talking about a system operating across a number of departments, is DOCS the appropriate agency for prevention and intervention?

CHAIR: And, specifically, where does Families First go, because it cannot stay in the Cabinet Office forever?

The Hon. IAN WEST: There is that issue. Looking at the prevention and early intervention end, and the training of case workers, it appears they have a considerable workload and are supposed to have a knowledge about so many different things. In respect of training, rather than training them about all the intricacies of physical disability, Aboriginal care and every other area in which they need to be experts, is there some way in which, in quarantining that prevention and early intervention, we can link them into getting the expertise rather than requiring them to have that expertise in their head?

Dr McCONNELL: Child protection decision making, or the decision to remove a child, involves four key factors. You assess the child's immediate situation, the risk assessment. There is a lot I would like to say about that, but I simply direct you to page 83 of the report. Secondly, there is the question: Can we improve this child's situation? Is this situation redeemable? That is a basic question because, if we can improve the child's situation, we do not have to take the child to court and look for foster carers who are not there, et cetera. They have to be equipped well enough or be skilled enough to make an assessment of a family's support needs, or be able to work in a collaborative, co-ordinated way with those who may have that expertise.

Thirdly, how relatively serious is this? What happens for the family living in Blacktown will not necessarily happen for the same family if it is living in Hornsby. It depends upon available resources. The last thing is: How strong is the evidence? That speaks of how driven the system is adversarially, and how driven it is by the prospect of court proceedings. Casework practice has become, I think, more about preparing for court and policing parents than it is about protecting children.

The Hon. IAN WEST: So are we are asking the wrong questions of caseworkers? Are we expecting them to have the wrong knowledge?

Professor LLEWELLYN: No. I do not think we, or you, have asked the wrong question. We debated this. Can a person whose legislative responsibility is to ensure that a child is safe—which carries with it all of the court procedures—be the same person who will truly play a preventative and early intervention role? I think that is key to the issue. It is a difficult question, and I do not pretend to have the perfect answers. I would prefer to see those functions separated. Whether those functions are performed by the same department I am not sure is the biggest is sue. We have expected people to be both helper and police person at the same time. That is probably unrealistic in that it is in fact an unprofessional and very poorly educated work force.

It may make a difference if you have a more professional, better educated work force. We do not know the answer to that. But we are expecting people with very minimal education and training—certainly not training in evidence-based practice, or in working with other people—to make very difficult decisions, based on both those things: literally and physically to take the child and the parent to court; then have to say afterwards, "I'm sorry your child has gone, but I can come and help you with something else." This is ridiculous.

CHAIR: Particularly if you are offering to come and help them with their next child.

The Hon. IAN WEST: It appears to me that we are expecting the caseworkers to have knowledge that is beyond 99 per cent of the population.

Ms SPENCER: We have talked about the difficulties faced by parents. I think many of our case workers are not far beyond the difficulties that they face themselves. I must admit that, in recent years, I have worked with departmental case workers who really want to do the right thing by those families. It is, perhaps, too easy for us to be critical of case workers. The vast majority of caseworkers are in the department because they care about families. The decisions and interventions that they need to make affecting families' lives require careful consideration and the time to give that level of consideration. Often, they are not given that time. Because they are being driven by the fear of the ministerial coming down, and having to answer a ministerial about what they did, they are always operating on the basis "What if something goes wrong?" rather than, "How do we do what is right for the families?" We need to change that culture around. One way to do that is by better resourcing our child protection system. We will better resource them also by providing better early intervention, so that people are not having to come into the child protection system.

Recently I met with Montrose, which is the assessment unit within the department. They themselves would say that now when they get called in to do an assessment on a family it is often too late, whereas before they were called on to make an assessment of families that could have made a difference. We see this time and time again. Often, the family is in such crisis by the time they come into the system that nothing can be done. Workers are faced with that problem. If we had a robust early intervention program that was catching parents earlier, when people came into the child protection system decisions that have to be made could be made in a very considered manner.

This is a question of the resources that we put into the system, and about education. They cannot have education on every issue. We cannot be experts on every issue. That is where collaboration comes in. But collaboration does not happen when you are working within a culture of fear, when you are working in a culture that says, "We have the answers, we have to be the ones that know best." I go to case meetings and say, "What you are doing is not good practice." But you come up against a stone wall because you are not part of the inner sanctum of the department. Whilst that culture operates, these people cannot collaborate and cannot get the information that they want because they will not call upon people from other agencies to work out the best decision that can be made for the family.

Dr McCONNELL: It is not just a matter of skills. It is about the child protection mentality. It is, fairly internationally, the mentality, as Gwynneth said earlier, that we see the parent as the problem and exclude from consideration the many other factors that impact on families and make things difficult for them.

We are too ready to see the parent as the problem. The problem for parents with intellectual disability is we conflate the intellectual disability with the very real difficulties they are having. Of course you cannot change the intellectual disability so people assume, falsely, that these parents cannot learn and we cannot make any change or difference. It is more than skills; it is about changing culture and changing the child protection mentality—the storm-trooper mentality—which has emerged over the past 15 years.

The Hon. IAN WEST: If the early intervention and prevention were more collaborative you would get away from having the all-knowing caseworker and if that caseworker moves on the world caves in for the client. If it were more collaborative and the caseworker worked more on the basis of accessing knowledge and creating a framework in which a child or family could operate without the caseworker—if the caseworker's objective was to make himself or herself irrelevant as opposed to the centre of all things—it would be more effective.

Professor LLEWELLYN: Yes.

The Hon. AMANDA FAZIO: I flicked quickly through your tabled document, David, and you state that the family at one stage after the birth of one of their children went into residential care facility—I assume that is one of those mothercraft places such as Karitane or Tresillian—for one week. Do you think there is adequate intake of parents with intellectual disability in those mothercraft services where they can receive help in raising their baby very early on before problems develop or is that group underrepresented?

Dr McCONNELL: Clearly supported accommodation would be an enormously useful resource for many of these families early on. Many do not need it, but it would be an incredibly useful resource to have along the spectrum of services that we need in this area. The services that are around such as Tresillian do very important work but there are some questions about how suitable such services are for people with intellectual disability. We want to teach people with intellectual disability the knowledge and skills that they will use in the environment where they will use them—home-based education support services are far more appropriate in most instances.

Professor LLEWELLYN: We would be able to provide you, if you are interested, with a report to be published in international literature which is the randomized control trial of such a home-based service for parents. It showed conclusively—as such control trials can do—that home-based education is needed. That is not to suggest that supported accommodation may not be useful; it can be useful for some parents—as it is for other parents in the community—but basically people need to be taught where they will use the skills.

Ms SPENCER: From my experience in terms of doing specialist consultation, services such as Karitane and Tresillian feel quite inadequate about educating parents with intellectual disability. They do not feel they have the skills, and I am often called in to adapt training programs for those services. In terms of a supported accommodation program, there is such a program for parents with mental health issues where they can go and see staff who understand their psychiatric disability and understand about education and adapting parent education to it. We have nothing like that in New South Wales or in Australia for parents with intellectual disabilities.

CHAIR: Are you talking about Charmian Clift Cottages?

Ms SPENCER: Yes.

CHAIR: We will be talking to its representatives tomorrow.

Ms SPENCER: We have nothing like that for parents with intellectual disability. As a result if it is seen that a parent with intellectual disability could do with being in a supported environment for a period until they find their feet and can be moved into their own accommodation, the only place for them to go is into a women's refuge for women with domestic violence and other issues. That is not appropriate. Those residential workers are not skilled in working with parents with intellectual disability. We could do with that in this State.

In terms of what is happening in New South Wales—I speak together with my colleagues from the university—we have developed something that is world class in terms of our knowledge and expertise around parents with intellectual disability. Professor Llewellyn would be considered one of the world leaders in this area. We are a small research group around the world, but here in Australia we are recognised for the work that we have done in terms of issues to do with parents with intellectual disability. We have something that is very good here. I also think the State's child protection Act has, in spirit, so much to offer families. By combining those things with the right allocation of resources we could strengthen our position as world leaders in what we are offering parents with intellectual disability.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is remarkable evidence compared with what we usually hear.

Ms SPENCER: It is true. We have something. We talk about exporting goods from New South Wales but we do not think about exporting our community services. However, in terms of our Act and what we could be doing, if the Government had the will to do it—there is certainly the commitment within the research sector, particularly for parents with intellectual disability—it could happen. Gwynnyth has done much work in that area of the past 10 years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Professor LLewellyn made a throwaway comment about caseworkers' education: You said that they were poorly educated. We have some evidence from a whistleblower in western Sydney about the difficulties between the new breed, the university-educated, sociological types, and the old school, who were welfare kids who were given the job because it was assumed they knew something about the sector. Is this a big problem? Is the DOCS culture very much steeped in old welfare practices from old welfare kids? You would think that the old welfare kids would try to avoid in the future the sorts of things that happened to them. Is this a real problem in the culture? Do you know the statistics—we have not asked DOCS this question—in terms of background?

Professor LLEWELLYN: I do not know the numbers and I do not think I am well qualified to talk about proportions of people coming from different education orientations. I do think I am well qualified to talk about the lack of attention to the whole spectrum of family support—from prevention, early intervention and child protection—in any university training. I think I am well qualified to talk about that. In other areas we have gone towards understanding that you need to educate people particularly about the field of study that they are planning on working in. There is no such thing for people working in the whole spectrum of family support services. Basically, we have social workers going into child protection—child protection is a small part of social work practice—or, as you said, originally people who were graduates of the system returned to monitor and police the system.

CHAIR: What training do people in family support services receive?

Professor LLEWELLYN: They have a wide variety of training. Many of them now have university training but they come from education, nursing and all sorts of other backgrounds.

CHAIR: They are not trained specifically but they come from a wide variety of backgrounds.

Ms SPENCER: Yes, they are. Some 93 per cent of family support workers in New South Wales have tertiary qualifications. In terms of further education, many have completed the diploma of community welfare through TAFE, which contains a family support certificate written by the Family Support Services Association. It was recently updated. Many complete that. We also find with family support, which differs from child protection, that our workers tend to be older. They tend to be parents themselves.

CHAIR: In our consultations and visits to different services I got the impression—perhaps I am exaggerating slightly—that everyone working in any other agency was a former DOCS worker.

Ms SPENCER: I survived DOCS and now I work for another agency.

CHAIR: I guess that leads to issues about the training of DOCS workers.

Professor LLEWELLYN: We do not have an overall model. If you look at other areas—even to disability, which is not always at the top of the list—at least we have undergraduate programs in specialty areas, and now we have some graduate programs that allow people to develop more sophisticated knowledge and to develop managers and leaders in the field. In child protection or in the continuum of services and family support and child protection we do not have opportunities for people to develop a more sophisticated level of knowledge. This is critical if we want to have leaders in practice—literally practitioners—and it is also critical if we wish to have leaders in policy.

CHAIR: Are you talking about New South Wales, Australia or the world?

Professor LLEWELLYN: New South Wales in particular. I think we have to be fairly humble in New South Wales. If we look at some of our counterparts in other States in the university sector and in government much more attention has been given to ensuring that policy personnel are well educated and to ensuring that there are adequate levels of more sophisticated education for people in leadership positions.

CHAIR: Are our universities not offering the kind of education that you are talking about because it is not in demand in DOCS? It is a chicken-and-egg situation, I guess.

Professor LLEWELLYN: It is a bit chicken and egg. Without the demand for that professionalisation of the work force—DOCS has kept its training very much in house—you will not see the universities responding. Of course it is the chicken and the egg.

CHAIR: I am reminded a little of the parallel with teacher training: it was not until the education authorities insisted that every teacher have a special education unit in their degree that the universities moved to offer special education as part of the training.

Professor LLEWELLYN: That is a perfect example, and it is the missing link in education for people working in family support through to the child protection end of the system.

Ms SPENCER: The in-house training of Department of Community Service workers develops that culture. It does not allow for critical thinking. You could broaden it in terms of collaboration between the different service providers if the training were linked with the university. Gwyneth might like to talk about the graduate diploma in developmental disability studies that is run through the University of Sydney. That is a collaborative model: people come from multidisciplinary backgrounds. People who will be working together are learning together. There is a great advantage in that in breaking down the cultures, starting to think critically or starting to recognise the areas of research that we need to turn to. I am aware from an interim report of the limitations on research that have occurred within the department. Research has not been linked with best practice. I think that would happen if we had training within a university setting. There are many creative ways of providing that training through Internet learning in rural-based settings, for example.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about audit people. You want to separate the care givers and supporters from the audit people, who presumably are the potential police who say, "You've done your bit but this ain't no good". The evidence from the early assessment child intervention learning difficulties is that it is very hard to come in as a one-off—no matter how clever you are—and assess a kid and their family. How do you suggest you could integrate those audit people? Are they from Montrose, are they trained separately or are they senior people who have done a lot of support work? You have someone working their butt off to get them supported and then someone else comes in for a short-term visit and says, "Sorry, but your work ain't good enough". It might be a marginal case. It is going to create a lot of tension within the department. If you have one person doing it, at least they will say, "Struth, I've tried hard but this doesn't work; I give up", and it will not be possible. Both models obviously have problems.

Professor LLEWELLYN: That is true, but we tend to focus so much on the difficulties for the workers and how we set up a model for the workers without perhaps always remembering difficulty for the family. If I am a family and people are saying, "I am here to help you", and they do that for six months and then they say, "You didn't do well enough, now I am taking you to court", clearly it is impossible for the family to trust that person or to trust anyone else in future. We set up a model where families—and we know that there is a very strong and very understandable fear of people coming to take their children away, the welfare coming to take their children away. All of us can attest to what happens, as I have done and everybody else here probably has done too. If you happen to drive up a particular street in a country town in a DOCS car you will know exactly what happens; everybody looks out the window to see what you are going to do to that family you are visiting. There is a very good reason never to take up the offer of a DOCS car if you happen to be doing some work for them. These are very practical issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that right?

Professor LLEWELLYN: Yes, absolutely. The message that gives to the community is that this family is bad—whether they are mad or bad, as I said before, or bad and incompetent. We must start thinking about not how to set up the services just to suit the workers. We have to start thinking about how to set up to provide the supports to families.

The Hon. IAN WEST: Both can be the same.

Professor LLEWELLYN: They can be the same but perhaps we need to have the families as the priority.

Dr McCONNELL: I think we are asking the wrong question. All around the world a lot of money has been invested in developing these risk assessment protocols which will never enable workers to be able to project with any great accuracy what will happen in the future—

Professor LLEWELLYN: For a particular family.

Dr McCONNELL: —for a particular family, the reason being that it is an inappropriate use of population data. They are asking the wrong question. The more honest question would be: What kind of support and what amount of support will it take to secure the safety and wellbeing of this child? If we are unable to provide that level of support, then when that child is 16 and leaving care they can go back and look at their records and say, "Okay, I understand the State at that time was unable to provide my mum or dad with the support they needed at that time." That would be the more honest approach.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting population studies, or are you suggesting rueful looks from juvenile justice facilities?

Dr McCONNELL: I am suggesting that our DOCS workers—our auditors, if you like—to take your turn of phrase, they should be looking and assessing what the support needs are of the child and family, rather than trying to assess risk and do a task which is unrealistic. We are putting an unrealistic burden, a burden of unrealistic expectation, on our child protection workers to begin with. That needs to be addressed. The real question is: What do the child and family need, and can we provide it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you say that this family needs 50 hours of care a week and we cannot afford that, what do you then say? Do they default to take them away, or what? If you say that this is the level of support they need, and we will have graded support, it is all great stuff and it is population based and so on. At what point do you say that the amount of support this person needs is impossible to deliver?

Ms SPENCER: As someone who is often called in, I often in reports will be saying that the amount of support that this family needs is unrealistic and not feasible, both for the community and also for the family because there is only a level of support that you can put into a family before it becomes impossible for the family. If you think of a plant in a delicate ecology if you overwater it to death, you can kill it with kindness, and I think the same thing with the families we are dealing with. I think we have to be realistic: Kids will have to come into care. Many of the kids of the parents we are talking about will need to come into care but it is how it happens. In 1999 I was fortunate enough to have a Churchill Fellowship and travel around Denmark, where they are able to work with families towards that point where the service and family actually say, "This is not working. We are not achieving what we need to achieve." It is very transparent and clear that the next step that needs to be taken is that you go into the child protection system, to the court system that may lead to adjudication in the court system..

A very small percentage of cases we are talking about are ones where things are so chaotic and so critical that we need to come in like the storm troopers. In the vast majority of cases, considered and proactive treatment could mean that parents and the department can come to the decision that alternative care may be best for my kids. In those situations where I have been able to work like that, it has been best for the kids and for the parents. I think that is what we are talking about.

The Hon. IAN WEST: There has been a team effort.

Ms SPENCER: Yes.

CHAIR: We are well over time but we have not asked a specific question that is obviously very important for people with disability, and that is the question about the Children's Court. We have talked to the Children's Court, and we are talking to the Family Court as well. We are conscious that they have criticisms of DOCS. We are also conscious that the Aboriginal people we spoke to earlier have criticisms of the way the Children's Court functions. I imagine that for parents with disability it is even more difficult than for the rest of the group.

Ms ROGERS: It is important to understand that having an intellectual disability means that things need to be explained in a way that you can understand. Once that happens, you are quite capable of understanding those things. As you can imagine with the Children's Court, there are a number of things that will pass a person by without having it adequately explained to them. Even things as simple as how to get to court and where to go and those sorts of things are something that a person with an intellectual disability would need some support in doing. I guess what we would be recommending is that there be some sort of accessibility audit or something in relation to the Children's Court, such that the issues of cognitive disabilities and, from my service's perspective, intellectual disability are considered in the way that people interact with the court.

CHAIR: Do you mean the court itself establishing various services, or would it mean DOCS or some other more independent body?

Ms ROGERS: We would favour an independent body to provide support to a person in attending court and to be able to explain to the person what is occurring. That would be in conjunction with training to legal practitioners so that they have the skills to explain to their clients what has happened in court, what is happening. It is important that people understand what happens in court because, as you would be aware, the majority of these matters are resolved by consent. That seems to be a little bit of a nullity unless a person is able to understand what they are consenting to and what the consequences of those agreements are for the person. So it is most important that a person with an intellectual disability is supported to understand the court process. That does not appear to always occur at present.

Dr McCONNELL: That is an understatement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It sounds like a wonderful euphemism.

Ms SPENCER: Yes.

CHAIR: Are the people associated with the court sympathetic or understanding, or is there a problem in their education as well?

Ms ROGERS: There is probably a need for education like a number of key players in this area, so court staff—

The Hon. JAMES SAMIOS: There is a culture?

Ms ROGERS: I do not know that it would be fair to say there is a culture but, like any members of the community, there are a number of prejudices and misunderstandings about people with intellectual disability. I think it would be important to equip court staff to assist a person with an intellectual disability.

The Hon. JAMES SAMIOS: Have you ever done an audit on that?

Ms ROGERS: No. I am suggesting that there could be an audit.

Dr McCONNELL: I interviewed virtually all the solicitors working at the Children's Court at Campsie, Cobham and Camden, and more or less uniformly they talked about being totally ill-equipped to work with these parents, that these parents take more than twice the amount of time, time which they do not have and time for which they are not remunerated. They emphasise their own lack of training and skills to be able to work with these parents. They were all quite honest in saying to take advice, to get instruction, is extremely challenging. There are a few of us here who have witnessed it ourselves, but I heard many stories when I was talking to the child protection workers and lawyers. The mother with intellectual disability comes out of the court, her child having been made a State ward, as it was back then, and then sits down on the steps in front of the court to wait for the lawyer and/or her child protection caseworker to emerge, only to ask them what happened and when is my child coming home. I witnessed that happen. They often do not have a clue what is going on. The child protection workers often do not have a clue what is going on either. They do not like the process one bit at all.

CHAIR: What do you mean by that—that the court somehow becomes—it is an adversarial thing, is it?

Dr McCONNELL: I do not think we can separate the court from what is happening in DOCS at the moment. The adversarial end, the tale is wagging the dog a little bit here, the adversarial culture of the system. The DOCS workers were the first to talk about how they would often have to play down, because of the adversarial nature of the court, the parents' strengths in the evidence they would put to the court. They did not want to give the parents' lawyer anything to fight them with. Of course, these parents, being so inadequately represented, not through any fault of the well-intentioned people involved, do not have a voice in this process at all. That important information does not get to the decision makers at all.

CHAIR: But if most things are resolved by consent, does that—

Dr McCONNELL: Can I address that?

CHAIR: I assume from what you are saying that it is not informed consent.

Dr McCONNELL: Often not, and that process of negotiation is driven in big part by the system imperative to stop these cases going to hearing. The whole system would collapse if many more cases went to hearing. The whole system would collapse. There is something of an agreement and pressure on lawyers to try to find a negotiated resolution to this so the parents and their children do not get a hearing. What they get is a compromise at the end of the day. I think we have to ask serious questions about whether an adversarial court process is appropriate in this jurisdiction. I believe that if we had a tribunal system, something different, it may pay off in terms of how child protection workers are working with their clients. The adversarial culture has to change. Unless we do something about the Children's Court, I cannot see it happening anywhere else down the system.

CHAIR: To what extent are you two disagreeing?

Professor LLEWELLYN: I think they are agreeing.

Ms ROGERS: Apart from the lack of understanding about disability that the key players have in the Children's Court, including the legal profession, another issue related to that is the level of Legal Aid funding. The time that is needed in interviewing a client with an intellectual disability is obviously more. We would question whether there is adequate Legal Aid funding to ensure that practitioners representing parents are able to spend the time to fully obtain the instructions of the client, like any lawyer should, and also to fully advise and explain the process to the parent.

CHAIR: It sounds as though you would not be very sympathetic to the evidence we have heard that suggests that one of the pressures and frustrations on DOCS workers is the difficulty they have in preparing files and getting in-house legal advice, et cetera, and preparing their case for the Children's Court so that they do not go through a lot of work and then go to court and fail and it is back to square one. That has been put to us quite passionately by some people but you would not be very sympathetic to making DOCS more efficient in getting more children the subject of court action.

Ms SPENCER: I think it is a sad indictment of the system that where decisions are made, it is about "Have we got enough evidence to take this to court?" That is how often face case planning happens with these families at the moment. In one case I am dealing with the moment the decision the department took was, "Wait and see because we will collect enough evidence if we let this mother languish without the support she needs". This mother was actually a ward of the State herself; she was 16 and had a child. I think it is sad that when we look at how we make decisions for families and children it is on whether we have enough evidence to get through the court: "Will it take this to win the case?" It should not be about winning a case but about what is right for these kids.

In terms of the paperwork of the department and the new Act and care plans that I know are being reviewed at the moment, they are very cumbersome and there is a lot of repetition in them. Some simple things could be done to streamline the care plans. I do sympathise with the department and with mental workers all the time because of their pressures. It is very easy to knock the Department of Community Services. The vast majority of those workers really care about kids and parents but they are ill equipped to do it. We then have a culture of fear, that if you speak out and you are not seen to toe the party line, and you have that hanging over you, it is very difficult to make good decisions.

If we want to have a good child protection system, we need to have a culture that enables good decision making because that is what we are on about. That will not be provided by any check list for risk assessment or fancy tools but it is about workers having the time to make good moral judgments, because that is what we are talking about. Unless we fund that we will have a system that is not going to serve our kids well.

The Hon. AMANDA FAZIO: Do you think there is a role for an individual advocacy service that will work with families who have intellectual psychiatric disability when they have dealings with the Children's Court, Family Court or wherever?

Ms SPENCER: Most certainly. Perhaps we will an opportunity at the end to put what we think should happen.

CHAIR: Yes.

Ms ROGERS: I have a wish list. One matter is the provision of individual advocacy and court support. I am talking about lay advocates not legal advocates, but people who will support and assist a parent through the process.

CHAIR: That is your main wish list entry, is it?

Ms ROGERS: It is one of a number.

CHAIR: We may need to get some of international references so that we can talk to you later, but we should conclude with each of you giving the Committee your wish list.

Dr McCONNELL: Could we provide that?

CHAIR: Yes.

Ms ROGERS: The first is the provision of appropriate support services for parents with intellectual disability. I am talking about specific and quarantined funding for family support and other services designed to support parents with intellectual disability. One example of such a service is the Parent Access Program. It is the view of the Intellectual Disability Rights Service that the lack of such support services is a real problem in New South Wales and contributes to the very problem we have been talking about today.

The second thing is the independent advocacy and court support. We suggest there needs to be a funding program to provide independent advocacy and court support to parent with intellectual disability to assist them as they negotiate through the care system. Third is the provision of resources and information for parents with intellectual disability. As we have identified, DOCS, DADHC and even solicitors do not take the time to explain to parents the nature of the proceedings and what is happening in them. We need resources for parents with intellectual disability to equip them to understand the care system and what is involved in going to the Children's Court. The fourth is for training to be provided to key personnel, that is, to DOCS and DOCS-funded service providers, DADHC workers, court staff and the legal profession about what intellectual disability is, to challenge the prejudices that people have about people with intellectual disability, to provide people with skills about how to communicate well with a person with intellectual disability, how to engage well parents with intellectual disabilities, how to work with advocates and support people and how to better use the potential of the Children and Young Person (Care and Protection) Act. The fifth thing is an adjustment of court processes in the Children's Court to better include a person with an intellectual disability and enable them to understand what is happening in the court.

Dr McCONNELL: I direct you to the executive summary in this report. Our recommendations in there remain the recommendations that I would put to you today, so I do not need to go into those. I would like to make one closing statement. When I was spending all that time in the Children's Court over three years and talking to child protection workers and magistrates, one of the really common things that came up was how the Children's Court and care and protection law is seen as gutter law—whether they saw it themselves that way or whether they explained to me that others saw it that way, nevertheless there is this view, that this area of law is the lowest of the low.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean that practitioners who cannot get proper work do this?

Dr McCONNELL: That is right.

CHAIR: Like ladies day is the reference to domestic violence issues.

Dr McCONNELL: Exactly. I think that is a sad reflection on our society and these children have a right to better than that.

Professor LLEWELLYN: We did not discuss issues of children with a disability at all, but what I would like to see come out of the inquiry is that we definitely have to have, as a matter of urgency, proclamation of the remaining parts of the Act. I have written to the Minister on this very issue several times. I have just returned from international sabbatical leave. We are seen in Australia as having a good Act but we have not implemented the out-of-home care parts and those dealing with the Children's Guardian, which would really put this country on the map, so I am very strong on that.

We have talked about separation and quarantining of funds to ensure that prevention and early intervention goes ahead. We must have a cross-department commitment to families with special needs. These families come before Attorney Generals, Housing, Education and Health. We have a model in early intervention. We must expand that model and do it properly for families with extra needs. We cannot continue to work in isolation. We have provided this sort of evidence over a number of years. I am happy to leave a copy of our report. It was distributed so widely that there are not so many copies left anymore but this was done for the Commonwealth on parents with intellectual disability. Our recommendations today would be the same as in this 1995 report, which was distributed around the country because it was done for the disability services subcommittee. The recommendations remain the same.

We provided information to the standing committee some years back on parent education. The recommendations remain the same today. They have not been implemented. They are based on good research evidence. That is the way forward for this inquiry. The last thing I want to say is that in medicine and in health we are not prepared any longer to tolerate daily practice which is based on, "Well, we have always done it that way around here. We'll keep doing it that way." We will not tolerate that with our health. In welfare we will still tolerate people saying, "We have always done it this way." We do not have a culture or a commitment in this State in family support and child protection, and I do not mean family support services but that continuum. We do not have a commitment to evidence-based practice. I find that very hard to understand when we have such a commitment to evidence-based practice in terms of our individual health, that we do not have that government policy and practice commitment to the same sort of evidence-based work with our families.

We clearly need that because if we do not do it with our families, everybody ends up less healthy. I would strongly urge you—we have not had the chance to talk about the importance of research—in this inquiry to talk about evidence-based practice, even if it means taking a word from the medical and health field because that is one of key components that is missing in the whole of the child protection system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We do not have evidence-based legislation yet.

Ms SPENCER: I have a wish list and I am very conscious of the time. My colleagues have summed up many of my points. In speaking from a family support services perspective, at the moment most family support services around New South Wales can provide families with about one to two hours a week. This is not sufficient for parents with intellectual disability. In our census we know that 17 per cent of parents who come into family support services are seen to be parents with special learning needs such as having psychiatric or intellectual disabilities or an acquired brain injury for one reason or another.

Those parents are a significant proportion of our work yet we cannot provide the support. As a result, many services now will say that they will not take on working with parents with intellectual disability, so that puts parents with intellectual disability are more at risk because we cannot give them what they need, and that is unfair. For that to change, in terms of money I strongly support priority being given from this inquiry to early intervention and prevention. However, for parents with intellectual disability this will not be enough unless funding is quarantined for them specifically because otherwise they will continue to miss out in the general population.

There is urgent need for resources and information that is accessible to parents with intellectual disability. They cannot parent if they are not provided with the information. They cannot access the information if it is in a form that is directed at middle-class families. We know what type of materials work. We have good evidence that we have used here in terms of a recent project with parent's health and wellbeing and a project on the health and safety of children under the age of five for parents. We know what the ingredients are. It is a matter of having the resources to do that.

Practical support is an issue in the Working for Children document. Recommendation 53 of the standing committee was that money be given for home care to provide for these families. At that point we have costed that. For the number of families needing support, providing two hours of home care a week would make the difference between many of them going into the Children's Court for issues of neglect, and it would cost $500,000, statewide. We could solve a lot of problems but unless that is quarantined for parents with special needs, it will go to aged care or individuals with disabilities because they will be given a low priority.

There is a need for supported accommodation. Parents with intellectual disabilities do not need 24-hour support but for this group of parents to be given a go, they must be given a go in an environment that understands their needs. Also, there is a desperate need for counselling services for adults with intellectual disability, but particularly for parents with intellectual disability. We have heard about the number of children who go into care with many of them suffering great loss and grief issues. The result is more children who are removed. We provide nothing. Once the mother walks out of court, there is nothing for that mother. She is no longer eligible for family support services because she is no longer seen as a parent. She is no longer eligible for child protection because child protection is concentrated on the child. These parents are left with nothing but great loss and grief issues.

New South Wales Family Planning has ceased all counselling at the moment to adults with intellectual disability because they do not have the funds to do that. There is not even Family Planning for people with intellectual disability, let alone genetic counselling for parents with intellectual disability. There is no counselling for issues concerning sexual abuse and sexual assault for people with intellectual disability in this State. As a result, we have 49 per cent of family support clients who have an intellectual disability who cannot even get the sexual assault counselling that they need to deal with those issues. In terms of the practical things that need to be done there are many practical things that can be done. We have reported that in many reports over the past nine years. There has to be a political will to do something.

(The witnesses withdrew)

(Luncheon Adjournment)

CHOONG-SIEW YONG, Medical Practitioner, President, Medical Practice Committee, Australian Medical Association, P.O. Box 121, St Leonards, and

MICHAEL DAVID GLIKSMAN, Medical Practitioner, Chairman, Medical Practice Committee, Australian Medical Association, level 2, 37 Bligh Street, Sydney, sworn and examined:

CHAIR: Do you appear as President of the Australian Medical Association?

Dr YONG: Yes.

CHAIR: Have you received a summons issued under by name under the Parliamentary Evidence Act?

Dr YONG: Yes.

Dr GLIKSMAN: Yes.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Dr YONG: Yes.

Dr GLIKSMAN: Yes.

CHAIR: You have not made a submission?

Dr YONG: No.

[SUPPRESSED – refers to confidential evidence]

CHAIR: As you probably know, the committee has tried to take evidence from almost groups involved one way or another with the child protection system. In terms of general practitioners, in particular, but obviously other members of the medical profession, a number of issues have been raised about mandatory reporting or the local agency work of doctors and so on. We are interested in finding out as much as we can about the general practitioners' perspective and other practitioners as well. Can you give the committee a brief overview of the role of the Australian Medical Association [AMA] and particularly the role that general practitioners and other doctors play in the child protection system?

Dr YONG: I can talk a bit about the AMA, and the role of doctors. First of all, the AMA is the peak representative body of the medical profession in Australia. It has a State and Federal structure. I am here in my capacity as President, AMA NSW. We have more than 8,000 members which represents about 50 per cent of registered medical practitioners in New South Wales. If you were to take the actively practicing doctors probably it is the majority of practicing doctors in New South Wales. Clearly, general practitioners are a large group of that membership. We can fairly well say that we speak for the profession in many ways and certainly accept that it is such a part of the profession.

I think that doctors, particularly general practitioners but also paediatricians, child psychiatrists and emergency medicine doctors are pretty much at the front-line of seeing children who are likely to be at risk and in need of child protection services. On that basis, those doctors particularly play a central role in perhaps identifying possibly those children who may need some child protection service. In addition, doctors have been quite concerned about optimising the health of children in out-of-home care. because those children have particular problems, it is my view, at the time that they are at risk of not receiving the best medical care that they can.

The trend we have seen over the past 20 to 30 years is a tendency for parents and other carers to bring children to health services when the problems are possibly more social or psycho-social. That is a trend that is occurring through society as other helping agencies, welfare agencies, church agencies and so on are being squeezed. As society becomes more secular there is a growing tendency to seek doctors or hospitals as a source of first help, even it is not immediately medical. Sometimes children or other adults presenting with what may be on the outside a seemingly medical problem, with more inquiry it turns out to be more a psycho-social problem. It is important that doctors are recognised as an important part of the whole child protection system. We should recognise that in fact seeking medical help often is, in fact, a cry for help within a child protection context. As such the medical profession needs to have a central role; it needs to dovetail its role quite well with the statutory child protection agency. I think that has been a problem in the past few years.

Dr GLIKSMAN: Medical practitioners can and should be important partners in the child protection scheme. They are the people, not necessarily most likely to first see non-accidental injury, but they are in a fairly unique position in the community to be able to assess the nature of the injury and the nature of what is before them and to determine whether it is an issue that requires child protection in that it involves danger to a child. My view is that the more that can be done to encourage and support general practitioners and other doctors to participate fully in the child protection scheme the better.

CHAIR: Various people have said that families now coming into contact with the child protection system may have greater complexity than in the past: their problems may be more complex with domestic violence, substance abuse, poverty, homelessness, isolation or particular needs arising from disability or mental illness. Does that fit in with your opening comments about the problems that people present with, being in some ways more social or broader than strictly medical? Do you think those issues are different from the sorts of problems that you were thinking about?

Dr YONG: That is a fair comment, and I would think most doctors would agree that they are seeing more of these sorts of families. As I said, general practitioners are often one of the few services available, particularly in isolated parts of the city or even outside of the city in the State. You would note that in regional and rural areas there has been a withdrawal of most services, the sorts of things that add to the social cohesion of a particular place such as its financial services, the post office, shops and so on. The local doctor is one of the last services to leave because the community values local doctor is very highly, but the isolation that brings when other services disappear or are reduced means that there is a higher burden on the doctor.

What happens more and more nowadays is that families and patients are presenting with the social problems as most medical problems. In the past it had to be quite a perceptive doctor to pick up that the context in which a medical problem would come up was, in part, due to poverty, such things as illnesses related to malnutrition or presenting very late rather than early and other sources of preventive health issues are becoming more apparent. But it is also increasingly clear that families are going to medical services, whether it is the hospital or the GP surgeries nominating social problems to do with poverty, isolation and disabled children as the primary problem for which they are seeking help. It is no longer obscured by a presenting medical problem as such, although that often is still the case.

CHAIR: What does the doctor, particularly the GP, do in that situation?

Dr YONG: What is happening is that there is a recognition that GPs have to try to work with other community services that are available, and there is increasingly an approach of having almost a team-like approach.

CHAIR: He cannot really do that if you are the only surviving service in the town.

Dr YONG: That is right, so it means that it is harder. What happens is that there is a desperate cry for GPs to the existing community health services, which can often be quite stretched as well, to take up that kind of burden of care.

The Hon. JAMES SAMIOS: Is this emphasis on the role of the GP aggravated by the fact that extended family networks are broken down by comparison with the past, and we now have working parents on both sides of both sexes? Is that also part of the dilemma?

Dr YONG: I think so, yes. One of the things is that it is harder to find alternative care for children who might be sick or if a parent is sick, how do they look after children at the same time.

There were more avenues for help before in terms of informal family contacts and informal social contacts than seems to be as available nowadays. There s a higher burden on existing carers, who have to sacrifice work and so on to provide that kind of care.

The Hon. JAMES SAMIOS: The mobility of couples now has also aggravated the situation; mobility in the sense that grandparents can be in Perth and the parents in Brisbane. You cannot call on that network.

Dr YONG: One of the issues is that you often see younger people moving to the cities from regional areas because of job opportunities, but that means that they leave extended families behind in regional areas. I have seen some of the opposite now, as well. I do some work up on the North Coast. You start to see families who are refugees, if you like, from the western suburbs and other areas of Sydney where they have had difficulty getting jobs and social support. They moved up to an area that is cheaper, at least to settle in, such as the North Coast, but then they are also just as isolated there and then they have problems of relatively poorer services than they would have had in Sydney and yet the same needs. I am starting to see almost the opposite in a way. You see these families isolated up there. For reasons of finance they cannot move back to the city. They are stuck. Physically it is a much more pleasant place to live, but these are families who are struggling at best, often with only one parent to care for the children, the children have multiple problems, health problems as well as psychological problems, and they do not have any family in that area to help them.

CHAIR: We have been given that evidence on some of our travels. There are certain places on the North Coast in particular where families with a variety of problems are becoming very high, and the range and seriousness of the problems is quite extreme.

Dr YONG: Yes.

The Hon. JAMES SAMIOS: And in relation to people from non-English-speaking backgrounds the interpreter translator services are not so visible, that is a further challenge.

Dr YONG: Yes, that is right. That is a particular problem as well as the problems of indigenous people, which we have not touched on here. Again, they have specific needs that are much greater.

CHAIR: We have asked you about whether you think doctors, as mandatory reporters, should have special arrangements for reporting children at risk of harm, but we should also ask you about whether you have a view about the reintroduction of mandatory reporting as such. Most people seem to support it, but some people suggest there are some problems with it.

Dr YONG: It would be fair to say that the majority of doctors probably support the idea of mandatory reporting. Although there is substantial minority who argue for a discretion rather than reporting, but the consensus would be that mandatory reporting is probably a good idea. The problem is the execution of it. There are some special arrangements for doctors in the hospital system because if you were to take, say, the DOCS Hotline there is a shorter way of getting through to them. But it is still often a long way to get there through special numbers and so on for people in the hospital system, but some of the GPs are not aware that there is such a system and others find it quite difficult, because of their workload and the pressure to keep patients moving through to spend the time waiting on the elpline to pass the message through.

The other thing, particularly for GPs, is that because they are not in a system that is mixing with other professionals engaged in the care or welfare for the family they may not be aware that there are other ways of doing it through some of the other agencies, of perhaps dealing in a co-ordinated way and so on. Sometimes children may have fallen through the cracks when GPs thought that some of the other agencies involved had notified and the other agencies have thought that the GP would notify. That is supposed to be Helpline management reporting, but people are often at pains to try not to duplicate things too much.

CHAIR: You are suggesting that most doctors are using the numbers that are limited and, therefore, they get through to the elpline more quickly, but that some are not aware of it. Would some use the faxes and the other mechanisms that people have told us about because they cannot wait?

Dr YONG: In the hospital system I think they are. Among GPs it varies depending on how much information has got through about the changes and also in terms of those who sees more or fewer children in their practice. It is an individual thing. It may be worth looking at other ways of disseminating information to GPs, perhaps through the divisions of general practice. There may be a way of expediting information through that infrastructure. We could look at what the AMA could do in conjunction with DOCS. We have had some talks with the Children's Commission about getting information about doctors' responsibilities out to them. That information must be fed to GPs and other doctors fairly regularly.

CHAIR: In the classic, typically busy GP practice with appointments scheduled throughout the day, regardless of how many doctors work in the practice, they cannot drop everything and wait on a telephone. Does a typical GP wait until the end of the day to make a report or does a staff member make the call to the Helpline if there is evidence of harm or strong grounds for suspicion? In terms of the practicalities, what does the typical GP do when he feels a report must be made?

Dr YONG: It varies widely. The GP would generally make the call.

CHAIR: It is supposed to be made by the GP.

Dr YONG: Yes. I do not know that it is a good idea to have a receptionist make those calls. Clearly, GPs must also let families know that they are making such a notification, and that can be difficult at times. It probably is left until lunchtime or after hours because of the pressure of other appointments. I do not think most GPs would say that they need to allow an hour in case they have to make a child protection report. It will most likely come up in the course of a consultation without warning. It may be very urgent or something than can be left until a more planned time, after being in touch with agencies to get more information. It is individual; it often needs to be left until after hours or spare time.

CHAIR: But the doctor would feel an ethical obligation to tell the parent who might present with the child that he intended to make the report.

Dr YONG: In general, yes.

CHAIR: I assume that that would be done during the consultation, although the report itself may be lodged some hours later.

Dr YONG: It would probably have to be, or even after the notification. He may make a report and speak to the parent later or at another appointment. In general, unless there is evidence indicating that it would be harmful for the parents to know, it is better to be up front. Often parents agree; they may be asking for help and it is a way of getting that help quickly.

Mr WEST: What percentage would that be?

Dr YONG: I cannot provide that figure. I see a biased population because of my practice as a child psychiatrist. I see the end, where parents are struggling. I probably make more reports than the average GP.

Mr WEST: As a guesstimate, what percentage would cause a breakdown in the relationship between the doctor and the patient?

Dr YONG: That is a good question.

Mr WEST: In what percentage of cases would the doctor lose a central role or an important role in the relationship between himself and the patient?

Dr YONG: I do not think anyone has looked at those figures. It is very dependent upon the existing relationship between the GP and the family. It also depends on the individual skill and sensitivity of the doctor. Other factors might have a bearing, such as whether the parents have suffered from a mental illness and their previous experience of agents such as doctors and welfare agencies.

They may have had negative or positive experiences. Much depends on the way the doctor approaches the situation with the family about why the notification needs to take place. Sometimes it is inevitable that that will lead to a breakdown in the relationship with the family. They may say that they do not want the doctor to deal with them anymore even though he has explained the reason. I do not know of any figures on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it the doctor's job? Surely, people in this situation would be Medicare patients who live in the country where many doctors do not bulk bill because it is totally uneconomic to do so. The amount of time they would have to put into such a case would mean that the Medicare rebate would be unrealistic, and it is becoming more so. Is that correct? If so, is the doctor fulfilling a role that he should not be fulfilling? Should other support agencies be doing this?

Dr YONG: You are right about the changing financial basis of medical practice, particularly in regional areas in that Medicare or bulkbilling are taking less of a role. You are right in stating that other agencies should be involved sometimes. The point we are making is that doctors are in the frontline. In many areas they provide one of the few shopfront community services left. Most conscientious doctors feel it is part of their role to make a report if they suspect there is a risk for the child. That is the law and it is certainly what they are taught.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not true that the AMA is advocating reducing bulkbilling and in many rural areas it is not available?

Dr YONG: That is a matter of choice on the part of the doctor. It also reflects the changing costs within practices. The AMA maintains that fees should be a matter for doctors and patients to determine. It has also advocated that rebates to patients should rise in line with the rising cost of medical care so that patients can afford to visit doctors and are appropriately reimbursed by the Government.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So what I am saying is not wrong in essence. You are stating the reasons and trends, but what I am saying is correct.

Dr YONG: Which is?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am saying that the Medicare rebate is not sufficient to maintain a practice at this standard.

Dr YONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the AMA has said so.

Dr YONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The reality is that, as the AMA said, the remuneration and the time that psychiatric and social work consultations take makes them totally uneconomic and, therefore, not available in many situations. Is that true?

Dr YONG: That may be so. I am not sure it means that when patients need that type of consultation doctors are not offering them. However, it does mean that it is harder for doctors to offer that type of service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And presumably harder for patients to get it.

Dr YONG: Yes.

The Hon. JAMES SAMIOS: It is not also true that the priority for reporting lies with the doctor as the most qualified emissary in the field?

Dr YONG: In some cases it would be.

The Hon. JAMES SAMIOS: Surely when a child's life and security is at risk, the question of bulkbilling and costs are irrelevant.

Dr YONG: If a child has been harmed and needs emergency care, he or she will be seen by the emergency services in the area. In some case, especially in regional areas, that is the GP or the GPs at the local hospital when they are working at the hospital.

The Hon. JAMES SAMIOS: Getting back to delays on the phone, should there not be a priority for doctors s the frontline operators?

Dr YONG: There should be.

CHAIR: There is.

Dr YONG: That is correct.

The Hon. JAMES SAMIOS: Are you sure of that?

Dr YONG: Yes. Despite that, we are still told by GPs that there is often a long wait because of the number of calls. Honourable members know better than I about the increase in calls since the Helpline has been established and mandatory reporting has been more publicised.

The Hon. JAMES SAMIOS: My point is that doctors should not be required to wait in the queue bearing in mind all the other needs to which they are attending; they should get priority in that situation.

Dr YONG: We would agree with that.

CHAIR: Police and teachers would probably say the same thing.

The Hon. JAMES SAMIOS: There would be others.

Dr YONG: They might well say the same.

CHAIR: We should address specific questions about how effective the Helpline is as an intake system. That is connected to what happens after a report has been made. Do your members get any feedback? The committee has taken up that issue with many witnesses. Do they know how effective DOCS assessments and investigations are once a report has been made? Do they know and can you say on their behalf how adequate the interventions are after the report and assessment?

Dr GLIKSMAN: When one does not have something positive to say one would rather not say anything.

CHAIR: Members do not mind; we have heard strong opinions voiced by many people.

Dr GLIKSMAN: The majority of doctors support mandatory reporting. It should be up to the statutory department to assess whether the report has features that require further investigation. Having such a system is predicated on the view that it is capable of responding appropriately, effectively and within as short a period as the specific circumstances of the case require. Without that, mandatory reporting has no meaning. I regret to say that I think that is the situation we have in New South Wales, and I cannot see a rational explanation for that.

If we were to use the department's figures of 130,000 notifications per annum and assume that the Helpline is open 10 hours a day for 365 days a year, that would yield an average of four notifications perfect hour. There is no cure. Why then is the response time so long? Why it is so manifestly inadequate and why does DOCS not know, even now, what are the risk factors that alert it on the first call that it is dealing with a case in serious danger? There is no satisfactory explanation except that DOCS does not know its business. It does not know the risk factors; it has no system that allows it to call up previous histories to establish whether that in itself represents a risk factor.

I guess what I am saying is that if the explanation being offered is that the number of calls to DOCS is responsible for a bottleneck that cannot be easily broken, that is simply not true. The average number of calls per hour, assuming that the Helpline is open 10 hours per day, is so small that that should not happen. It gives the department 15 minutes on average to begin the assessment process. In other words, the Helpline has been a disaster. It was a disaster from the start, and that was predicted because DOCS had no apparent effective means of collecting information, assessing it or responding to it, and it is still the case. Doctors do not receive feedback on the outcomes of reports, except on the odd occasion indirectly.

How effective are DOCS assessments and investigations regarding abuse? The answer is in the existence of this committee, which would not be needed if the answer were other than what I have suggested.

Once the child has been assessed, how adequate are the interventions put in place to meet their needs? There are no such interventions to meet their needs. The interventions are not proportionate to the risk. They are not, except in the rare circumstance, brought about in a timely manner. And they do not result in good outcomes for the child. The intervention, when it does occur, is either too late, inadequate, or compounds the problem.

The Hon. JAMES SAMIOS: Has the AMA taken up this matter with the relevant authority?

Dr GLIKSMAN: With the Department of Community Services?

The Hon. JAMES SAMIOS: Yes.

Dr GLIKSMAN: I cannot speak for the AMA itself, but we have taken it up with the Children's Services Commissioner. My history with DOCS goes back well before my history with the AMA, so I speak partly from that experience.

CHAIR: There may be something wrong with my maths, but I think I am right in saying that the figure you should have is 40 an hour.

Dr GLIKSMAN: I am sorry, you are right, it is 40.

CHAIR: We could still discuss the detail, but there is quite a difference.

Dr GLIKSMAN: Yes.

The Hon. IAN WEST: That is assuming they are at perfect intervals.

Dr GLIKSMAN: It is on that assumption.

The Hon. IAN WEST: And predictable.

Dr GLIKSMAN: There are predictable occasions when they will be much higher, and one would assume that DOCS would have more workers on station for that.

CHAIR: For instance, the busiest time of the day, which apparently is two hours or three hours after school finishes.

Dr GLIKSMAN: And the busiest time of the year is when school goes back after holidays.

The Hon. JAMES SAMIOS: Over what period of time have you assessed the inability of DOCS to deal with these matters?

Dr GLIKSMAN: I have been closely involved now for a decade, partly professionally and partly as a foster parent. What I have seen, I would have to say, is a relentless decline in standards.

CHAIR: I do not think what you are saying is really about the Helpline. As we understand it, the Helpline takes the calls, and therefore clearly should have access to the files. I think the evidence is incontrovertible that the files are a mess and that the new information system is not up and running. But after an initial assessment at the Helpline, the case is then, in theory, moved to the local community service centre, where the kind of detailed work that you are talking about is supposed to be carried out, and the priority system means that the clearest cases should get interventions quickly, and so on down through the levels. I guess you are talking about the whole system, from the Helpline down to the case workers in the CSCs. Or are you meaning to say that the whole assessment process should take place at that Helpline level?

Dr GLIKSMAN: A fair amount of the assessment already takes place at that level, where they are assessed on priority as to which will be given an urgent tag or not. On what basis, I have no idea, but certainly not on risk factors.

CHAIR: But then, in turn, all of them are referred to the CSC, where the level can, at least in theory, be changed.

Dr GLIKSMAN: In theory.

CHAIR: With local knowledge or further information being taken into account.

Dr GLIKSMAN: But if that is the case, why have the Helpline? It simply adds one layer of barrier.

CHAIR: So, would you get rid of the Helpline?

Dr GLIKSMAN: If we had a department that operated as it should, it probably does not matter whether we have a Helpline or not. With the system we have at the moment, it is my opinion that it simply adds one layer of barrier.

CHAIR: So you probably would get rid of it?

Dr GLIKSMAN: Probably.

CHAIR: I am pushing that because, as you may have noticed from our interim report, most people have said that the reasons for setting up the Helpline were good, even if they have criticisms of how it has operated. They have referred to a clearinghouse function, to equity function between regions and local areas, a way of solving the fact that notifications do not come in the nine to five working hours, and so on. Some people have suggested regionalising the Helpline, and all sorts of things. But most people think there needs to be some kind of centralised intake system.

Dr GLIKSMAN: I was hesitant in answering the question because my concern is that, given the enormity of the problem and its durability, there is an understandable and natural drive to try to identify an easy problem. Abolishing or keeping the Helpline will make no difference, in my opinion.

Dr YONG: I think what Dr Gliksman is saying that it is not that the notification process that is a problem, but what happens afterwards. I want to say a couple of things about the Helpline. The feedback is that you generally get back a fax saying, "We received your report on the Helpline, and we have transferred it to such-and-such a CSC," and generally speaking that is about the end of it. So there is feedback about the outcome of the Helpline as such, you are quite correct, but it is not meaningful because you do not know what has happened in terms of interventions for that family or for that child, unless you inquire further yourself.

CHAIR: One of the questions, which we have asked a number of witnesses—but which is perhaps less relevant to doctors, and particularly general practitioners—is the extent of interagency work at local level, and the extent in particular to which the CSCs are plugged into the networks of other departments and non-government organisations, so that there is in effect more feedback because these people are actually talking to one another. One of the statements made by some people who are critical of the Helpline is that it has tends to reduce the level of local interagency discussion amongst differing professionals. I do not know whether you wish to comment on that, either way.

Dr YONG: In terms of general practitioners, you are right: there is not so much interagency work done. I think there are other specific issues for general practitioners. But, for other doctors who see lots of children who either are in care or been involved with DOCS in some way, say paediatricians and psychiatrists, that is a particular issue because the existing interagency agreements are centred around children who need investigations done about allegations of abuse generally. As you know, that has been quite well developed over the past couple of years. There is a very comprehensive interagency agreement between police, Health, Community Services and other welfare agencies. That is not a problem.

The problem lies in the fact that after the investigation has been done and there are some recommendations, the child may have been in out-of-home care for a while, then be back in the family's care but with certain supervisory requirements or conditions attached, and there is a huge need for DOCS to be involved in those cases where there is a clear issue for the treating doctor, say a paediatrician or psychiatrist, to continue working with that child and that family, with DOCS as an active partner. The usual approach with DOCS is, "They are seeing Dr So-and-so, so that is all right, and we do not have to be involved anymore. As far as we are concerned, we can wash our hands of it." In fact, it is central that DOCS remains involved—sometimes in the case management role, sometimes on the periphery. DOCS is the statutory body that can provide some of the momentum to keep going, because these are families that often do not come easily to using other agencies. Their tendency is to run away and hide, perpetuating the problem, not to approach things from the point of view of trying to resolve them. Without DOCS being involved, the other agencies have no element of coercion, if you like, over that family. As far as Health is concerned, all Health can do is to make yet another notification to DOCS and go through the whole process again.

CHAIR: How would DOCS coerce someone into keeping an appointment with a child psychiatrist, for instance?

Dr YONG: When DOCS is involved it can say, "This is part of your conditions for retaining care of the child," or, "This is part of the conditions agreed to in the Family Court." That is enough. I am not talking about bringing in the Tactical Response Group or anything like that. It is just that with a group of families where we see a need to intervene in a therapeutic way, we must use a bit of the carrot and stick approach. DOCS is the only statutory body that can do that. I think it also demonstrates to the other agencies: This is an important problem; we are here for the welfare of the child; this is paramount. That is why are all these agencies are involved.

The Hon. JAMES SAMIOS: You are saying that, although all of those agencies are involved, the constant co-ordinating authority should be DOCS?

Dr YONG: In many cases, or there should be an agreement between the agencies as to who should drive what at an individual case level.

The Hon. JAMES SAMIOS: I would have thought that was pretty obvious. I am surprised that has not been the case over the last decade or so.

Dr YONG: It is obvious, and it occurs partly at the initiative of the individual district officer or case worker in DOCS. But it is also partly due to priority management by the local manager at the CSC. Managers often override the case worker and say, "You are not to deal with this case in any way, except to deal with emergencies. I will not release you to attend a case conference with the doctor and the social worker, or the doctor and the child and family health service that is involved," and so on. Such decisions made at that level have a clear impact on the care of the child.

CHAIR: Is that decision of "I will not release you to attend" made for workload reasons, or because of the number of cases to be dealt with?

Dr YONG: It is a case of the managers saying, "This is my management decision because I have to manage the workload in my centre, and I am going to prioritise everything."

CHAIR: So they may, in principle, think that case conferences and so on are good things, but they are saying, "We do not have time."

Dr YONG: They are saying: We are not allocating priority to that.

CHAIR: We had representatives from some Aboriginal organisations give evidence this morning. They said, as have others representing different groups, particularly the more disadvantaged groups in our community, that there is a big problem in a sense that there is conflict: that DOCS is the enemy, that people see DOCS as being punitive, particularly for Aboriginal communities but not only for them. Some of that may be a matter of separating the child protection stream in DOCS from the family support case worker type of stream. When we talked to those groups, they clearly expressed reservations. You used the expression carrot and stick. They would say part of the problem is that when DOCS itself is seen as playing a punitive or coercive role, it is never going to work if you have to intervene to make families work better.

Dr YONG: That is a problem in particular in indigenous families because there is a reluctance to involve DOCS or for DOCS sometimes to be involved. I think it comes down to judging each case individually. My experience is that some children who have really needed to have DOCS intervene, because from the point of view of the child the community was so chaotic that no-one else was effectively taking that parental responsibility and there needed to be an outside agency. But, because this was an indigenous community that was semi-isolated from the rest of the local area, it was very difficult to do that. It meant, effectively, that the reluctance of DOCS to be involved, for all those reasons, meant that the child would not get the sort of care we were recommending because no-one was taking charge. That is a real conundrum, and it comes up often in these sorts of cases. It is partly a philosophical approach about what is best for that child.

Often, there may be some areas of conflict between what we as doctors view as being in the best interests of the child and what welfare agencies might view as being in the best interests of the child. At least if everyone came to the meeting and talked about it, we could come to some sort of agreement. The difficulty I have is quite often the reluctance of the doctor to be involved to that degree, and the tacit assumption, just because the family or the child is seeing a psychologist, psychiatrist or paediatrician, "It is then all okay and we do not need to have any further involvement."

CHAIR: "We can therefore move on to the next case."

Dr YONG: Yes, we can move on to the next case. They say, "This is not an important case because this child is no longer being abused". We then say, "But this child is at risk of further psychological and emotional damage because of other factors". Or they will say, "This child is too old for us to be concerned about" because a 13- or 14 -year-old might be at risk of going further and further down the custodial criminal justice path as a result of their disorder rather than being in direct physical harm.

The Hon. JAMES SAMIOS: Returning to what you said earlier, do you still support mandatory reporting by doctors across the board?

Dr YONG: The majority of doctors would be in favour of that. Some do not agree, but in general there is more evidence to show that it is helpful than harmful. There is a danger that some children will be ignored if mandatory reporting is not a priority. Making it a legal responsibility sometimes helps families who might be angry about a report being made to come to terms with the fact that the doctor was forced by the law to make the report. So the law can be the ogre rather than the doctor.

CHAIR: You have painted a fairly black picture of how successfully DOCS is intervening and caring for children who are still with their families. What about the out-of-home care system and the situation for those children who have been removed from their families?

Dr YONG: I will make some brief comments and then refer the question to Michael. There have been some successes. I have certainly had children under my care who have done very well because we have worked closely with DOCS and we have had a good relationship with the DOCS worker involved. However, it has often taken a huge amount of advocacy on our part. "Advocacy" is a polite word; it is more dragging people kicking and screaming, in terms of managers and so on, to the group and saying, "This is really important". When doctors see children in out-of-home care and under an agency—perhaps the foster parents—it is hard to know whether there is any quality control in place with regard to the agency. We do not know how good it is or is not. Some doctors tend to see a lot of these children—for example, doctors who work in emergency departments and particularly centres such as the High Street Medical Centre in Parramatta, which is part of the Western Sydney service and is geared towards homeless children and adolescents or those in out-of-home care. It is often hard for doctors to judge the quality of carers. We do not know whether there is a quality control process.

CHAIR: What ensures that carers bring those children to you?

Dr YONG: It is pretty much reliant on individual initiative.

CHAIR: So the carer has agreed that the child needs continued support from a child psychiatrist, for instance?

Dr YONG: Yes. It is often up to the carers. They might bring a child to an emergency department or to a general practitioner either because there is a medical problem or because a particular behavioural problems cannot be dealt with at a local service level. The difficulty is that the quality of those carers is quite variable. The quality in terms of knowing when those children should see the doctor is also variable. I suppose it is like real life: Some parents are much better at taking children to the doctor; others may be a little too lax and others tend to take their children for every little complaint. It would help if we tried, where possible, to maintain the same GP for a child. We recommend that for all families. That can be difficult if children are moved from one foster carer to another, from one agency to another and so on.

Children often fall through the cracks. It is harder to have follow-up of ongoing conditions. Many of these children are on regular medication for emotional or behavioural problems. They may be disabled in multiple ways and need further care. When they have a physical disability there tends to be a very good system of ensuring that children attend the same clinic, are seen by the same specialist and liaise with the same GP. The system is well established for physical disability. When it comes to psychiatric and emotional problems, the system is less well established and care tends to be more fragmented: they go from one doctor to another, depending on where they are moved around the State. It also depends on the individual initiative of carers: some are very good about attending follow-up visits and identifying why the child needs to see a doctor but other carers are not as good.

CHAIR: The same sort of point has been made about changing schools and the harmful effects that that can have on a child's entire future, let alone their education future. It has been suggested in terms of the hierarchy of priorities that DOCS should have in place for children that continuity of education should be very high on the list. I guess you are suggesting that continuity of medical care should also be taken into account in terms of the geographical placement of a child who moves from one foster carer to another.

Dr YONG: Yes, I think it is important. Continuity of education can be quite difficult. Children have specific problems in schools—learning difficulties or significant behavioural problems—so they often have to move schools because of that. However, continuity is important where possible.

Dr GLIKSMAN: I will address question No. 5 specifically. When our foster son came into our care at the age of 11 he had been notified more than 30 times as a child at risk and was in his eleventh placement. His story is by no means atypical; he was a total mess. He is now almost 22 years old and a father himself, and a very fine father and partner to his wife. The problems we had in obtaining good input from DOCS still exist and are, if anything, worse. Once our son was out of sight he was out of mind. The statistics from DOCS show that children in care can have multiple placements that are disruptive and are often made according to a rationale that cannot be fathomed. There is no continuity. The rate of retention in school is poor. No other group apart from Aboriginal people have such low school retention rates. No other group is more represented in juvenile justice and in gaols.

The problem that has developed here is much the same as in relation to child protection: the department has other priorities. Once an organisation becomes dysfunctional its priorities become self protection, not child protection. As to having any proposal adopted—for example, that children should maintain the same practitioner and the same school, which I think are positive things, especially for a child who has had multiple disruptions—I suspect one would need to do what organisational psychology tells us to do: make the retention of managers and their promotion dependent on achieving those goals. In other words, you tie retention and promotion to measured outcomes for children and families and you decide specifically what those measures are.

For those with managerial responsibility in out-of-home care, it is a reduction in the number of times a child is placed—in other words, a drive for stability. It is an increase in the number of children who are retained at school through to their higher school certificate. It is a reduction in contact with Juvenile Justice. DOCS should say, "If you want a managerial job and you want to retain it, achieve these things". With child protection it is reduced waiting times on the Helpline, it is better categorisation of incoming calls, it is a faster response for those who are most in need and a reduction in the number of deaths. Unless retention and promotion of senior managers are tied to those sorts of performance outputs, there is no ultimate motivation that can override the desire to keep things quiet when things are going wrong. I guess I am saying that the major problem in DOCS that has led to these things is an acculturation problem that stems from under-resourcing and poor management structures that lead to the inevitable and then to a pressure that is not related to child protection. This is considerably beyond my remit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have heard evidence that non-government organisations will not take more kids unless they have more money—in other words, they say "For each kid we want this many dollars". It you take that quantum of dollars per kid, kids with DOCS have many fewer dollars per head. Do you think that is why suboptimal practices exist, because they cannot be funded to that extent?

Dr GLIKSMAN: It is why suboptimal practices came about but it is not the reason they exist now. In other words, if you were to put much more money in the system I am not sure that the system could respond in a beneficial way until the culture is changed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What about if you were to quarantine out-of-home care money? If there are no data systems to follow and therefore to measure your outcomes, you obviously cannot do that. Is that a direction to follow?

Dr GLIKSMAN: If you predicate it on instituting a number of management changes that will attempt to alter the process of acculturation, yes, I think extra money would be essential to achieving equivalent outcomes as the private agencies seem to have done. But I believe just putting money in by itself will not achieve the goals that one desires. The system is now dysfunctional and I am not sure that it is capable of utilising extra resources appropriately.

…

[SUPPRESSED – refers to confidential evidence]

CHAIR: Returning to your overall damning comments about DOCS, we have heard some evidence that there is a considerable variation between geographically based officers, individual CSCs and broader regions. Some of them are performing much better than others, whether you measure the number of notifications, the number of cases they deal with, perhaps slightly subjective evidence about how out-of-home care is working in their area or the fact that they seem able to retain foster carers, for instance, when there is a revolving door in other areas. Obviously there is a range of different ways of measuring these things. I wonder whether you have any knowledge of regional or local variations, and how you would fit that into the comments you were making about the managerial culture in DOCS.

Dr GLIKSMAN: In part I can make some observations. One is that there will be variability in any system and that is irrespective of the sort of mechanisms or managerial systems you have in place. It is where the broad range is or the averages around which those variabilities occur that I think is the main issue. I have come across some district officers, some officers, who have worked very well and have tried very hard to make things work against all odds and at times have achieved that, but they had to work against the system. One should achieve excellence by working with the system, and that is not possible in my opinion.

CHAIR: But you do not have any particular comments to make on what it is about one region or one office that may cause it to function much better than another one.

Dr GLIKSMAN: For a time they will have a manager or an assistant manager who will make it work while they can and then they burn out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you were in charge of DOCS, if you were the Minister—let us assume you had a lot of power—what changes do you think should be made in a sense of what this Committee should do? If we were advising the Minister what would we do? We have had a lot more people defining problems than defining answers.

Dr GLIKSMAN: I will predicate this by saying the interim report, thorough as it is, has identified nothing that no-one else has not. We all know what the problems are. The question is: How do you fix it? I guess I have fairly strong views, as you can appreciate, as to how one fixes it. If I were the Minister I would not give the reform of DOCS to the managers who helped bring it about. So there would be a wholesale change in the management. But if I did not change the management system at the same time I would simply recreate what I have removed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure.

Dr GLIKSMAN: So the things that are needed are several but the most important one is to tie measurable achievement with outcomes for children and families to retention and promotion. That should become the main priority for every manager to see improvements in those figures. And those figures will have to be assessed independently. You cannot ask DOCS to collect those figures and then be promoted on the basis of them. So one needs an independent means—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you have an audit department or you drag in some university academics to diffuse their way through the system.

Dr GLIKSMAN: By whatever means, as long as it was independent and valid, and able to be validated.

CHAIR: Some people have pointed more to structural change like, for instance, the division into three streams that was suggested by Robert Fitzgerald, amongst others, and which DOCS has adopted. So there is an attempt to quarantine the child protection stream from the out-of-home care stream and the broader protection stream. In our interim report we recommended that the focus be shifted as much as possible without ignoring the importance of the crisis end and that if we are to make progress in the long term we need as a whole community to shift our focus to prevention and early intervention. Do you have any comments to make? I guess everyone agrees that the crisis end of things has overwhelmed all kinds of other priorities in DOCS and perhaps for all of us where we might believe in the priorities but the hard end, the crisis end, keeps overwhelming them in terms of resources, of workers and of money.

Dr GLIKSMAN: Yes. It is hard to achieve a right balance in the way in which you divide up limited resources. There is no question about it. I am not sure whether dividing up the areas will quarantine the resources. I think they will get cannibalised anyway, and we will have a very depleted out-of-home care section and a very depleted prevention section and a crisis response team that is barely coping. That is partly an issue of resourcing but again it is partly an issue of having a management structure that responds to feedback that is coming from the coalface—in other words, what is being achieved and what is being done. For the area of crisis intervention, there are certain outcomes that should be measured, and for the other areas there are also outcomes that should be measured. However, this is probably the most difficult thing. The things that hit the media are those related to the crisis end, particularly with the young, and that leads to understandable pressure to try to stop this. But the effect of that on what one can do in a prevention sense and in an out-of-home care sense is corrosive, and I think we see the effects of that. What else would I do as a Minister? If I had a DOCS that was functioning properly I would stand up and defend it and I would make sure—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that is a hypothetical at the moment.

Dr GLIKSMAN: It is a hypothetical. I do not think any Minister at the moment could stand up and defend it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They have to; that is their job. How could you get to the position where you had a DOCS you could defend? You could not attack your own department. You would be the first Minister in history, would you not?

Dr GLIKSMAN: I am not so sure, but the way in which I would do it is to ensure that I had managers who are committed to meaningful change, and I would tie their retention and promotion to achieving that change.

CHAIR: And having hypothetically sacked them all, where would you find their replacements?

Dr GLIKSMAN: From very low down the food chain in DOCS, the ones who have—

CHAIR: Except one of the comments people make is that there is already a very high turnover in DOCS and that there are grave difficulties in recruiting qualified staff to DOCS.

Dr GLIKSMAN: I would get the ones who are there who are not yet burnt out.

The Hon. JAMES SAMIOS: Would you borrow from interstate?

Dr GLIKSMAN: If one could show achievement in the areas that were important, and I would try to borrow from the private agencies. There are some that are very good. But interstate has been tried and overseas has been tried without much success in the past.

The Hon. JAMES SAMIOS: So it is the private sector that has the potential.

Dr GLIKSMAN: It depends on what you are trying to achieve and what your outcome is and what you see in a person as being the important qualities that qualify them for this job. In my opinion it is not their administrative ability whatever—I am not interested. I think someone who has vision and commitment and who understands managerial processes can have the administrators they need under them to ensure that the papers are shuffled in the correct way. But someone who is a career administrator would be someone who actually carries out the vision and the priorities that are necessary. That person is a facilitator, not the person to run it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you start at the top, though. Promotion within the public sector is an interesting subject, is it not? It used to happen on a seniority basis and then the SES came and there was some patronage and nepotism and political priorities or whatever, qualifications. To simply say you would find the good people and bring them to the top and it would be all right is obviously a good objective but presumably that is what somebody must have been trying to do for a decade.

Dr GLIKSMAN: I have not seen it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably somebody in there must have been trying to do that for some time. Presumably they are not choosing somebody because they are incompetent or better at covering up. Is that what you are suggesting?

Dr GLIKSMAN: Yes, that is exactly what I am suggesting. I think the dysfunction in the system is such that people are promoted and rewarded on the basis of being able to keep things quiet, being able to conceal.

The Hon. IAN WEST: And in changing this culture what would you do? On one side of the coin we are ticking the outcomes, but before you can tick the outcomes there has to be some catalyst that causes this change of culture. What do you have—some training system or what?

Dr GLIKSMAN: I guess I predicate it by saying what I said before: The people to carry out this change are not the ones who brought about the current situation. So I would like to replace them with people who already have achievements. For example, in the private sector what those people laid down in the organisation who have received good feedback from clients and private organisations and other groups, those few who make the system work while they survive.

The Hon. IAN WEST: But usually in this vision you have a concept. Are you talking about promoting something that grows around a team concept? What conceptual arrangements do you have on the product side of the agenda as opposed to the outcome side?

Dr GLIKSMAN: In terms of delivering a product, I think the organisation structure that currently exists, with the three divisions, is quite reasonable and it would work well.

The Hon. IAN WEST: You are saying it is just people's thought patterns that is the problem.

Dr GLIKSMAN: I am saying it is the result of a decade of underfunding, of neglect of the area, of not having promotion tied to performance, at least not the sort of performance one would want to see.

CHAIR: I think we would have to go back more than a decade, certainly in terms of funding.

Dr GLIKSMAN: My knowledge of it closely comes in terms of a decade but you are quite right—it comes more clearly to the late 1980s.

CHAIR: Dr Yong, other than the suggestions Dr Gliksman has made, do you have any specific suggestions about how DOCS might improve its role?

Dr YONG: I think I addressed earlier the needs of children with mental illness and the need for DOCS to be involved in actively helping that case with the other agencies, particularly Health. When we have had that working, it has been very effective. That means caseworkers being allowed to have that role, for a start, actually looking after cases rather than pure investigation or management of the priority list and also the resources to do that, the time to do that, because that does take time. We have talked about some of the concerns about doctors in rural and regional New South Wales.

CHAIR: Yes.

Dr YONG: In terms of the recommendation for prevention and early intervention, that is something of particular interest to me. The AMA at the federal level is developing some policy on that because it has become a concern to some of our members, particularly paediatricians and psychiatrists, that we should have a comprehensive early intervention policy. So I think you will be seeing more from the AMA.

CHAIR: In child protection or across the board for families?

Dr YONG: Across the board. One of my concerns up until now—it is not specifically germane to this inquiry—is that I think the Children's Commissioner's office has been woefully wasted in that area of early intervention and child development as opposed to the child protection issues.

CHAIR: Are you talking about the Commissioner for Children and Young People?

Dr YONG: Yes. I think it is a great shame that that office has not had that role up until now. I think that is a good proposal to make it a government priority that you have recommended in your other report and that you have mentioned in the interim report. I would love to see the political realities of getting that through. I guess you are thinking in terms of the Ontario experience to some degree.

CHAIR: Yes, and Sure Start in the United Kingdom and so on. We do not claim that this is a bright new idea.

Dr YONG: Ontario had a particularly committed Premier in that province and I will certainly look with interest to see how you can interest our Premier in the same thing and make him as enthusiastic.

CHAIR: I think we made the point that had been made to us that an absolutely committed leadership of individuals seemed to be necessary in the places around the world that have made this shift.

Dr YONG: That is something that the AMA will wholeheartedly support. Any approach to the Government promoting childhood development, identifying children at risk early and intervening early will definitely have a good health outcome, as well as other outcomes such as social cohesion, less burden on the criminal justice system and probably an economic pay-off for the State as well. I think we would be in agreement with that because there seems to be more and more evidence pointing towards that.

CHAIR: But there will still always be a need for a child protection agency across this function as well?

Dr YONG: Yes, and I think I would agree with you, that it probably needs to be separated from child protection. I think one of the problems up until now is that there has not been any agency clearly charged with that purpose and it is difficult for an agency that has to deal with something as emotive and as newsworthy as child protection in fact doing other things. This has just not been possible and as Dr Gliksman said, it ends up with a cannibalisation of other resources to feed that one because it has the political imperative and it ends up on *Sixty Minutes* or *Four Corners* or in the newspaper that another child death could have been avoided and so on.

CHAIR: You would not have any broad objection to our proposal that there might be a new department set up to take on those prevention and early intervention functions, the primary, population-based ones, and therefore limit DOCS to what we have called secondary prevention specific family support services and child protection functions?

Dr YONG: No, I do not think we would object to that. We would look forward to working with that sort of agency and, clearly, that agency would need to define its role in terms of informing other government departments about changes they might need to make about deciding how we were going to improve the evidence for those sorts of interventions, research into the area and so on, and how it is going to interdigitate with the Federal structures that are occurring.

It would be a very good initiative and may avoid some of the mistakes that the Federal Government is looking like it is likely to make in the area of tying some social policy to the idea of development. If this agency could look at the issue of child development in looking at evidence rather than trying to fit it in with the existing social policy of whichever colour of government comes in, we will more likely find success.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The opposite of what you are saying is that if things were evidence based it would be a lot better?

Dr YONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What creates social policy now is presumably ideologically driven rather than evidence based?

Dr YONG: Some of it is being ideologically driven and that is a matter for debate in other quarters rather than here, but also, there is growing evidence as to what works without having to pull in ideological standpoints. I would prefer to see that promoted and it is certainly what the AMA would support in general. There will be more from the AMA about this later on because it is something that they are just developing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not an expert in the area, but to say that there is evidence of what should be done, presumably you have to say that what is being done now is ideological and not backed by evidence and then contrast the two and say, "This is good evidence, this is what is being done and this is how you move across", presumably?

Dr YONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the AMA working towards a project like that?

Dr YONG: Ultimately, yes. Initially, the AMA has to put forward a comprehensive policy that is based on the opinions of its members, particularly input from paediatricians and psychiatrists. Also, the AMA's other rule is to help in co-ordinating some response to offset policy amongst lots of different medical organisations and so on. Ultimately I can see the AMA having an eventual policy similar to its indigenous health one, which is actually producing a report card on indigenous health, that had a listing of what happened in each State and what the evidence is behind that, or the shortcomings in evidence. I would like to see that in the AMA eventually with regard to early intervention services and child development.

The Hon. JAMES SAMIOS: That is in all States?

Dr YONG: Yes, that was done across the States and was done on behalf of the AMA by our indigenous committee, with a lot of academic input. Indigenous health is interesting because a lot of that has been driven by ideology over the years rather than evidence. All the policies in that area have been driven by ideology rather than evidence. The AMA is very careful to find evidence when making certain statements, so this is a very good example of what could be done and it is something I would like to see in this area as well in the future.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is not entirely members' opinions because presumably they are more diffused anecdotally based, which even if distilled would not necessarily correspond to the best evidence of random-like control trials?

Dr YONG: No, it is not a poll of members as such because with these sorts of social movements it is important for the AMA to look at health issues related to that. Clearly, there are lots of health issues to do with child development and our medical research is at the forefront of looking at some of the biological antecedents of that. So it is important for us to keep our role within that relevant and germane to our field of expertise.

The Hon. JAMES SAMIOS: Is the AMA likely to be proactive in the next 12 months in relation to this issue?

Dr YONG: Yes, it will be at a Federal level and I will be doing my best to promote it at the State level as well. I am involved at the Federal level with the committee that is driving this.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you will be looking at the sociology as well as the medicine, hopefully?

Dr YONG: Yes, very much so. At least we will look at the biology, which is all the data that is coming through now, which is very exciting.

(The witnesses withdrew)

(The Committee adjourned at 5.06 p.m.)