GordonCare
for children and families in need

Submission to the Enquiry into Department of Human Services, Child Protection Victoria.

A. Commentary on the current child protection system

GordonCare contends that the present system of child protection based on mandatory reporting has inadvertently created major drawbacks:

1. Inordinate resources are devoted to investigations which often do not result in any meaningful action or intervention.
2. The policy debate and resource investment can become overly focused on the tertiary end of child protection rather than a balanced spread of resourcing primary and secondary intervention.
3. The public "knowledge" of mandatory reporting policies often result in parents that need the most assistance becoming service avoidant.
4. When substantiations are made a focus on, getting certain kinds of results in the courts can reduce the focus on capacity building in parents and support for positive change efforts.
5. Removal of children and placement into out of home care is seen as a solution but too often it creates additional problems for the young people and their families.
6. Residential care design is fundamentally flawed. The therapeutic pilots offer some hope but a rethink is warranted urgently.
7. Effective reunification services should be a priority for the child protection system instead this area of opportunity is sadly neglected.
8. Cost benefit analysis is not evident in program development or justification
9. System monitoring data, if it exists and is meaningful, is not shared with the community sector.

1. Inordinate resources are devoted to investigations which often do not result in any meaningful action or intervention.

The classic funnel effect of mandatory reporting, namely a very large number of child protection reports, has resulted in many reports not being investigated. (Although this has been improved with the establishment of Child First programs which follow up less concerning notifications). This has led to a reduction in the number of investigations with many resulting in non substantiations and those substantiated not necessarily resulting in any further action. This has large cost implications, yet not much evidence has been advanced by DHS as to the beneficial effects of such activity on children and their families.

In fact, we believe the negative effects of investigations which are not substantiated need to be considered when evaluating the mandatory reporting design. This is not an argument against the need for investigations, but a plea that the action should be geared to assisting the families function more effectively as a rule, not merely seeking whether further intervention by the state is warranted. If the philosophy driving Child Protection is less of "forensic investigation" and more like that which prevails in Disability then the priority ought to be on focusing on what resources will

benefit the family to progress the development of the child and assist in family functioning rather than what are the deficits which may justify the removal of the child into Out of Home Care (OOHC).

2. The policy debate and resource investment can become overly focused on the tertiary end of child protection rather than a balanced spread of resourcing primary and secondary intervention.

There are many excellent primary interventions in Victoria like the universal Maternal and Child Health Nurse (MCHN) system and the more targeted Enhanced MCHN program. Additional child, family and parenting resource centres, as are provided in the Scandinavian countries could build and enhance help seeking by particularly young or less experiences parents. We suggest building up a bank of interventions from the ground up in the local communities would be worth trialling on a geographical basis (say a high growth municipality) and then comparing results over a three year period to the usual resourcing of a similar matched demographic area. This could guide investment decisions away from a crisis driven response to a more considered community resourcing response.

3. The public “knowledge” of mandatory reporting policies often result in parents that need the most assistance becoming service avoidant.

It is our experience in the outer south eastern growth corridor areas that the families in greatest need of advice and support avoid services for fear of “losing their kids to welfare”. This makes it difficult to engage such families in early interventions or other assistance which could be beneficial for their children's development or their family functioning. In addition, our staff have observed in a large local Pakenham Primary School that about 20% of the children entering school are not school ready. This further compounds their disadvantages. There is a gap in the institutional engagement of families where the MCHN system stops (around 3 years of age) and kindergarten and preschool begins. We believe that schools hold wonderful potential for parental engagement as a non threatening community place for delivery of many support services both surrounding the early education experience to facilitate school readiness and parental engagement in self help and community building. Education should be a vehicle for socialisation, citizenship and community participation and importantly a vehicle for exiting disadvantage.

4. When substantiations are made a focus on, getting certain kinds of results in the courts can reduce the focus on capacity building in parents and support for positive change efforts.

Through our Access Program we have noticed that Child Protection (CP) workers seem reluctant to accept positive observations about parents using the program as they appeared to be working toward a particular result at court. In the period when the program was being evaluated, 30% of parents ended up reunifying with their children even though this was not in the original case plan. The CP workers were discouraging positive observations about parental changes. The opportunities of the Access Program are that in a community service organisation creating an environment that is non threatening and child friendly. Parents become known and are shown respect. Staff, including reception staff show interest in them and treat them with dignity. The Access workers can begin both facilitating a positive relationship between parents and their children and also supporting parents with help seeking and addressing their self identified issues. Frequently parents have expressed that they were directed to seek assistance by CP workers but did not

know where to turn or who to trust. The extended period of court ordered access between parents and their children who are in OOHC creates an excellent opportunity for parenting development, relationship building and support of positive change which may either result in a realistic possibility of effective reunification or if that is not a realistic option the acceptance by the parent that their child is well looked after in alternate care and they will focus on developing a positive relationship with their child even though they are not able to achieve ongoing day to day care. It is worth noting that the parents using the GordonCare Access Program 70% grew up in OOHC! What chance have they of being effective parents without adequate experience of parenting models through their formative years?

5. Removal of children and placement into out of home care is seen as a solution but too often it creates additional problems for the young people and their families

This is not an argument against removal of some children into OOHC. GordonCare has the view that some parents are not able to care for their children and may be downright dangerous to their children's survival. However there is an assumption operating that the removal into OOHC is a solution to the problem of child safety and well-being. It should be but on too frequent occasions it is not. According to the UN Convention on Children's Rights, children who have experienced torture and or abuse have a right to rehabilitation. Issues including:

- Multiple placements:
- Inadequate case plans
- Case drift;
- Premature attempts at reunification resulting in the revolving door patterns of OOHC;
- Inadequate assessments and intervention/treatment services;
- Lack of meaningful engagement with education;
- Exits at 17 and a half into
    - Homelessness;
    - Unemployability;
    - Early pregnancy;
    - Transient lifestyles;
    - Tenuous personal relationships;
    - D&A abuse;
    - Persistent mental health issues

are hardly markers of system success. In “loco parentis” the state and the rest of us who form the child protection system with DHS are indeed poor parents and we need to do a lot better than at present. Effective casework practice, effective intervention and rehabilitation programs and sound system design are critical to young people experiencing abuse and neglect getting a better chance at life and positive participation in community life.

6. Residential care design is fundamentally flawed. The therapeutic pilots offer some hope but a rethink is warranted

The idea of community placement close to the community of support for the young person who is placed in residential care is laudable especially as a reaction to the old institutional care of the past. However, 4 bed units in the community cannot be a replica for the family in any sense of the word. By doing away with the Family Group Home model, the rostered staff alternative risks replicating a mini institution.

Adding to the change in personnel, the changing composition of the young people residing in the units makes it difficult to provide and create the predictable, caring, secure, containing and rehabilitative experience that traumatised and acting out young people need to make progress along their developmental path. The pay and conditions do not attract high calibre staff. And most do not stay in their positions very long. Due to the paucity of beds at a regional level the pressure of numbers builds to use the beds available and this takes priority over optimal matching at the unit level.

Agencies have little say over who will be admitted, for how long and when and where the young people will be exited. It is almost impossible to institute any meaningful program for the young people in residence when the composition of staff and young people is constantly changing. The current models are very expensive to operate, they have limited positive impact on the young people placed and can become unstable in response to the number and type of changes of residents and staff.

It is time to explore purpose designed models as developed in the USA and some European countries which combine planned placements, incorporating educational, therapeutic and rehabilitative design elements working intensely with the young people and their families with a clear purpose to address identified problems and assist the young persons and their families resume full pro-social participation in community life.

7. Effective reunification services should be a priority for the child protection system instead this area of opportunity is sadly neglected.

In the Southern region approximately 45% of entrants into the OOHC system are re-entries. This suggests a serious flaw in the system. Which industry or sector survives with a “failure” rate of 45%? Young people’s lives should be much more significant that recall rates of motor cars or mobile phones. The re-entry figure has several implications. It creates demand for OOHC placements so substantially it drives increased costs of “essential service components”. This is akin to the hospital system returning patients home prematurely and having to readmit them for further costly procedures because of inadequate discharge or after-care practices. GordonCare contends that the high re-entry figure into OOHC suggests:

- inadequate addressing of identified issues that brought the young person into care;
- inadequate preparation for the return to family of both the young person and their family;
- inadequate support in the transition period;
- no after care to ensure the reunification is going on successfully;
- and lack of provision for requests for ongoing assistance which may prevent the family or reunification breakdown.

Furthermore we contend that by not completing the work in the first place; after all, having the young person removed from home or relinquished by the family must have indisputable and clearly identifiable issues that need to be resolved or worked on and; it follows that these should be changed sufficiently before a reunification is contemplated and proceeded with. Greater care and focus on reunification would, we believe, result in a reduction of re-entries and therefore less cost to the system at the investigation and processing end (courts etc.) and these “savings” ought to be invested in more effective long term results by working with families and young people especially when the issues are critical and undeniable.

8. Cost benefit analysis is not evident in program development or justification

The suggestions above about a greater focus on effective reunification services are predicated on the contention that investing in one part of the system will create pay-offs in another. It would help DHS and the community service organisations plan more effectively if such analyses were undertaken and results disseminated and debated.

For instance, could the total investment in Child Protection, early intervention and family support in a region be monitored and decisions made at the regional level to put more resources into early intervention, family resource centres, educational hubs in schools, placement prevention services and reunification services and divert some of the CP investigation resources toward boosting support services on the ground with anticipation that investing in the former will reduce the need for the later. The result of such decisions should answer the questions: does the community benefit with better functioning families, greater participation in school etc., fewer child abuse notifications and fewer OOHC placements?

Cost analysis should not be program based and year budget based rather “client career” based. It is not the cost of 12 months of foster care or Families First intervention that is important, but the cumulative costs of “failure”. So when evaluating the worth of a particular program its benefits should also be tallied up. For instance, to set up an effective reunification service may be costly but if it is effective the cost should be juxtaposed against cost savings of further CP investigations, court processes, additional placements and the additional trauma and disillusionment of the young person generated by failed attempts at reunification or no attempts at all. There is also a potential additional benefit to the next generation. If the young person successfully reunites with their family and they experience more effective parenting it is more likely they will become better parents themselves in time. And their children will be less likely to need CP intervention.

9. System monitoring data, if it exists and is meaningful, is not shared with the community sector

The CP protection system ought to publish key statistical information about outcomes to children and families at least annually.

This would focus the minds of DHS and the community sector on the issues that need addressing. Are young people in care participating in schooling and employment at similar rates of the rest of the community? Are substantiation rates reducing as a result of different investment emphases on early intervention and prevention? Are re-entries significantly reducing? Are reunifications holding for more than 24 months? Etc.etc.

Like in the health system which monitor rates of disease, and systemic targets are set for eradication via vaccination etc., so should a holistic child protection system be gearing up to reduce the incidence of abuse and neglect and improved functioning of young people who come into OOHC or are subject to significant state intervention.

B. Some background and illustration of GordonCare's experience of the CP system with a specific proposal to improve residential care design

GordonCare for Children has had a long involvement with DHS Child Protection in the capacity of providing medium to long term residential care for children and young people. From the 1950's GordonCare has provided care for children and adolescents via a range of models including family group homes, residential care units and access program. GordonCare has a specific concern with residential care of young people in the child protection system and would like to draw attention and focus to the area of case management and placement of children/young people in residential care.

It has been the recent experience of GordonCare Residential Program employees that the climate in the southern region is one of urgency and desperation. A shortage of case managers, a lack of beds and an increase in the volume of children and young people requiring out of home care has created a bottle neck in the system which impacts directly on all of those involved. It is particularly in the placement of young people into GordonCare's facility that there is much to be commented upon. Young people are frequently being placed into GordonCare's units through the Placement Coordination Unit giving little or no time for preparation, minimal assessment of the young person has been carried out to determine their specific needs and little or no consideration of the young people already residing in that unit often resulting in an inappropriate 'client mix' which provides less hope for a successful placement. In many cases the young person arrives with no LAC documentation and scant details. One example of this is given in the following case study vignette.

Jenny:

(This case is hypothetical and is a composite of the experiences of a number of children in our care illustrating system issues)

Jenny is 11 years old and has been in out of home care since the age of 3. Jenny had a history of residing in a family group home over three years ago prior to being placed with her sibling in foster care. Two month's ago the foster care placement broke down and Jenny was referred into GordonCare's RP2 unit apart (for the first time) from her sibling. Initially, Jenny had no contact from her case manager for the first month and little information had been handed over to the unit. As she has only an interim case manager, the contract for her case management is being handed to an agency. Going through old archives, a file for Jenny was located as she had resided in our houses in her past and it holds copies of assessments from three years ago which have diagnosed her with Reactive Attachment Disorder, Foetal Alcohol Syndrome and an Anxiety disorder. The new case manager makes contact with one of the assessing psychologists and the paediatrician only to find that Jenny had been attending twice weekly treatment for over 3 years with the psychologist and it was only in the last four months that Jenny "Just stopped coming". Meanwhile, the DHS team leader was making a referral to Take Two for Jenny to begin treatment…having no knowledge that Jenny had already established a helpful attachment with her psychologist over many years. Within the first month of placement at GordonCare's RP2 unit, Jenny has been suspended from school for 'acting out behaviours' and has already broken several windows in her unit and harmed other residents and staff.

Needless to say after a relatively short time and despite the best possible efforts of carers, the young person placed is often then needed to be moved again to a 'more appropriate' placement. This has wide consequences to both that young person in that they are at risk of being re-traumatised by another rejection from a home and for the other residents of the unit who are also exposed to the acting out of that young person in their home environment. It is often a re-enactment of each young person's previous experiences of a disruption in attachment and adds to the cumulative harm for all children involved. This is a dilemma which needs focussed attention to resolve.

From all that can be understood at this point, the Placement Coordination Unit has limited tools at their disposal to ascertain the appropriateness of a placement. Children and Young People are classified as requiring RP2 or RP3 care according to minimal and unshared criteria which seems arbitrary and changeable according to the availability of beds rather than any formal assessment of that child/young person's functioning. It is in our recent experience that young people are moved from an RP3 unit and into an RP2 unit with no explanation of how their behaviours have changed to be re-classified. Many young people are placed in an RP2 unit with severe and frequent challenging behaviours which one would imagine could be considered to be needing an RP3 model of care, however due to a lack of beds in these units the child is given the RP2 classification and subsequently placed in a unit less equipped to manage their 'acting out'.

Proposal for an Assessment and Stabilisation Unit.
GordonCare proposes that in the Southern region funding be made available for the provision of an 'assessment and stabilisation unit' auspiced by a community based residential care organisation. This unit would provide two beds and provide a 24 hr model of care with one staff member sleeping over with access to on-call. The unit would be gender specific. It is anticipated that this unit provide care for six weeks for a child/young person as an initial placement or as a re-stabilising unit when a placement has broken down. During the six weeks of residency, the young person will have access to a range of professionals who may assess medical/psychological/educational/developmental needs and inform and develop initial care and placement plans/ treatment plans. Appropriate referrals for treatment will be made. LAC information will be established in this unit. In this period it will be ascertained which care options will be most appropriate for the young person and once this decision is final, the transition to that care arrangement will happen over a measured time frame to best prepare both the young person and the carer for success. It is also anticipated that the child's parents/family will undergo assessments in this time also to determine the capacity for a) parenting therapy and b) potential reunification. Young people will be provided with an opportunity to begin making connections with the community in which they will likely be placed and begin the long process of acquainting themselves with co-residents and carers whilst maintaining access arrangements with their families.

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