Submission to

Protecting Victoria's Vulnerable Children Inquiry

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Introduction

This submission **relates specifically to the 'residential care' component** of the child protection system in Victoria. That is, group homes run by NGOs and DHS. This segment of the child protection system can serve both as a 'first entry point' into longer-term residential or foster care, or as itself a long-term placement (e.g. several years).

I have worked in the residential care system in Western Australia (2005-2008) and in Victoria (2009-2011). In Victoria I have both worked directly for an NGO and also as an agency worker, which afforded me the opportunity to work at 8 sites across 4 different NGOs, plus 4 DHS-run units. In addition to this I have taught a TAFE-based course for young people disengaged with mainstream education, and designed and facilitated workshops in high schools for at-risk and disengaged young people.

Summary of Submission

It is no exaggeration to say that I have been horrified by key elements the state of the residential care system in Victoria. In my wide exposure as a youth-worker at a variety of sites I have observed a systematic failure to ensure both the safety of residents in residential care, and to provide an environment in which young people can in any way heal from prior experiences, particularly abuse.

This failure is not subtle or minor: I have seen young people endure daily severe beatings from their fellow residents, and be forced to steal for other residents, with no action taken. Worse, I have seen young people with minor behavioural issues turn into severe offenders within the space of only weeks in care, to the extent of prostituting themselves for drugs (two under-16 year olds), and being charged with armed robbery (an under-14 year old). In each case these were not behaviours they exhibited prior to entering care.

In my observation <u>one cluster of elements is key to this systemic failure</u>:

> **Placement decisions (i.e. placing and keeping a young person at a particular site) are made centrally by DHS with no choice by the agency (or DHS unit coordinator) or the young person; and these decisions do not take as their reference ensuring positive therapeutic and life outcomes for that young person, or the other young people at that site. Rather, it is assumed that it is enough to place and keep a young person anywhere. Even where the agency or young person is consulted, this consultation is not given any power or weight. This systematically undermines the work of coordinators and staff at residential units; makes it impossible for agencies and DHS houses to produce positive outcomes; and creates the most appalling and unsafe living conditions for young people.**

Detail in relation to Inquiry Panel's Terms of Reference

I have organised my submission into **6 summary issues**, below, which relate primarily to the following three elements of the **Inquiry Panel's Terms of Reference**:

> *3.1.4 Is the overall structure of statutory child protection services appropriate for the role they are designed to perform? If not, what changes should be considered?*
>
> *3.5.3 What more might need to be done to meet the needs and improve the outcomes of children in out-of-home care and those leaving care regarding...[t]heir education, heath and mental heath needs*
>
> *5.1.4 Is it necessary to strengthen the capability of organisations in the nongovernment sector to better equip them to work with vulnerable children and families and if so, how?*
> *[including some reference to points 4.1.1 (adequacy of relationship of government and non-government parties), 4.1.3 (useful interstate models of collaboration), and 4.1.5 (NGO funding models)]*

In addition **Appendix A recommends proposed practical changes to the operating procedures** of Victoria's residential facilities.

Issue 1: Agencies (or coordinators for DHS units) have no say in whether they accept a client

When I worked in Western Australia as a residential care worker, the admission process went as follows: an NGO would get a phone call from the equivalent of DHS stating that they had a client who needed accommodation (always urgently) and requesting they be housed with the agency. They would give a brief history of the client, and contact details. Then either I, as the youth-worker, or the unit coordinator, would contact the young person and undertake a brief phone assessment discussing their situation, recent history, drug and alcohol issues etc. and outlining the unit expectations. We would also seek (and almost always receive) permission to speak to previous units where they had stayed, and let the young person know we would contact them shortly. We would then contact the other units and discuss the client's behaviour and interactions with co-clients. Then the coordinator and the youthworker(s) (or just the youth-worker(s) if it was an evening or weekend) would discuss the likely interaction of the proposed new client given the existing case plans for the current clients, and the issues / triggers of current clients. If it was clear that accepting the current clients would seriously jeopardise our ability to make good progress against the case plans of the current clients we would contact the young person and the DHS-equivalent and say that unfortunately we weren't able to take that client at this time.

The effect of this is that as a unit (i.e. residential house) we were able to ensure that our case management plans were effective, and that the positive progress of existing clients was not unduly interrupted. This isn't to say that we would reject people at whim, not at all. Also, it's accepted that all clients in this sector are to some extent challenging. But it **allowed us to avoid predictable, calamitous combinations**, such as accepting a current heroin user into a house with a recovering user.

In Victoria the residential units have NO ability to negotiate with DHS regarding the clients they are given. In my experience the management of NGOs are nothing short of terrified that DHS will withdraw their funding if they do not accept anyone who is given to them. Consequently, **even in the case where a particular new client will have a predictable, catastrophic effect on the current clients and house configuration no consideration is given to this**.

Example 1

Client A, a young adolescent, entered a unit in 2009. He had been displaying various challenging behaviours and his parents were no longer able to have him at home. Also at the unit were three adolescents with significantly worse behaviours. Within a week client A was stealing cigarettes from the local shops for these clients. Within three weeks client A was arrested by the police for taking part in an attempted armed robbery at a city bottle shop.

In this case, client A did NOT exhibit these extreme behaviours prior to placement, and this situation was entirely predictable given the vulnerability of this young person, and the known extreme behaviours of the other clients. The situation was also exacerbated by point 3 (below) which is that the unit had no capacity to move client A or the other clients even as this situation unfolded.

Unit coordinators (both NGO and DHS) absolutely need the ability to discuss and if necessary veto particular clients at particular times based on the particular situation and needs of their current residents.

Issue 2: Young people have no say in their placement decision

In Western Australia clients could request to leave a particular unit. This meant that at some level clients were always at a unit at their own choice. This choice was not always particularly substantive – they may have felt that they had only one option, for instance. However, **the young person's choice was part of the placement process**.

As in all fields, this meant that the young person was already to some extent oriented towards a successful outcome. Moreover, it meant that as youth-workers we could start with the basic stance of "You are not required to be here; but if you do choose to be here we will do everything we can to help you; but in order to be here you need to stick to some basic ground-rules around safety and respect".

In Victoria young people have no choice or even consultation in their placement. Whether or not this is the policy, it is the way placement is carried out. This means that clients are NOT oriented towards success. Rather, they have the sense of being unfairly 'imprisoned' with trial or possibility of appeal, and this tone radically affects the possible ways of working with the young people. **If young people do not have the element of choice, then the only possibilities left are coercion or emotional blackmail**.

Young people absolutely need the ability to discuss their placement options with DHS prior to placement.

Issue 3: Agencies (or coordinators for DHS units) have no ability to move clients who are either a. clearly suffering placement breakdown, or b. significantly, ruinously disrupting the entire unit and the case plans of the other clients

In Western Australia agencies were able to identify and respond when either:

a) the client was not responding to their case plan and were getting worse
b) the client was significantly disrupting the entire unit and the case plans of other clients

In both of these cases the unit would of course try various things to address this situation. However, in the case where they identified that it was beyond their capacity to address at that time, the unit could request the DHS-equivalent to move the client. Generally this was identified with enough notice that this could be done relatively smoothly, though in some cases the unit would have to evict the client and call the police to come and remove them.

In Victoria agencies do not have this ability, and the placement management part of DHS does not respond to case recommendations or incident reports which detail increasingly ruinous behaviour. Again, I'm not referring here to merely challenging behaviour, but to violent, criminal, seriously damaging behaviour.

Example 2

Clients B and C had been at a placement for several months in 2009. They both had significant behavioural issues. After several months of coordinated case management and consistency the staff team had managed to markedly improve their behaviour, and things were looking up for them. At that point, however, client D entered the service (note that point 1 above also applies to this example, as client D was older and known to have far more extreme behaviours). Client D rapidly moved to a position of influence over clients B and C and their behaviour deteriorated. Client D also relapsed to a heroin habit. At this point the unit clearly identified that not only were they unable to manage client D effectively (a higher support placement was required), but also clients B and C were a significant risk. However, no action was possible other that submitting numerous incident reports and case notes, none of which were responded to. Consequently, about 6 weeks after client D arrived, clients B and C started prostituting themselves for drugs, and also became completely disengaged from the unit's previously successful case management.

In this case (which I remain furious about) this outcome was predictable, and had a clear progression that could have been halted had the unit had the authority to move client D to a more appropriate placement.

The exact circumstances in WA differ from Victoria in some ways, but the basic principle holds: a unit absolutely requires the ability to remove clients who are endangering and significantly disrupting themselves and other clients. **Without this basic right, agencies cannot guarantee or even attempt significant progress against overall positive outcomes for the young person**.

Issue 4: Young people have ability to request to change units and have this be actioned

I'm not referring here to a young person whimsically or cynically asking to be moved as a control mechanism, but about a young person living in highly unpleasant and unsafe conditions which persist over time, and this still not being grounds to request to be moved.

This issue relates to issue 2 where the effect of their lack of choice regarding placement is discussed. However, this issue stretches further and impacts the young person's ability to manage their own choices and life outcomes.

Example 3

Client E entered a unit in 2009. He had challenging behaviours and a tendency to abscond from placement. At this unit he was highly unpopular with the other clients, who systematically bullied him. I observed on every shift two of the clients would punch, kick and shove this client, leaving bruises. They also continually hassled him and terrorised him. Staff were unable to change this situation due to issue 3 above (inability to move clients), and submitted regular severe incident reports, and eventually a police report. None of this was considered enough to move the client despite his request. This living situation, obviously, completely removed the young person's ability to choose to address his own issues, or make positive life choices.

There needs to be a mechanism for clients to request and justify their desire to move placement, and, if justified, that request be respected rapidly.

Issue 5: Central decisions do not make reference to actual positive therapeutic and life outcomes

What appears to be completely **missing from placement decisions is any sense that a residential care placement can be a therapeutic and positive developmental experience for the young person**. When agencies have the ability to manage their client intake, they are able to develop sophisticated and effective case plans for clients. I have seen in Western Australia this process have highly desirable outcomes for clients.

DHS is clearly not making reference to the notion that they might partner with agencies to produce therapeutic and positive outcomes. I don't know what the criteria is instead, but it seems to be more like 'it's crucial that all young people be accommodated immediately'. This, of course, is true...but **the way it is implemented puts it at odds with positive outcomes for Victoria's vulnerable young people**.

Issue 6: Central decisions are based on a superficial and inaccurate assessment of the client's situation, and ignore input from those 'on the ground'

DHS case assessments are generally based on short visits during the day-time, and often out of the unit. At these times there are usually multiple staff on shift (including the coordinator), often the other clients are not home, and most clients in residential care have less severe issues during the day (for many clients, nights were when they were abused and they find it very difficult).

The staff on site, on the other hand, see these clients behaviour in the full range of situations, particularly at night with a full-house of clients and only one staff member on. Staff make copious case notes and submit numerous incident reports, but placement decisions are based on the superficial assessment of the DHS worker seen during the safe hours, not based on a robust assessment of the client which the staff team can develop in a coordinated way.

Placement decisions need to be made with reference to the robust and thorough observations and conclusions made by the staff team. As mentioned in issue 3 (above) staff teams should have the ability to make overarching case management decisions themselves, such as placement-breakdown.

Next steps

Thank you for the opportunity to contribute to this Inquiry. I would be delighted to provide further detail on any of these points. I can be contacted at [redacted].

Appendix 1

Proposed changes to operating procedures in Victoria's residential care facilities

Note: These changes were written specifically to apply to a specific NGO. However, the points are generic to any Victorian residential facility.

1. Implement a written warning system for serious breeches of unit requirements, leading to client removal from facility if they receive 4 written warnings[1] (additional detail below)
2. Mandatory, well-planned day program operating most week days for every client
3. Clients to cook evening meals except Sundays (staff to prepare) and pre-planned take-away or outings. Clients to negotiate nights and specify meals (to enable shopping) at weekly house meeting. Timetable and menu to be displayed outside office and in kitchen
4. Clients to have a weekly household chore each, to rotate between set chores
5. Implement structured system for clients to request transfer to another residential facility. This choice to be actioned within 5 working days
6. Clients behaviour in evenings and on weekends to receive significantly increased attention and weight in case management
7. Shift change to include paid handover period of 20 minutes. Handover to include focus on debrief of outgoing youth-worker
8. New clients not accepted until support plans and other crucial case management documents received (substitute detailed and authoritative verbal handover in some cases) AND staff have been able to review them and develop an initial approach (min 1 hour)
9. Coordinator power to refuse a new client in cases where the client's behaviours and current situation present a clear threat to the running of the unit and the existing client cohort
10. Principles of restorative justice to be used when clients assault or are exceptionally abusive to staff. Restorative justice brings together the offender and perpetrator with elements of their family and community in order to come to terms with and heal damage done

'4-Warning' system

Clients to be given a written warning for the following breeches of household expectations:

- violence to staff or co-clients[2]
- significant property damage, or repeated minor property damage
- extreme verbal abuse, or consistent moderate verbal abuse, to staff or co-clients
- mistreatment of neighbours inc. abuse, graffiti, and throwing objects over fence
- repeatedly not attending day-program
- repeatedly not returning to placement when required or expected to do so
- repeatedly refusing to cook or undertake weekly chore

[1] I have adapted this system from the '3-warning' system used by Anglicare in Western Australia

[2] Staff team will need to workshop and clearly specify and document which actions count as violence under this expectation

If clients are consistently demonstrating any of these behaviours and staff are unable to moderate their actions then it is impossible that they will achieve positive outcomes at Glasgow Avenue, and it is impossible that staff can ensure positive outcomes for other clients while that young person resides at the facility. Written warnings do not substitute for rewards-based practices and other standard behaviour management procedures.

The 4 warning-system operates according to the following procedures:

- each written warning relates to an incident as a whole i.e. if a person breeches several expectations in one incident they only receive one warning
- warnings are not to be presented during the incident, but later or the following day
- warnings are to be carefully prepared, presented to the client using the principles of the therapeutic method, and signed by the young person and staff member
- warnings are to clearly state the relevant household expectations and breech
- once clients receive a 3rd warning the unit will contact DHS to begin to organise next placement options
- once client receives a 4th warning they must exit the unit within 5 working days. If the 4th warning relates to repeated violent or dangerous behaviour client must exit within 2 working days
- a warning will lapse automatically after 2 months. Warnings can be ‘worked-off’ quicker by an agreed 1 week additional daily chore or development activity AND no repeat of the behaviour during that period. Only 1 warning per week can be 'worked off'
- 4th warnings cannot be 'worked off'