RCH Social Work Department and Wadja Aboriginal Family Place

Vulnerable Children Inquiry Submission

The Social Work Department of the Royal Children's Hospital respectfully makes the following submission to the Inquiry. It is hoped that the suggestions and comments offered will be of some assistance to the Inquiry's investigation into the effectiveness of existing systems, processes and enhancements in systems and services to protect children.

The submission is based on a child centred, family focussed approach to child health and welfare with particular emphasis on the needs of children with medical needs.

The health system sees children at all stages of the child protection spectrum; from those who are vulnerable or at risk of harm to those who have sustained abuse or neglect.

Understanding children's health needs

The health needs of children must be a central consideration for child protection and welfare services.

An understanding of child health and child development could be improved in a number of ways. Greater education of child protection staff, co-location of child protection worker at paediatric hospitals, enhanced curriculum in social work training programs could be considered.

There is currently no medical expertise in DHS child protection services. This is a considerable barrier and means in practice that protective workers do not have the skills or training to understand or respond to children's medical needs.

To illustrate this need, consider a child who is in Paediatric Intensive Care with a cardiac condition. The protective worker phones daily for an update and is told that the child is 'stable'. The worker has no understanding that the child is critically unwell, requires assistance with breathing, nutrition and will need further surgery if she is to survive beyond infancy. Another example could be a child diagnosed with 'failure to thrive'. The DHS worker receives information about the child's weight and uses this to decide that the child has experienced neglect. However the worker does not understand that the child has other complex medical needs and therefore her weight is appropriate for a child who was born prematurely and has complex needs.

Other jurisdictions (including Boston Children's Hospital and Morgan Stanley Children's Hospital New York) have a liaison nurse employed by the child protection agency. This role assists child protection staff to understand and plan for the health needs of vulnerable children. It is recommended that the Inquiry consider a joint appointment between DHS and major paediatric hospitals- a health specialist who could help translate medical information for child protection staff. It would be in the best interests of children to include input from medical, mental health, sexual health and other specialists in case planning where appropriate.

It is worth noting that the Victorian Child Death Review Committee Reports 2006- 2009 identify that children with complex medical needs continue to dominate the child death reviews. This highlights

the need for DHS to have greater understanding of children's medical needs to inform decision making.

Children with Disabilities

The literature shows that children with disabilities are vulnerable to abuse and neglect for many reasons including inability to communicate, physically remove themselves from abusive situations, additional care needs, reliance on others to meet intimate care needs, lack of sufficient respite services, carer burnout etc. These children are amongst the most vulnerable in society.

However the child protection system does not adequately respond to the needs of children with disabilities.

The Dept of Human Services currently has responsibility for both child protection and disability services. However these two areas appear to operate in isolation from each other, without adequate communication, collaboration or joint case planning.

Children with disabilities who are at risk or have been abused are 'difficult to place' in alternative care arrangements. These children are sometimes even more vulnerable when the system fails to respond to their special needs. It is our experience that children with disabilities sometimes remain in unsafe or suboptimal situations because they are not a high priority for child protection services. Too often, children with disabilities are admitted to hospital for social reasons, where carers are no longer able to cope and require emergency assistance. Increased emergency respite places are needed to meet the needs of these children and their families. It is heart breaking to see carers present at the emergency department, feeling they have failed their child, feeling desperate for help only to be told there are no placements available and they simply have to take the child home.

It is recommended that the DHS establish clear processes for collaboration and joint working between the Disability and Child Protection branches of the Department and health services.

Health as key consideration in DHS Management of Children with Chronic Illnesses

Children with chronic medical conditions also need greater attention within the child protection system. For example, children with type 1 diabetes need additional care and their parents undergo comprehensive diabetes education at the time of diagnosis. However if the child's carers change or the child is placed in a residential facilities, those new carers must also have diabetes education in order to safety care for the child. Without this, the child is at risk of severe diabetic ketoacidosis or even death. Too often we have seen children placed in out of care without their new carers having any education about their serious health needs.

The concept of medical neglect and the cumulative harm it causes; where caregivers consistently fail to meet their child's medical needs, also needs to be examined. For example, if a child with an eye problem fails to attends multiple appointments the child may therefore miss out on specialist treatment which could result in a life long vision impairment. These situations are complex and create much concern for hospital staff. However it is difficult to convey these concerns to DHS child

protection, anecdotally because the DHS intake staff do not understand the health issues or consequences of non compliance. This is a further example of the need for child protection services to better understand children's health issues.

Aboriginal Children

There have been considerable improvements in the capacity of the child protection system to meet the needs of Aboriginal children; but more is needed. The health of Aboriginal children is not only physical health; it includes cultural, social, emotional and spiritual health. The Royal Children's Hospital Wadja Family Place employs Aboriginal health workers and case managers to support children and their families negotiate the acute health system. It is recommended that funding for similar services be increased to ensure that Aboriginal families are supported in all mainstream health services meeting their children's health needs.

The Children Youth and Families Act 2005 (Sections 12-14) sets out additional decision making principles for Aboriginal children. In practice this includes a requirement that Lakidjeka staff from the Victorian Aboriginal Children Care Agency (VACCA) participate in decisions and case planning for children involved with the child protection system. It is our experience that Lakidjika staff are not always included in DHS case conferences or meetings within this hospital regarding the health needs of Aboriginal children. More involvement of VACCA in case planning is necessary to ensure that the child's family and medical history and culture are effectively communicated to the hospital. Further we would suggest that Aboriginal hospital staff (in our case Wadja team) be included in DHS case planning meetings regarding Aboriginal children with medical issues who attend RCH.

Whilst there are a number of Aboriginal Focus Units within DHS Child protection, there is a clear shortage of Aboriginal people working in the child protection system. At present there are no Aboriginal identified positions in the Aboriginal Focused Teams in DHS in Victoria. We would suggest that greater priority be given to training and ongoing professional development for Aboriginal staff in this sector. In New South Wales for example, comprehensive training is provided to ensure Aboriginal staff are employed and retained in positions within the Department of Community Services (DOCS).

CALD Families

The child protection system is founded on Western, Anglo saxon values, policies and staffing. It is strongly recommended that services for culturally and linguistically diverse families be enhanced. Tertiary education places should be offered to students from CALD backgrounds; to develop the capacity of the child protection and family services systems to meet the needs of CALD families. It is suggested that DHS Child Protection consider appointment of cultural advisers from key CALD communities, in a similar model to the current Specialist Infant Protective Worker role.

Furthermore, it is recommended that access to interpreters be improved through increased funding for interpreting services. At present there are situations where interpreters are not available or utilised therefore increasing the vulnerability and powerlessness of families entering the child protection system. The particular cultural aspects of the situation are not taken into consideration.

Parents' needs

Supporting parents is necessary in order to help each child reach his or her potential.

The child protection and welfare system needs to better support parents. The system should sustain and support vulnerable children and their families. It is argued that the state should provide broader universal services to support all families e.g. community health centres, MCHN services and parenting education to strengthen families and prevent children entering the child protection system. More resources are required for local health services, particularly in areas of increasing population that are currently underserviced e.g. outer western metropolitan area. The mode of service delivery needs to be flexible and should include increased home visits.

Children with complex medical needs require a high level of care. Children are sometimes discharged from hospital into their parents' care with care needs that (in hospital) would require 24 hour nursing care. Increased respite places are required; and funds needed to train respite carers to look after medically complex children. This would better support parents to meet their child's needs in a long term and sustainable way.

Service sector

It appears to be a considerable problem for vulnerable families that the human service sector is not integrated. Families are forced to access multiple services e.g. housing, health, domestic violence, mental health etc. This can be overwhelming for families particularly those on low incomes and without access to transport. Some families are currently assisted in navigating the service sector for family support workers. It is suggested that a 'one stop shop' be considered to provide necessary services to families. This could perhaps be achieved by improving and enhance community health centres.

It is noted that regional differences create significant inequality at present e.g. eastern vs western region of Melbourne appear to have very different resources and access to appropriate social services. Services to rural families are also limited therefore reinforcing geographical inequality.

Cumulative harm

Although described in the Children Youth and Families Act 2005, the concept of cumulative harm does not appear to be utilised in practice. Currently, DHS appears to employ a 'three strikes' rule to define or determine whether cumulative harm has occurred and whether protective investigation is warranted. It is recommended that further resources be committed to investigating and responding to reports of cumulative harm.

Preventative work with families and Child FIRST

Although Child FIRST was intended to provide services to vulnerable families; the system appears to be significantly under resourced. Long waiting lists and lack of family support staff in several Child FIRST areas mean that vulnerable families do not receive support in time and therefore become

clients of DHS Child Protection services. We would strongly support increased resources for family support services, early parenting centres, Maternal and Child Health Nursing and Child FIRST intake services.

The launch of Child FIRST and attempt to integrate family services is welcome. However the sector is very under resourced; with difficulties in attracting and retaining staff also evident. Long waiting lists exist. Families in the Western metropolitan region can wait up to three months to be allocated a family support worker. Wait time for Child FIRST assessment has added another layer of bureaucracy and delay. Family services need increased funding to meet the needs of vulnerable families.

The system of intake assessment through Child FIRST needs to be evaluated; to determine whether families to access the package of services they require.

Communication and feedback from Child FIRST should also be addressed. At present, there is significant variation across regions, with no consistent practices in place for how Child FIRST actually operations. It is essential that feedback is routinely provided to referrers; to avoid situations where families fall through the gaps and do not receive any service.

<u>High risk adolescents</u>

Greater attention should be paid to the needs of adolescents at risk of harm. Young people who are self harming, substance affected or homeless need special attention. In our experience, these young people may attend at hospital Emergency Departments and wait for long periods for appropriate placements to be found.

There is some anecdotal evidence that in these situations young people are sometimes admitted to hospital as 'social admissions' until a suitable placement is identified. This is inappropriate for young people who are not medically unwell and therefore should not be in hospital. Greater resources are needed for emergency placements for young people.

Early intervention and support for young people at risk is essential. Closer cooperation between child protection / family services and the education system is necessary.

It is suggested that the capacity of mental health services be enhanced to work together with child protection and education systems in order to meet the needs of these vulnerable young people.

<u>Non accidental injury of children</u>

Children may be admitted to hospital or treated in the emergency department where they have sustained non accidental injuries. These can range from minor bruising to serious or life threatening injuries.

In many such cases, case conferencing and interdisciplinary working appears to work well. However it is perhaps too little, too late for these children. There also remain a significant number of cases where DHS' inability to understand or interpret medical situations hampers their capacity to respond appropriately and in a timely manner.

Where children sustain serious injuries believed to be as a result of abuse, we would suggest that a comprehensive multidisciplinary case review be undertaken to identify 'what went wrong'. This would be similar to the current child death reviews. In Philadelphia, US, for example, the Coroner's legislation requires a systematic and multiagency review of child abuse cases that are classified as 'near fatalities'. A case review including chronology of events is used. We would recommend that this approach be considered, in order to identify areas where systems have failed children and their parents.

Out of home care

Children living in out of home care need additional support in relation to their health needs. All children in out of home should have a comprehensive paediatric assessment upon entering care and annually thereafter. This practice is in place in the UK Looked After Children guidelines; which emphasise the State's responsibility to ensure that children's health and developmental needs are met whilst in care. Similarly, Boston Children's Hospital has a dedicated 'foster care clinic' whereby children in out of home care receive paediatric assessment.

Attendance at specialist appointments for children in out of home care are currently problematic. Children must attend medical appointments with their carer (not DHS or agency worker) so that their health needs and daily routine can be discussed with the treating doctor. Children must also come with relevant health information e.g. immunisation history.

A formalised system is required to ensure that DHS holds the child's history, that it moves with the child and that it is recorded in an appropriate manner.

There are times when the state (as carer) can be a neglectful parent. We have seen children attend medical appointments in shoes that are too small, without correct eye glasses and without necessary equipment such as orthotics or hearing aids. These are examples of children's medical needs not being met whilst in out of home care. Other developmental needs of children in care must also be addressed – e.g. toilet training , social activities, preschool opportunities. These are not 'optional extras' but are essential to help vulnerable children realise their potential.

Where young people in care are parents themselves, consideration should be given to foster care placements where the teenager and their infant be placed together, to promote attachment and parenting education.

Young people leaving Care

Currently protective services for young people appears focussed on immediate safety and accommodation. More work is needed with young people to address their experiences of trauma

and separation before they leave the care system. Young people who become parents whilst known to protective services need additional support. Too often these young parents 'graduate' from the protective system and are without support as they struggle with the challenges of becoming parents.

Young people with disabilities and / or chronic illness also need special consideration. At present there is no consistent support in place from DHS to assist young people to successfully transition to adult health care services.

Interagency communication

Several local informal arrangements exist for interagency communication e.g. regional liaison meetings between police, child protection and medical services. These are ad hoc and can depend on the good will of individuals to convene and continue the meetings. Instead it is suggested that quarterly liaison meetings be mandatory and convened by DHS to ensure ongoing attendance and effective interagency communication between key agencies.

Improved multidisciplinary cooperation

Co-location of protective services and interdisciplinary training may assist with better multidisciplinary cooperation in working with vulnerable families. Some US jurisdictions have co-located child welfare, police and medical services (e.g. Child Advocacy Centres in New York state) which appear to improve joint working. It is suggested that this be considered in a Victorian capacity e.g. allocation of a protective worker and child welfare trained police officer in paediatric hospitals.

Sharing expertise in child welfare

Victoria does not currently have any process for child welfare or family services to consult with experts about practice situations or complex cases. In other jurisdictions (most notably Pennsylvania, US) a state-wide Child Abuse Review Panel meets quarterly to offer advice and practice directions to child protection practitioners. This board would comprise of child protection staff, lawyers, magistrates, child psychologist, family therapist, paediatrician, police and representative from child death review panel. It is suggested that a similar model be considered in Victoria.

Child Protection workforce

The ongoing turnover of staff in protective services and family support agencies has a considerable impact on the best interests of vulnerable children and their families. For example, the allocated worker for a child in out of home care undergoing cancer treatment may change several times during the child's illness. Information about the child's health needs is sometimes lost in handover processes and the lack of continuity is a considerable barrier to communication with health services.

Lack of continuity in the workforce is also a considerable barrier to the quality of the engagement and work with families.

There are anecdotal signs that the child protection workforce is unskilled, unsupported and that the most junior staff are at the 'front line' managing complex situations. It is therefore unsurprising that workforce turnover is high. There is no evidence that expert practitioners are working directly with families or supporting junior child protection workers in day to day case practice.

Education of the child protection workforce needs to be addressed. In hospital social work, for example, the minimum qualification to be able to undertake social work a Bachelor of Social Work (and increasingly a Qualifying Masters of Social Work). We would recommend that this is made mandatory for all new appointments to DHS, and pathways be set up for existing staff to study social work through the provision of scholarships and paid study leave.

Children's Court Processes

It is suggested that the adversarial nature of the current Court system is not sufficiently child focussed. Consideration should be given to adoption of a Guardian ad litem system as currently exists in the UK.

It is also suggested that better use be made of family conferencing through the Court system; to engage and involve parents and families in decisions about their child's care.

Court Orders pertaining to children with medical needs

It is the experience of the SWD that some Children's Court Orders do not adequately account for the health needs of the child. Children who are critically unwell for example may not benefit from parental access three times per week. We have observed instances where infants with serious cardiac problems have become distressed during parental access, which has negatively impacted their breathing and heart rate. Such visits appear to benefit parents rather than children. It is recommended that, for children with additional medical needs, access be varied based on the advice of the treating physician regarding the child's capacity to participate in or tolerate access visits.

Similarly Family Court Orders need to be examined where they pertain to children with medical needs. Custody arrangements for children need to include provision for their health and medical needs. For example, where a non-custodial parent cares for the children each school holiday period, it is important to ensure that parent has sufficient education in relation to the child's health care needs and is competent to meet these.

Conclusion

The Royal Children's Hospital treats children of all ages with a wide range of medical issues from emergencies and acute illnesses to chronic and long term medical problems. The examples provided above are based on the experiences of social workers in this acute paediatric hospital setting.

This submission is an attempt to highlight the health and developmental needs of children; and to advocate for the needs of these most vulnerable children in Victoria's child protection and family service system.

It is hoped that the comments and suggestions above will be useful and productive in assisting the Inquiry with its work.