

Report
on
Child Protection Services
in
Tasmania

October 2006

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1. Overview

The child protection system is struggling to cope with escalating demands

Child abuse within families is not an issue that is pleasant to confront and one that is generally kept to the margins of community awareness. We prefer to believe that children are harmed outside of the safety of their family by strangers or paedophiles that represent a threat to the safe communities in which we live. In reality a high proportion of child abuse is perpetuated by a biological family member and this percentage is greater if extended family members and new partners are included.

In the face of this reality about child abuse, it is imperative that the child protection system designed to keep children safe within their families is effective, highly focused and has high credibility.

Yet increasingly the evidence suggests that this is not the case in Tasmania. While the vast majority of child protection workers do a difficult job to the maximum of their ability, the system in which they are working is collapsing.

For several years the number of cases that have not been allocated for further investigation (unallocated cases) has continued to grow; industrial action has been continually threatened and occasionally instigated by over worked and overwhelmed staff; and the generally positive public perception of the system and capacity of child protection workers to intervene has been shaken.

Short term strategies such as increasing staff numbers have not alleviated the problem. In addition, staff have become increasingly disillusioned and weary of constant reviews, consultations and efforts to respond to their growing concerns without any significant changes being evident. The community has become disillusioned with the chronic problems that appear to continue despite increased government funding.

In March 2006, the former Minister for Health and Human Services, David Llewellyn, commissioned the present project - the *System Development and Operational Improvement Project*. He requested the newly appointed Deputy Secretary (Human Services) and the Commissioner for Children to undertake the project as a partnership. The project was completed in July 2006 having received evidence during over seventy consultations with staff, stakeholders and experts in the field as well as investigation into best practice evidence in other places. This report provides the results of the *Project*.

The report provides evidence that the present child protection system in Tasmania is not only overwhelmed and struggling to cope, but is failing to ensure the safety and well being of children to the extent that would be expected by government and the wider community.

While many staff have used every effort available to them to overcome the overwhelming issues they confront, the report found evidence of poor professional practice, ineffective management and decision making processes, unsatisfactory infrastructure and basic resources, inadequate support and training for staff and lack of quality and safety provisions. Many of the issues are long standing and do not derive from a few unfortunate and atypical cases reflecting poor decisions by a few individuals. The problems identified are significant and systemic. They are also issues that have developed over a long period of time and over the course of different governments having responsibility and accountability for the system.

With evidence of serious shortcomings and serious issues raised during the consultation, it would be easy to promote a 'culture of blame' directed at the workers and management involved with child protection services in this state. However, all the evidence suggests that this issue is about failure at a complex system level with multiple factors contributing to shortcomings. It is overwhelmingly a case of 'good people in bad systems'.

This review involved confidential consultation with numerous individual staff members who shared their views and suggestions for change. The general findings and suggested directions were also presented and discussed at regional staff meetings on several occasions. Those working in the child protection system recognise the serious nature of the issues and during this consultation process they have had the courage and honesty to name up the problems and suggest solutions and ways forward. They are to be commended for their resilience in continuing to work at a difficult and stressful job as well as their willingness to acknowledge the issues.

Everyone agrees that major change is required and these changes have already begun, to the credit of staff involved. For example: a full induction program is now being provided; the outdated information technology system is being upgraded; and a pilot project aimed at diverting families from the statutory child protection system is showing great promise.

However, these staff initiated improvements are not enough. It is time to confront the underlying shortcomings and provide a direction for major reform. This will need to be enacted through fundamental structural and cultural changes requiring ongoing planning and effort over several years.

It will be disappointing if the opportunity for this systemic reform is overshadowed by media and political reaction and blame directed to those very people who will be needed to take on board the change required and move forward. There is a genuine commitment from within the service to reform and the community needs to get behind the staff involved and help to make this happen.

All Tasmanians must shoulder responsibility for supporting the changes that are necessary to reform the child protection system and ensure the safety and well being of our children.

2. Executive summary and recommendations

Report of the System Development and Operational Improvement Project

This report provides the findings of the *System Development and Operation Improvement Project* on child protection services in Tasmania.

The Project was commissioned by the honourable David Llewellyn, MLA, the former Minister for Health and Human Services, and undertaken between March and July 2006.

The project was conducted by David Fanning, the Commissioner for Children, and Alison Jacob, Deputy Secretary (Human Services) in the Department of Health and Human Services.

Assistance was provided by a project team who assisted in data collection and consultation processes.

Terms of reference

The terms of reference were:

1. Examine the data relating to the Child Protection Service;
2. Examine and report on the efficiency and effectiveness of the current structure and service delivery model;
3. Examine and report on the current services and programs;
4. Examine and provide advice on the adequacy of current legislative and policy frameworks; and
5. Review and provide advice on human resource issues.

Process for the project

The Project involved extensive data collection, consideration of the findings of other recent reports and reviews and consultation with staff, stakeholders and non-government organisations.

Expert advice was obtained from two international authorities in child protection: Professor Dorothy Scott and Dr Marie Connelly. Visits to Victorian services were conducted to view good practice services and meet with staff at state and regional level.

A limited audit was also conducted of a sample of child protection files.

Findings from other reviews

The Project incorporated work already completed including a *Review of the Tasmanian Family Support Service* and *Child and Family Services Consultation with Staff Review*. The results of a Child Death Review conducted concurrently and an analysis of child protection files related to children previously involved with the child protection service whose deaths had been recorded in the preceding 18 months, were also considered.

Data and quantitative information

Data on the current child protection service was compiled to provide an objective picture of the number of children involved with child protection services and the work of the service including notifications, investigations, substantiations and court orders. Figures on the out of home care system and after hours service are also provided. A summary of staffing and funding are included.

Critical issues and findings

Critical issues and findings are discussed. They include:

- Capacity and functioning of the system;
- Understanding of the role and function of the child protection service;
- Profile and status of the child protection service;
- Defined direction and purpose of the child protection service;
- Complexity of child protection work;
- Capacity of family and child support services to support child protection work;
- Legislative framework;
- Policy and guideline framework;
- Intake, advice and referral processes;
- Allocation, assessment and investigation processes;
- Case management and case planning practices;
- Out of home care services;
- Out of hours services;
- Staff issues, support and management;
- Infrastructure and resourcing; and
- Quality assurance

Vision statement

A vision statement for child protection services in Tasmania is presented as an articulation of a quality service that should be the aim of the reform process. This vision emphasises the need for:

- Clarity of purpose and function;
 - Child centred services;
 - Shared decision making and a 'strengths' based approach;
 - Opportunities for diversion and earlier intervention;
 - High status, public confidence and respect;
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- Responsiveness, timeliness and flexibility;
 - Child safety being everyone’s business;
 - The ‘State’ being a good parent; and
 - Cultural sensitivity.
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Ten high impact strategies for reform

Ten high impact strategies for reform were identified and recommendations provided under each of these strategies:

1. Build a framework for professional practice
2. Undertake legislative and policy reform
3. Reform management practices and organisational structure
4. Strengthen family support and early intervention services
5. Make children’s safety and well being everyone’s business
6. Build a professional and supported workforce
7. Provide the tools that staff need to do their job
8. Make the ‘State’ an exemplary parent
9. Enhance stability and permanent solutions for children affected by abuse and neglect
10. Improve accountability and quality assurance

High impact strategy	Recommendations
<p>1. Build a framework for professional practice</p>	<p>1.1 Adopt an evidence based, professionally sound framework as the basis for professional practice</p> <p>1.1.1 The Tasmanian child protection system will develop a practice framework based on the NZ <i>Care and Protection Practice Framework</i>.</p> <p>1.1.2 The Framework will be further refined to reflect Tasmanian custom and practice and the vision presented in this report.</p> <p>1.1.3 Practice ‘triggers’ and professional standards based on the framework will be developed and used in training and supervision.</p> <p>1.1.4 The Framework will be used as the basis for professional learning for all staff.</p>

2. Undertake legislative and policy reform

2.1 Implement the *Children, Young Persons and their Families Act* more comprehensively

- 2.1.1 An implementation plan will be developed to further promote the 'objects' of the *Children, Young Persons and Their Families Act* (contained in Part 1, Section 7) to *provide for the care and protection of children in a manner that maximises a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential.*
- 2.1.2 The "principles" of the *Children, Young Persons and Their Families Act* (contained in Part 1, Section 8) will be incorporated into the professional practice model as triggers for best practice and as the basis for professional training.
- 2.1.3 Training on the spirit and legal interpretation of the *Children, Young Persons and Their Families Act* will be incorporated into induction programs and professional learning of staff and prospective staff.
- 2.1.4 A practice manual that provides a clear policy position for all relevant clauses of the Act that are open to interpretation will be developed.
- 2.1.5 Work with the Aboriginal community will be undertaken to ensure that Section 9 (*Principles relating to dealing with Aboriginal Children*) of the Act is fully implemented.
- 2.1.6 Multi-disciplinary and interagency Advisory Panels will be established in each service centre to provide independent advice and review on decisions as required in Section 84 of the Act, and protocols for the operation of these panels developed.
- 2.1.7 The current training processes, promotion, management and coordination of Family Group Conferences will be reviewed and revised with a view to increasing the use of Family Group Conferences especially on a voluntary basis before matters are directed to legal intervention.

2.2 Amend the *Children, Young Persons and Their Families Act* to improve efficiency and effectiveness

- 2.2.1 The legislation should be amended to allow for the taking of notifications of unborn children. Notifications of unborn children should be treated as if the unborn child was a born child for all other purposes of the Act.
 - 2.2.2 Section 20 of the Act should be repealed.
 - 2.2.3 The Act should be amended to allow a child to be removed without a warrant and placed on a temporary order where the authorised officer believes that there is an unacceptable risk for the child to remain with the person with whom the child is residing. The
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authorised officer should be required to make an application to the Children's Court within 24 hours for the child to remain on a temporary order. The amendments should allow for a warrant to be applied for in circumstances similar to those currently set out in section 20 of the Act. A temporary order should expire after 5 working days but an application can be made to the Children's Court prior to the expiration of the 5 days for an Assessment order under section 22.

- 2.2.4 The legislation should be amended to allow the Children's Court to extend an Assessment order beyond the current maximum period of 8 weeks to a period of 12 weeks, provided it is in the child's best interests to do so.
- 2.2.5 The legislation should be amended to allow for adjournments of proceedings for periods of up to 30 days if the child is not living with their parents and 45 days if the child is living with their parents during the adjournment period. Adjournments should only be granted if it is in the child's best interests or where there are compelling reasons.
- 2.2.6 The provisions in the Act relating to family group conferences should be amended so that the Secretary can convene a conference without needing to consider a report from an advisory panel. The Act should be amended to prohibit the discussions and information shared at a family group conference to be used or referred to by any person following the conclusion of the conference in other than exceptional circumstances.
- 2.2.7 The current barriers in the legislation relating to the sharing of relevant information should be amended. These amendments should include the requirement for specified persons and organisations to be compelled to share information in circumstances where the safety and protection of a child require this information to be shared. Safeguards for the responsible sharing of information should be included in the amendments.

2.3 Clarify and communicate policy positions

- 2.3.1 A policy audit will be conducted to identify current policy positions and policy gaps and clarify the status of current documentation.
- 2.3.2 A policy folder containing the policy position on all important aspects of work will be provided to all staff and an electronic version made available on a dedicated website.
- 2.3.3 Practice manuals for all aspects of current practice (intake, assessment, case management, support to out of home care and support work) will be developed and provided to staff to use to guide practice decisions and define standards.

2.3.4 Practice manuals will contain proformas for standard procedures (such as writing an affidavit and file notes). A practice manual will also be developed for court work and undertaking legal processes.

2.4 Revise processes for the development and approval of policies

2.4.1 Policy development and communication will be the dedicated responsibility of a senior officer working to a business plan under the direct line management of the Director.

3. Reform management practices and organisational structure

3.1 Integrate child protection services with other children and family services

3.1.1 Children and Families Services will be structured around teams of integrated services reporting to the same regional or central manager.

3.1.2 Training and professional learning programs will be developed for all professional groups involved in children and families services to promote a coordinated approach and shared understanding of working with children and families.

3.2 Create four regional integrated service teams that will include child protection services

3.2.1 Regional child protection services will be part of four regional teams in the south, south-east, north and north-west of the state, sharing common boundaries with education, police and housing.

3.2.2 Regional teams will include Family, Child, Health Services; Family Support Services; Children's Therapy Services, Family Violence Counselling and Support Services; Sexual Assault Services as well as Child Protection Services. The development of this regional model will be gradual with some services being regionalised immediately and others over a longer period of time.

3.2.3 Each regional team will be responsible to a senior manager who will be accountable for the integrated continuum of services including child protection, reporting directly to the Director (Children and Families Services).

3.3 Develop a new model for child protection intake services

3.3.1 A central intake service will continue in the short term but the community advice and public education aspect of the role will be transferred to regional teams.

3.3.2 The model for processing notifications calls will be revised with calls first being referred to senior staff for an initial assessment before being allocated to a child protection worker for further information gathering.

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- 3.3.3 Call centre technology will be investigated as a way of providing supervision and monitoring of incoming calls by senior staff.
 - 3.3.4 Ways to track progress on processing notifications in a more transparent way will be investigated so that staff workload and time being taken to complete a notification can be more closely monitored.
 - 3.3.5 All staff recruited into the intake service will receive mandatory training before undertaking their role (with a practice manual forming the basis for training).
 - 3.3.6 An electronic form for emailed notifications will be developed with mandated fields that prevent notifications being accepted unless basic information is completed.

3.4 Develop a new model for regional child protection teams

- 3.4.1 New service teams and models for operation will be developed by the Director of Children and Families Services and her senior staff.
- 3.4.2 Consideration will be given to including provision for a 'response team' responsible for the immediate assessment of new notifications and progressing a new case to the point of either case closure or an initial court order within enforced timelines.
- 3.4.3 The level, number, role and title of positions and senior positions at regional level will be reviewed and revised to ensure consistency across the state.
- 3.4.4 The two teams in the south may share some functions between teams where it is not practical to split the responsibilities.
- 3.4.5 Additional assessment positions will be created for twelve months to assist in clearing the 'unallocated' list.

3.5 Develop a new model for after hours services

- 3.5.1 A costed model for after hours' services that clearly differentiates the different aspects of after hours work (and in particular separates emergency and routine work) and provides for appropriate permanent staffing structures will be developed.
 - 3.5.2 Consideration will be given to a model that provides for some service centre staff to work flexible hours allowing coverage of routine work and staff support in the late afternoon and early evening.
 - 3.5.3 The possible utilisation of an existing call centre infrastructure as the base for an emergency notification service will be investigated.
 - 3.5.4 The relationship of after-hours services to the parent information line will be investigated.
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3.6 Reform business practices in line with principles of the *Fit* program

- 3.6.1 Guidelines for determining when cases must be transferred between teams will be reviewed and updated and processes for managing these transfers implemented.
- 3.6.2 Management practices for allocation of cases and determining case loads to ensure state wide consistency will be developed.
- 3.6.3 All present committees and meeting groups will be reviewed to determine their purpose and whether their business could be expedited in other ways.
- 3.6.4 Staff delegations will be reviewed to ensure that they are at the level required for efficient decision making and financial management.
- 3.6.5 A regular communication bulletin will be provided to staff with updates on issues of interest and concern.
- 3.6.6 Consideration will be given to co-locating some central services and support functions at regional level.
- 3.6.7 Consideration will be given to rotating some positions between teams on a regular basis so that staff members have opportunities to develop skills and experiences across the range of services and insular work practices are reduced.
- 3.6.8 A professional conduct protocol will be developed with staff to outline agreed standards of professional conduct.
- 3.6.9 Roles, accountability and line management for all positions will be reviewed in accordance with *Fit* principles.

4. Strengthen family support and early intervention services

4.1 Strengthen capacity for government services to provide support and assistance to vulnerable families

- 4.1.1 The role and training of Family Child Health Nurses will be considered to determine how their role in providing early support to targeted families can be facilitated.
- 4.1.2 A plan will be developed and implemented with Disability Services to ensure that children with disabilities have access to services that may prevent them becoming involved in the child protection system.

4.2 Improve capacity for early intervention in the early years of children's lives

- 4.2.1 The whole of government *Early Years Plan* should be finalised and submitted to government for approval as soon as possible.
- 4.2.2 Responsibility for implementation of the whole of government early years strategic plan should be resolved, with consideration given to Children and Families Services managing this plan with the support of an interagency governance structure.
- 4.2.3 Increased priority will be given to strategies involving the first five years of life in all Children and Families Services business planning and policy development.
- 4.2.4 Selected staff will be supported to undertake the Early Years degree recently established at the University of Tasmania, to strengthen the staff knowledge base about early childhood development.

4.3 Develop a new family support service program along the lines of the model proposed in the *Review of the Tasmanian Family Support Service*

- 4.3.1 A model of local service delivery areas that could be used as the basis for the development of family support services will be developed.
 - 4.3.2 A framework and model for local child and family networks that could be used for delivering more coordinated family support services including government and non-government services will be developed.
 - 4.3.3 A model for a 'community information service' in each local service delivery area, where families could access information on the family support services that are available in that area and be referred to appropriate services, will be developed.
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- 4.3.4 As a second stage, a proposal will be detailed on how these 'community information services' could be further developed to provide an assessment role that would enable them to become an alternative child protection referral point.
 - 4.3.5 A common assessment instrument that could be used at the community level to assess the needs of vulnerable families and match them to available services will be developed.
 - 4.3.6 Issues related to information sharing between both government and non-government organisations, with legislative reform if necessary will be resolved.
 - 4.3.7 Protocols and policy on information sharing required to remove any barriers that prevent appropriate exchange of information about children and their families who are involved in the child protection system will be provided.

4.4 Enhance the quality, availability and range of non-government family support services

- 4.4.1 In collaboration with the non-government sector develop a quality assurance model, including a standards framework that will specify the level of service required by family support services contracted by DHHS and tools and processes for the assessment of standards.
 - 4.4.2 A process and tools for collection of data sets by organisations receiving funding for family support services will be developed.
 - 4.4.3 Service specifications for existing family support services will be detailed in collaboration with the organisations and the peak bodies.
 - 4.4.4 The effectiveness and sustainability of services receiving small amounts of funding with limited hours will be reviewed and consideration given to the way forward for these services.
 - 4.4.5 An appropriate funding model for future family support services that includes the unit prices and specifically accounts for management, supervision, infrastructure and operating costs will be developed.
 - 4.4.6 A business case will be developed, to support the need for increased funding to family support services as a fundamental part of the reform of child protection services.
 - 4.4.7 Funding of the *Early Support Program* pilot will be continued until the new model can be completed and considered, with increased funding where this can be identified.
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5. Make children's safety and well being everyone's business

5.1 Promote the shared responsibility for children's safety and well being

- 5.1.1 A new position will be created for a child protection worker in each region to be available for consultation with other government and non-government services; provision of advice and support on cases that potentially require child protection intervention; provision of public education about child protection services and to act as a point of linkage between support services and child protection services.
- 5.1.2 A child protection worker position will be created at the Royal Hobart Hospital with the possibility of creating similar positions in the other public hospitals. This position will provide advice, support and liaison for issues relating to child protection issues including antenatal, neonatal and paediatric services.
- 5.1.3 A specific 'person for contact' will be designated in CPAARS and all three regional assessment teams for referrals from the public hospital system and other medical practitioners, to ensure that communication is facilitated.
- 5.1.4 A website on child protection services will be developed as a means of providing public and community education about child protection issues and providing a point of contact to available services.
- 5.1.5 A dedicated position in Alcohol and Drug Services will be provided that can serve as a reference point for consultation with child protection workers on clients where drug and alcohol abuse are an issue.

5.2 Develop an agreed position on the role and purpose of interagency collaborative processes and structures

- 5.2.1 An agreed position should be developed and approved on interagency collaborative processes and structures involving a high level reference group with representation from the Departments of Education, Police and Public Safety, Health and Human Services, Justice and Premier and Cabinet.

5.3 Promote an interagency approach to children's safety and well being

After consideration of outcomes from recommendation 5.2:

- 5.3.1 A proposal for interagency liaison and collaboration on child protection matters will be developed building on existing processes.

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- 5.3.2 Work with the Department of Education will be undertaken to develop a protocol outlining roles and responsibilities for clients that are involved with the education system and the child protection system, and referral processes.
 - 5.3.3 Work with the Department of Police and Public Safety will be undertaken to develop a protocol for referral of children to child protection services with due consideration of the *Family Violence Act*
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6. Build a professional and supported workforce

6.1 Build the status and image of working in child protection and provide for the recruitment of suitable staff

- 6.1.1 The creation of an academic chair in *Child and Family Well Being* will be discussed with the University of Tasmania. This position could assume responsibility for input about child protection issues into schools of social work, education, nursing, psychology and medicine as well as having a role in community education and research.
- 6.1.2 Work will also be undertaken with the University of Tasmania to develop options for increasing coverage of child protection content in existing relevant courses, particularly social work degrees and degrees involving work with children and families, and improving opportunities for practicums.
- 6.1.3 Planning will be undertaken with professional staff that do not have a professional qualification to establish ways in which they could gain this qualification.
- 6.1.4 Development of a scholarship program for encouraging suitable people to enter the child protection profession will be considered.
- 6.1.5 Recruitment processes including advertising, screening and selection processes, and making appointments to ensure regional consistency and best practice across all child protection teams will be reviewed and revised.

6.2 Provide ongoing professional learning opportunities

- 6.2.1 The *Beginning Practice* induction program (a comprehensive manual and professional learning model for staff induction that has been modified for the Tasmanian context from that used in Victoria) will be provided to all new recruits in accordance with a timeline developed by their managers.
 - 6.2.2 A central professional learning unit will be established to have oversight of professional learning on a state-wide basis.
 - 6.2.3 An annual professional learning program will be implemented (after consultation with staff on their individual and system needs) that will detail a comprehensive range of learning opportunities delivered internally and externally.
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- 6.2.4 Priorities for professional learning for all staff will include:
- Capacity for working collaboratively ;
 - Facilitating case conferences;
 - Engaging with 'hard to engage' families;
 - Using the *Looking After Children* case planning tool; and
 - Conducting risk assessments.
- 6.2.5 Staff exchange opportunities and other possible processes for selected staff to work in other states and territories and New Zealand will be investigated.

6.3 Review and revise the career structure for child protection workers

- 6.3.1 The current positions in child protection services will be reviewed and a revised structure developed that:
- Provides for the range of roles and functions of the reformed child protection model;
 - Uses consistent titles for the same positions across the state;
 - Provides for more senior roles in areas such as intake where there is evidence of the need to recruit more experienced and skilled child protection workers;
 - Clearly defines line management and supervisory responsibilities of senior roles;
 - Ensures positions are established at levels commensurate with responsibilities and key tasks.
- 6.3.2 Through negotiation with unions a fair and equitable process will be provided to allow present staff to express interest in positions they would like to be considered for and be appointed to, according to their suitability and on merit.

6.4 Develop models of practice that define both the expected workload and model of staffing operation

- 6.4.1 Models of practice and rosters for all positions that take account of the workload and model of operation will be developed.
- 6.4.2 Staffing plans that are based on the roles and responsibilities and expected model of operation of all staff will be developed.
- 6.4.3 Models of operation and rosters that recognise the need for rotating duties over regular periods of time, respite from high pressure tasks, provision for 'time in lieu', and time required for administrative and supervisory roles will be implemented.

6.5 Implement staff performance management practices

- 6.5.1 A performance management policy will be developed with staff.
- 6.5.2 All professional staff will have opportunities for structured performance management according to the policy.
- 6.5.3 An annual Ministerial 'excellence awards' process will be initiated to recognise staff and others involved with child protection services who perform at an exceptional level.

7. Provide the tools that staff need to do their job

7.1 Facilitate the immediate upgrading of electronic tools for data management and routine work

- 7.1.1 The Electronic Information Tool (incorporating CWIS functions) will be finalised with immediate priority.
- 7.1.2 Longer term investigation and planning to determine data management needs for child protection services over the next 5 to 10 years will be undertaken.
- 7.1.3 Business planning will be undertaken to assess how staff could be provided with laptop or other mobile computers when they are undertaking field work (such as visiting clients at home to complete assessments or undertake case planning) so that tasks could be facilitated and duplication of effort avoided.
- 7.1.4 All staff will have access to a computer in order to undertake their routine work.
- 7.1.5 After-hours access to data bases for staff members that are on after hours duty will be provided.
- 7.1.6 Electronic formats for documents that are written on a frequent basis (such as affidavits and written case notes) will be developed so that the information required is prompted and the formatting is consistent.

7.2 Upgrade accommodation, with the southern service centre and CPAARS having immediate priority

- 7.2.1 As a priority, alternative accommodation options for the two southern service teams and the new Intake Service will be investigated.
- 7.2.2 There will be investigation of ways that child protection service centres can be more family friendly and supportive environments while still providing for staff security.

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- 7.2.3 Expert advice will be sought on the physical configuration of accommodation to provide for maximum staff interaction, while also providing privacy, interview facilities, meeting facilities and communal spaces.
 - 7.2.4 Use of space in schools and other accessible public buildings where there may be surplus requirements will be investigated to provide accommodation options for some children and families services (including out-posted child protection staff) that could be accessible to local communities.

8. Make the 'State' an exemplary parent

8.1 Provide best practice guidelines, staff training and practice models necessary to allow more children to be safely maintained with their families

- 8.1.1 Current policy, guidelines and practices will be reviewed and revised to ensure that options allowing children involved with child protection services to remain with their immediate families are used to the maximum level of safety.
- 8.1.2 Kinship care will be reviewed and revised with a view to increasing the use of kinship care as an out of home care model in Tasmania.
- 8.1.3 Tasmanian targets based on national average figures should be established for increasing the number of children maintained with their family and placed in kinship care.
- 8.1.4 The legislation will be clear and unambiguous in requiring the Secretary to be an exemplary parent. The responsibilities of the Secretary will be set out in the legislation. The Secretary will also have the capacity to assist young adults who had been on an order in care, up to the age of 21 years.

8.2 Provide priority access to existing government health and therapeutic services for children in state care

- 8.2.1 Mandatory health screening will be provided to all children entering state care through paediatric clinics provided at public hospitals utilising protocols and processes to be developed with paediatric medical services.
 - 8.2.2 A protocol will be developed with Child and Adolescent Mental Health Services to ensure that children in state care have priority access to therapy and counselling services.
 - 8.2.3 Increased provision for psychological assessment will be established within each regional service centre to ensure that children can be assessed within the service whenever possible.
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- 8.2.4 Recommendations from the current project (Farr, 2006) considering children in state care who are also clients of Disability Services will be a priority for the Human Services Group to action.

8.3 Work with the Department of Education to improve educational provision for children in care

- 8.3.1 Children in care will be identified as a defined group for disaggregated data collection (attendance, disciplinary processes, and retention and achievement figures) published by the Department of Education so that their educational situation can be more accurately monitored.
- 8.3.2 Work will be undertaken with the Department of Education to address specific areas of concern in relation to children in care and ensure that there are strategies in place to improve attendance, retention and achievement levels.
- 8.3.3 A specific policy and plan for action will be developed as a matter of urgency with the Department of Education in relation to children in care who are suspended, excluded, expelled or subject to full or part time exemption, to define roles and responsibilities and financial arrangements.
- 8.3.4 All children who have state guardianship for 12 months or longer will have an individual educational plan (updated on an annual basis) with accountability resting with school principals.

8.4 Review and revise the staffing model for out of home care with central and regional services clearly defined

- 8.4.1 Central and regional roles and responsibilities for out of home care will be clarified as part of the new staffing model, including responsibility for community awareness, recruitment, screening, support, dealing with complaints and liaison with stakeholder groups.
- 8.4.2 A policy and guidelines will be developed for the role of support workers.
- 8.4.3 Guidelines covering access visits will be developed and the role of support workers clearly defined. The greater use of existing Contact Centres will be explored.

8.5 Improve case planning approaches and documentation

- 8.5.1 Steps will be taken to ensure that the *Looking After Children* (LAC) planning tool is consistently used and documented for all children in out of home care.
- 8.5.2 All children in care will have case plans updated every 12 months, or when there is a change of circumstances that requires new decisions to be made.
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8.5.3 Case planning will involve all significant people in the child's life with the child involved to the maximum extent possible given the child's age and developmental level.

8.6 Contract an external review of present services and models for out of home care for children and young people with complex and exceptional needs

8.6.1 Urgent expert advice will be sought to review and provide specific recommendations relating to out of home care for children and young people with intensive and complex needs. The consultancy will be used to provide:

- o Service model frameworks for the out of home care of children and young people with complex and/or challenging needs;
- o Identification of service gaps and recommendations for the future; and
- o A summary of good practice and research in the field.

9. Enhance stability and permanent solutions for children affected by abuse and neglect

9.1 Clarify policy positions and implement strategies to improve permanent solutions for children involved in the child protection system

9.1.1 The policy position on planning more permanent solutions for children in care will be clarified and specific guidelines provided to facilitate implementation of the policy position, including the time frame and reasonable conditions for attempting unification with parents.

9.1.2 The option of a permanent arrangement for the child should be clarified and strengthened in the legislation.

9.1.3 Where permanent arrangements have been determined to be in the child's best interests, the task of working on planning more permanent solutions will be specifically allocated through existing staff responsibilities or contracting this task to a non government organisation.

9.1.4 The necessary long term financial and other support services (including provision if the placement breaks down) that are required for a child placed in a permanent relationship outside their family will be clearly specified and provided.

10. Improve accountability and quality assurance

10.1 Establish the DHHS *Progress Chart* as the basis for business planning and driving improvement

- 10.1.1 The DHHS *Progress Chart* will be used as the basis for annual business planning and regular data collection at business unit level.
- 10.1.2 A set of indicators in each key category and supporting area will be developed for child protection services.
- 10.1.3 Key data sets will be published regularly so that progress towards improvements is open and transparent.

10.2 Establish professional supervision and consultancy as integral parts of service delivery

- 10.2.1 All staff will have compulsory professional formal supervision at required levels as determined by professional guidelines.
- 10.2.2 The role of practice consultants will be reviewed and their responsibilities and accountability for professional standards and practices more clearly defined and communicated.
- 10.2.3 An annual business plan will be developed with practice consultants to ensure their work is focused on achievement of agreed outputs and outcomes, including regular reports to the Director on professional issues.
- 10.2.4 Case audits and reviews will be conducted on a regular basis according to a business plan for each service centre.

10.3 Establish a formal process and model for responding to complaints and concerns involving the child protection service

- 10.3.1 A unit dedicated to investigating and responding to complaints and serious issues relating to child protection services will be established as part of the overall organisational model, after further consultation with staff.
- 10.3.2 This unit will encompass responsibility for complaints about children in care but will assume a wider scope for other internal and external complaints.
- 10.3.3 A policy and process for responding to complaints and issues will be developed to guide the work of this new unit and detail the procedures and accountabilities.
- 10.3.4 The Commissioner for Children should have responsibility for oversight of all complaints processes in relation to children. The Ombudsman should retain responsibility for the investigation of individual complaints if a person is dissatisfied with the internal response to the complaint.

10.4 Create a legislated child death investigative process

10.4.1 A legislated process for the investigation of child deaths and serious injuries where the child has been involved with the child protection system should be implemented according to the recommendations of the Commissioner for Children.

Process for implementing recommendations

If accepted, these strategies will form the basis of a more detailed implementation plan designed to be implemented over the next three years. This plan will be provided within two months of the release of this report.

3. Terms of reference

The terms of reference for the project were:

1. Examine the available data relating to child protection services (including notifications, referrals for assessment, substantiations, court orders, case management, out of home care, etc) together with other information management tools (including communication systems and record keeping) and provide advice as to the adequacy of these processes as well as recommendations for their improvement.
 2. Examine and report on the efficiency and effectiveness of the current organisational structure and service delivery model, including management and governance, with reference to national and international best practice.
 3. Examine and report on the current services and programs that are available to protect children and assist families including early intervention, family support, statutory child protection services, therapeutic and other professional support services.
 4. Examine and provide advice on the adequacy of current legislative and policy frameworks involving the protection of children in Tasmania and provide recommendations for any changes to the existing legislation, regulations, policies and practices and advise on any other documentation that may be required to improve efficiency and effectiveness.
 5. Review and provide advice on human resource issues including: the necessary skills, qualifications and experience for staff to deliver a quality service; recruitment and retention of staff; pre-service and in-service professional learning; leadership; and management.
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4. Glossary of terms

Children, Young Persons and Their Families Act 1997: The relevant Act governing child protection in Tasmania.

Notification: Legally defined term (section 16 of the Act) given to an allegation of child abuse made to the Secretary of the Department of Health and Human Services (DHHS)

CPAARS: Child Protection Advice and Referral Service, being part of the Department of Health and Human Services, responsible for accepting Notifications usually by telephone but can be via email or fax.

Priority 1, 2 or 3: Refers to expected response time given to Notifications by CPAARS which are deemed to require an investigation (defined as an "Assessment" under the Act, section 18). Priority 1 has an expected response time of a half day (Priority 2, within 5 days and Priority 3, within 10 days). The Priority rating is directly related to the level of risk to the child at the time of the Notification.

Service Centre: Regionally based work unit that is part of DHHS and responsible for all child protection services in that region.

Assessment: Part of a Service Centre and responsible for the investigation of Notifications referred by CPAARS. Also refers to an **investigation** following a Notification being referred to the Service Centre by CPAARS

Unallocated list: Those Notifications which have been assessed by CPAARS as requiring investigation and have been referred to a Service Centre but are not in fact being investigated - includes at the present time almost all Priority 2's and 3's.

17(b): Refers to that provision in the Act whereby some Notifications, as determined by CPAARS, which would otherwise be referred for investigation are in fact not referred to a regional Service Centre for investigation where "proper arrangements exist for the care and protection of the child and the matter of the apparent abuse or neglect or the likelihood of the child being killed or abuse or neglected has been or is being adequately dealt with".

EIT: Electronic Information Tool being developed for Child Protection Services.

CWIS: Child Welfare Information System, which is the present electronic database for Child Protection Services.

LAC: Looking After Children case management tool used for planning for, and management of, children in out of home care.

LGA: Local Government Area.

ESP: Early Support Program, which is a trial program funding non-government organisations to provide support services to children and families referred to the Child Protection Service.

TAC: Tasmanian Aboriginal Centre.

TRF: Tasmanian Risk Framework, which is an assessment tool used to assist in assessment of risk to children referred to the Child Protection Service.

CAG: Court Advisory Group, which is the group of child protection officers in each Service Centre that provides advice on cases where legal intervention may be required.

5. Reasons for undertaking the project

There was recognition that the child protection system was struggling to cope

This project was undertaken in recognition that the current child protection service was struggling to cope with an unprecedented escalation in demand and increased complexity of the client group. There was also recognition that there were long term structural and system issues that may have been contributing to the stress being experienced by child protection services.

Initial responses had failed to alleviate concerns

The issues being experienced by the child protection workforce had been raised by concerned staff on a number of occasions and received a positive response from government in the form of increased staff numbers. In fact, since 2003 an additional 96 positions had been approved by government. However, it was evident that the staffing increases had not been able to match the increases in demand and had not addressed the more pervasive strategic issues.

Industrial unrest and continued negative comment in the community and media reports were also exacerbating a difficult situation. Many staff within the service have voiced the view that fundamental change concerning broader service delivery directions and options was urgently needed, translating into significant service reform.

Problems being experienced are not unique to Tasmania

The problems being experienced are not unique to Tasmania, with systems across the world and in other Australian states and territories also reporting escalating demands and overloading to their child protection systems. In most cases this has reached a point of crisis at which major reform has been initiated.

Over the last four years almost all Australian states & territories have undertaken major reform of their child protection systems:

- *An Integrated Strategy for Child Protection and Placement Services, 2002, Victoria*
 - *Care and Support: Final Report on child Protection Services, 2002, NSW*
 - *Our Best Investment: A State Plan to Protect and Advance the Interests of Children, 2003, SA.*
 - *Commission of Inquiry into the Abuse of Children in Queensland Institutions, 1999 and Protecting Children: an inquiry into the Abuse of children on Foster Care, 2004, and Progress in Reforming the Queensland Child Protection System, 2006, Qld.*
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- *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal communities, 2002, WA*
 - *The Territory as Parent: a review of the Safety in Care in the Act and of ACT Child Protection Management, 2004 and The Territory's children – ensuring Safety and Quality Care for Children and Young People. Report on the Audit and Case Review, 2004, ACT*

It is also evident that these major reviews in other states and territories have precipitated major additional investment in child protection services across the country.

There were some specific concerns about the present system

There were four specific concerns that led to this examination of the child protection system:

- **There was an escalating number of children involved with the child protection system**

From 2003-04 to 2005-06 there was:

- An 80% increase in the number of notifications received;
- a 196% increase in the number of these notifications requiring investigation;
- a 31% increase in the number of children placed on care and protection orders; and
- a 40% increase in the number of children in out of home care.

These dramatic increases were a cause for considerable concern. They were also evidence that investigation of the underlying reasons for the increase was required before solutions could be provided.

- **The inability of the system to keep pace with demands**

The inability of the system to cope with the increased demand was evident in all areas of the system but particularly evident in the escalating number of 'unallocated notifications'. 'Unallocated notifications' are initial referrals that require investigation and assessment by a child protection worker to determine if the notification of child abuse or neglect can be substantiated with appropriate action taken to protect the child. If there is no capacity for a child protection worker to undertake this task the notification remains 'unallocated'.

While child protection services have continued to respond with an initial investigation within the required half-day time frame for 'priority one' notifications that represent the potentially most serious and urgent of cases, the number of unallocated cases was 1441 on May 30 2006. Numbers of unallocated cases represent an unacceptable risk to the safety of the children concerned and the responsibility to ensure these children's wellbeing.

- **Compelling evidence of increasing complexity of families referred**

In recent years issues such as long term unemployment, family violence, drug and alcohol abuse and mental health issues have had an increasing impact on the capacity of some parents to keep their children safe and meet their needs.

The majority of children referred to the child protection system come from families that are affected by a combination of other issues that include financial difficulties, substance abuse, mental health symptoms, inadequate housing and family violence. In particular, an increase in the use of illicit drugs and alcohol by parents has added to the level of risk of many children being notified to child protection services.

This is reflected in the rate of children referred to child protection for emotional abuse which has doubled from 2003-04 to 2005-06. The rate for neglect has also substantially increased.

Increasingly, children who are clients of child protection services also demonstrate other characteristics including poor school attendance, challenging behaviour, sexualised behaviours, streetwise behaviours, involvement with juvenile justice and responses to dysfunctional family circumstances.

In short, the complexity of issues surrounding children and families who are involved with the child protection services has increased dramatically and this was perceived to be adding to the stress on the service and the need to consider organisational and system reform.

- **Lack of clear strategic direction**

Finally, it was evident that there was no clear, articulated over-arching strategic direction for child protection services in the state and responses to increases in notifications were occurring in the absence of a coherent and coordinated planning structure. There was therefore an urgent need to articulate such a direction and implementation plan that pro-actively addressed service reform and the current vexed issue of sustainability of the service.

6. Process for the project

Timeframe	<p>Due to the urgency of the task the review was conducted on a tight timeframe commencing in March 2006 and providing a report in October 2006. Interim reports were provided to staff at regular intervals so they were kept abreast of findings and likely directions for recommendations.</p>
Personnel	<p>The review was conducted by an executive consisting of the Deputy Secretary (Human Services) Alison Jacob, and the Commissioner for Children, David Fanning. The Reviewers were assisted by members of the project team (Alison Pears, David Anderson and Jim Andrew) led by a senior experienced staff member, Margaret Nolan, who was acting manager of the <i>Our Kids</i> Bureau.</p>
Data collection	<p>Data was compiled from a variety of published and unpublished sources. The project team contributed useful documentation and commentary. Major support documents that helped inform the project included:</p> <ul style="list-style-type: none">○ <i>After Hours Service Provision 2005</i> (Robynne Andrew)○ <i>After hours Service Provision in Child and Family Services 2005</i> (Noreen Hayes)○ <i>Profile of the DHHS Parenting Line 2006</i> (Alison Pears)○ <i>Diversionary and Legal Practice Pathways Project 2006</i> (Helen Marshall)○ <i>Child and Family Services and Disability Services Inter-face Project 2006</i> (Zoe Farr)
Consultation with staff	<p>Over 40 meetings were organised with single members and groups of staff from child protection services and related areas to draw on the benefits of their experience and expertise and provide feedback on progress.</p> <p>The opportunity was provided for individuals and groups of staff members to meet with the executive and provide confidential advice and input.</p> <p>The executive met with each regional service centre on several occasions to provide feedback on the initial findings and seek advice and comment on data and issues that had been identified.</p> <p>All findings contained in this report were thoroughly and openly canvassed with staff during the course of the project.</p>

Consultation with non-government providers	Major non-government providers and peak organisations were also consulted with the opportunity to comment on services and current models as well as identify issues.
Consultation with experts in the field	<p>The Reviewers consulted with two acknowledged ‘expert’ practitioners in the field of child protection:</p> <ul style="list-style-type: none"> ○ Professor Dorothy Scott, Director, Australian Centre for Child Protection, University of South Australia. ○ Dr Marie Connelly, Chief Social Worker, Department of Child, Youth and Family Services, New Zealand. <p>These two expert practitioners provided invaluable advice, knowledge and wisdom on the situation confronting child protection services in Tasmania.</p>
Visits to services in Victoria	The Reviewers visited Victoria on two occasions to speak with senior members of the <i>Office for Children</i> and spend extended time in two regional offices. These visits were very valuable in providing models for efficient and effective practice as well as providing the opportunity to discuss issues and possible solutions with experienced practitioners in the government and non-government sectors.
File audits	A limited desk audit of files was commissioned from KPMG to review case practices, decision making processes, identify trigger points for cases to move on to different teams of child protection workers, and examine the throughput of cases in the system. Although this only involved 15 files, the audit identified significant findings that were incorporated into the evidence base.
Contribution of other relevant reviews	<p>The project drew on work that has already been completed and recent relevant reports including the following:</p> <ul style="list-style-type: none"> ○ <i>A Review of the Tasmania Family Support Service System</i>, undertaken by KPMG in 2005; and ○ <i>Child and Family Services Consultation with Staff Report</i>, 2005.
Findings from a Child Death Review	<p>During the timeframe in which the current review was being undertaken, a Child Death Review concerning a child who had died while his case was the subject of assessment processes within the child protection service, was undertaken.</p> <p>The review Committee was established as a sub-committee under the auspices of the Council of Obstetric and Paediatric Mortality and Morbidity Committee, as determined by the <i>Perinatal Registry Act 1994</i>. The committee members included David Fanning, the Commissioner for Children and</p>

Alison Jacob, Deputy Secretary (Human Services) who also conducted the present project. Other members of the Child Death Review Committee were the Director of Woman's and Children's Clinical Services at the Royal Hobart Hospital, Dr Elizabeth Hallam, and an external consultant Ms Anne Foot.

The findings and recommendations of this review are being reported separately but provided an important source of evidence for the current project.

Analysis of files where a child who had died during 2005-06 or their siblings was known to child protection services

A file audit and review was also undertaken of child protection services files related to children whose deaths had been recorded during 2005 and the first half of 2006. Although these children were not active 'open' cases of the child protection service at the time of their death, in each case the child or their siblings had been notified to child protection services within the previous 14 months.

This file audit identified some significant issues and considerations that were also incorporated into the findings of the current project.

7. Data and quantitative information

Caveats about data analysis

This section of the report contains data on the child protection system in Tasmania. While the figures are as accurate as possible, there are severe limitations to the data systems that are themselves of concern. Figures provided and published at various times can differ substantially. This may be due to lags in the time taken to input data on new cases or close old cases. In addition, as data extraction is manual, there may also be some integrity issues.

Where there are nationally comparable figures these have also been included. However, particular care should be taken when considering national comparisons as there are major differences in definitions, methods of data collection and differences in policies and approaches to child protection matters between states and territories that contribute to differences in the figures.

Although child protection service activity does vary and should not be taken to accurately reflect the incidence of maltreatment between jurisdictions, it is still useful as the means of comparing referral and substantiation patterns between states¹.

1. Number of children involved with the child protection system

As noted earlier there has been an escalation in the number of families and children that are involved with the child protection system in Tasmania. The data on rates of notification and cases is provided below.

Table 1 : Rates of involvement in the child protection system

	2002-03	2003-04	2004-05	2005-06	% inc. 2003-04 to 2005-06
Notifications	n/a	7,248	10,788	13, 029	80%
Investigations	641	1,294	1,833	3, 824	196 %
Allocated cases	n/a	937	1,206	1, 410	50%
Unallocated cases	113	132	412	1, 452	1000%
Children on care and protection orders	600	634	716	833	31%
Children in out-of-home care	468	487	576	683	40%

¹ Australian Institute of Family Studies (2005) National Comparisons of Child Protection Systems.

2. Notification numbers and rates

Notifications

A notification is a referral to the child protection service. The number of notifications provides a measure of the numbers of children believed by the notifier to be at risk of abuse or neglect. Notifications are made to a central service in the state called the Child Protection Advice and Referral Service (CPAARS) located in Hobart

Notifications are described as finalised or not finalised.

A completed notification is a notification that has been fully processed and signed off by the CPAARS workers and the outcomes about the notification recorded in the file.

All referrals are counted as notifications

Since 2003, all contacts related to children received by the Child Protection Advice and Referral Service (CPAARS) are counted as notifications regardless of whether the child protection worker believes the notification is warranted or not. This is in contrast to some other states and territories where the contacts are screened at the point of contact and only those deemed to meet criteria for a notification are recorded.

A new notification is also recorded regardless of whether the child in question is already being investigated and the case is still open. This can result in multiple notifications of the same child while the investigation process is underway.

Rate of notifications

The number and rate of notifications has increased by 49.0% over the past three years and is presently about 1,000 per month or approximately 12, 400 in 2005-06.

Rate of 'incomplete' notifications

The rate of 'complete' notifications has declined, suggesting an ongoing backlog of incomplete work in CPAARS. This may mean that the initial assessment work has not been completed; that the child protection workers' assessment has not been endorsed by a senior staff member; or simply that details of the case have not been entered into the administrative data base.

A 'point in time' analysis conducted on 17 March 2006 indicated a cumulative total of 1,194 incomplete notifications.

The likelihood of the notification being incomplete is higher for emailed and faxed notifications, as staff give priority to processing telephone calls received while they are on duty.

A breakdown of this pattern is as follows:

Table 2: Completion of notifications

Classification	Phone calls	Correspondence Email/fax	Total
S.17a ² notifications not entered into data base	29	0	29
S.17b ³ notifications not entered into notification record	86	349	435
S.18 notifications requiring more information and research where follow up has not occurred	84	168	252
Notifications not yet read or endorsed by senior worker	340	1	341
Unclassified notifications - not yet assessed or prioritised	137	0	137
Total	676	518	1,194

Notification rates in relation to population

Tasmania was responsible for 4.26% of total Australian notifications in 2004-05 which is considerably more than our population share, being around 2% of the nation's population.

Rates of re-notification

The number of notifications is greater than the number of children who are the subject of a notification, as some children are the subject of more than one notification in any one year.

In fact, a very high proportion of children and families that are referred to the child protection system have previously been notified. The rate of re-notification of the same child has increased from 58.3% in 2003-04 to 74.2% in 2005-06.

Re-notification of the same sibling group is even higher and increased from 70.2% in 2003-04 to 85.1% in 2005-06.

The number of multiple notifications is cause for concern. Since July 2004, 1,588 children had received two notifications, 815 had received three notifications, 496 children had received four notifications, 305 children had received five notifications, 216 children had received six notifications, 145 children had received seven notifications and 298 had received between eight and 25 notifications. This later group includes 10 children notified twenty times or more.

² Used when it is not believed there are sufficient grounds for further action concerning the notification

³ Used when it is believed that there is a proper arrangement to ensure the care and protection of the child or the matter is being adequately dealt with

While there are not direct comparisons of multiple notifications in other states, there was an average of 1.8 notifications per child in Tasmania in 2004-05 which was the second highest re-notification rate after ACT with an average of 2.04.

At the other end of the scale Western Australia had the lowest re-notification rate with 1.08 notifications per child in that same year. This again reflects practice differences particularly in relation to how notifications are defined and recorded.

Types of abuse and neglect being notified

The type of abuse and neglect being notified shows a change in the proportion of children being notified according to the type of abuse and neglect alleged. The percentage of children being notified for physical abuse has decreased while the percentage notified for emotional abuse has doubled and rates for neglect have also increased.

Table 3: Types of abuse and neglect being notified

	2003 - 2004	2004 - 2005	2005 - 2006	2003 - 2004	2004 - 2005	2005 - 2006
Physical	1,805	2,129	1,655	24.1%	20.0%	18.4%
Emotional	1,159	3,001	2,858	15.5%	28.2%	31.7%
Sexual	1,001	1,309	961	13.4%	12.3%	10.7%
Neglect	2,673	4,179	3,528	35.6%	39.3%	39.2%
Beyond Control	69	3	1	0.9%	0.0%	0.0%
Family Problems	720	1	0	9.6%	0.0%	0.0%
Homeless	38	0	0	0.5%	0.0%	0.0%
Assistance/Advice	32	4	1	0.4%	0.0%	0.0%
	7,498	10,626	9,004	100%	100%	100%

- Note: Different point in time notification data to Table 1
- Note: Changes in numbers relating to types of neglect reflect changes to definitions and 'counting rules' with some categories ('beyond control'; 'family problems'; 'homeless' and 'assistance/advice' ceasing to be used from 2004-05).

Possible options following notification

The categories used for notifications are based on the wording of the *Children, Young Persons and Their Families Act (1997)* and are as follows:

○ **17 (a) No investigation possible/no action**

This category is used when the child protection worker does not believe that there are sufficient grounds for further action to be taken concerning the notification.

In 2004-05, 20% of notifications were in this category, with comparable figures not available for other jurisdictions.

-
- **17 (b) – dealt with by other means**

This category is used when the child protection worker believes that the child may be at risk but there is a ‘proper arrangement’ to ensure the care and protection of the child or the matter is being ‘adequately dealt with’.

In 2004-05 this category was used for 63% of notifications, a figure comparable with NSW, Victoria and South Australia, with comparable figures not available for other jurisdictions.
-
- **Priority for investigation**

This category is used when the child protection worker determines that the child is at risk and that direct contact and more detailed investigation is required to complete the assessment. The child protection worker then determines a priority rating and forwards the referral to the relevant service centre.

The case is then provided with a rating as follows:

 - Priority 1- Must be investigated within half a day
 - Priority 2- Must be investigated within 5 days
 - Priority 3- Must be investigated within 10 days

Number and percentage of notifications with each priority rating At May 2006 there were 12, 200 notifications with the following priority ratings:

Priority 1 – 691 (21%)

Priority 2 – 2,221 (69%)

Priority 3 – 322 (10%)

Meeting time frame for priority ratings All priority 1 notifications were allocated for investigation within the 24 hour timeframe unless it was established through further contact with the notifier, school or family member that the child was no longer at a high risk of harm. Timeframes for priority 2 and 3 notifications are currently not being met with these notifications generally being relegated to the ‘unallocated list’.

3. Investigations and substantiations

Notifications referred for further investigation The percentage of notifications that are referred for further investigation was 17% in 2004-05 and 26.5 % in 2005-06.

On the basis of 2004-05 figures, Tasmania’s rate of notifications referred for investigation is low in comparison to other states and territories (Table 4).

(In interpreting this table it should be remembered that there are major differences between states in the way that notifications are defined and recorded making direct comparisons problematic.)

Table 4: Rates of investigations relative to notifications

NSW	Vic	Qld	WA	ACT	NT	TAS
44%	32%	87%	99%	41%	56%	17%

Notifications referred for further investigation that were 'unallocated'

There has been an overall increase in the number of cases allocated to a child protection worker as a result of additional staff allocations. For example, in 2004-05 an average of 100 notifications per month were allocated for investigation and in 2005-06 the average was 120 notifications per month.

Despite this, the number of cases that were referred for further investigation but were unable to be allocated to a child protection worker continues to grow. The number of unallocated notifications increased from 412 on 1 July 2005 to 1,486 on 26 May 2006.

In the south there were 798 unallocated notifications relating to 782 children. In the north there were 166 unallocated notifications relating to 166 children and in the north-west there were 522 unallocated notifications relating to 434 children.

While there is immediate follow-up of priority 1 notifications within 24 hours to determine the immediate level of risk and undertake any action that is required, many of these cases remain 'unallocated' in the sense that they are not assigned to the caseload of a child protection worker.

Of the May 2006 unallocated notifications, 45 were priority 1; 1,206 were classified as priority 2; and 235 were classified as priority 3.

This is an unacceptable risk to a large number of children.

Substantiations

A substantiation results from an investigation into an incident that validates that significant harm occurred or is likely to occur.

The substantiation rate is an indicator of how well targeted investigations are to notifications. In an effective child protection system, the rate of substantiations to notifications and investigations should be neither too high nor too low.

- A low substantiation rate might mean that notifications and investigations are not accurately targeted at appropriate cases and that child protection resources are being dissipated over too many cases;
 - A high substantiation rate might mean that some appropriate cases are being overlooked at notification or investigation.
-

Rate of substantiations as proportion of notifications and investigations

The rate of substantiations in relation to the number of notifications shows that Tasmanian rates of substantiation are significantly lower than in other jurisdictions.

However, when considered as a proportion of investigations, Tasmania's rates are comparable with other states and territories:

Table 5: Substantiations relative to notifications (2004-05)

State	Notifications	Substantiations	Proportion of substantiations
NSW	133, 636	15, 493	11.6%
Vic	37, 523	7, 398	19.7%
Qld	40, 829	17, 307	42.3%
WA	3, 206	1, 104	34.4%
SA	17, 473	2, 384	13.6%
Tas	10, 788	782	7.2%
ACT	7, 275	1, 213	16.6%
NT	2, 101	473	22.5%

Table 6: Substantiations relative to investigations (2004-05)

State	No. of investigations	No. of substantiations	Proportion
NSW	40, 984	15, 493	38%
Vic	11,486	7, 398	64%
Qld	23, 404	17, 307	74%
WA	2, 391	1, 104	46%
SA	6, 250	2, 384	38%
Tas	1, 333	782	59%
ACT	2, 529	1, 213	48%
NT	1, 003	473	47%

Rates of children aged 0-16 who were the subject of a substantiation

Analysis of the rate of children who were the subject of a substantiation shows that the rate in Tasmania increased from 1.1 per 1,000 in 1998-99 to 5.8 per 1,000 in 2004-05.

The rate of substantiation per 1,000 children in Tasmania was in the middle range compared with other states and territories. The rate was 5.8 compared to the higher rates of 14.1 in Queensland and 12.0 in ACT, and the lowest rate of 2.3 in Western Australia.

Proportion of children who were the subject of an investigation and decision not to substantiate, who were the subject of a subsequent substantiation within 12 months

The proportion of children who were the subject of an investigation and decision not to substantiate, who were the subject of a subsequent substantiation within 12 months, has also increased in recent years.

Table 7: Proportion of children substantiated within 12 months of a decision not to substantiate

2001-02	2002-03	2003-04	2004-05	2005-06
1.7%	1.7%	1.8%	9.1%	8.5%

This suggests that either:

- The circumstances for the child being notified deteriorated in the 12 month period following the initial notification, causing an escalation in the level of concern at a subsequent notification; or
- That the initial threshold for referring a notification for investigation was initially too high, with a child failing to be referred for investigation despite the presence of 'at risk' factors.

Either way, the figure is concerning.

4. Profile of children being notified, investigated and substantiated and their notifiers

Age of children being notified

The age of children being notified is often not known, but where this information is available it is evident that children aged from birth to five years of age are more likely to be notified (with infants under the age of one posing the highest category of children notified and the group at highest risk). Another peak occurs in the 13 to 15 year age group as children enter adolescence.

Home suburb and local government areas

Child protection notifications and substantiations are not evenly spread throughout the community and there are higher numbers and rates of notifications in some local government areas and suburbs than in others.

The notification and substantiation rates are most meaningful when considered in relation to the number of children in the age range 0-17 who live in this area. To provide this comparison, the proportion of notifications per 1,000 children was calculated for all local government areas.

The eight Local Government Areas (LGAs) with the highest rates of notifications are provided below.

- **Notifications by Local Government Area population in 0-17 years range**

Table 8: Notification rates relative to LGAs

Local government area	No. of notifications 2003-06	Rate per 1,000 pop 0-17
Brighton	2,422	570.3
Burnie	1,769	357.6
West Coast	498	340.1
New Norfolk	842	337.1
Devonport	1,672	288.6
Launceston	3,860	261.9
Glenorchy	2,732	259.5
Southern midlands	369	231.0

- **Substantiations by Local Government Area**

Where the notifications were investigated and substantiated the pattern of rates changed.

The number of these notifications that were subsequently substantiated are as follows:

Table 9: Substantiation rates relative to LGA

Local government area	No. of substantiations 2003-06	% of substantiations in the time period
Brighton	232	12.1%
Launceston	373	10.7%
Glenorchy	197	10.3%
Clarence	149	7.8%
Kingborough	116	6.1%
Hobart	106	5.5%
New Norfolk	62	3.2%
Burnie	100	2.9%
Sorell	42	2.2%

- **Number of notifications per suburb**

The actual number of notifications received about children living in particular suburbs is also provided although it was not possible to calculate relative to head of population. The 11 suburbs that each accounted for 2.0% or more of the State's notifications in 2005 are also provided.

Table 10: Notifications per suburb

Suburb	Notifications 2003-06	% of total Notifications
Burnie	1,279	5.1%
Gagebrook	1,262	5.0%
Devonport	1,152	4.6%
Bridgewater	997	4.0%
Glenorchy	813	3.2%
Ravenswood	705	2.8%
Launceston	617	2.5%
Clarendon Vale	612	2.4%
New Norfolk	467	2.3%
Kingston	502	2.2%
Ulverstone	500	2.0%

**Aboriginal and Torres
Strait Islander children**

Aboriginal and Torres Strait Islander children are statistically more likely to be the subject of substantiation than other children in all jurisdictions except Tasmania. In Tasmania the rate of substantiation per 1,000 children was 4.8 for Aboriginal children and 5.8 for other children. However, it is very likely that this difference is due to lower rates of recording Indigenous status at the time of substantiation, in Tasmania

Children with disabilities

As of January 2006, 117 of the 317 children (36.9%) recorded as clients of Disability Services were known to Child Protection Services. This means that over one third of all children involved with Disability Services were involved with Child Protection Services. This group included 25 children on care and protection orders or voluntary care agreements. This number is probably an underestimate as there may be children involved with child protection services that have a disability, but are not clients of Disability Services.

Family circumstances

Of the notifications received in 2005-06, 45% were from a single parent family. This is considerably higher than the overall rate of 23.1% of single parent families in Tasmania.

People who make notifications

Notifications are received from a variety of people in the community but are disproportionately received from some professional groups, all of whom are mandatory reporters. For example, police officers have the highest rates of referral whereas medical practitioners make very few referrals.

The source of referral does appear to influence whether the notification is referred for further investigation. For example, a notification from a departmental officer is more likely to be referred for investigation than a referral from a police officer.

This may relate to the perception of the notifier but may also relate to the use of the 17(b) (being dealt with by other means) response. This category may be more likely to be used when the notifier is already providing some other service that is judged to provide ongoing protection for the child's safety. In these circumstances the child is not referred for investigation.

Table 11: Analysis of notifiers in 2004-05

Source of report	No. and % of notifications	No. and % referred for further investigation
Police	2,678 (25.4%)	398 (14.9%)
School person	1,481 (14.0%)	363 (24.5%)
Parent/guardian	1,322 (12.5%)	117 (8.9%)
Relative	1,083 (10.3%)	118 (10.9%)
Social worker/psych	583 (5.3%)	75 (12.9%)
Dept officer	748 (7.1%)	229 (30.6%)
Hospital/health worker	383 (3.4%)	87 (22.7%)
NGO	623 (5.9%)	106 (17.0%)
Medical practitioner	32 (0.4%)	3 (9.3%)

5. Court orders**Defining court orders**

If a child has been the subject of a child protection substantiation there is often a need for continued involvement with the child and family. This may occur through provision of appropriate support services or it may be necessary for the Department to apply through court processes to have a particular order put in place. Recourse to court should normally be seen as a last resort, for example, where supervision and provision of family support are resisted by the family, or where such services are not available.

Numbers and types of orders issued in 2005-06

In 2005-06 the following numbers and type of orders were issued:

Table 12: Court orders in 2005-06

Order description	No. and % of all orders
Guardianship to 18 years	82 (5.3%)
Guardianship to 12 months	155 (10.1%)
Custody to 12 months	162 (10.6%)
Conditions to 12 month	51 (3.3%)
Extensions to 3 years	2
Transfer from other state	1
Requirement	118 (7.7%)
Warrant S20	80 (5.2%)
Interim assessment order	92 (6.0%)
Assessment order	206 (13.4%)
Assessment order extension	145 (9.4%)
Interim care and protection order	201 (13.1%)
Legal requirement order	14 (0.9%)
Family support	16 (1.0%)
Voluntary care agreement	126 (8.2%)
Warrant S97	2
Youth support	3
Youth allowance	4
Court ordered report	2
Contravene	1
Restraint	5
Emergency care	63 (4.1%)
Total	1,531
	Total children 580

It is noteworthy that the types of orders that allow children to remain at home, subject to certain conditions being met or with the provision of family support services, are relatively low in comparison to orders that involve the removal of the child from the care of their parents.

Number of new children admitted to orders in 2004-05 and 2005-06

The number of children who were admitted to an order involving some form of care continues to increase as indicated in Table 13.

These figures suggest that there are significant differences in practice between the regions. For example, in the south there is more likely to be a voluntary care agreement than an emergency care agreement.

Table 13: Number of children admitted to care orders during 2004-05 and 2005-06

	2004-05				2005-06			
	South	North	NW	Total	South	North	NW	Total
Emergency Care	14	26	23	63	16	22	19	57
Voluntary Care	83	25	16	124	69	35	17	121
Assessment Orders	50	45	49	144	115	45	46	206
Care and Protection	75	79	60	214	157	99	57	313

Proportion of children on some form of care and protection order

Care and protection orders may involve conditions under which the child can remain with his or her parents or guardians; custody of the child being provided to other family members, non government or government agencies or the guardianship of the Secretary of the Department.

The proportion of children who were the subject of substantiation and who were placed on a care and protection order within 12 months varies from state to state and reflects differences in practices and policies.

At June 2005 Tasmania had 716 children⁴ on a care and protection order.

In 2003-04 Tasmania had the highest percentage of children substantiated, on a care and protection order within 12 months.

Table 14: Proportion of children on care and protection orders relative to substantiations

NSW*	Vic	Qld	WA	SA	Tas	ACT	NT
	28%	16%	26%	14%	29%	19%	11%

*NSW was unable to provide figures

Type of order in comparison to other states

Types of orders differ from state to state and this makes comparisons between states difficult and some data is not provided. However, the ratio of children on orders that allowed the child to remain at home in the care of their parents

⁴ This figure may have been an over-estimate as more recently verified figures (Marshall, July 2006) suggest that this number was 577. This discrepancy is concerning and due to inadequate data management systems.

(with conditions rather than being placed in an out of home care situation) in Tasmania appears relatively low in comparison to Victoria (24%) and ACT (11%) although comparable with Queensland (5%).

Children on care and protection orders over recent years

The number of children on care and protection orders is increasing:

- o 508 in June 1997;
- o 600 in June 2003;
- o 634 in June 2004 ;
- o 716 in June 2005; and
- o 833 in June 2006.

Children on care and protection orders (per 1,000)

When this is calculated in terms of the rates per 1,000 children the increase is also confirmed.

Table 15: Rate of children on care and protection orders per 1,000

2001-02	2002-03	2003-04	2004-05	2005-06
3.9	5.1	5.4	6.1	7.2

Comparison to other states

Comparative figures for other states and territories in 2004-05 are as follows:

NSW	5.4
Victoria	4.9
Queensland	6.0
Western Australia	3.7
South Australia	4.5
Tasmania	6.1
Australian Capital Territory	6.1
Northern Territory	7.0

These figures suggest that the Tasmanian rate is at the higher end of the range.

Children with Indigenous status on care and protection orders

As at June 2005 there were 94 children of Indigenous origin on care and protection orders equating to 11.5 children per 1,000. This compared to a rate of 5.7 children per 1,000 for children of non Indigenous origin, suggesting that Indigenous children are more likely to be the subject of a care and protection order.

6. 'Out of home' care

Defining 'out of home' care

Children who are on care and protection orders either live in a supervised arrangement with one or both parents or in some form of 'out of home care' situation that ranges from living with a relative to living in a home staffed by paid carers.

Arrangements can also be expected to vary over time as some children are returned to their parents care after a period of living in another care arrangement.

Living arrangements for children on care and protection orders

The proportion of children in various out of home care situations at June 2005 is shown in Table 16.

These relative proportions show that the major difference between Tasmania and other states is that Tasmania has the lowest rate of children in kinship care (living with a relative).

The relatively high proportion of children living with their parents may seem to contradict the previous assertion above that the proportion of children on supervisory orders who are left with their parents is low. Out of home care figures include some children returned to their parents after being removed and placed away from parental care. This is supported by figures on the length of time that children are in out of home care that suggest that Tasmania has the second highest rate of children (after the NT) who are in out of home care for six months or less.

This might mean that more children are taken away from their parents in the initial period, but that these children are returned to their parents' care.

Table 16: Living Arrangements for Children on Orders at June 2005 (expressed as a percentage) (Note: Category of "other" not included, hence not all percentages equal 100%)

Living arrangements	Parents	Kinship care	Foster care	Residential care	Family group home	Independent Living
NSW	3	52	40	4		1
Vic	29	29	29	5	2	1
Qld	6	26	62	4		2
WA	11	36	44	5	2	1
SA	1	22	60	2	3	12
Tas	21	18	40	Not recorded	8	3
ACT	28	27	35	10		1
NT	9	27	57	6		

Number of foster carers

There were 26 additional carers recruited from April 2005 to April 2006. As at April 2006 there were 334 children in foster care out of a total of 678 children in out of home care. This is an increase of 71 children in this 12 month period.

Number of children placed with foster carers

The number of foster carers is clearly not keeping pace with the number of children being referred for foster care. The most recent figures on multiple children being placed with foster carers suggest that there is an upward trend in the number of children being placed with the same foster carer.

Table 17: Number of children in an individual foster care situation

Children	30 Jun 04	31 Dec 04	30 Jun 05	31 Dec 05	30 Apr 06
1	93	80	73	81	74
2	23	30	39	38	49
3	15	17	20	20	22
4	4	5	8	9	8
5	4	7	6	10	8
6		1	1	1	3
7					
8					1

Number of foster carers

The number of foster carers has increased but not sufficiently to provide for the number of children who may benefit from foster care.

Table 18: Number of children per carer

	30 Jun 04	31 Dec 04	30 Jun 05	31 Dec 05	30 Apr 06
Children	220	252	279	309	336
Carers	139	140	147	159	165
Average	1.58	1.80	1.90	1.94	2.04

Indigenous children in out of home care

At June 2005 there were 78 Indigenous children in out of home care in Tasmania. This equates to 9.5 children per 1,000 compared to a rate of 4.6 per 1,000 for children of non Indigenous origin.

Only 27% of Indigenous children were placed in out of home care in accordance with the *Aboriginal Child Placement Principle* that outlines a preference for the placement of Aboriginal and Torres Strait Islander children with other Aboriginal and Torres Strait Islander people when they are placed outside their family. This was a reduction from the previous year (40%) and compares unfavourably with other jurisdictions where the rate of adherence to this principle was generally in excess of 60%.

7. After hours service

After hours services operate at regional level and cover all functional areas of child protection

An after hours service operates in each of the regional centres overnight between 17.00 and 08.30 on weekdays and during weekends and public holidays. There are two people on duty after hours within each region:

- An 'on call or standby' officer who is the point of contact for all incoming calls; and
- A call out officer/s who is available to attend to matters if requested to do so by the 'on call or standby' officer.

At times the standby service for the north-west has been directed to the south as there are insufficient staff numbers in the north-west to staff the service

The 'on call or standby' officer takes all calls that are diverted to a mobile phone which is carried with the officer. This officer is the point of contact for all functional areas relating to child protection services. All matters relating to Youth Justice are also managed by this service.

Number of calls received after hours

There is no central data base for the number of calls received by the after hours service although calls are logged on log sheets at each service centre.

An analysis of log sheets for a 'snap shot' of August 2005 shows the numbers of calls received. (NB 'priority' defined on p. 36)

Table 19: Snapshot of calls received after hours during August 2005

Priority	South	North	Burnie	D'port	Total
No Priority	12	2	3	4	21
Priority 1	22	8	6	6	42
Priority 2	75	28	27	11	141
Priority 3	9	9	3	0	21
Total	118	47	39	21	225

Callers

A breakdown of the callers to the after-hours services is provided in table 20.

Table 20: Callers to after hour service in August 2005

Child or Young Person	5
Foster Carer	44
Doctor	2
Extended family member	13
Friend/neighbour	8
Police	21
Hospital	2
Non-government agency	6
Service Centre worker	21
Support worker	26
Anonymous	12
Other	7
Total	218*

*Number does not equate to the total in Table 19 as the status of callers for the remaining calls is not known.

This analysis indicates that most calls are not emergency referrals of children at risk of abuse or neglect but calls seeking more general advice or providing information. The main type of work is support to foster carers (44 calls) and response to, and information sharing with, staff (47 calls).

Time of calls

An analysis of this same sample (August 2005) of calls shows the times that calls were received:

Mon-Fri before 8.30 pm	Mon - Fri 8.30- midnight	Mon-Fri After midnight	Weekday Call outs
72	31	1	11

Sat-Sun 8am - 2pm	Sat- Sun 2.pm - 10pm	Sat- Sun After 10pm	Sat- Sun Call outs
78	40	5	8

- Note: 'Call outs' indicate that a worker was required to visit the family. This analysis indicates that most calls are received before 8.30pm on weekdays and during daytime hours at the weekend.

8. Staffing

Staff numbers

There are currently 328 staff (not FTEs) employed in child protection services.

Table 21: Child Protection Staff Numbers

SUMMARY	
Assessment & Case Management - South	5
Case Management - South	18
Intake & Assessment - South	57
Service Centre Operations - South	64
Out of Home Care - South	9
Child Protection Advice & Referral Service	27
Manager Child Protection	1
Total South	181
Case Management - North	17
Intake & Assessment - North	14
Service Centre Operations North	16
Out of Home Care - North	6
Total North	53
Assessment North West	10
Case Management Nth/West	7
Service Centre Operations N/West	28
Kinta/Support Work North West	13
Out of Home Care Nth/West	10
Total North West	68
State-wide Relief (Support Workers)	26
Total State-wide	328

○ **Additional staff appointed since 2003.**

To address the increase in demand the Government has funded an additional 67 permanent positions in child protection services between February 2003 and September 2005. Since October 2005 a further 30 temporary positions have been funded.

○ **Sick leave taken by staff**

The average number of days sick leave taken by staff working in the Child and Family Services team (that incorporates child protection staff) was 1.6 days in 2003-04; 2.2 days in 2004-05; 1.5 days in 2005-06 (year to date).

This compares favourably with other staff teams within Children and Families Services and suggests that, while staff are under pressure, they are not taking excessive amounts of sick leave.

○ **Case loads**

Case loads are a measure of the number of cases assigned to a staff member. Case loads do not take account of the complexity or time commitment that a case may require.

In February 2006, case loads in *Assessment Teams* (including coordinator) were:

- North - 17, South - 11 and NW - 12

The average case load across the state was 13 cases per child protection worker.

In *Case Management* average case loads in case management teams (including coordinators) were:

- o North - 16, South - 13 and NW - 15

The average case load across the state was 13 cases per child protection worker.

9. Funding and resource allocation

Budget allocation for Services

- o **Budget Breakdown**

The full year actual budget breakdown for Child Protection Services for 2005-06 (including salary and non-salary items) is:

Service Centres	\$5,154,586
Case management	\$8,857,789
Carer support	\$2,122,013
Client support	\$2,183,749
Assessment and protection	\$5,344,619
Rostered care	\$2,300,400
Notifications (CPAARS)	\$2,497,373
Challenging behaviour	\$168,474
State-wide management unit	\$1,741,762
Information service	\$193,889
TOTAL	\$30,428,356

8. Findings from contributing reviews

1. Review of the Tasmanian Family Support Service System, KPMG, 2006

Scope of the Review	<p>This review considered the programs that are available for support to families and present limitations and suggested a model based on local coordination of services and earlier intervention.</p> <p>Major findings of the Review were:</p>
○ Cost and number of services	<p>DHHS funds 33 family support services under two funding streams - family support and personal and family counselling.</p> <p>A total of \$1.99 million is provided to these services.</p>
○ The service has developed in an ad hoc way	<p>The review concluded that the system has evolved in an unplanned and ad hoc manner with programs and services being poorly linked and unconnected.</p>
○ There is a serious limit to the availability of family support services for vulnerable and at risk families	<p>The review also found that the quantum and distribution of family support services is inadequate with some services being reluctant to take on families with more complex needs, including those families that have been referred to child protection services.</p>
○ Type of service provision	<p>A snap shot of service usage found that:</p> <ul style="list-style-type: none">○ The majority of services were provided through office or centre based contact with only 11% of contacts provided in the home;○ The majority of services were provided through planned appointments;○ The majority of families self-referred;○ 64% of families were receiving some form of Centrelink payment; and○ Only 11% of families were considered 'high risk' while the remaining 89% were considered to be 'medium' to 'low' risk families.

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- **Strengths of present services**

Strengths of present services were considered to be:

 - Most were based in local communities;
 - The workforce was dedicated and committed to their role; and
 - Services were diverse, flexible and had capacity to work with families over the short, medium and long term.
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- **Gaps or weaknesses of current services**

Gaps or weaknesses of current services were:

 - Limited accountability with no outcome measures or routine data collection - there are currently no accountability mechanisms or service specifications which specify the type, quantity and intensity of services that are to be provided;
 - Time limited funding resulting in instability of services;
 - Families have difficulty navigating the service;
 - There is limited use of case management and case planning approaches;
 - There is limited information sharing between services;
 - A lack of coordination and planning between services;
 - Limited response to high risk adolescents; and
 - Limited or no capacity to provide a crisis response.

2. Child and Family Service Consultation with Staff (May/June 2005)

Child and Family Service Consultation with staff report, 2005

In response to industrial action and overall staff concerns an internal review was undertaken in 2005 and a subsequent report produced. This report also noted issues identified by staff specifically in the north-west that had been the subject of a separate external investigation by Davidson Trahaire Corpsych. The Staff Consultation report identified issues associated with workload and employment conditions of child and family services staff. Work was also undertaken on benchmarks for caseloads for child protection workers with suggested levels of caseload.

Concerns from staff

Following concerns expressed by staff about increasing workloads and conditions in 2005, a five week review was undertaken to provide more details on concerns and issues facing staff. The terms of reference for this review were to:

- Identify current issues facing the service across Tasmania;
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- Identify potential solutions to those current issues; and
 - Identify improvements that could be made to the current system or practice.

At the end of this time, staff acknowledged that more work needed to be done to address future planning and the broader issues of service delivery options. The *Consultation with Staff* review (including its findings) was therefore incorporated in the *System Development and Operational Improvement Project*.

Summary of issues identified

The following issues were identified by staff:

- Inadequate accommodation, particularly in the Southern Service Centre, Northern Service Centre and CPAARS – the accommodation was found to be unsuitable for both clients and staff resulting in increases in client agitation and discomfort and staff feeling demoralised and undervalued. Over-crowding, unsafe interview rooms, shared offices which compromised confidentiality issues and generally drab and run down conditions were raised as issues.
 - Resources in a variety of areas were judged to be inadequate – staff identified an inadequate supply of basic tools such as stationary, access to vehicles for home visits, access to computers and reliance on outdated manual data management systems.
 - Increased workload over the previous five years was identified as a major concern – increases were judged to be due to increased numbers of notifications, increased court work and implementation of assessment and management tools such as *Tasmanian Risk Framework (TRF)*, *Looking After Children (LAC)* and new funding methodologies. An increase in administration and paper work was also adding to workload.
 - Caseloads were found to be unmanageable with significant inequities across the state in the number of cases assigned to child protection workers and supervising staff.
 - Recruitment, retention and professional learning opportunities were all found to be inadequate with difficulties in recruitment, lengthy delays in appointments, poor induction and inadequate opportunities for continuing professional learning identified.
 - Out of home care and placement options – staff expressed frustration and feeling compromised in their ability to meet the needs of children and young people in need of care and protection. Traditional placement options such as foster homes and family group homes were judged to be difficult to sustain and inadequate for some children and young people.
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- Poor morale and workplace culture were also identified as issues with significant dissention between staff groups in some workplaces adding to work pressure and personal stress.

3. Findings from Review conducted by the Child Death Review Committee in relation to a child who died while an active case with child protection services

A child death review was conducted during the period of the current review

A review committee was established in February 2006 to investigate the circumstances surrounding the death of a child who was an active case with child protection services at the time of his death. In particular the review committee was asked to examine the contact, advice and decisions relating to this child and his family.

The Child Death Review collected evidence from file reviews (including Royal Hobart Hospital files; Alcohol and Drug Services files; Family, Child and Youth Health files and child protection files) and interviews with staff and external providers who had been involved in this case.

The Child Death Review Committee included David Fanning, the Commissioner for Children, and Alison Jacob Deputy Secretary (Human Services) who were responsible for the current review. The findings of the Child Death Review were therefore an important source of information for the current review.

A full report for the Child Death Review will be reported separately through the *Council of Obstetric and Paediatric Mortality and Morbidity*.

Major findings

The major findings were grouped under four themes:

- **Inadequate communication and cross service interaction and cooperation**

The findings under the heading of “Inadequate communication and cross service interaction and cooperation” included:

- The processes for the case conference preceding the child’s discharge from hospital did not include all the relevant professionals;
 - The case conference process did not afford the opportunity for information from professionals involved to be fully considered;
 - Input from Alcohol and Drug Services was not accessed adequately or well considered;
 - There was over reliance on the support and assessment of Family, Child Youth Health nurses to monitor the child’s safety;
 - The communication between staff at the Royal Hobart Hospital and child protection services lacked clarity;
 - There was ambiguity and absence of protocols to define the role of the Tasmanian Aboriginal Centre in the case;
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- There was no clear practice protocol for the movement of the case between CPAARS and Assessment services; and
 - Documentation in files was poor and in some cases inappropriate.
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- **Unclear notification practices**

The findings under the heading of “Unclear notification practices” included:

- Incapacity for child protection services to be involved with the case in the antenatal period;
 - No capacity for services to be alerted to the family’s previous involvement with child protection services;
 - Lack of timely consideration of previous involvement with child protection services;
 - Lack of capacity for previous involvements with child protection services to provide an ‘alert’ when new notifications were received; and
 - Inadequate weighting provided to the notification information from Alcohol and Drug Services.
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- **Inadequate risk analysis**

The findings under the heading of “Inadequate risk assessment and analysis” included:

- Undue emphasis and reliance on the use of the Tasmanian Risk Framework;
 - Misplaced optimism about the capacity of the child’s parents and grandparents to provide for his care and well-being;
 - Inadequate analysis of the effects of risk factors associated with this child’s parents being long term drug users;
 - Inadequate case supervision and review by senior staff;
 - Inadequacies in the present priority ratings;
 - Inappropriate use of the 17(b) category rating when a case is on the unallocated list; and
 - Inappropriate case closure when there were substantial risk factors evident.
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- **Impact of cultural dysfunctions**

The findings under the heading of “Impact of cultural dysfunctions” included:

- Practice influenced by staff feeling powerless and helpless in the face of their workload and unable to influence the child’s future; and
 - A lack of reflective practice and opportunities to critically review practice.
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4. Findings from analysis of files where a child who had died during 2005-06 or their siblings were known to child protection services

Deaths recorded on the paediatric register of deaths were analysed

All paediatric deaths in Tasmania are recorded on a register compiled by the *Council of Obstetric and Paediatric Mortality and Morbidity*. This register also notes whether children who have died were known to child protection services prior to their death.

Eight children who died during 2005 were identified. These children included one child who was an open child protection services case whose death was the subject of a Child Death Review (above).

Seven other children, or their siblings, had been known to the child protection services during a period of between 1 and 14 months prior to their deaths. Deaths were classified as due to a variety of medical and environmental causes and no causal link with failure of child protection services is being asserted. However, in the absence of a formal child death review process any contributing factors remain undetermined.

A file analysis was conducted of the child protection files related to these children and their siblings

A comprehensive chronology of events was compiled for each child and their siblings. The chronology included references to all notations in files including notifications, assessment processes, communication between services and family members and information from other professionals.

A number of findings were summarised from the file reviews

Findings from these file reviews included:

- Multiple notifications that were not referred for further investigation;
 - No system to provide an alert when a child or his/her siblings had been previously notified;
 - No system of providing direct linkages between files of siblings who have been notified so that patterns of behaviour could be identified;
 - A lack of liaison with hospitals to provide an alert when a new baby is born to a family where siblings have been notified;
 - Use of the 17(b) category (dealt with by other means) in circumstances where the 'other means' did not afford a high level of care and protection (eg 'extended family making alternative arrangements'; 'Doctor will keep an eye on him');
 - Poor documentation that made it difficult to follow the decisions and processes that had occurred and who was accountable for decisions;
 - High proportion of drug and alcohol issues in families involved;
 - High level of family violence in the history of families involved;
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- Lack of case conferencing and consultation between professionals involved with a case; and
 - Inadequacy of support services provided to families that were suffering multiple issues including poverty, poor parenting, drug and alcohol issues and family violence.

The lack of a process to ensure that all deaths of children who have had involvement with child protection services are investigated is concerning

Unlike most states and territories (ACT and NT are the other exceptions) there is no legislation in Tasmania to mandate a process for investigation of deaths of children who have been involved with child protection services.

This means that it is discretionary for these deaths to be the subject of review. The information that is likely to be provided by such reviews and the probability that system issues would be identified during the process, makes this 'gap' more regrettable.

9. Critical issues and findings

1. Capacity and functioning of the system

The present rate of notifications is overwhelming the system

The number of notifications is overwhelming the Tasmanian child protection system - the system is processing too many notifications in order to identify those children who require statutory intervention. Only 26.5% of notifications are referred for further investigation and only 7.2% of those notifications are substantiated. Both of these figures are the lowest in the country suggesting the net is being spread too wide.

This system does not make sense. It is akin to referring anyone who is feeling unwell to a hospital emergency room and expecting staff to triage and prioritise every case before deciding who needs treatment in hospital and who should be treated by other services.

As cautioned by Professor Dorothy Scott:

*'Legally compelling professionals to make notification of possible child abuse and neglect, regardless of their professional judgement, and then doubling the number of child protection workers every decade to keep pace with the doubling of notifications, is not working. It is completely unsustainable. In some parts of the world this is now well understood. In other places it is necessary to keep on doing more of the same for a little longer until it so obviously fails that necessity forces us to find the courage to change policy direction....Some systems in the English speaking world, including some in Australia, catch too many children into the child protection net and as a result fail to protect and respond in a timely way to the most vulnerable children in the net.'*⁵

A major factor contributing to the increase in number of notifications is mandatory reporting

The mandatory reporting requirements in the *Children, Young Persons and Their Families Act (1997)*, which were proclaimed in 2000, are a major reason for the dramatic increase in notifications. While introduced in Tasmania and elsewhere to increase the referral net for child protection referrals and improve child safety, mandatory reporting has had the unintended negative consequences of overloading the statutory system without necessarily improving child safety.

Family violence legislation has added to the overload

The *Family Violence Act 2004*, proclaimed in March 2005, added to the rate of notifications as it amended the definition of a child at risk of abuse and neglect to include circumstances where a child was affected by family violence. Notifications from police officers now total over one quarter of all notifications. Although there is no current data to allow police referrals to be divided into

⁵ Dorothy Scott *A Vision for Family Services – Support and Prevention that Works for Families at Risk* - conference paper delivered in Sydney, 2003.

those that are specific to family violence involvement, anecdotally it is estimated 80% of notifications from police officers are a result of involvement in family violence incidents. While some of these notifications represent children in need of statutory child protection intervention, many do not require this level of intervention.

Overload to the system represents a very substantial risk

Overloading the system represents substantial risks:

- The response time is likely to be either too slow because cases are unable to be dealt with in a timely manner, or too hasty and superficial because there is pressure to move through cases quickly;
- There is a temptation to close cases or not refer them for further investigation to avoid further pressure on the system;
- There is likely to be a high rate of ‘false positives’ – families who are subject to a child protection investigation that is unwarranted;
- The number of families involved with child protection far exceeds the capacity of the system to serve them responsibly and effectively;
- The focus of staff is dissipated over a very large group of children and families rather than being focused on those families who require child protection intervention; and
- The demands take a very high toll on staff who feel the system is out of control and however hard they work they can never regain control over their workload.

These risks are impacting on the Tasmanian system

There is evidence of these increased risks impacting on the Tasmanian system:

- **There is an increase in the number of children whose risk is not appropriately identified**

As reported earlier, the rise in proportion of children whose possible abuse or neglect was investigated but not substantiated, but where there was a subsequent investigation and substantiation within 12 months, suggests that the system may be missing an increasing number of cases of abuse or neglect.

While some of this finding could be explained by deteriorating circumstances in the children’s lives, the sharp rise in this figure over the past two years suggests there may be practice reasons also impacting, such as reluctance to recommend cases for investigation given the high number of unallocated cases.

- **The use of section 17 (b) – (dealt with by other means) is probably too expansive**

It is probable that the category ‘dealt with by other means’ is sometimes being used inappropriately. While the category is intended to deal with cases where there are sufficient safety mechanisms in place to closely monitor the child’s safety or ameliorate the risk, file audits suggest the use of the category is inconsistent.

Case audits and findings of the Child Death Review suggest that sometimes interpretation of this category is extremely expansive – it is apparent that if there is any professional service or relative involved with the child, this is interpreted as a ‘proper arrangement’.

At times the use of a ‘strengths based model’ appeared to put undue weight on positive factors operating in the family even when there was no evidence of increased safety for the child at risk.

Parents were sometimes given ‘the benefit of the doubt’ with child protection workers accepting parental ‘willingness to be involved’ with a support service as equating to the actual use of the service.

Of more concern is use of this category if the case has been referred for further investigation, regardless of whether the case has been allocated or is in fact on the ‘unallocated’ list. This represents a potentially dangerous practice that could result in a child who is at risk being overlooked and it should cease.

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- **The temptation to make the decision to remove the child in order to mitigate risk is high**

There is evidence that child protection workers, faced with overwhelming case loads, and lack of experience and training in the development of alternative options, are more likely to decide to take statutory action that involves removal of the child from the situation in which they are at risk rather than putting a safety plan in place that may allow the child to remain at home with appropriate safeguards.

Further evidence of the system dysfunction is the high re-notification rate

Further concern in relation to the overloaded system is the very high re-notification rate.

It is apparent that, to a very high degree, the system is ‘churning’ through referrals about the same group of children and families. The high re-notification rate is cause for concern as it necessitates processing information on the same child on multiple occasions.

This is likely to occur for several reasons including:

- Action taken when the child or family was first referred has not alleviated concerns about their welfare or safety;
- There are insufficient support services to which children and families are able to be referred, so their issues are on-going;
- There is a perception that if a child is referred frequently there may be some action.

Whatever the reasons, the rates of re-notification are adding to the overload and system dysfunction and must be a focus for attention.

Most notifications involve a range of 'welfare' issues rather than single incidents of 'abuse'

As stated above, one reason for the high re-notification rate is that many of the current notifications are not 'once off' incidents of abuse or neglect but involve families that have multiple and complex needs and more generic problems such as housing and financial difficulties, incapacitated parents, drug and alcohol involvement and mental health issues.

Most recent commentaries on child protection systems suggest that it is a mistake to look at child abuse and neglect as a 'point in time event'. With the exception of very severe assaults and sexual maltreatment, long term difficulties for children seldom follow from a single abusive event – they are more likely to be a consequence of living in an unfavourable environment.

Two thirds of notifications involve children neglected or suffering from emotional abuse and neglect. This suggests that most notifications involve families with multiple problems and long term factors that affect the lives of children.

It is clear that a significant reason for the high rate of notifications and re-notifications is that concerns about children are not being directed to other services either because they simply do not exist or because they are not known.

These families require help and support, but, in most cases, the incident being notified does not reach the threshold for statutory intervention.

Child protection services have become the 'default' service for all concerns related to children

Rather than the service of last resort, child protection has become the gateway to all child and family services. Child welfare has become child protection, not just in terminology, but in the system that we have.

Child protection services are expected to deal with all children's issues regardless of their severity or the involvement of other services.

Other services and the wider community have absolved themselves of responsibility for child safety and well being

The concept of child protection as the only service responsible for children's safety and well being has been unconditionally accepted within other child and family services as providing justification for passing responsibility to the 'expert group' rather than maintaining a level of responsibility and ownership for cases relating to children's wellbeing and safety.

The concept of mandatory reporting has added to this perception, implying that other professional groups that have a connection with children and families have a mandated responsibility to refer to child protection services and that this service will then assume all future responsibility for investigation and any necessary intervention.

In addition, other services tend to also be 'risk averse' in a culture of sensitivity about child protection issues. They are more likely to make referrals to child protection services in order to reduce any personal or professional liability that may result from the child suffering harm or abuse and neglect subsequent to their involvement.

Other services have felt less responsible for ensuring children's safety and well being

The result of this misunderstanding of the role of child protection services is that the issue of child safety and welfare has been passed from family and community services and has become 'someone else's' problem.

Other services and the community generally have therefore been relieved of their share of responsibility for child safety and the result is a child protection service that is overloaded with referrals that do not meet the threshold for statutory intervention.

2. Understanding of the role and function of Child Protection Services

Child protection services are not well understood

It is obvious from the discussion above that the role of child protection services in the overall context of government services and community organisations is not well understood. There are several reasons that contribute to this poor understanding.

Organisational arrangements are not clear

The organisational structure of child protection services is not clear to the wider community.

The relationship between different layers of the service (Child Protection Advice and Referral Service (CPAARS), Assessment teams, and Case Management teams and Out of Home Care teams) is certainly not clear to those outside the service, while the structural organisation within Children and Families Services and the Department of Health and Human Services is also obscure to most.

The constant changing of terminology, roles and staff within the service as well as the overlapping and duplication of functions (for example, the same information being requested by child protection workers in CPAARS and in Assessment) add to the general lack of clarity.

This situation causes considerable confusion about roles and responsibilities; where decisions are made; and where complaints and enquiries can be addressed.

Child protection services have mystique and 'isolationist' image

It is also evident that the work of child protection occurs in a model of relative isolation. Advice and consultative services are regarded as difficult to access, decisions are made in relative isolation from other professional groups, and services have been accommodated in relatively isolated offices that do not encourage interaction with other services or the community.

Child protection services do not often work as part of an integrated and coordinated team of other professionals, even within DHHS. Routine interaction with associated services such as Family, Child Health Services; Disability Services; Alcohol and Drug Services and Mental Health Services are surprisingly infrequent.

<p>Child protection services staff are regarded as 'experts'</p>	<p>There is an emphasis on child protection services as the 'expert' in the field of child safety, which has tended to alienate these services from family support and other social work services. In particular, the forensic style and court related work of many interventions by child protection services has distinguished these services from generic services that are then convinced that they are unable to be involved. Many community social workers are reluctant to become involved with child protection cases on the basis that they do not believe they have the necessary expertise and are likely to make mistakes involving risk to the child or themselves.</p>
<p>Child protection services are not well integrated within the broader continuum of services</p>	<p>There was a strong rationale presented by experts in the child protection field of the need for child protection services to be well integrated within the broader continuum of services. However, at present in Tasmania, child protection services are relatively isolated from and unable to work to the extent that they should in collaboration with other government and non-government services.</p> <p>There is also a severe lack of appropriate support services and preventative and early intervention services with which child protection services are able to work in a collaborative way.</p>
<p>Present organisational structures do not encourage collaboration and integration of child protection with other services</p>	<p>The present continuum of services available to children and their families includes universal services such as child health services and education, that are available to all children and their families; secondary services such as family support services and early intervention programs that target families who require more intensive support due to their particular circumstances; and tertiary services such as therapeutic services required for a smaller number of children and their families.</p> <p>Child protection services should fall into the continuum as a tertiary service, only required for a small group of children and families, with capacity to make referrals to, and take referrals from, the full range of other services.</p> <p>However, the present organisational structure and government responsibility for these services does not encourage this range of services to be well integrated into a single continuum of care. These services operate within different management structures, have different priorities and funding mechanisms and tend to operate independently.</p>
<p>Child protection services have an associated stigma</p>	<p>In addition, involvement with delivering child protection services is regarded as stigmatising and many family support services are reluctant to be associated with child protection due to a fear that this will taint the image of their services and make other clients reluctant to have an association with them.</p>

Inappropriate emphasis is placed on the distinction between ‘voluntary’ services and ‘involuntary’ services

Added to this perception, is a strongly held distinction between services provided to children and families that are accessed by families on a voluntary basis and child protection services where involvement is imposed by legal processes.

Many other government and community services are reluctant to become involved with child protection cases on the basis that this will change their relationship with their client from being one where access is ‘voluntary’ to one that the family has no choice about, or control over. This is also perceived to be a different way of working with a family that many family support service workers find uncomfortable or stressful. Many believe that their work with families will be compromised by becoming involved with child protection cases.

Despite this perception, it is evident from high functioning child protection services elsewhere, that involvement in statutory child protection work can be quite compatible with working with a family in a voluntary capacity, without compromising either role.

Child protection workers have little capacity to be involved in supporting families outside their statutory obligations

Child protection services generally have no capacity to become involved with a family unless a child is being assessed as part of a formal investigation or is on an order. This unofficial ‘rule’ is used as a gate keeping mechanism to limit the scope of work in an overloaded system.

There is therefore very limited capacity for early provision of advice, involvement in consultation processes such as case conferences and a general presence in the community that might alleviate some mystique of the service. This increases the isolation of the service and reduces access from other professionals that are working with children and families at risk.

Involvement of child protection staff in existing whole of government collaboration strategies is limited

Tasmanian government strategies that are aimed at increasing the level of integration and collaboration between agencies and services are generally producing positive results. These strategies include *Interagency Panels* instigated by Tasmanian Police as a strategy to focus on early intervention and crime prevention; *Collaboration Strategies* being used in the youth justice system to respond to young people at risk of further involvement with crime; and the Family Violence service model designed to take a more integrated approach to the provision of services to adults and children affected by family violence.

Child protection services are involved in all of these initiatives although evidence suggests that participation is limited by other priorities and the perceived need to respond to the daily crisis driven nature of their work. While all of these models have potential application to future directions for the child protection service, it is obvious that some rationalisation of interagency initiatives may also be required to ensure that the various collaboration strategies bring those involved in service delivery together in ways that use their time efficiently and effectively.

Child protection work is perceived as 'unsafe' and 'risky' to personal safety of those involved

Working with child protection and family violence referrals is also regarded as being in the dangerous 'front line' by some community social workers including school social workers. Child protection workers have some safeguards in place at the place of work (such as duress alarms and code accessed doors) and access to the security of police escorts that are not available to community workers.

It was also argued that child protection workers have anonymity and are able to 'visit and depart' from a neighbourhood. Community social workers who were well known and worked in the neighbourhood do not have this advantage.

For all these reasons, some community workers believed that their safety was at risk if they assumed a child protection role.

There is a perception that a child can either be a client of child protection services or a client of other services, but not both

Finally, it is apparent that children are regarded as either being 'clients of child protection' or 'clients of other services', but mostly these services do not share responsibility with child protection for a case. Community case conferences are infrequent and involvement of other professional groups in decision making is not common practice or encouraged. There was also a perceived (rather than actual) 'conflict of interest' involved in being a potential notifier to child protection as well as a support worker involved in the case.

For all of these reasons, a 'them and us' approach to child protection remains the prevalent model of practice.

3. Profile and status of child protection services

Perception of service is person dependent

It should be stressed that perceptions of child protection services are extremely varied and inconsistent across the state and between and within service centres. The comment was frequently made that impressions of the service depended on the individuals concerned and some staff were regarded very highly and had a very positive reputation in their community.

However, the general view is a lack of a consistent standard of service and a sense that the response to a child protection matter is dependent on the person who happens to be involved rather than the system as a whole.

Child protection services have a mixed public image and profile

It is evident that child protection services in Tasmania have a mixed profile and status. While the level of overload within the service and over-work of staff is generally stressed and there is a high level of sympathy for staff, the service is regarded as:

- o Lacking in effective communication and provision of feedback to other professional groups;

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- Having a dysfunctional ‘culture’ that is regarded as negative, chaotic, disempowering and where things are ‘in crisis all the time’;
 - Being internally focused rather than building links with other services and the community;
 - Unreliable and ineffective in following up queries, returning phone calls, keeping appointments, doing things on time, and showing professional practice;
 - Suffering from a high staff turn over with a resulting lack of staff continuity and lack of established networks with other services;
 - A ‘least preferred’ employer, attracting staff who are unable to find employment in other areas; and
 - Having little capacity for effective intervention with families.

To a greater or less extent (depending upon the extent to which mandatory reporting is enforced with the practice guidelines and policies of a service) some areas of the professional community and some professional groups have virtually ceased to make notifications, because they do not see that it makes a difference and is ‘a waste of time’.

4. Defined direction and purpose of the child protection service

There is a lack of strategic planning and direction and purpose for the service

Despite a considerable number of policies, protocols and articulated framework documents covering various aspects of the service, there is an overall lack of a clear sense of direction and purpose for staff and the broader community.

In the absence of such direction and over-arching strategic planning, the service has tended to operate in a reactive way, contributing to a sense that staff ‘lurch from crisis to crisis’ rather than operating in a controlled and predictable way. Child protection work therefore tends to be crisis driven rather than the result of a planned and proactive approach.

The lack of a professional practice framework hampers practice

Staff commented on the lack of a cohesive and professionally sound practice framework to provide the foundation for their work and the basis for decision making and professional standards. There is good evidence⁶ that such a framework would not only provide a fuller understanding of what informs decision making and casework, but would also have the potential to trigger best practice.

⁶ Connolly 2006

5. Complexity of child protection work

Child protection work has become increasingly complex

Evidence was provided that child protection work has become increasingly complex with the families involved likely to present with an array of intertwined and long standing issues, many of which are related to poverty. Families involved with child protection services face many challenges and difficulties with increased numbers of parents with housing issues, psychiatric illness, serious problems of drug and alcohol abuse and experience of domestic violence and marriage breakdown.

Families involved in family court disputes are over represented in the child protection system

An additional level of complexity in child protection work is provided by families that are involved with family disputes and matters involving the Family Court. There is evidence that many child abuse and neglect cases involve families in which there has been marriage breakdown and involvement of new partners in the family dynamics. There are also examples of vexatious notifications to child protection services as part of ongoing disputes between parents.

There is reported confusion for some parents between legal intervention that is child protection focused and Family Court matters. This is exacerbated by a general lack of communication and working relationships between child protection services and those involved in Family Court matters.

This is added to by some inappropriate requests for child protection services to provide supervision for children involved in custody disputes, where there are no protection matters involved.

Children with disabilities are over-represented in the child protection system

Children with disabilities are also over-represented in Tasmanian child protection referrals, and pose particular issues for child protection services.

In some cases parents have formally indicated their unwillingness or inability to provide full time unsupported care for their child. In other cases, parents have simply failed to collect their children from a respite facility, but their intention for continued involvement with their child has not been clear.

Some children with disabilities are referred to child protection services and taken into care as a result of their parents simply being unable to access services and support. There was a strong suggestion that some of these parents would have been willing and able to maintain guardianship and custody of their children, had appropriate support and respite been available on an ongoing basis. However, it is apparent that some parents perceived that the only way to get help was to request the state to care for their child.

There was also evidence that collaboration and methods of interface between child protection services and disability services were often less than effective and inconsistent across the state. Success appears to lie with the attitudes and

expectations of particular staff and not the structure of the system to facilitate this cooperation.

A project on the interface between child protection services and disability services will be completed at the end of 2006. This project will provide more specific examples of issues and make recommendations for the future collaborative work of these services.

There is evidence of increased numbers of parents affected by alcohol and drug abuse and mental illness

There is anecdotal evidence of increased numbers of notifications involving parents suffering effects of drug and alcohol abuse and mental illness. This represents a significant challenge for child protection services in terms of the increased risk to children and the requirement for specialist interventions and services.

It also means that capacity for maintaining children's safety with their families, or successfully reuniting families, is significantly diminished.

Increased numbers of mothers affected by drugs and alcohol are being identified at antenatal clinics

This trend was supported by Family, Child Youth Health nurses and midwives and nurses associated with hospital services who suggested an increased number of mothers with needs relating to drug and alcohol abuse presenting at antenatal clinics.

Drug and alcohol abuse was reported as often being linked to poor parenting, lack of routine within the family, diversion of financial resources from basic needs and other factors which may place a child at risk.

In recognition of this increasing need, a specialist complex care midwife position and clinic has been created at the Royal Hobart Hospital. The aim of this position is to work within a broader multi-disciplinary team to provide management plans during the antenatal, intrapartum and post-natal period and commence discharge planning.

Behavioural issues exhibited by children and young people are also increasing in intensity

Evidence was also provided that the number of children and young people involved in the child protection service who exhibit extreme behavioural issues in response to environmental and personal stress and trauma is increasing. This includes a high number of children presenting with inappropriate sexualised behaviour. Children whose behaviour is extremely challenging are at high risk of harming themselves or others, making intervention and successful out of home care placements difficult to achieve.

Issues within the education system add to the stress on child protection services

There was also clear evidence that the school system is often unable to cope with many of these children exhibiting challenging behaviour and that this places additional pressure on the child protection system. Where these children are suspended or otherwise excluded from school, their risk within the family environment is increased. In addition, the breakdown of out of

home care placements is often threatened when school placement is compromised.

6. Capacity of family and child support services to support child protection work

Capacity of child protection services to make a difference depends on availability of other services

To a large extent the success of child protection services depends on the availability and quality of other support and intervention services that can be used to provide intervention and assist with monitoring children.

Evidence suggests that the capacity of both government and non-government services to support and assist in child protection is extremely limited.

Early intervention services are limited

As stressed earlier, there is increasing recognition that strategies for the prevention of child maltreatment need to be part of much broader strategies aimed at addressing social disadvantage and supporting parents in the broader social context.

Early intervention approaches linked with universal services are generally perceived to be one of the most effective ways to ameliorate the effects of abuse or neglect, with evidence based approaches showing good outcomes in other states and territories.

While this need has been recognised in the development of the whole of government *Early Years Strategic Framework*⁷ that has been endorsed by Cabinet, the plan to support the framework is still being developed. Although there is valuable early intervention work being undertaken within the Department of Health and Human Services and the Department of Education, with the full support of the Department of Police and Public Safety, there is no over-arching governance structure and impetus to ensure initiatives are fully exploited and coordinated.

While other states and territories are expending considerable effort and funding on early parenting programs, home visiting programs, and family support programs, these services exist in a more limited and uncoordinated way in Tasmania.

Services that would enable intervention to occur at an early stage before issues escalate to a point when involvement of child protection is required are as yet not provided on a sufficient scale to have sufficient impact on child protection.

⁷ Early Years Strategic Framework

<p>Family support programs are not operating to support children and families involved with the child protection system</p>	<p>As evidenced by the <i>Review of the Tasmanian Family Support System</i> detailed earlier there are serious limitations to the quantum and capacity of current family support systems to assist families in need of support. In addition to the overall inadequacy in the quantum and distribution of these services, weaknesses include:</p> <ul style="list-style-type: none"> ○ A lack of planning and ad hoc development of these service resulting in poor linkages and coordination; ○ Lack of accountability and data collection to assess effectiveness; ○ Reluctance of services to take child protection referrals; ○ Difficulties in accessing services; and ○ Time limited funding models.
<p>Interventions that are available are generally not sufficiently intensive to make a difference</p>	<p>Intervention required for families that may otherwise be headed for statutory child protection involvement are usually not simple or short term. Interventions that have demonstrated the greatest promise generally offer long term, intensive services.⁸ These interventions address multiple issues on several fronts and include numerous components that require constant review and adjustment and a long term commitment.</p> <p>Services available in Tasmania are usually time limited and funding arrangements are such that intervention is only provided for relatively short periods that may be insufficient to provide the change that is required. Money is spread too thinly across services and they, in turn, do not allocate sufficient resources to the more complex and difficult cases. This approach is wasting money and services.</p>
<p><i>Family Support Innovations Program</i> in Victoria appears very encouraging</p>	<p>There are models for how to provide support and intervention to children and families so that their circumstances do not escalate to the extent that statutory child protection services are required.</p> <p>For example, the <i>Family Support Innovations Project</i> has been gradually implemented with success in Victoria with 62% of the state now covered with enhanced family support services. The key features of this program are:</p> <ul style="list-style-type: none"> ○ Tight contractual arrangements with non-government providers with percentage targets for reductions in notifications and re-notifications and formal written commitments to meet the targets;

⁸ Allen Group, *Protecting Children - the Child Protection Outcomes project – final report for the Victorian Department of Human Services, 2002.*

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- Trialling of new ways of working with vulnerable families including community based child protection workers and a flexible range of options available for families;
 - A focus on assisting families to maintain basic needs at a practical level (housing, financial management, hygiene, school attendance) rather than secondary services such as counselling; and
 - Development of local support networks to engage the broader range of services and key notifier groups such as police and teachers.

Interim evaluation data shows a measurable 'significant diversion' of families and measurable reductions in notifications and re-notifications as well as improved service capacity for supporting families.

A pilot *Early Support Program (ESP)* in Tasmania is also producing encouraging results

A limited trial of an early support program based on the Victorian model is presently being undertaken in Tasmania. The pilot involves families notified to child protection services, being referred to a non-government agency that has been specifically funded to provide support and intervention. Five non-government agencies are involved in the pilot: Centrecare; Anglicare; Colony 47; Good Beginnings and the Salvation Army.

Although in its early stages, the response from both non-government agencies and child protection services suggest that there are encouraging results for many families.

A number of issues surrounding the model remain to be resolved. These include the legalities involved in sharing information between government and non-government services; processes for determining which referrals could be most appropriately handled; management and coordination of the service; the model for continued liaison and collaboration between the child protection service and the non-government agency; and issues concerning differences in practice models.

However, the indications are that the pilot provides the basis for a useful expanded support program.

Involvement of non-government organisations (NGOs) in child protection work is presently ad hoc

The involvement of non-government organisations in supporting child protection services is presently too ad hoc. Specific organisations are contracted to provide a range of services in particular regions - these range from training for foster carers to providing out of home care.

In most cases these contracts appeared to be the result of incapacity of the government system to provide the service or to fill a temporary gap rather than more strategic consideration of how non-government services could be most effectively utilised to work with the government system. There has been little cost benefit analysis or evaluation of this mix of services and there are unanswered questions about relative costs and benefits of non-government service provision.

There was strong support from larger NGOs to be further involved in supporting the child protection system

Several of the larger non-government organisations indicated their willingness to be further involved in some child protection functions provided that it was adequately resourced and there was effort spent in building their capacity to undertake these roles.

This would involve:

- Development of standards and evaluation approaches;
- Defining what is required and the standard that is expected for the available funding; and
- Consideration of the economies of scale required for an NGO to develop the infrastructure and staffing models that would be required.

Interest was expressed by non-government organisations in providing a range of services including family support, reunification and permanency planning and early intervention.

7. Legislative framework

The capacity of the legislative framework is not being exploited

There is general consensus that the *Children, Young Persons and Their Families* Act provides a sound philosophical and practice foundation for implementation of child protection services in this state and contains clear objectives and guiding principles.

The aim of the Act was to reduce child abuse and neglect through:

- Raising community awareness;
- Supporting and strengthening families;
- Working in partnership with relevant stakeholders; and
- Using formal legal intervention with extreme discretion.

The Act emphasises that the primary responsibility for the care and protection of children rests with the immediate and extended family network. The Act gives a high priority to supporting and assisting families to carry out this primary responsibility in preference to commencing legal proceedings. The Act also introduced more flexibility and a greater range of voluntary and legal interventions for families and recommended that legal action be used only as a last resort.

It is evident that the spirit of this legislation and the scope that it provides for child protection services is very much in keeping with current 'best practice' for child protection systems. It is also evident that, while the Act could be improved by some minor amendments, the overall legislation remains a sound basis for the child protection service in this state.

The Act has not been adequately implemented or incorporated into current practice and culture

The Act was proclaimed in 2000 but it appears that there was an insufficient implementation strategy, especially professional learning, to ensure that the intent of the legislation was fully realised. There is an absence of materials, including regulations and guidelines, to support staff to work within the intent of the Act.

In addition, there has been a considerable turnover of staff since that time and many new employees have not had the opportunity to become fully familiar with the Act or understand its implications for their work.

Aspects of the Act could be more fully developed to improve practice

There are several aspects of the current legislation that could form the basis for driving practice reforms if there were more strongly emphasised and enacted.

These include:

o **Partnerships approach**

The Act emphasises the importance of all government agencies, local government and the community sharing responsibility for child safety. However, there is no evidence that this has changed practice - children who are involved in child protection not only do not receive priority for other government services, but are often refused access. There is also evidence of 'cost shifting' to child protection services from other parts of the agency (such as Disability Services) when a child becomes involved with the service.

o **Coordinated strategies and preventative and early intervention**

The Act emphasises the need for collaboration and early intervention utilising a range of services. There is evidence that greater collaboration and coordination across services is regarded as a high priority for improving child protection service delivery. However, the need for additional early intervention and preventative services has also been emphasised throughout this Review.

o **Assist recognised Aboriginal organisations to establish and provide services**

The Act recognises principles for dealing with Aboriginal children including the need to consult with a recognised Aboriginal organisation in making decisions about Aboriginal children.

Since the Act was proclaimed, there has been ongoing discussion between the Department and the Tasmanian Aboriginal Centre (TAC) on the best ways for recognised Aboriginal organisations to work for the care and protection of Aboriginal children. The TAC has worked towards a position that would allow responsibility for Aboriginal children to be assumed by the Aboriginal community.

The TAC is presently completing a project to examine ways in which Aboriginal people might exercise formal responsibility for the protection, placement and care of Aboriginal children, taking account of Aboriginal values and aspirations.

At the same time a draft protocol has been developed, outlining the agreed roles and responsibilities of the Tasmanian Aboriginal Centre and Children and Families Services in relation to Aboriginal children, but this has yet to be finalised.

○ **Advisory Panels**

The Act mandates the establishment of advisory panels to be a source of independent advice to the Secretary on cases of abuse or neglect. The potential use of Advisory Panels has not been realised and panels have not been substantively created despite this being a requirement (under Section 84). Many people consulted during the Review believed that Advisory Panels had the potential to involve a greater range of disciplines and agencies in child protection matters. This was regarded as potentially helpful in improving accountability for decisions by child protection staff and strengthening quality assurance processes. It was also believed to be a useful way to involve other agencies and share responsibility for child safety.

○ **Family group conferences**

The Act provides for family group conferences to be held as a way of resolving issues and planning a way forward when neglect or abuse has been substantiated. Research evidence suggests that family group conferences can have a very positive effect in not only reducing the power differences between professionals and families but helping to ‘democratise’ decision making⁹

While capacity for family group conferences is universally applauded as a positive characteristic of the Act, there is evidence that it is being under utilised. Only 367 family group conferences have been conducted since the proclamation of the Act and only 2% of these have been conducted on a voluntary basis with most being undertaken at the direction of Magistrates.

There are some aspects of the Act where amendments would be useful

Evidence was presented that there are some aspects of the legislation that would benefit from amendment:

○ **Lack of capacity for involvement of child protection services before a child is born**

The Act does not allow for child protection services to be involved with a family before a child is born, even if prior family history or presenting characteristics of the parents during the antenatal period suggest the new born child will be at risk.

In these circumstances where the family is known to child protection services, an unofficial ‘alert’ is sent to the hospital where the mother is likely to present and staff are requested not to discuss this alert with the family. This places staff involved in antenatal care in a compromised position in working with the

⁹ Institute of Child Protection Studies, Principles for Child Centred Practice

mother and building a trusting relationship.

It also means that assessment of the child's risk cannot be initiated until the child is born, often resulting in hurried assessment processes conducted before the child and mother leave the hospital. In the worst case scenario, a new born child can be removed from the family soon after birth without direct interaction and discussion with the parents. This is traumatic for the child, the family and staff involved.

- **Capacity for the Secretary to retain custody of a child for a period of up to 120 hours without a court order**

The Tasmanian Act is the only Australian child protection legislation that allows children to be taken into the custody of the Secretary for up to 120 hours (five days) without applying to the Courts for an order. There was evidence that this practice may have increased the number of children being removed from their home circumstances on a temporary basis.

While allowing for a child to be removed without a warrant and placed on a temporary order, where an authorised person believes that there is an unacceptable risk in allowing the child to remain with the person with whom the child is residing, a reasonable requirement would be to immediately apply to the Children's Court for the child to remain on the temporary order. There was a strong belief that this formality would ensure that children are not removed, even on a temporary basis, unless the circumstances are likely to be substantiated before the court, while still allowing for emergency action to be taken when a child is at immediate risk.

- **Length for assessment orders**

There was evidence that the current eight week period for an assessment order did not always allow for the processes of assessment to be undertaken to an acceptable level with an extension to this time being supported.

- **Limit to adjournments in the hearing of an application**

The Act precludes more than one adjournment in hearings of assessment orders. This may be impractical when cases are heard in circumstances necessitating meal breaks or hearings over more than one day. There was strong support for amending this unintended anomaly as well as allowing extensions to adjournment periods where this was in the best interests of the child or there were other compelling reasons.

- **Family group conferences**

There was evidence that any restrictions concerning the convening of family group conferences should be removed so that this forum is able to be used as widely as possible. There was also evidence that the information shared in family group conferences should be regarded as confidential and not used for other purposes.

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- **Responsibility of the Secretary for guardianship**

There was evidence that the Act needed to more clearly define the roles and responsibilities of the Secretary acting as guardian in order to ensure that children in care received services expected of an exemplary ‘parent’. There was also strong support for the Secretary to continue to have some capacity to support young adults who have been on an order for an extended period of time, in line with the support that parents normally provide to their adult children.

 - **Permanent care options**

Some concern was expressed that while the Act did not preclude considerations of permanent placement for children for whom reunification with their families was not a possible future consideration, there was room for this option to be strengthened and clarified in the legislation.

 - **Role of the Commissioner for Children in relation to complaints**

Strong support was provided for strengthening and clarifying the role of the Commissioner for Children in relation to a complaints process relating to children. While the Ombudsman was still considered the suitable authority for investigation of individual complaints if a person was dissatisfied with any internal process, it was believed to be appropriate for the Commissioner for Children to have the authority to request information and review internal departmental processes pertaining to children.

8. Policies and guidelines

Policy and guideline development has not kept pace with needs

Despite an acceptance that it is difficult to have good practice without good policy and program frameworks, the present child protection system is not well supported with policy and guideline documents. This causes frustration and concern amongst staff and has resulted in inefficiencies.

This situation exists despite the concentrated efforts of dedicated child protection policy writers in the past few years to provide policies and guidelines that cover some critical areas of practice and the production of several insightful policies and guidelines on important issues. The sheer volume of work to be undertaken and frequent changes to priorities has led to unsystematic and ad hoc policy and guideline production.

This has resulted in unnecessary duplication of effort at regional level to develop guidelines needed to govern practice and inconsistency of practice across the state. Some regional services have chosen to write their own documents or actively adopt draft guidelines and manuals, rather than wait for lengthy delays in approval processes.

There is lack of clarity on policy positions

There is also a lack of clarity on the policy position relating to key areas of practice. This situation is exacerbated by:

- Documents staying in draft form for extended periods and issues about version control;
- Documents being partly developed and then abandoned;
- Lack of clarity about the status of documents;
- The process for policies being approved by senior management group appeared laborious and the role of senior managers lacked clarity in relation to approving policy positions;
- The language, format and length of policies making them difficult to access and apply in practice;
- Lack of contact and interaction between those developing policy and those working in the field, resulting in policies lacking credibility; and
- Policy and guidelines documents being difficult to locate on electronic sites adding to the level of uncertainty.

Consistent practice manuals are not available

A major gap in current documentation is the lack of practice manuals that can be used as a point of reference for decisions and to guide consistency in processes. Practice manuals are also integral to staff training and induction. The lack of practice manuals adds to the lack of consistent practice between regions and even within service centres.

There is limited expectation of compliance with policy and guideline documents

A laissez-faire attitude appeared to prevail towards compliance with policy and administrative guidelines: "If you don't want to do it you don't have to". Work pressure and lack of clarity about policy positions have provided convenient reasons for not being expected to comply with policy or best practice guidelines.

There is little accountability or consequence for not working according to policy or guideline positions.

9. Intake, Advice and Referral Processes

Intake services are critical to the effective functioning of child protection services

'Intake' is possibly the most technical aspect of statutory child protection services and the subject of the greatest variability between states and territories. The main focus of intake services is the screening and initial assessment of notifications.

The main determination at the point of intake is whether or not a case reaches the threshold for statutory intervention.

Intake workers have arguably the most important role in the child protection service as they provide a 'gatekeeper' service as well as determining which notifications should be further investigated.

In Tasmania this function has been undertaken by a central Child Protection Advice and Referral Service (CPAARS) since July 2003. Prior to this time the service was undertaken at the regional service centre.

Child Protection Advice and Referral Services (CPAARS) was designed to overcome disadvantages of a regional service

The new Child Protection Advice and Referral System¹⁰ was established as part of a previous refocus of Children and Families Services.

The service was designed to provide a single point of entry (with one state-wide phone number) to the child protection system and strengthen service delivery through the provision of a consistent state-wide response to child protection notifications.

It was intended that the new model would also improve the advice and community education function of child protection.

It was also intended that the service would provide better coordination with other services that support children and vulnerable families with an emphasis on early intervention and a decrease in the number of families for whom legal intervention was necessary.

Arguments in favour of the new centralised intake services were:

- Consistency in decision making and levels of risk thresholds for investigation;
- Easier staff recruitment and retention;
- Greater staff collegial support; and
- Economies of scale in staffing model and supervision.

There was also strong support during the Review for a return to a regional intake service

While the stated intentions of the central CPAARS service are laudable, strong support was evident during the Review for a return to a regional model of intake services. This support came particularly from staff at regional level who felt that their capacity to respond to a notification had been diminished by the centralised model.

Arguments in favour of regional intake services were:

- Easier communication between intake and service centre teams including capacity for interaction and discussion;
- Local knowledge of support services;
- Better networking and connection with local services such as schools, general practitioners and non-government agencies; and

¹⁰ Child and Family Services refocus 2001-04 Discussion paper July 2001.

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- Better capacity to build a relationship with local professional people and develop trust and rapport that would facilitate notification processes.
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Expert advice suggested caution in making changes to the regional model

Advice from expert practitioners suggested that regionalised intake models have definite advantages to child protection systems, provided that the intake system is sufficiently well established, robust and well functioning to survive being devolved.

Evidence suggests that the present CPAARS system does not meet these criteria and that regionalisation may further diminish its effectiveness and efficiency.

There are several significant issues and deficits inherent in the present intake service

There are several significant issues inherent in the present intake service:

- Time taken to complete notifications due to the workload;
 - Inadequate data management systems;
 - Lack of capacity of some staff and staffing models;
 - Communication with notifiers and other professionals; and
 - Communication with other parts of the service.
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- **Time taken to complete notifications often exceeds acceptable benchmarks**

The time taken to process a notification through CPAARS and complete the case is dependent upon a number of factors including the quality of information received, the capacity to contact the notifier and other people who may be involved with the child and family, as well as the work load of child protection workers and senior staff. There is a three day benchmark for notifications to be processed, but this is often exceeded.

- **Practice of accepting emailed and faxed notifications delays completions**

A high proportion of notifications, especially from Tasmanian Police, are made by email. This is seen as a useful practice as it provides a 'paper trail' for verifying when and if the notification was received.

However, when the notification is by email or fax, there is less opportunity for interaction with the notifier to fill any gaps in the information required. As there are no mandatory fields of information on the notification form there are frequently information 'gaps' that are required before an initial assessment can be made. In addition, there is often a further time delay in locating the notifier (especially police officers on different shifts) to obtain further information. In reality, emailed and faxed notifications are treated as a 'secondary priority' of work usually processed by senior staff when there is any spare time from their role in monitoring telephoned notifications. As a result there are likely to be considerable delays in processing these notifications.

○ **The data management systems are totally inadequate**

Reliance on out-moded electronic data management systems and paper files considerably adds to the workload of intake staff in establishing if the child or family being notified is already known to the service and in accessing previous history. In addition, the process of cross referencing with the Family Violence Service data base is presently laborious and time consuming.

As well as being time consuming, the lack of capacity to refer to previous history of the child and siblings and track the case through assessment and case management processes is a very high risk to the service. The lack of electronic files and the laborious processes for inputting data and completing paper work associated with the case being either closed or referred for further investigation, adds to delays and inefficiencies.

According to any acceptable standards of data management, the current intake system is totally inadequate and is potentially dangerous to a child protection service.

○ **Experience and training of intake staff is often inadequate for the job they are required to do**

The intake role requires a high level of professional judgement that is most likely to develop from extensive experience in the field as well as specific training.

At present staff can be directly recruited into CPAARS from a variety of backgrounds and with a variety of experiences and this can mean they are not all adequately prepared for the position:

- There is no requirement for staff to have prior experience of child protection which may mean that they lack 'on the ground' knowledge of how the protection system operates;
 - There is minimal induction and supervision of new recruits which could mean that staff lack sufficient experience and expertise to make complex assessments requiring a high level of professional judgement; and
 - Staff are trained 'on the job' and current phone technology does not allow for calls to be easily monitored and supervised by senior staff.
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○ **Model of operation is not suited to all staff**

The present model of operation, which largely involves taking calls and making initial enquiries concerning the circumstances of cases, is not an attractive mode of work to all child protection workers. Many find the work repetitive and lacking in job satisfaction and miss the opportunity to be involved with clients on a more on-going basis. This leads to high staff turnover and the tendency for the job to attract new recruits rather than experienced staff.

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- **Staffing model is hampered by staff leave and numbers**

The roster model used in CPAARS is based on the principle of staff working one day on receiving calls and alternative days writing up information, making enquiries and completing cases.

However, if there are staffing gaps due to sick leave or other absences, staff can be required to take calls on consecutive days which leads to delays in completing cases as well as fatigue and burnout.

 - **Senior staff are involved in cases only after they have been processed by child protection workers**

Senior staff are consulted after the child protection worker has collected initial information and made an assessment decision. Senior staff are required to sign off the assessment decision and any priority rating assigned by the child protection worker. This ensures quality assurance for cases through the supervision and final endorsement of assessment decisions by the more experienced (senior) child protection workers. Senior staff are also available for child protection workers to consult with during the assessment process.

However, it is possible that the use of senior staff to 'triage' notifications at the point of referral (before the case is assigned to a child protection worker for further information gathering) would ensure that the most experienced and highly trained staff acted as 'gatekeepers' to effectively screen notifications before they were assigned for further investigation.

This process, used in some Victorian regions for example, has the potential to improve the consistency and quality of intake decisions.

 - **Opportunities for provision of advice and public education are limited**

While one of the stated objectives of CPAARS is to promote opportunities for community education about child protection services, it is obvious that, despite best intentions, the capacity of the service to undertake this role is very limited.

There was also evidence that undertaking this role from a state-wide perspective without local knowledge of services and networks is a significant barrier to effectiveness.

 - **Opportunities to provide feedback on notifications is limited**

The lack of feedback to notifiers on the outcome of their notification was often raised in consultation with professional groups and both government and non-government organisations. At present CPAARS staff have little capacity to provide this feedback and there are also issues related to privacy and the need to keep some information confidential.

However, there is no doubt that the lack of feedback is a disincentive to notifiers to continue to make referrals.
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- **There are communication and interaction issues between CPAARS and service centres**

Evidence was presented during the Review that communication and interaction between CPAARS and service centres depended on the staff involved and whether they had established a good working relationship.

At best, the relationship is cooperative and professional with occasional robust debate on the risk assessment being undertaken. At worst, the relationship is characterised by disputes over priority rating, demarcation debates about roles and responsibilities and personal antagonism.

The lack of regular interaction and networking between CPAARS and service centre staff, that is partly the result of the different physical location of the teams, adds to communication difficulties.

The lack of effective communication was evidenced by:

- Disagreements about classifications not being adequately resolved through professional means;
- Examples of notifications being accepted at the service centre rather than being directed to CPAARS; and
- The priority rating allocated by CPAARS being changed by assessment team staff on the basis of their knowledge of the case and ‘practice wisdom’ of the child protection worker.

10. Allocation, assessment and investigation processes

Current processes and concerns

When cases have been initially assessed at CPAARS as requiring further investigation, they are referred to assessment teams in the relevant service centre.

Assessment teams are responsible for obtaining more information from the child, the family and professional people who have contact with the family in order to inform their more detailed assessment of the child’s level of risk and decide the most appropriate way to proceed.

Several concerns and issues were identified during the Review concerning case allocation, investigation processes and assessment decisions.

However, it is significant that there are apparent differences in practice between regions. While issues were raised about assessment practices in all service centres, many of the concerns were more evident in the Southern Service Centre than in the north or north-west.

Concerns and issues included:

- Inconsistent allocation processes;
 - Risk and safety assessments that lacked elements of best practice;
 - Ambiguity about risk thresholds and risk management;
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- Decision making processes that lacked elements of best practice; and
 - Prolonged time taken to complete assessment processes and move cases to case management.
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Allocation processes at service centre level are often unclear

Although all cases are read by team coordinators who decide whether there is capacity for the case to be allocated within the assessment team and which cases should be dealt with, the process and rationale for determining which cases are allocated upon transfer from CPAARS, and which are placed on the unallocated list, is not always clear.

Similarly, the process for updating risk assessments and maintaining an overview of the unallocated cases are inconsistent across the state.

Risk and safety assessments sometimes lack completeness and elements of best practice

A routine part of the work of all child protection workers is to conduct risk and safety assessments to determine the level of risk for a child who has been notified. This involves gathering information about the case from the child, the child's parents, extended family and professional people involved with the case. This information is then analysed to ascertain the harm consequences and harm probability for the child.

Issues identified included:

- There is evidence that some assessments have been conducted and concluded without the child protection worker being actively involved in normal assessment processes such as interviews with the child and parents, observations of child-family interaction and advice from other professionals involved with the child and family;
 - In the Southern Service Centre it appears that child protection workers are not conducting their own risk and safety assessments and that referrals are routinely made to external psychologists to provide this service;
 - Some child protection workers are reluctant to engage with potentially volatile and hostile families for the time required to build a relationship and make a more comprehensive assessment of the case, prior to reaching an assessment decision;
 - The process leading to assessment decisions is inconsistent with the roles of child protection workers, senior staff, senior practice consultants and coordinators lacking in clarity and varying between teams;
 - Unlike most other jurisdictions there are no additional safeguards in place for assessments of infants (0-3 years) who are acknowledged to be at the highest level of risk; and
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- In the Southern Service Centre it appears that police routinely accompany child protection workers on their first visit as common practice rather than on an 'as needs' basis, which is likely to depict the service as overly authoritative and interventionist, rather than supportive and attempting to engage the family.

The Tasmanian Risk Framework (TRF) is inconsistently used to guide assessment decisions

When conducting risk and safety assessments, child protection workers are required to use an assessment tool called the *Tasmanian Risk Framework (TRF)* to determine a child's level of risk. The TRF is intended to provide support for the professional judgement of the user but cannot in any way be regarded as a substitute for their judgement and experience.

There are several issues that were identified in relation to the use of the TRF:

- The use of the framework is inconsistent – for example, in the Southern Service Centre, use of the TRF appears to be restricted to those cases that are more complex or going to court;
- The format and paperwork involved with completing the TRF is regarded as repetitive with an over-reliance on 'tick a box' approach; and
- The appropriate use of the framework requires training and supervision that is not always provided.

This means that the potential benefits of the tool are under-utilised and, at worst, the tool may actually discourage child protection workers from developing their own professional judgement.

Assessment processes are dominated by deciding whether to proceed to court

There was strong evidence that assessment processes have become driven not by the question of 'What are the risks to the child? (What would alleviate the risks; what safety planning could be implemented; what are the supports and strengths that could be utilised?)' but, 'Do we have enough evidence to remove the child?' These are very different questions and lead to very different responses.

Where legal processes are a dominant process for child protection workers to manage, the use of tools to gather evidence in a manner acceptable to the courts becomes the accepted style of practice. Much time is therefore spent by child protection workers in gathering and preparing evidence suitable for use in formal legal proceedings.

For example, child protection workers complete affidavits for court rather than an assessment based court report. These affidavits report on processes undertaken within the child protection system rather than clearly presenting the protective concerns, the outcomes of the risk assessment, the ability of parents to address the concerns, and a case plan.

This means that documentation concerning these other elements is often lacking. Where time is limited (for example when preparing a court application for an assessment order) an affidavit may be completed without a risk assessment having been undertaken.

Where legal processes are initiated the relationship with the child's parents inevitably changes

In addition, legal intervention in child protection matters almost inevitably involves an adversarial relationship with the child's parents as the courts decide whether there is sufficient evidence of child maltreatment to justify statutory involvement in family life.

This means that the opportunity for less adversarial work such as family group conferencing and building a trusting and mutually respectful relationship is more difficult.

Family group conferences are rarely used as a problem solving process prior to court intervention

It appears that child protection workers are not routinely using family group conferencing as a problem solving activity prior to deciding to follow a direction towards court intervention. Yet, their use at this stage is very likely to decrease the need for court intervention.¹¹

Family group conferences have well documented potential to engage families and children in a positive way in seeking assessment and solutions to problems and risk issues that have been raised. There is evaluative evidence¹² that suggests the use of family group conferences contributes to:

- A higher percentage of children remaining with their extended family;
- Increased stability for the children;
- High family support and family functioning; and
- Better sharing of information about family circumstances.

There are a number of reasons for the relative lack of family group conferences, especially in the initial stages of engagement with families.

These include

- The process is seen as outside the control of the child protection worker as it is facilitated externally;
 - Family group conferences take time to arrange and plan and this time is not available in the busy work schedule;
 - There is a preference for 'family conferencing' that is managed and controlled internally by the child protection workers; and
 - Family violence issues impede the capacity of family members to engage as they fear repercussions.
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¹¹ Marie Connerley.

¹² Martin, D. (2005) A look at family care meetings in South Australia in 2005.

The risk threshold level for substantiation is ambiguous

While the use of the TRF provides a framework for assessing risk, there are always likely to be differences in professional opinion with regard to the threshold of risk required for substantiation. Guidelines for guiding risk assessment are presently being developed but remain in 'draft' adding to the lack of guidance in this area and contributing to inconsistent practice:

- On the one hand, there are cases in which elements that appear to place a child at high risk do not lead to substantiation; and
- On the other hand there are cases where substantiation has been determined despite the absence of elements of high risk.

Evidence suggested that assessment decisions lacked grounding in consistent practice logic that enabled reasons for the decision to be clearly identified and articulated. As the rationale for decision making and the decision to substantiate are often not well documented on files, this added to the lack of clarity. Some staff lamented that assessment decisions were made in 'corridor meetings' rather than according to formal processes.

Staff are probably working in a risk averse culture

Experience in other child protection services suggests that risk thresholds tend to move up and down according to the culture at a particular point in time. Where staff are under pressure or do not feel that their decision making will be supported they are likely to make more conservative and risk averse assessments. This is likely to follow a child death enquiry for example.

There was evidence that some child protection workers are fearful of what might happen if they make a wrong risk assessment. They are not confident of the systems support for their decision making and feel a need to manage their own risk. Child protection workers also do not have the time to devote to this type of case work activity and are forced into a circumstance where removing the child is the least risky (to the child and the child protection worker) and most expedient option.

Court Advisory Groups (CAGs) do not operate with maximum effectiveness and encourage robust debate

Court Advisory Groups (CAGs) provide a forum for in-house colleagues to discuss cases and provide collective advice prior to a decision being made by the coordinator on whether to proceed to court action.

Evidence suggested that the efficiency of CAG processes is sometimes threatened by inadequate documentation and/or inadequate time to consider documentation prior to the meeting so that cases could be given full consideration.

Several staff also believed that CAGs did not provide sufficient opportunity for robust debate that was more likely when there was input from other professionals who may have provided a perspective from medical, educational or other backgrounds. There was a belief that the CAG process was too insular and lacked the rigor that a more multi-disciplinary interagency group would provide. Instead, CAGs appear to routinely endorse the recommendations

made by the presenting child protection worker. Diversity of opinion is often not encouraged or welcomed.

Decisions about whether on not to substantiate a notification often exceed the benchmark time

While there is an administrative instruction stating that all decisions to substantiate (or not substantiate) notifications must be made within 6 weeks of the notification being received, this instruction is not being adhered to. With many cases not being allocated, presently the time for this decision often exceeds 12 months.

This is clearly a significant lapse from acceptable practice.

11. Case management and case planning practices

Case management services

Case management services coordinate services for children on care and protection orders. This includes support of the child in their placement, maintenance of family contact and ensuring provision of services such as education and counselling and applications for further court orders where required.

Children in out of home care are a potentially disadvantaged group that require ongoing support

Children and young people in out of home care have been recognised globally as a highly vulnerable group of children with increased physical, mental and social health and education issues and with associated limited access to resources. For example, there is clear evidence that children entering foster care have a higher prevalence of acute and chronic health problems and developmental disabilities¹³.

This means that ongoing intensive planning for the needs of this group of children is necessary to ensure they are not further disadvantaged.

While there is evidence of case management there is less evidence of high quality case planning

While it is evident that cases involved with child protection are actively 'managed' (in the sense that arrangements are made for things such as educational and medical services, access to basic requirements and funding) the case 'planning' processes (involving more considered and comprehensive preparation for, and thinking about, a child's short and longer term needs) are not well documented in files – some staff estimate that only about 50% of children in care have documented care plans in place.

While case planning may be occurring, the lack of documented processes and timelines for achieving aspects of planning may contribute to lack of timely review and decision making and retard throughput of cases.

¹³ Health of children in Out of home Care, Paediatric policy statement from the Royal Australasian College of Physicians (2006)

The *Looking After Children* (LAC) planning tool is not being consistently used

The *Looking After Children* (LAC) tool is intended to be used to assist case management and planning. The use of *Looking After Children* is a mandatory practice for all children in care.

However, there is evidence that LAC is being inconsistently used at the practice level, depending upon: staff workloads; training programs; access to the electronic form of the tool (LACES); familiarity with the tool; and staff endorsement of the model.

This is a major concern to staff and carers alike.

Case management processes are limited

Case management work appears to be limited by work pressures and lack of capacity for long term intervention with families.

The following issues were identified:

○ **Case conferences are rarely used to inform decision making or review cases**

Case conferences are a routine part of case management, to facilitate effective communication and achieve better coordination of services and contact with families.

However, there is very little evidence of case conferences or case planning meetings (with or without families being present) being routinely used. Where this process is used, it is usually initiated by professionals from other services and agencies.

○ **Face to face meetings with families do not occur frequently**

At all stages of the assessment and case management process there appears to be limited direct contact with families, especially in the home setting. Where contact with families is arranged these meetings often take place in centre offices or contact is made by telephone.

The lack of home visits and face to face case work appears to be the result of:

- Perceived concerns about the safety of child protection workers;
- Lack of time to visit families at home; and
- Lack of access to cars to use in visiting families at home.

This represents a significant gap in good practice.

○ **Some staff do not have sufficient skills or time to engage in case work with 'hard to reach' families**

There is also evidence that the success or otherwise of case work intervention is highly dependent upon the relationship that is established between the family and the child protection worker. There is evidence that some staff simply do not have the capacity to form a productive relationship with families that are 'hard to engage' and work with them over an extended period.

○ **Case work is increasingly delegated to paraprofessional support staff**

Case work in child protection cases is increasingly being undertaken by non professional 'support workers' or 'case workers' under the supervision of professional case management staff.

Evidence was provided that case workers provided a very valuable role in working directly with families and undertaking functions such as supervised access visits and accompanying children and families to professional appointments. The opportunity to appoint staff that had significant life experience and personal characteristics that enabled them to work successfully with a range of families, but no mandated formal qualifications, was highly regarded. The separation of this role from the role of the case manager, who had more formal statutory responsibilities in relation to a family, was also seen as positive by some child protection workers.

Some concern was expressed that using case workers rather than professional staff in casework might further distance professional staff from their core business of working with families through a professional and respectful relationship. There was also concern that there are substantial risks in allowing case workers to undertake case work with families unless there is close professional supervision and understanding of the limitations of their role.

The poor level of file documentation represents a substantial risk

It is apparent that, while files were being administratively managed in very difficult circumstances with space restrictions and lack of electronic tools, the general level of file management and security was good. However, there was evidence of duplicate files for the same child; files being lost or mislaid and files not being stored securely by all child protection workers.

It is also apparent from case audits and reviews of cases (including child death review cases) that the level of documentation in files is generally poor:

- Chronology is not clear and dates on notes are often lacking;
- First names are used in case notes without explanation of who the person is;
- Background information on the case is often assumed;
- There are inaccuracies of detail relating to information such as dates of birth;
- Copies of emails that are casual in tone and contain personal comments are used to document decisions as a substitute for case notes; and
- Decisions are often not signed and signatures are unclear.

Although poor file documentation is undoubtedly one of the casualties of staff feeling over-worked and under pressure it is not only time wasting and inefficient but potentially dangerous in reducing communication and child protection workers' awareness of risk factors involving a child's case. It also

represents a deficiency when cases are required as evidence or are subject to quality assurance processes. Poor documentation is also indicative of a low level of personal accountability for decisions and professionalism.

Permanency planning is not receiving sufficient time and attention

Permanency planning is the process of securing the long term safety and care of children who are deemed to be at risk of abuse or neglect, either by reunification with their family once issues have been addressed, or permanent placement in an alternative situation. Permanency planning is intended to minimise the feelings of uncertainty and unconnectedness that can burden or harm a child for whom statutory care and protection is required.

The primary aim of permanency planning is to achieve stability in the life of the child. Where there are children who cannot return to their families, the aim of permanency planning is to secure an alternative permanent, stable care placement including adoption.

Staff report that they are unsure about when the process of permanency planning should begin and believe there is a lack of clarity about the policy position.

It was also reported that case management staff do not have sufficient time and resources to devote to the process.

Non-government agencies indicated that this was an area that could be successfully outsourced and provided examples of permanency planning that had resulted in successful reunification.

Adoption services have expertise and capacity to assist in permanency planning

There is some overlap in the type of work undertaken by Adoption Services that may allow this service to assist with placing children in more permanent care arrangements.

12. Out of home care services

Out of home care

Out of home care is provided for children who have been removed from the care and responsibility of their parents on a short or long term basis.

Out of home care services recruit, train, supervise and support carers in a range of care models. Arrangements include foster care, kinship placements and residential options. These arrangements can be instigated either by voluntary arrangements or via a court order.

Out of home care services were extensively reviewed in 2000 - 2001

The out of home care system in Tasmania was extensively reviewed in 2000- 01 with a 2002-04 plan¹⁴ developed for implementation of the recommended model. A continuum of care model detailed in this plan is both evidence based and clearly presented. However, while some of the plan has been implemented, the current status of recommendations and work towards implementation is not clear.

It is evident that there remain a number of issues associated with out of home care:

○ **Young people in care have preference for certain models**

Consultation with young people in care (through the CREATE Foundation that supports children in care) found that consistency of care and accommodation options were important to these young people with frequent moves and changes being unsettling. Several young people indicated a preference for clustered family group home accommodation that allowed young people contact with each other and opportunities for playing together.

○ **There is a separation of the role of supporting children in care and supporting their carers**

Children in out of home care are supported by an assigned case manager while management of care placements and support to carers is provided by a separate out of home care team in each region.

While the separation of these roles ensures that the interests of the child and the interests of the carers are provided in ways that do not compromise either, the model depends on excellent cooperation and collaboration between the teams. There were examples of confusion for carers when the roles of different child protection workers were not made clear.

While communication between teams varied across the state, and was largely dependent on the individuals concerned, there was evidence that collaboration and liaison between support workers and out of home care teams was sometimes not productive as a result of a 'siloed' approach to their roles.

Some out of home support workers felt that they had a lower status than other teams within the overall child protection system and this added to friction.

¹⁴ Department of Health and Human Services, Out of home Care Services in Tasmania – Strategic Framework 2002-2004.

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- **There are some regional inconsistencies in types of care models and roles and responsibilities**

Out of home care is provided through regional teams responsible to regional service managers.

There are policy positions and procedures for many issues such as training and recruitment of carers and processes for dealing with complaints in care. However, there is a perceived disconnection between regional service delivery and some policy positions.

There was some confusion evident between the roles and responsibilities that were best provided at central and regional level. For example, the out of home care team in one region had worked hard to develop promotional and marketing materials about foster care for use at local shows and events, without realising that there were central officers available to undertake this type of role.

 - **Models for children who have complex and intensive needs have not been systemically developed**

Out of home care services also include services to children with more complex and intensive support needs.

Besides the very high cost of providing care arrangements for these children and young people, present models have been developed on an ad hoc basis and there is no systemic position on how to best provide for this group or a funding model that is effective and efficient.

 - **There is a shortage of suitable care options**

Evidence was provided that there is a chronic shortage of suitable care options with responses to out of home care needs often being made as emergency placements rather than as the result of careful planning and matching of children with suitable care models.

Placement options are frequently made on the basis of providing 'a bed' for a child requiring immediate removal from his/her family home rather than a judgement on what would meet the child's needs.

For example, although intended as a short term care option, family group homes have increasingly been used for more permanent out of home care for children due to the lack of other options.

 - **Inequities between voluntary and paid staff models**

While much out of home care has traditionally been provided by kinship carers, foster carers and in family group homes who receive minimal financial remuneration and allowances, more recent out of home care models utilise paid departmental employees or contracted carers. The inequities between these two groups caused considerable comment during the Review with a view expressed that voluntary models were unsustainable in the long term, especially for children and young people with more complex care needs.
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<ul style="list-style-type: none"> ○ Confusion between government and non-government provided services 	<p>The current model provides a confusing amalgam of government and non-government services that vary from region to region. Often these services work well together and may share staff training and in-service opportunities.</p> <p>However, there was also evidence that some contracted services represented an expensive option and were only used as a last resort.</p> <p>There was also reported confusion about accountability for children when children were cared for by a community organisation.</p>
<ul style="list-style-type: none"> ○ Cessation of support at age of eighteen 	<p>Young people and their carers believed that the sudden cessation of financial and other support at the age of eighteen also posed an unrealistic expectation on these young people to cope on their own as soon as they were officially an 'adult'.</p>
<p>Foster carers raised a number of issues</p>	<p>Given the high proportion of children being cared for in foster care situations, it is not surprising that concerns from foster carers were stressed during the Review.</p> <p>These concerns included:</p>
<ul style="list-style-type: none"> ○ The pool of potential foster carers is not sufficient for the number of children requiring care 	<p>While the number of carers has marginally increased there is evidence that there are not sufficient carers for the number of children requiring this type of care. Difficulties in recruiting and maintaining foster carers include:</p> <ul style="list-style-type: none"> ○ Lack of effective recruitment practices; ○ Lack of financial and personal support to foster carers; ○ Perceived increase in legal liability and vulnerability of carers because of 'complaints in care' processes; and ○ Lack of public recognition and endorsement of the foster care role. <p>There is also evidence that current foster carers are being over-extended by the number of children being placed with them, putting the placements at risk.</p>
<ul style="list-style-type: none"> ○ Financial support to carers is often perceived as inadequate and difficult to obtain 	<p>Financial support for children in foster care is an ongoing issue.</p> <p>A new policy and guidelines <i>Expenditure on Children and Young People in Out of Home Care</i>¹⁵ has been developed. This policy resulted from a detailed analysis of the cost of caring for children in Tasmania conducted by the Social Policy Research Centre at the University of NSW. This involved analysis of goods and</p>

¹⁵ Policy and guidelines – Expenditure on Children and Young People in Out of Home Care, Department of Health and Human Services, September 2005.

services needed to provide a specific standard of living that provides the opportunity for children and young people to participate fully in society.

The expenditure on children and young people in foster care varies according to their needs. Basic costs involved in caring for a child are met through standard reimbursement, establishment costs and short term care allowance. Additional needs are met through sanctioned case management services or an ongoing reimbursement to carers and/or special care allowances.

The *Looking After Children* (LAC) tool contains planning documents which can be used to record the needs and circumstances of a child that requires additional payments, but there was evidence that the lack of routine case planning had a detrimental effect on obtaining appropriate payments for children in care.

In general, complaints about payments and financial assistance were in relation to the seemingly complex and laborious processes required to obtain permission for additional or special payments. While designed to ensure that funding is used wisely and reduce financial over-run, evidence was provided that approving funding for children in out of home care is overly bureaucratic with decisions requiring multiple signatures and often being finally approved by staff that had no knowledge of the child or their circumstances. As a consequence, gaining additional funding for children in care appears to have assumed the status of a 'beat the system' game with attention given to how to identify loopholes and 'creative accounting' practices.

Carers also expressed frustration about time taken to resolve issues such as insurance cover that may have placed them at a financial disadvantage.

o **Training and preparation of carers is inconsistent**

Evidence was presented that preparation and training of carers and potential carers is presently inconsistent with roles and responsibilities requiring clarification.

The potential use of a training program based on a Victorian model (*Shared Stories, Shared Lives*) was very positively regarded, but there was some confusion about the delivery of this program and inconsistency across the state.

While this is required to be a joint responsibility between Departmental officers and the Foster Carers Association, foster carers did not feel they were always formally involved. In addition, this role had apparently been contracted to a non-government organisation in the south.

o **Role of the Foster Carer Association is not well understood**

The Foster Carers Association of Tasmania is provided with a minimal level of funding by government to provide support, training and advice to foster carers. In addition, the association has an advocacy role on behalf of carers.

Staffed entirely by volunteers, this association provides an important role and is highly regarded. Some office bearers (particularly the president) have

assumed almost a full time role on an unpaid basis for many years and have gained the respect of staff and carers alike.

However, there is increasingly a lack of clarity in relation to the different roles that office bearers within the association assume, with advocacy on behalf of carers being potentially at odds with a role in relation to the complaints in care process.

Increasing numbers of children are being placed in kinship care

Increasingly, children are being placed in an out of home care situation with a member of their extended family in either an informal or formal kinship care arrangement. This trend follows similar patterns overseas and interstate where kinship care has become a preferred option for out of home care.

Some additional funds were made available in the 2006-07 state budget to increase support to kinship carers where the child was placed informally and not under a court order.

However, the relative lack of financial assistance to kinship carers, who care for children informally, is a continued point of issue and concern at state and Australian Government levels. The Community and Disability Services Ministers' Conference has agreed that jurisdictions need to work to develop a mechanism for grandparents caring for their grandchildren without formal authority to be eligible for a range of Australian Government and State Government payments and services.

Kinship carers require considerable support and help

Of equal concern to many kinship carers was the overall lack of practical and moral support. Many kinship carers find themselves becoming carers unexpectedly and require intensive and ongoing support. In particular, where grandparents assume the role of kinship carer, there are often complex family dynamic issues associated with their assumption of the caring role in addition to the age of the carers. A government support booklet for kinship carers, published in 2005, provided a source of information and advice, but this will need continual updating.

Complaints about care situations

Finally, it was noted that the quality of care situations continues to give rise to concerns from some quarters. A new '*Complaints in Care*' policy and process implemented from the beginning of 2006 has resulted in 116 formal complaints being made about a care situation.

While a proportion of these complaints has not been substantiated, the high response to the complaints process indicates that there are some significant tensions and issues relating to children in care.

Clearly this is an area that requires an assurance of excellent management including well developed quality assurance processes if the community is to be confident that children in care are being well cared for and mistakes of previous care arrangements are not to be repeated.

13. Out of hours services

The present after hours model raises a number of issues

Child protection services are clearly required to operate on a 24 hour day/seven days a week basis. To provide for after-hours referrals and necessary statutory action, an after-hours service operates within child protection services. The service is staffed by child care workers who volunteer to go on the after-hours roster.

The present service provides both an emergency response service for after hours child protection notifications and a more general advice and support service, particularly for staff and foster carers involved with children in out of home care. The role is very broad, covering advice to rostered carers and after hours work for the Youth Justice system. The majority of calls to the service seek general advice and support rather than emergency notifications of child abuse or neglect.

The following concerns were expressed about the present service:

- **There is potential overlap between the after-hours service and the Parent Helpline**

A parent helpline also operates in Tasmania on a 24 hour basis. The purpose of this line is to provide accessible parenting information and advice. Most calls are of a medical nature and relate to issues with young children. However, there is some potential overlap and confusion of roles with this service and the after-hours service.

- **The voluntary nature of staff involvement is a concern**

The after-hours service is operated by service centre staff who volunteer to participate in an after-hours roster. Standby staff are paid at their normal hourly rate for six hours for an overnight or day shift and call out staff are paid an 'on call' allowance with additional payment if they are called out.

On one level, wide coverage of after hours' issues is provided in a minimally staffed model. On another level, the nature of many of the calls could be dealt with during normal hours or with a more flexible model of normal operating hours. If the service was only dealing with emergency notifications it could be substantially reconfigured.

As the number of people who volunteer as standby staff is quite small, many of those that are involved are earning a considerable amount – in some cases as much again as they earn for working their regular hours. The costs are difficult to identify as they are not covered by a single cost code (being spread over staff overtime costs). This means it is difficult to monitor the quantum cost of the service, which is unsatisfactory.

- **There are potentially occupational health and safety issues**

There is an organisational health and safety issue involved in staff volunteering for after hours work in addition to their regular daytime position. Staff may be called out in the night yet expected to be on duty the next morning.

While many staff who are involved, claim there are no occupational health and safety issues, many other staff do not believe that a service based on voluntary participation is sustainable.

- **The coverage of issues is very broad and goes beyond an emergency service**

Staff may not always be sufficiently experienced to make professional judgements across the range of areas and do not have access to other child protection workers to discuss their decision (although senior service centre staff expect to be involved in after hours verifications of assessment decisions).

There is no specific framework or formal process to provide supervision, guidance and support to staff.

- **There is no way for staff to access relevant data bases after hours**

Staff working from home are unable to access central data bases, resulting in a lack of relevant information that may be required to make decisions and provide a service. After hours staff have to rely on information provided by other staff or work from their own knowledge and experience. This obviously may not include detailed knowledge of children about whom there are enquiries or who are being notified.

- **Quality assurance and accountability processes are lacking**

The quality of record keeping and information recorded on log sheets is worker dependent and log sheets often have significant gaps in the information collected and in some cases are not completed at all. There is no central record of after hours calls other than in terms of these manually completed log sheets.

There is lack of accountability in the present service:

- The service is run by officers working with a mobile phone in an unsupervised setting, with no central record keeping.
- There is no way to independently assess the work, for example, the numbers, purpose and duration of calls. While the calls are recorded on a log sheet, there is no way to verify this information.
- The quality of advice and information provided is not monitored.

This is unsatisfactory from the point of view of system accountability as well as safeguarding the interests of the staff involved.

14. Staff issues, support and management

The job is not easy

Working in child protection is not easy.

While it is easy to be critical of many aspects of the child protection service, it should be remembered that staff are working in a difficult job with children and families with some very complex and long standing issues. Their job often involves stressful and difficult tasks such as removing a distressed child from a family or attempting to find safe emergency accommodation for a behaviourally disturbed teenager. In addition, staff are also often working in restricted physical conditions and without all the appropriate tools and support.

There are many staff within the system who are doing an excellent job

There are many staff within the child protection system who work very hard, with high professional standards and who do their job well. It is unfortunate that in describing a general culture, the many positive aspects of the child protection system may be overlooked.

During the Review, staff provided many examples of 'success stories' in working with children and families that brought both personal satisfaction and credit to the service. Some have worked in child protection for many years and have persevered despite the problems they have experienced.

In addition there was evidence of new initiatives and systems that were being successfully implemented. These included: the ESP pilot program in the south, development of a residential care system in the north, the development of a new data management system and the recent introduction of an induction program for all new staff.

However, the Review found that the overwhelming impression of staffing issues in child protection was of a workforce that is struggling.

Many staff are burnt out

The evidence during the Review suggested that many staff, at all levels of the child protection system, are exhausted and emotionally burnt out. Despite the considerable increase in resources and staff over the past three years, many feel that they have been coping with the demands of the job with inadequate resources and support over many years:

- They exhibit symptoms of depression, lack of energy and capacity to change, and fluctuate between being angry and apathetic;
 - They feel undervalued and unsupported at the professional, community, departmental and political level;
 - They feel overwhelmed by the scale of reform that is required and the time and energy that will be required to turn the system around;
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- They have been asking for help, additional support and direction for a long time and despite a number of reviews, industrial campaigns and promises of change, there is little evidence of any improvements; and
 - They have run out of ideas or the energy to make changes.
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The workforce is typified by a negative culture

Some of the characteristics that are further evidence of a negative workplace culture:

- Industrial unrest;
- Formation of factional groups;
- Frequent friction and infighting between and within teams;
- Formal and informal allegations of harassment and misconduct;
- Lack of confidence in line management structures;
- Alleged favouritism, cronyism, nepotism and inequitable promotional practices;
- Lack of professional practice exhibited in general conduct, dress standards, lack of adherence to non-smoking policies, inappropriate language used in emails and face to face interactions; and spreading of rumour and innuendo; and
- A culture of separate 'tribes' that tend to blame each other for difficulties and be protective of their own members to the exclusion of others.

There is a lack of unity and communication within the service

There was evidence that all too often the various work teams in the child protection workforce did not work in a collaborative or cooperative manner. There was no sense that this was a unified system headed in the same direction.

Despite a 'meeting culture' that allowed some groups to meet regularly, channels of communication and opportunities for face to face contact at the general level, were limited.

Staff commented on a sense of isolation – from each other and from those in senior positions.

Staff talked about 'secret squirrel' decisions and lack of communication to explain what was happening in the service and document any changes. Some staff lamented the fact that regular staff communiqués had ceased as these had afforded a useful source of information.

In the absence of clear lines of communication, rumour and inaccurate versions of events were frequent.

Perception of management is outdated

An obvious divide exists in child protection services between 'workers' and 'management' based on an outdated perception of how systems operate. 'Workers' are often reluctant to assume middle management positions and assume any form of responsibilities that might be seen to align them with those in management. This culture has been perpetuated by:

- Lack of management training for those assuming senior positions;
- Physical isolation of teams working in policy/management areas from those in the field;
- Multiple layers of management in the organisational structure that often removes those with decision making delegations from those at the 'coalface';
- Perceived inequities in resource allocation and decision making between different regions with those in the north and north-west citing examples of disproportionate resourcing of the south;
- 'Personality driven' management practices that have allowed decisions to be 'person based' rather than systems based;
- Management decisions being overturned at higher levels without explanation;
- Strict adherence to 'pecking orders' in decision making processes rather than using the best people for the task; and
- Lack of role clarity in relation to some positions such as practice consultants.

Performance issues have not been sufficiently addressed

As in any organisation there are some staff who are not performing at optimal level but evidence suggested that performance issues are not being systematically addressed or strategies introduced to support improvements. There appears to be a reluctance to deal with staff non-performance and this is having a detrimental effect on staff that do perform well.

Recruitment practices have not necessarily assured the best pool of staff

Staff are recruited into child protection services from a variety of professions including social work, psychology and education. There is some inconsistency across regions as to the minimal requirement for a child protection worker, depending on the difficulties in recruitment. In some cases an Arts degree is considered adequate. There is no additional screening to assess applicants' suitability for the work, beyond the normal application, interview and referee report process.

Some frustration was expressed about inefficient recruitment practices with long delays in filling positions and high numbers of 'acting' positions.

Recruitment of Social Workers from University of Tasmania is not facilitated

Child protection workers' perception was that the liaison and communication between the School of Social Work (UTAS) and child protection services was limited and that child protection work was seen as low status and not a rewarding career opportunity. Opportunities for undertaking practicums were valued by both students and child protection workers although the physical conditions, such as lack of office accommodation, made such placements less appealing. However, where a student had undertaken a successful practicum they were often interested in employment opportunities within the service.

There is inadequate training and induction practice

Given the diverse nature of recruits and the different levels of understanding new recruits are likely to have of working in child protection services, an extensive induction program and ongoing training are vital.

The recently introduced *Beginning Practice* induction program is receiving very positive comment and is long overdue.

Opportunities for further training and professional learning are presently limited to 'in house' programs provided at service centre or team level. These provide valuable opportunities to cover areas of practice and content knowledge such as drug and alcohol issues or sexualised behaviour.

However, there is not a more systemically planned and developed professional learning program that can be assured for all staff.

Professional supervision is not consistently available

While there is provision for professional supervision by more senior staff there was evidence that this was not consistently provided across all teams and was often a casualty of increased workloads of senior staff.

There was some confusion between professional supervision and line management.

Senior staff also felt that they were not given sufficient training in how to undertake the professional supervision role.

There are inequities in pay structures

Staff did not generally raise the overall level of pay as an issue for the workforce, given recent increases in award salaries.

However, the inequity between staff paid on the professional scale and those paid on the administrative scale did cause comment. Staff doing similar jobs may be paid at different rates and those in senior line management positions may be paid less than their staff that have professional roles.

This does little to attract suitable people into senior management roles.

15. Infrastructure and resourcing

General infrastructure for the service is poor

There was evidence that the general level of infrastructure that would enable staff to undertake their role with maximum efficiency and a reasonable level of comfort and safety, was not satisfactory.

Access to basic tools was lacking

There were numerous examples of low level but often repeated complaints about lack of access to basic items such as stationary, mobile phones and computers that contribute to the impression staff have that they are under-resourced and unsupported.

The most serious issue appears to be difficulty in gaining access to government vehicles that precludes staff doing home visits and getting out of the office to attend case conferences, network with other professional services and be part of the community.

Information and communications technology is not adequate for the job

A serious issue is the inadequacy of the information management system.

The current information management system (Child Welfare Information System: CWIS) was introduced in 1989 on a platform that was already considered outdated. The system has numerous technical and practical difficulties and has long been regarded as obsolete.

The CWIS system is supplemented by other data bases and shared drives that have been independently developed and implemented by the various services in a pragmatic attempt to find solutions to long standing data management and sharing issues.

There is no doubt that archaic and ineffective data management systems represent a very substantial risk to child protection services in this state, that are untenable in a modern child protection service.

Risks and issues include:

- Ineffective and time consuming practice for data input that involves duplication of effort and greatly increases workload;
 - Laborious processes that reduce the likelihood that data will be accurately recorded by staff and contribute to poor quality file management and lack of data integrity;
 - Lack of shared access to consistent information on children and families so that new notifications can be cross referenced, updates can be made, there is clarity about current status and progress of cases, supervisors can oversee cases being managed by child protection workers and good practice can be promoted;
 - Lack of after-hours access; and
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- Over dependence on expert staff who can operate systems and lack of user friendly software options.
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Development of a replacement system is underway

In recognition of the need for this system to be replaced, a new system (Electronic Information System: EIT) is being developed. The development of this new tool has been exceptionally productive given the relative lack of resourcing and high level project management within the agency. With a recent renewed focus and commitment to completing this project it is expected the new system will be available by early 2007.

Accommodation is over crowded and of poor quality

The poor quality and over-crowded accommodation for child protection services in the south and north is interpreted as indicative of the lack of value that the agency and the community place on this service.

Issues include:

- Lack of privacy and over-crowded offices for staff;
 - Poor interview rooms that lack privacy;
 - Public areas and reception areas that are not family friendly and have an institutional, unwelcoming feel;
 - Toilet facilities that feel unhygienic; and
 - General lack of upkeep and attention to maintenance.
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16. Quality assurance

The culture does not encourage quality assurance processes

It is evident from the Review that the processes and responses provided for addressing quality and safety issues are inadequate. There is a general dearth of routine quality and safety processes in place, apart from a specific process for dealing with complaints concerning children who are in care.

There is also a lack of clear standards and processes for accountability for working to these standards.

This is concerning and surprising in a service where management of risk and acceptance of the checks and balances that this entails would be expected as part of the culture.

Instead, many staff appeared to view quality assurance processes as adversarial or personally directed rather than as processes for identifying system issues and recommending improvements. There was also a fear that mistakes and errors of judgement will be 'blamed' on individual child protection workers and reflect negatively on their personal performance. This is not a culture in which improvements based on identification of system error is likely.

<p>Quality assurance processes are not independently staffed</p>	<p>Quality assurance processes and the investigation of complaints are presently handled by staff as an additional task to their other duties and may not be accorded the time and attention that they demand.</p> <p>There is also a lack of independence between those involved in a complaint and those undertaking the investigation, which may cause a conflict of interest.</p>
<p>There is no process for regular case auditing or questioning of professional decisions</p>	<p>There is presently no process for undertaking routine quality audits of cases to ensure consistency in decision making and a consistent standard of service. Case audits are regarded as a management practice that challenge rather than support professional decision making.</p> <p>Decision making processes do not encourage robust debate or child protection workers to justify their decisions in an evidence based way.</p> <p>Since most cases are not contested in the court system, there is also not the assurance that poor decisions will be identified through subsequent legal processes.</p> <p>There is also little opportunity for outside scrutiny of decisions or processes through interaction with other professionals.</p>
<p>The role of senior practice consultants is underutilised</p>	<p>The exception to this is the role of senior practice consultants who operate in all services and maintain a professional overview of practice that is independent from line management.</p> <p>While this role has the potential to provide the basis of a robust quality assurance system, the role presently lacks clarity and leadership with staff being diverted to other duties.</p>
<p>There is no process for formally investigating critical incidents or deaths</p>	<p>Carers are required to report critical or serious incidents to the child's case manager, but there is evidence of inconsistency in practice.</p> <p>There is also an expectation that briefings will be provided to senior managers about serious incidents when children in care are involved in a serious incident including serious injuries, involvement in crime, hospitalisations and drug overdoses. However, there is no central record of these incidents nor any ongoing monitoring or analysis.</p> <p>There is presently no legislated process for review of critical incidents or child deaths that occur during the time that a child (or their siblings) is either an active child protection case or has been involved with the child protection system during a prior period of time. This is in contrast to the practice in most other states and territories.</p>

There is no formal complaints process for grievances about services and staff

There is also no formal process in place for handling complaints and grievances about service delivery or staff behaviour and performance other than state services processes.

Complaints are investigated internally by senior officers, with the option to request an external review should the case appear to demand this response.

As there is a lack of clarity about how to make complaints and because there is no well communicated point of contact, complaints are frequently inappropriately referred to the Commissioner for Children or Ombudsman.

A process for investigating complaints relating to children in care has received a high number of complaints

A formal process for responding to complaints about the safety and well being of children in out of home care was enacted from January 2006. This process has produced a very high response rate and has resulted in a considerably increased workload for senior practice consultants, that has diverted them from other duties.

The response indicated the need for this process to be appropriately factored into an overall quality assurance process.

Moving forward

Previous sections have provided data and detailed the issues that need to be addressed

The previous sections of this report have provided data and identified areas that need to be addressed in reforming the child protection service in Tasmania.

As stated in the overview, most staff working in the child protection system recognise the serious nature of the issues and are keen to see major reform.

A vision for child protection services is first required

To move forward, a vision for an effective, high quality child protection system is required. This vision should be informed by evidence of best practice as well as the principles of business reform that are presently being implemented in the Department of Health and Human Services. It should also be compatible with the views of the majority of staff who are seeking a clear direction for their profession.

This vision for child protection services in Tasmania is presented in section ten.

The vision must be translated into action

The vision requires specific strategies and recommendations in order to be implemented.

Ten high impact strategies to make the vision a reality

The final section of this paper proposes ten high impact strategies designed to form the basis for reforming the child protection system.

If accepted, these strategies will form the basis of a more detailed implementation plan designed to be implemented over the next three years. This plan will be provided within two months of the release of this report.

While some of the actions are cost neutral and can be managed by reallocations within existing resources, others will require an injection of funds in the short or long term.

The directions and strategies being suggested will not provide a 'silver bullet' and many will affirm or build on initiatives such as structural reform that have already begun. Others will require concentrated effort over several years.

The important thing is to undertake the process of reform in a systematic and planned way and to continue to communicate with staff and stakeholders on progress.

10. Vision statement for child protection services in Tasmania

Child protection services must be based on a clear vision that includes:

Tasmania's child protection system must be capable of meeting government's responsibility to protect children whose safety is at risk through a well managed and professionally grounded service. A vision for child protection services in Tasmania is for a service that has the following characteristics:

○ **Clarity of purpose and function**

Child protection services must be well understood by the community, professional colleagues, and the client group. Services must also be well integrated and linked to other services while also clearly differentiated from other forms of support and assistance.

○ **Child centred services and emphasis on placement stability**

Children's well being and safety should be at the centre of all service arrangements and decision making:

The best interests of the child must be the paramount consideration¹⁶

The needs of the child should be regarded as the first priority and the views of children must always be incorporated into decision making processes. The developmental needs of children should be clearly understood by child protection workers and efforts made to ensure that solutions are developmentally appropriate and create the conditions for children's healthy development.

Being child centred also implies the recognition of critical time frames in children's lives including the importance of the first three years of life and the importance of early intervention.

In addition, services must consider children's underlying need to have stability and predictability in their lives. Whenever possible, the aim should be to safely maintain children in their family home. Where this is not possible, stability of placement and minimum change to care arrangements should be a focus.

○ **Emphasis on shared decision making and a 'strengths based' approach**

In the past two decades child protection work has been strongly influenced by a greater orientation towards family centred practice. An underlying tenet of this approach is that all families have strengths and capabilities that can be developed through a collaborative relationship between services and families. The aim is to give children the best possible start in life and to give parents the help they need to achieve this. This involves professionals sharing decision making power with families and more participatory practices with families of

¹⁶ Children, Young Persons' and Their Families Act, 8 (2) (a)

children at risk. At the same time, a focus on family strengths does not deny shortcomings or provide an excuse not to take statutory action when it is needed.

Child protection services should genuinely involve parents in decisions about their children and their future care and protection and encourage parents to take responsibility for these decisions.

○ **Opportunities for diversion and earlier intervention**

In robust child protection services a strong investment in early childhood and early intervention programs is evident. Child protection services should be embedded as part of a continuum of service delivery that includes the range of universal, secondary and tertiary services for children and families. However, protection services have inadvertently become the major point of referral for families who require support and assistance at all levels. Often the circumstances of the family do not warrant involvement of child protection services at the statutory level: unhealthy family situations sometimes have to further deteriorate before the intervention of statutory services can be justified.

Child protection services should be structured on the premise that the needs of children and families are often better served by providing more support and assistance at an earlier stage before the requirement for intervention by statutory services and particularly a focus on 'child removal' processes.

The proposed structure of services should provide for differential responses to reports of concern about a child's safety and well being, including improved services for lower risk families where stresses and problems may be impacting on children's wellbeing and there are concerns about the parents' capacity to deal with them.

○ **High status, public confidence and respect**

Child protection services must have high credibility and status and engender respect from other professional groups and the broader community for the quality of services that are delivered and soundly based decision making.

Services should also promote excellent communication with others and provision of feedback on decisions that can be supported with confidence by government.

○ **Responsiveness, timeliness and flexibility**

Services must be capable of responding to immediate demands and requirement for action as well as longer term planning requirements. Management practices must allow separation of workload issues from the need to move cases through the system in a timely manner according to accepted guidelines.

There should also be sufficient flexibility to respond to local community needs and priorities. Services should be community centred and forge alliances with local communities through being responsive to their particular requirements and priorities. There should be capacity to design and deliver innovative solutions to meet the needs of specific communities.

- **Child safety is everyone's business**

Child protection services should be an important element of a continuum of services that contribute to the safety and well being of children. However, the responsibility for child protection must be shared with other professional and community services.

While it is mandatory for many professional and other workers involved with children to report concerns about child safety to statutory services, this does not mean that child protection services can or should assume this responsibility to the exclusion of others.

- **State is a 'good parent'**

In cases where parents are not able to ensure the safety and well being of a child, the state has a responsibility to provide for that child's needs and wellbeing. In assuming this role, the state should be an exemplary 'parent' providing the range of services and support that would be expected in the highest functioning families. The parenting bar should be set high and our parenting should be exemplary if children are removed from their families.

- **Cultural sensitivity**

Where child protection services are involved with children and families who are Aboriginal or from other cultural backgrounds, services should respect cultural diversity and custom and aim to strengthen the capacity of the cultural community to care for the child and support the family.

11. Ten high impact strategies for reform

The ten high impact strategies are:

1. Build a framework for professional practice
2. Undertake legislative and policy reform
3. Reform management practices and organisational structure
4. Strengthen family support and early intervention services
5. Make children's safety and well being everyone's business
6. Build a professional and supported workforce
7. Provide the tools that staff need to do their job
8. Make the 'State' an exemplary parent
9. Enhance stability and permanent solutions for children affected by abuse and neglect
10. Improve accountability and quality assurance

1. Build a framework for professional practice

Professional practice framework

There is a need for a professional practice framework

An evidence based and professionally sound practice framework is required to provide a foundation for child protection practices and the basis for decision making and professional standards. This framework should clearly articulate the principles for professional practice and the 'intervention logic' that guides decision making.

There is good evidence that such a framework would not only provide a fuller understanding of what informs decision making and casework, but also has the potential to be the basis for practice standards used in training and supervision.

The framework should provide both 'practice triggers' that guide good practice at various stages of a child and family's involvement with the service and the practice standards that guide quality assurance processes.

The New Zealand *Care and Protection Practice Framework* is a suitable starting point

The New Zealand *Care and Protection Practice Framework* was presented to a wide cross section of staff during the Project's consultation phase and was well received. This model captures key elements of empirically based effective practice in a way that was relatively simple to conceptualise and easy to communicate. As Tasmanian legislation was strongly influenced by NZ practice, it is also very compatible with our current Act. This framework would provide a useful starting point and model for a Tasmanian Practice Framework

Recommendation 1.1
Adopt an evidence based, professionally sound framework as the basis for professional practice

- 1.1.1 The Tasmanian child protection system will develop a practice framework based on the NZ Care and Protection Practice Framework.
 - 1.1.2 The Framework will be further refined to reflect Tasmanian custom and practice and the vision presented in this report.
 - 1.1.3 Practice 'triggers' and professional standards based on the framework will be developed and used in training and supervision.
 - 1.1.4 The Framework will be used as the basis for professional learning for all staff.
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2. Undertake legislative and policy reform

Implementation of *Children Young Persons and Their Families Act* to the full extent of the legislation

Full implementation of the *Children, Young Persons and Their Families Act* should be facilitated

For various reasons, the potential of the *Children, Young Persons and Their Families Act* has not been fully realised. The Act contains several strategies and some mandatory requirements with the potential to improve the outcomes of child protection services in this state.

Recommendation 2.1
Implement the *Children, Young Persons and their Families Act* more comprehensively

- 2.1.1 An implementation plan will be developed to further promote the 'objects' of the *Children, Young Persons and Their Families Act* (contained in Part 1, Section 7) to *provide for the care and protection of children in a manner that maximises a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential.*
 - 2.1.2 The principles of the *Children, Young Persons and Their Families Act* (contained in Part 1, Section 8) will be incorporated into the professional practice model as triggers for best practice and as the basis for professional training.
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- 2.1.3 Training on the spirit and legal interpretation of the *Children, Young Persons and their Families Act* will be incorporated into induction programs and professional learning of staff and prospective staff.
 - 2.1.4 A practice manual that provides a clear policy position for all relevant clauses of the Act that are open to interpretation will be developed.
 - 2.1.5 Work with the Aboriginal community will be undertaken to ensure that Section 9 (*Principles relating to dealing with Aboriginal Children*) of the Act is fully implemented.
 - 2.1.6 Multi-disciplinary and interagency Advisory Panels will be established in each service centre to provide independent advice and review on decisions as required in Section 84 of the Act, and protocols for the operation of these panels developed.
 - 2.1.7 The current training processes, promotion, management and coordination of Family Group Conferences will be reviewed and revised with a view to increasing the use of Family Group Conferences especially on a voluntary basis before matters are directed to legal intervention.
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Amendments to the *Children, Young Persons and Their Families Act*

The Act would be improved by some amendments

The *Children, Young Persons and Their Families Act* is generally a sound piece of legislation that supports the work of child protection well. However, there are some minor amendments needed to improve its overall efficiency and effectiveness. These particularly relate to consideration of when child protection services can intervene and legal processes.

Recommendation 2.2 **Amend the *Children, Young Persons and Their Families Act* to improve efficiency and effectiveness**

- 2.2.1 The legislation should be amended to allow for the taking of notifications of unborn children. Notifications of unborn children should be treated as if the unborn child was a born child for all other purposes of the Act.
 - 2.2.2 Section 20 of the Act should be repealed.
 - 2.2.3 The Act should be amended to allow a child to be removed without a warrant and placed on a temporary order where the authorised officer believes that there is an unacceptable risk for the child to remain with the person with whom the child is residing. The authorised officer should be required to make an application to the Children's Court within 24 hours for the child to remain on a temporary order. The amendments should allow for a warrant to be applied for in circumstances similar to those currently set out in section 20 of the Act. A temporary order should expire after 5 working days but an application can be made to the Children's Court prior to the expiration of the 5 days for an Assessment order under section 22.
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- 2.2.4 The legislation should be amended to allow the Children’s Court to extend an Assessment order beyond the current maximum period of 8 weeks to a period of 12 weeks, provided it is in the child’s best interests to do so.
 - 2.2.5 The legislation should be amended to allow for adjournments of proceedings for periods of up to 30 days if the child is not living with their parents and 45 days if the child is living with their parents during the adjournment period. Adjournments should only be granted if it is in the child’s best interests or where there are compelling reasons.
 - 2.2.6 The provisions in the Act relating to family group conferences should be amended so that the Secretary can convene a conference without needing to consider a report from an advisory panel. The Act should be amended to prohibit the discussions and information shared at a family group conference to be used or referred to by any person following the conclusion of the conference in other than exceptional circumstances.
 - 2.2.7 The current barriers in the legislation relating to the sharing of relevant information should be amended. These amendments should include the requirement for specified persons and organisations to be compelled to share information in circumstances where the safety and protection of a child require this information to be shared. Safeguards for the responsible sharing of information should be included in the amendments.
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Policy and guideline development and use

Policy positions require clarification and communication

There is a need to clarify and communicate policy positions in order to improve consistency of practice, reduce ambiguity, provide a clear point of reference for practice and reduce unnecessary duplication of work.

There is also a need for clear policy positions and practice manuals to cover all aspects of work.

The expectation that staff will adhere to policy positions and practice standards also needs to be enhanced through induction and training programs as well as professional supervision.

Recommendation 2.3 Clarify and communicate policy positions

- 2.3.1 A policy audit will be conducted to identify current policy positions and policy gaps and clarify the status of current documentation.
 - 2.3.2 A policy folder containing the policy position on all important aspects of work will be provided to all staff and an electronic version made available on a dedicated website.
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- 2.3.3 Practice manuals for all aspects of current practice (intake, assessment, case management, support to out of home care and support work) will be developed and provided to staff to use to guide practice decisions and define standards.
 - 2.3.4 Practice manuals will contain proformas for standard procedures (such as writing an affidavit and file notes). A practice manual will also be developed for court work and undertaking legal processes.
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Future policy development

Future policy development should be highly focused and managed

Future policy development should be highly focused on the areas of greatest need and involve well managed business processes to ensure they are high quality and approved by the appropriate staff member within minimal time lines.

Recommendation 2.4
Revise processes for the development and approval of policies

- 2.4.1 Policy development and communication will be the dedicated responsibility of a senior officer working to a business plan under the direct line management of the Director.
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3. Reform management practices and organisational structure

Child protection services will be an integrated part of Children and Families Services within the Human Services Group

Child protection will be managed within Children and Families Services

Child protection services should be one aspect of the overall continuum of care provided by Children and Families Services with maximum integration encouraged with other services. This integration will be encouraged by common management structures, co-location of services when possible, and shared central support services for the development of policy directions, training and professional learning, human resource management and reporting and planning processes.

The Director of Children and Families Services will be responsible for ensuring that all services are coordinated and work in an integrated way and that the principles of the DHHS *Fit* program form the basis for management models and decision making processes.

The *Fit* program underpins all the high impact strategies

Principles of the agency *Fit for Service – reforming the way the DHHS does business* provide the basis for this reform and underpin all the high impact strategies.

The *Fit* program emphasises the need to commit to significant changes in the way we go about governance of the agency in eight critical areas of governance:

- Establishing a clear and shared purpose and direction throughout the agency;
- Achieving integration of services within and without the agency;
- Implementing effective ways to plan for, measure and improve our performance;
- Becoming more solutions-oriented and decision-focussed;
- Improving the way we communicate;
- Improving our management and leadership capability;
- Strengthening our staff capacity; and
- Reforming our organisational arrangements.

These elements will be incorporated into the strategies and recommendations.

Recommendation 3.1
Integrate child protection services with other children and family services

- 3.1.1 Children and Families Services will be structured around teams of integrated services reporting to the same regional or central manager.
- 3.1.2 Training and professional learning programs will be developed for all professional groups involved in children and families services to promote a coordinated approach and shared understanding of working with children and families.

Most children and families services will be incorporated into four regional teams

Four regional teams will be developed in the south, south-east, north and north-west. These regional boundaries will coincide with boundaries for the Department of Education, Housing Tasmania and Tasmanian Police to facilitate opportunities for collaboration and integration of services across agencies.

Recommendation 3.2
Create four regional integrated service teams that will include child protection services

- 3.2.1 Regional child protection services will be part of four regional teams in the south, south-east, north and north-west of the state, sharing common boundaries with education, police and housing.
- 3.2.2 Regional teams will include Family, Child, Health Services; Family Support Services; Children’s Therapy Services, Family Violence Counselling and Support Services; Sexual Assault Services as well as Child Protection Services. The development of this regional model will be gradual with some services being regionalised immediately and others over a longer period of time.

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- 3.2.3 Each regional team will be responsible to a senior manager who will be accountable for the integrated continuum of services including child protection, reporting directly to the Director (Children and Families Services).
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New intake processes and staffing models

A new model is required for intake services that recognises the pivotal role

Intake services are one of the most important aspects of child protection services as staff members have the responsibility for determining the level of risk experienced by a child and their priority for further child protection intervention. This requires a high level of experience and practice wisdom. These staff members are also the first point of contact for the public and other professionals and their credibility and professionalism must therefore be of the highest order.

While it is proposed that most of the current functions of the Child Protection Advice and Referral Service remain, at least in the short term, some significant changes are recommended:

Recommendation 3.3 Develop a new model for Child Protection Intake Services

- 3.3.1 A central intake service will continue in the short term but the community advice and public education aspect of the role will be transferred to regional teams.
- 3.3.2 The model for processing notifications calls will be revised with calls first being referred to senior staff for an initial assessment before being allocated to a child protection worker for further information gathering.
- 3.3.3 Call centre technology will be investigated as a way of providing supervision and monitoring of incoming calls by senior staff.
- 3.3.4 Ways to track progress on processing notifications in a more transparent way will be investigated so that staff workload and time being taken to complete a notification can be more closely monitored.
- 3.3.5 All staff recruited into the intake service will receive mandatory training before undertaking their role (with a practice manual forming the basis for training).
- 3.3.6 An electronic form for emailed notifications will be developed with mandated fields that prevent notifications being accepted unless basic information is completed.
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New processes and models for regional service centres

The operation of child protection services within regional structures will be reformed

The structure of regional child protection services teams will be further developed through ongoing consultation with staff.

The principles will include:

- Capacity for a response to all cases referred for assessment and investigation;
- Clear guidelines for transfer of cases between teams within stipulated time lines;
- Management of case allocation according to priority;
- Processes for good communication and liaison between teams; and
- Assurance that staff can undertake assessment processes without the need to contract out these essential functions.

Recommendation 3.4

Develop a new model for regional child protection teams

- 3.4.1 New service teams and models for operation will be developed by the Director of Children and Families Services and her senior staff.
- 3.4.2 Consideration will be given to including provision for a 'response team' responsible for the immediate assessment of new notifications and progressing a new case to the point of either case closure or an initial court order within enforced timelines.
- 3.4.3 The level, number, role and title of positions and senior positions at regional level will be reviewed and revised to ensure consistency across the state.
- 3.4.4 The two teams in the south may share some functions between teams where it is not practical to split the responsibilities.
- 3.4.5 Additional assessment positions will be created for twelve months to assist in clearing the 'unallocated' list.

New model for after hours work

There is a need for clarity of expectations and scope for after hours work

In order to provide a more sustainable and accountable model for after-hours services, there is a need to:

- Fully review and revise after hours work and the scope of services;
 - Cost alternative models for delivering the various components of service including advice and information services, staff support and emergency notification; and
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- Improve provision for accessing data bases after hours and accountability.
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Recommendation 3.5

Develop a new model for after hours services

- 3.5.1 A costed model for after hours' services that clearly differentiates the different aspects of after hours work (and in particular separates emergency and routine work) and provides for appropriate permanent staffing structures will be developed.
 - 3.5.2 Consideration will be given to a model that provides for some service centre staff to work flexible hours allowing coverage of routine work and staff support in the late afternoon and early evening.
 - 3.5.3 The possible utilisation of an existing call centre infrastructure as the base for an emergency notification service will be investigated.
 - 3.5.4 The relationship of after-hours services to the parent information line will be investigated.
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New ways of doing business

There is a need to change business practices

Many of the issues related to the staffing, management and culture of child protection services suggest that some systemic reform of basic business practices are required.

Many of these have been identified as requiring attention as part of the *Fit* program.

Recommendation 3.6

Reform business practices in line with principles of the *Fit* program

- 3.6.1 Guidelines for determining when cases must be transferred between teams will be reviewed and updated and processes for managing these transfers implemented.
 - 3.6.2 Management practices for allocation of cases and determining case loads to ensure state wide consistency will be developed.
 - 3.6.3 All present committees and meeting groups will be reviewed to determine their purpose and whether their business could be expedited in other ways.
 - 3.6.4 Staff delegations will be reviewed to ensure that they are at the level required for efficient decision making and financial management.
 - 3.6.5 A regular communication bulletin will be provided to staff with updates on issues of interest and concern.
 - 3.6.6 Consideration will be given to co-locating some central services and support functions at regional level.
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- 3.6.7 Consideration will be given to rotating some positions between teams on a regular basis so that staff members have opportunities to develop skills and experiences across the range of services and insular work practices are reduced.
- 3.6.8 A professional conduct protocol will be developed with staff to outline agreed standards of professional conduct.
- 3.6.9 Roles, accountability and line management for all positions will be reviewed in accordance with *Fit* principles.

4. Strengthen family support and early intervention services

A best practice model for child protection must include provision for early intervention and support

A best practice model for child protection must include provision for adequate support and early intervention as well as an unequivocal commitment to take action to remove children whose safety or well being is seriously at risk when this is necessary.

This approach aims to create a more efficient service through better targeting and investigation of more serious allegations, while concurrently providing access to a broader range of support services for families that have high needs and face ongoing problems.

This shift in focus and resourcing is urgent if the rate of notifications to statutory services is to be better contained so that appropriate time and attention can be devoted to children seriously at risk.

There must be recognition that families referred to child protection services often require support rather than statutory intervention

It should be recognised that families reported to statutory child protection services will often be better served by providing more support and assistance and less focus on 'legal' and 'child removal' processes when problems develop. The philosophical underpinning is that authoritative, involuntary approaches should be reserved to protect those children when the parents are unwilling or unable to make efforts to change their behaviour.

An alternative trajectory must be provided for children and families that require a level of support and may require statutory intervention, but do not involve removal of the child from his or her family.

Strengthen capacity of present government universal and secondary services

Recommendation 4.1 Strengthen capacity for government services to provide support and assistance to vulnerable families	4.1.1 The role and training of Family Child Health Nurses will be considered to determine how their role in providing early support to targeted families can be facilitated.
	4.1.2 A plan will be developed and implemented with Disability Services to ensure that children with disabilities have access to services that may prevent them becoming involved in the child protection system.

Strengthen intervention in the early years

Early intervention is established as the most likely way that success with vulnerable families can be achieved	<p>Across the world there is increasing recognition of the importance of early child development, as this sets the foundation for learning, behaviour and health through the school years and into adult life. There is also increasing recognition that strategies for the prevention of child maltreatment need to be part of much broader strategies aimed at addressing social disadvantage and supporting parents in the broader social context.</p> <p>The whole of government early years policy framework is currently being used as the basis for a strategic plan that will provide government with a clear direction for implementing strengthened intervention in the early years.</p>
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Recommendation 4.2 Improve capacity for early intervention in the early years of children's lives	4.2.1 The whole of government <i>Early Years Plan</i> should be finalised and submitted to government for approval as soon as possible.
	4.2.2 Responsibility for implementation of the whole of government early years strategic plan should be resolved, with consideration given to Children and Families Services managing this plan with the support of an interagency governance structure.
	4.2.3 Increased priority will be given to strategies involving the first five years of life in all Children and Families Services business planning and policy development.
	4.2.4 Selected staff will be supported to undertake the Early Years degree recently established at the University of Tasmania, to strengthen the staff knowledge base about early childhood development.

Develop a family support services program

A comprehensive review of family support services and suggested model has been provided

The commissioned *Review of the Tasmanian Family Support Service System*¹⁷ provides a detailed rationale and proposed plan for implementation of a new family support services program.

This Review provided a substantial evidence base and summary of best practice being adopted internationally and nationally.

The proposed implementation plan therefore provides a useful basis for the development of a new family support services model.

In addition, the current pilot *Early Support Program* provides useful data on the way to expand this program in line with the model suggested by the KPMG report.

It will be important to work in close collaboration with the non-government sector and peak organisations to develop the new family support services program over the next 2-3 years.

Recommendation 4.3

Develop a new family support services program along the lines of the model proposed in the *Review of the Tasmanian Family Support Service*

- 4.3.1 A model of local service delivery areas that could be used as the basis for the development of family support services will be developed.
- 4.3.2 A framework and model for local child and family networks that could be used for delivering more coordinated family support services including government and non-government services will be developed.
- 4.3.3 A model for a 'community information service' in each local service delivery area, where families could access information on the family support services that are available in that area and be referred to appropriate services, will be developed.
- 4.3.4 As a second stage, a proposal will be detailed on how these 'community information services' could be further developed to provide an assessment role that would enable them to become an alternative child protection referral point.
- 4.3.5 A common assessment instrument that could be used at the community level to assess the needs of vulnerable families and match them to available services will be developed.
- 4.3.6 Issues related to information sharing between both government and non-government organisations, with legislative reform if necessary will be resolved.

¹⁷ KPMG, 2006

4.3.7 Protocols and policy on information sharing required to remove any barriers that prevent appropriate exchange of information about children and their families who are involved in the child protection system will be provided.

Recommendation 4.4

Enhance the quality, availability and range of non-government family support services

- 4.4.1 In collaboration with the non-government sector develop a quality assurance model, including a standards framework that will specify the level of service required by family support services contracted by DHHS and tools and processes for the assessment of standards.
- 4.4.2 A process and tools for collection of data sets by organisations receiving funding for family support services will be developed.
- 4.4.3 Service specifications for existing family support services will be detailed in collaboration with the organisations and the peak bodies.
- 4.4.4 The effectiveness and sustainability of services receiving small amounts of funding with limited hours will be reviewed and consideration given to the way forward for these services.
- 4.4.5 An appropriate funding model for future family support services that includes the unit prices and specifically accounts for management, supervision, infrastructure and operating costs will be developed.
- 4.4.6 A business case will be developed, to support the need for increased funding to family support services as a fundamental part of the reform of child protection services.
- 4.4.7 Funding of the *Early Support Program* pilot will be continued until the new model can be completed and considered, with increased funding where this can be identified.

5. Make children's safety and well being everyone's business

Promotion of awareness and responsibility for child safety

There is a need to promote community awareness and build responsibility for child safety

Effective child protection services depend on a government system that supports children's development and family functioning and builds the resilience of all children and families. Responsibility for children's well being and safety must be shared amongst family, community, government and service providers.

It is important that the various levels and stages of assistance and advice for vulnerable families are well understood and ways to access this support are increased.

It is also important that the purpose and function of statutory child protection services are clarified and the processes for referring children who require this level of intervention are facilitated.

Recommendation 5.1**Promote the shared responsibility for children's safety and well being**

- 5.1.1 A new position will be created for a child protection worker in each region to be available for consultation with other government and non-government services; provision of advice and support on cases that potentially require child protection intervention; provision of public education about child protection services and to act as a point of linkage between support services and child protection services.
- 5.1.2 A child protection worker position will be created at the Royal Hobart Hospital with the possibility of creating similar positions in the other public hospitals. This position will provide advice, support and liaison for issues relating to child protection issues including antenatal, neonatal and paediatric services.
- 5.1.3 A specific "person for contact" will be designated in CPAARS and all three regional assessment teams for referrals from the public hospital system and other medical practitioners, to ensure that communication is facilitated.
- 5.1.4 A website on child protection services will be developed as a means of providing public and community education about child protection issues and providing a point of contact to available services.
- 5.1.5 A dedicated position in Alcohol and Drug Services will be provided that can serve as a reference point for consultation with child protection workers on clients where drug and alcohol abuse are an issue.

A multi agency approach

There is a need to promote a whole of government response to child safety

An effective child protection system depends upon the involvement of all government agencies and a strong inter-Ministerial commitment.

This has been recognised in other states where a multi-agency approach has already been established in other states and territories as a key component of child protection reform. For example, Queensland has established high level Child Safety Directors in Police, Education, Health, and dedicated positions in Disability Services and an Aboriginal and Torres Strait Islander Policy.¹⁸ The function of Child Safety Directors is to provide a coordinated approach to policy and service development across state government with respect to child protection.

Victoria has recently proclaimed new legislation¹⁹ designed to promote whole of government and community responsibility for promoting the

¹⁸ Queensland Government, *A Blueprint for Implementing the Recommendations of the January 2004 Crime and Misconduct Commission report – Protecting Children – an Inquiry into abuse of Children in Foster Care*.

¹⁹ *Child Wellbeing and Safety Act, 2005*.

'well being and safety of children'. The Act provides for the establishment of a *Childrens' Services Coordination Board* consisting of the Secretaries of Departments of Premier and Cabinet, Treasury and Finance, Human Services, Education and Training, Justice, Victorian communities and Police. This Board has the responsibility for reviewing and reporting on the outcomes of government actions in relation to children, particularly the most vulnerable children and supporting the coordination of government actions relating to children.

Maximise interagency collaboration and cooperation

There is a need to rationalise and provide a better overview of present interagency strategies

There are already several processes in place that are designed to improve interagency collaboration and cooperation – especially in relation to children, young people and families.

Within DHHS itself there are a number of present projects and activities such as the *Collaboration Strategy* designed to encourage closer working relationships and problem solving between areas of the agency.

At whole of government level there are also several successful initiatives including:

- *Interagency Panels* managed and facilitated by Tasmania Police and operating at local government level, aimed at strengthening collaborative case work at the local level as part of crime prevention;
- *Collaborative Case Conferences* developed within Youth Justice to facilitate inter-disciplinary case conferences in relation to young people with complex needs involved in the justice system;
- *Safe at Home* processes designed to ensure a collaborative and integrated approach to family violence issues with regular meetings at several levels including an interdepartmental committee; regional coordinating committees (north, north-west, south); integrated case coordination committees (north, north-west, southern and eastern); and interdepartmental committee working groups.

Child protection workers are potentially involved with all these processes to varying degrees and while the aims of each are entirely laudable and participation needs to be encouraged, there is a danger that staff are committed to attending an unrealistic number of separate meetings.

Structurally there are also a number of very positive initiatives across government aimed at promoting 'joined-up' solutions to complex social issues:

- Cabinet's new *Social Policy Committee* designed to ensure a collaborative approach to social issues at the government level;
- The *Social Policy Unit* within the Department of Premier and Cabinet that has responsibility for facilitating a whole of government approach to complex social issues;
- The recently announced *Office for Children and Young People* that has a role in encouraging a whole of government approach; and
- A high level *whole of government Early Years Steering Committee* that is charged with overseeing a whole of government approach to the early years.

Work is currently being undertaken in the Social Policy Unit (DPAC) to provide a plan for considering the current processes and determining ways to reduce overlap or duplication.

This work is very important in ensuring the continued success of collaborative approaches that are already showing significant success in encouraging agencies to work together and focus on preventative approaches and early intervention. However, simply adding a new process or structure specific to interagency collaboration on child protection matters into the mix, without first considering the relationship to existing processes and structures, would be extremely unwise.

Recommendation 5.2

Develop an agreed position on the role and purpose of interagency collaborative processes and structures

- 5.2.1 An agreed position should be developed and approved on interagency collaborative processes and structures involving a high level reference group with representation from the Departments of Education, Police and Public Safety, Health and Human Services, Justice and Premier and Cabinet.

Recommendation 5.3

Promote an interagency approach to children's safety and well being

- After consideration of outcomes from recommendation 5.2:
- 5.3.1 A proposal for interagency liaison and collaboration on child protection matters will be developed building on existing processes.
- 5.3.2 Work with the Department of Education will be undertaken to develop a protocol outlining roles and responsibilities for clients that are involved with the education system and the child protection system, and referral processes.
- 5.3.3 Work with the Department of Police and Public Safety will be undertaken to develop a protocol for referral of children to child protection services with due consideration of the *Family Violence Act*.
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6. Build a professional and supported workforce

The workforce is the most important resource in the child protection system

People are the most important resource within the child protection system. The number and quality of staff and the ways they are supported to undertake their work are arguably the most important factors to making the child protection system work well.

There is a need to work at all levels to encourage new graduates to enter the profession and recruit appropriate staff; provide ongoing support, supervision and training; encourage opportunities for exchange of practice ideas from other places; and encourage experienced staff to stay in the profession through an attractive career structure.

Training and recruitment of suitable staff

It is important that the general status, image and knowledge base surrounding child protection is improved

It is important that the image and status of child protection in the state is improved so that high level graduates are attracted to the field and the standard of pre-service and in-service learning and training related to protection and abuse and neglect issues is facilitated.

It is also important that there is capacity to recruit the most suitable and promising graduates from relevant professions into child protection work. Although most of these recruits can be expected to come from social work, recruitment from other relevant professional areas should continue to be considered.

Recommendation 6.1 Build the status and image of working in child protection and provide for the recruitment of suitable staff

- 6.1.1 The creation of an academic chair in *Child and Family Well Being* will be discussed with the University of Tasmania. This position could assume responsibility for input about child protection issues into schools of social work, education, nursing, psychology and medicine as well as having a role in community education and research.
 - 6.1.2 Work will also be undertaken with the University of Tasmania to develop options for increasing coverage of child protection content in existing relevant courses, particularly social work degrees and degrees involving work with children and families, and improving opportunities for practicums.
 - 6.1.3 Planning will be undertaken with professional staff that do not have a professional qualification to establish ways in which they could gain this qualification.
 - 6.1.4 Development of a scholarship program for encouraging suitable people to enter the child protection profession will be considered.
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- 6.1.5 Recruitment processes including advertising, screening and selection processes, and making appointments to ensure regional consistency and best practice across all child protection teams will be reviewed and revised.
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Ongoing professional development and learning

Opportunities for professional learning should be ongoing

It is important that professional learning is provided on an ongoing basis during the time a staff member is involved in the service.

Recommendation 6.2 Provide ongoing professional learning opportunities

- 6.2.1 The *Beginning Practice* induction program (a comprehensive manual and professional learning model for staff induction that has been modified for the Tasmanian context from that used in Victoria) will be provided to all new recruits in accordance with a timeline developed by their managers.
- 6.2.2 A central professional learning unit will be established to have oversight of professional learning on a state-wide basis.
- 6.2.3 An annual professional learning program will be implemented (after consultation with staff on their individual and system needs) that will detail a comprehensive range of learning opportunities delivered internally and externally.
- 6.2.4 Priorities for professional learning for all staff will include:
- Capacity for working collaboratively;
 - Facilitating case conferences;
 - Engaging with 'hard to engage' families;
 - Using the *Looking After Children* case planning tool; and
 - Conducting risk assessments.
- 6.2.5 Staff exchange opportunities and other possible processes for selected staff to work in other states and territories and New Zealand will be investigated.
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Career structure

The career structure should allow for a range of positions suited to a range of skills and experience

A career structure should allow for a range of positions that call for different levels of skills and experience; allow staff to be paid according to the job they are doing; and encourage skilled and experienced staff to remain in the field.

There should also be consistency in title, level and type of role across the state and the responsibilities for which particular positions are accountable should also be clear as well as the relationship between roles.

Recommendation 6.3
Review and revise the career structure for child protection workers

- 6.3.1 The current positions in child protection services will be reviewed and a revised structure developed that:
- Provides for the range of roles and functions of the reformed child protection model;
 - Uses consistent titles for the same positions across the state;
 - Provides for more senior roles in areas such as intake where there is evidence of the need to recruit more experienced and skilled child protection workers;
 - Clearly defines line management and supervisory responsibilities of senior roles;
 - Ensures positions are established at levels commensurate with responsibilities and key tasks.
- 6.3.2 Through negotiation with unions a fair and equitable process will be provided to allow present staff to express interest in positions they would like to be considered for, and be appointed to, according to their suitability and on merit.
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Capacity for staff to work in a best practice professional model

Staff need workplace practice models that allow them to manage their workload

There is no question that present staffing models place staff under considerable stress and contribute to a perception that the workload is unmanageable. While accepting that there will always be some level of unpredictability (by nature of the work), new staffing and rostering models are needed that are more flexible and provide for a more manageable and reasonable workload for all staff.

It is also important that occupational health and safety issues are addressed so that staff can work safely and are not in danger of 'burn out' through being asked to work at a level that is unsustainable over time.

There is also a need for improving equity of workload across positions and workplaces in different parts of the state.

Recommendation 6.4
Develop models of practice that define both the expected workload and model of staffing operation

- 6.4.1 Models of practice and rosters for all positions that take account of the workload and model of operation will be developed.
- 6.4.2 Staffing plans that are based on the roles and responsibilities and expected model of operation of all staff will be developed.
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6.4.3 Models of operation and rosters that recognise the need for rotating duties over regular periods of time, respite from high pressure tasks, provision for 'time in lieu', and time required for administrative and supervisory roles will be implemented.

Performance management

Staff performance has not been systematically recognised or managed

Evidence provided in the Review suggests that many staff do not receive regular feedback on their performance and feel unrecognised within the agency and the wider community.

In addition, poor performance issues have not been systematically addressed. This has resulted in a number of staff members who are struggling to perform, resulting in additional pressure on remaining staff and a general lowering of morale.

Performance management, including regular feedback from line managers, should be regarded as integral to a high performing workforce and accepted as a part of an overall support framework.

Recommendation 6.5

Implement staff performance management practices

6.5.1 A performance management policy will be developed with staff.

6.5.2 All professional staff will have opportunities for structured performance management according to the policy.

6.5.3 An annual Ministerial 'excellence awards' process will be initiated to recognise staff and others involved with child protection services who perform at an exceptional level.

7. Provide the tools that staff need to do their job

Staff cannot operate efficiently if they do not have the tools to do the job

No system can operate with maximum efficiency unless staff have the basic tools to do their job. There is clearly a need to ensure that some basic infrastructure is in place so that the child protection system can be more efficient and effective.

The most pressing areas of infrastructure in the child protection system relate to information technology and accommodation.

Information management

Information technology and data management systems are in urgent need of upgrading

It is evident that the present data management system and access to electronic tools are unsatisfactory.

Long term solutions to the data management issues require substantial planning and investment. This must be considered in the longer term scoping of information technology projects for the agency as a whole.

In the short term, an acceptable solution is to facilitate finalisation of the Electronic Information Tool (EIT) with the increased scope to also replace the current Child Welfare Information System (CWIS).

Recommendation 7.1
Facilitate the immediate upgrading of electronic tools for data management and routine work

- 7.1.1 The Electronic Information Tool (incorporating CWIS functions) will be finalised with immediate priority.
- 7.1.2 Longer term investigation and planning to determine data management needs for child protection services over the next 5 to 10 years will be undertaken.
- 7.1.3 Business planning will be undertaken to assess how staff could be provided with laptop or other mobile computers when they are undertaking field work (such as visiting clients at home to complete assessments or undertake case planning) so that tasks could be facilitated and duplication of effort avoided.
- 7.1.4 All staff will have access to a computer in order to undertake their routine work.
- 7.1.5 After-hours access to data bases for staff members that are on after hours duty will be provided.
- 7.1.6 Electronic formats for documents that are written on a frequent basis (such as affidavits and written case notes) will be developed so that the information required is prompted and the formatting is consistent.

Accommodation

Present accommodation for staff and client interaction is poor adding to low morale

Present staff and client accommodation requires upgrading to ensure a minimal standard of offices, interview rooms, and general facilities. This particularly applies in the south and to a lesser degree in the north of the state.

Present accommodation also does not facilitate interaction between teams and this is another issue that needs to be addressed.

Recommendation 7.2
Upgrade accommodation,
with the southern service
centre and CPAARS
having immediate priority

- 7.2.1 As a priority, alternative accommodation options for the two southern service teams and the new Intake Service will be investigated.
- 7.2.2 There will be investigation of ways that child protection service centres can be more family friendly and supportive environments while still providing for staff security.
- 7.2.3 Expert advice will be sought on the physical configuration of accommodation to provide for maximum staff interaction, while also providing privacy, interview facilities, meeting facilities and communal spaces.
- 7.2.4 Use of space in schools and other accessible public buildings where there may be surplus requirements will be investigated to provide accommodation options for some children and families services (including out-posted child protection staff) that could be accessible to local communities.

8. Make the ‘State’ an exemplary parent

Children in out of home care should be in circumstances that are likely to be better than if they remained at home

The power to remove children from their family comes with an expectation that the out of home care placement will be successful. It would be expected, at the very least, that the child would be better off than he or she was without state intervention.

Despite recent reviews and attempts by staff to provide alternative models for children in need of out of home care, it is evident that current models for out of home care are under considerable pressure and may not be appropriate for the entire range of children referred for placement. There are inequities in provision to children under different models and varying levels of support to various carers. There is also a confusing mix of government and non-government services.

Priority to retain children with their families whenever possible

Best practice suggests keeping as many ‘at risk’ children as possible with their families

Evidence suggests that most children who are at risk are ultimately best served by remaining with their families, where this can be done within the bounds of reasonable risk management. Most children will choose to remain with their immediate or extended family, even when this option is less than ideal when viewed from the aspect of desirable parenting and nurturing arrangements.

At the same time, there must be effective processes and a capacity to take immediate action to remove children from their family when a risk

assessment suggests that this is the only possible course of action likely to ensure the child's safety and well being.

The evidence suggests that too many children who are the subject of sustained abuse or neglect in Tasmania are being removed from their families because the option of maintaining the children at home is deemed to carry too high a risk – both for the child and for the child protection worker.

It is also true that, while the number of children placed in kinship care is increasing, this option is used less in Tasmania than in most other places.

This is partly because pressured child protection workers are not able to put in the time and effort required to develop and supervise a safety plan, and partly because a legal trajectory leading to removal of the child from the family has become 'normal' practice, with other options not being as clearly defined or supported.

Recommendation 8.1

Provide best practice guidelines, staff training and practice models necessary to allow more children to be safely maintained with their families

- 8.1.1 Current policy, guidelines and practices will be reviewed and revised to ensure that options allowing children involved with child protection services to remain with their immediate families are used to the maximum level of safety.
- 8.1.2 Kinship care will be reviewed and revised with a view to increasing the use of kinship care as an out of home care model in Tasmania.
- 8.1.3 Tasmanian targets based on national average figures should be established for increasing the number of children maintained with their family and placed in kinship care.
- 8.1.4 The legislation will be clear and unambiguous in requiring the Secretary to be an exemplary parent. The responsibilities of the Secretary will be set out in the legislation. The Secretary will also have the capacity to assist young adults who had been on an order in care, up to the age of 21 years.

Priority access to the range of government services

Children who are in the care of the state should have priority access to health and support services

Children who are in state care are acknowledged to be more likely to suffer from a range of physical and mental health, and educational issues.

Yet at present there is both a reluctance of other government services to become involved with child protection issues and a lack of systemic services to ensure that their needs are met.

There is also evidence that out of home care placements are often threatened by children's lack of access to other services, including basic educational provision.

It is reasonable that the state should ensure that these issues are addressed as a matter of priority.

Recommendation 8.2
Provide priority access to existing government health and therapeutic services for children in state care

- 8.2.1 Mandatory health screening will be provided to all children entering state care through paediatric clinics provided at public hospitals utilising protocols and processes to be developed with paediatric medical services.
- 8.2.2 A protocol will be developed with Child and Adolescent Mental Health Services to ensure that children in state care have priority access to therapy and counselling services.
- 8.2.3 Increased provision for psychological assessment will be established within each regional service centre to ensure that children can be assessed within the service whenever possible.
- 8.2.4 Recommendations from the current project (Farr, 2006) considering children in state care who are also clients of Disability Services will be a priority for the Human Services Group to action.
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Schooling and educational services

Access to education

Schooling for many children in state care is not a routine provision. Many of this group of children make exceptional demands on schools as they exhibit a range of behavioural and psychological symptoms as well as often suffering the effects of broken schooling or poor attendance.

At the same time, where these children are suspended or excluded from school, the effects on their out of home care placement are often disproportionate, compared to children living at home.

There have been several attempts to develop workable protocols to ensure more collaborative and supportive working relationships between the Department of Education and child protection staff and these have often been implemented successfully at the local level.

However, there continue to be too many cases of children in care not attending school regularly; being excluded from school for extended periods; or being caught in the middle of a debate about responsibility for financial resources needed to maintain a child in the school system.

There is a need for government commitment to ensure that children in care continue to attend school regularly and receive the level of support that will allow them to benefit to the maximum level from the education system.

Recommendation 8.3 Work with the Department of Education to improve educational provision for children in care	<p>8.3.1 Children in care will be identified as a defined group for disaggregated data collection (attendance, disciplinary processes, and retention and achievement figures) published by the Department of Education so that their educational situation can be more accurately monitored.</p> <p>8.3.2 Work will be undertaken with the Department of Education to address specific areas of concern in relation to children in care and ensure that there are strategies in place to improve attendance, retention and achievement levels.</p> <p>8.3.3 A specific policy and plan for action will be developed as a matter of urgency with the Department of Education in relation to children in care who are suspended, excluded, expelled or subject to full or part time exemption, to define roles and responsibilities and financial arrangements.</p> <p>8.3.4 All children who have state guardianship for 12 months or longer will have an individual educational plan (updated on an annual basis) with accountability resting with school principals.</p>
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Staffing models for out of home care

There is presently some ambiguity about staffing roles and responsibilities at central and regional level	<p>The roles and responsibilities surrounding children in care that can best be undertaken at central and regional levels require attention. There is a need to ensure that state-wide consistency is improved while also promoting the benefits of local knowledge and networking that these services require.</p> <p>The use of paraprofessional staff also requires urgent policy development to ensure they have appropriate well defined roles and responsibilities with supervision.</p>
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Recommendation 8.4 Review and revise the staffing model for out of home care with central and regional services clearly defined	<p>8.4.1 Central and regional roles and responsibilities for out of home care will be clarified as part of the new staffing model, including responsibility for community awareness, recruitment, screening, support, dealing with complaints and liaison with stakeholder groups.</p> <p>8.4.2 A policy and guidelines will be developed for the role of support workers.</p> <p>8.4.3 Guidelines covering access visits will be developed and the role of support workers clearly defined. The greater use of existing contact centres will be explored.</p>
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Case planning processes

Evidence suggests that case planning is not as comprehensive or well documented as would be expected

The evidence provided suggests that case planning and documentation is not being undertaken at a level that is acceptable across all service centres.

There is a need to ensure more consistent practice across the state and increase the use of planning tools and routine case planning practices such as case conferences.

Recommendation 8.5
Improve case planning approaches and documentation

- 8.5.1 Steps will be taken to ensure that the *Looking After Children* (LAC) planning tool is consistently used and documented for all children in out of home care.
- 8.5.2 All children in care will have case plans updated every 12 months, or when there is a change of circumstances that requires new decisions to be made.
- 8.5.3 Case planning will involve all significant people in the child's life with the child involved to the maximum extent possible given the child's age and developmental level.
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Children and young people in care who have intensive and complex needs

Investigate and make recommendations on 'out of home care' models for children and young people with intensive and complex needs

It is evident that a range of models and practices have been developed in order to respond to the needs of children and young people who have intensive or complex needs. These models range from 'rostered care' and 'residential care'; to contracting external providers to provide the service. In some regions, specialist teams have been developed to work with this group of young people. There is also some overlap with the needs of young people involved with the juvenile justice system.

An overall lack of clarity about accountability for the services is evident. This area of out of home care requires very careful consideration in view of the high risk of the children and young people involved and the very high financial costs of services.

Recommendation 8.6
Contract an external review of present services and models for out of home care for children and young people with complex and exceptional needs

- 8.6.1 Urgent expert advice will be sought to review and provide specific recommendations relating to out of home care for children and young people with intensive and complex needs. The consultancy will be used to provide:
- Service model frameworks for the out of home care of children and young people with complex and/or challenging needs;
 - Identification of service gaps and recommendations for the future; and
 - A summary of good practice and research in the field.
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9. Enhance stability and permanent solutions for children affected by abuse and neglect

Permanency planning requires a clear direction

Permanency planning has long been recognised in the agency as an area where more exploration and policy development would be productive. A 2004 workshop and discussion paper²⁰ on this topic endorsed the need for more work to explore how permanency work may best be enacted within statutory child protection services.

A clear policy direction on permanency planning requires a clear understanding of the role of child protection services in ensuring the safety of children, while at the same time, preserving families whenever possible. In particular, a pre-requisite for permanency planning is a policy position on whether there is a limit to the number of attempts made to return a child safely to their family; when a decision should be made to permanently remove the child; what ongoing contact with the child's birth family should be planned; and how alternative permanent placements can be organised and supported.

Recommendation 9.1 Clarify policy positions and implement strategies to improve permanent solutions for children involved in the child protection system

- 9.1.1 The policy position on planning more permanent solutions for children in care will be clarified and specific guidelines provided to facilitate implementation of the policy position, including the time frame and reasonable conditions for attempting unification with parents.
 - 9.1.2 The option of a permanent arrangement for the child should be clarified and strengthened in the legislation.
 - 9.1.3 Where permanent arrangements have been determined to be in the child's best interests, the task of working on planning more permanent solutions will be specifically allocated through existing staff responsibilities or contracting this task to a non government organisation.
 - 9.1.4 The necessary long term financial and other support services (including provision if the placement breaks down) that are required for a child placed in a permanent relationship outside their family will be clearly specified and provided.
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²⁰ Building Bright Futures – our five point approach to securing the safety and care of children and young people: a framework for permanency, Children and Family services, Draft paper, 2005.

10. Improve accountability and quality assurance

Quality assurance requires a systemic approach

It is apparent that while there are various processes in place to address accountability and quality assurance issues as well as respond to complaints, there is an overall lack of a quality assurance framework and long term plan for improving quality in the child protection service.

Data collection and performance reporting

There is a need to more systematically monitor performance data

The agency has introduced a *Progress Chart* model to inform policy development, strategic and business planning and performance management.

The DHHS *Progress Chart* enables managers to specify what they are seeking to achieve as a business unit and how to measure progress.

The DHHS *Progress Chart* model specifies three categories of performance - Achievement, Quality and Access – that can be used to monitor the overall performance of a business unit. In addition there are five supporting action areas:

- High performing, motivated and supported workforce
- Community involvement in and satisfaction with DHHS
- Collaboration and integration
- Innovation and improvement
- Efficient and effective resource management

These categories are intended to be used as a framework for developing measures to monitor progress and planning initiatives that are likely to make a difference.

The DHHS *Progress Chart* therefore provides a useful framework for planning accountability and quality assurance processes in the child protection service.

Recommendation 10.1

Establish the DHHS *Progress Chart* as the basis for business planning and driving improvement

10.1.1 The DHHS *Progress Chart* will be used as the basis for annual business planning and regular data collection at business unit level.

10.1.2 A set of indicators in each key category and supporting area will be developed for child protection services.

10.1.3 Key data sets will be published regularly so that progress towards improvements is open and transparent.

Professional supervision and maintaining practice standards

Professional supervision and consultancy is an important part of maintaining standards

Child protection services have provision for professional supervision by line managers as well as independent consultancy support from practice consultants employed in each service centre and at central level.

Professional supervision should be an integral part of any professional service that entails making professional judgements to ensure that less experienced staff have the opportunity to reflect on their practice and that their decision making and work is subject to critical scrutiny from more senior colleagues. It is important that professional supervision is regarded as compulsory and does not become neglected due to work pressures or 'urgent' tasks.

In addition to line managers, practice consultants can make an important contribution to promoting and facilitating professional practice standards. The present role of practice consultants is interpreted inconsistently across the state and the focus of these staff is frequently diverted to supporting line management matters or general day to day business.

Recommendation 10.2

Establish professional supervision and consultancy as integral parts of service delivery

10.2.1 All staff will have compulsory formal professional supervision at required levels as determined by professional guidelines.

10.2.2 The role of practice consultants will be reviewed and their responsibilities and accountability for professional standards and practices more clearly defined and communicated.

10.2.3 An annual business plan will be developed with practice consultants to ensure their work is focused on achievement of agreed outputs and outcomes, including regular reports to the Director on professional issues.

10.2.4 Case audits and reviews will be conducted on a regular basis according to a business plan for each service centre.

Response to complaints and concerns

A more systemic approach is required to respond appropriately to complaints and concerns

The lack of a systematic approach to addressing concerns and complaints has resulted in an ad hoc and inconsistent approach. Concerns and complaints are addressed in different ways at the discretion of managers, with no overall public assurance of service accountability. As an area of practice involving serious risk to children's safety and well being, it is imperative that compulsory risk management processes are in place and that there are processes for responding to concerns and complaints.

Recommendation 10.3
Establish a formal process and model for responding to complaints and concerns involving the child protection service

- 10.3.1 A unit dedicated to investigating and responding to complaints and serious issues relating to child protection services will be established as part of the overall organisational model, after further consultation with staff.
- 10.3.2 This unit will encompass responsibility for complaints about children in care but will assume a wider scope for other internal and external complaints.
- 10.3.3 A policy and process for responding to complaints and issues will be developed to guide the work of this new unit and detail the procedures and accountabilities.
- 10.3.4 The Commissioner for Children should have responsibility for oversight of all complaints processes in relation to children. The Ombudsman should retain responsibility for the investigation of individual complaints if a person is dissatisfied with the internal response to the complaint.

An approach to investigation of child deaths and serious injuries where the child protection system has been involved is needed

It is evident that a mandated process is required to ensure that all critical issues, including serious injuries and deaths of children involved in the child protection system, are fully investigated and reported.

Tasmania is the only state or territory, apart from the Northern Territory and ACT (where a process is being developed) that does not have a legislated process in place for the review and investigation of serious injuries and deaths of children involved in the child protection system.

The Minister has asked the Commissioner for Children to recommend how Tasmania should proceed in relation to this issue and a report for the Minister is being prepared.

Recommendation 10.4
Create a legislated child death investigative process

- 10.4.1 A legislated process for the investigation of child deaths and serious injuries where the child has been involved with the child protection system should be implemented according to the recommendations of the Commissioner for Children.

Implementation Process

If accepted, these strategies will form the basis of a more detailed implementation plan designed to be implemented over the next three years. This plan will be provided within two months of the release of this report.

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