Submission to Inquiry

I am writing in my professional capacity [redacted] This submission provides my personal views only.

[redacted] is funded by the Department of Child Safety (the Department) to provide mental health care to children and families who are supported by the Department. The scope of [redacted] extends from individual therapy through family therapy, medication management, and training for stakeholders. A key part of this work is to bring together all these stakeholders who have a role in the care of the young person involved, including residential carers, the Department, teachers, correctional staff, other health practitioners, and emergency service workers.

Often referrals to [redacted] are made because a child's situation is more complicated than usual. Indeed, children at [redacted] are amongst the most complicated and complex in the mental health and child protection systems. A major part of [redacted] remit is to assist in helping a team to function more cohesively. While this broad systemic approach with a mental health focus cannot solve all problems, we are experts at keeping the child's experience in mind and bringing stakeholders together to work towards a common goal.

- **Problem**: A focus of the Inquiry is the high cost of residential care. In my work I notice that many foster and kinship carers, and biological parents struggle with low incomes and find it hard to juggle all the commitments they have while also earning money to support themselves and the children in their care. Children involved with Child Safety (the Department) usually need more care, and more time from their carers than those who have no contact with the Department – they are not 'typical' or 'average' children.

➢ **Possible Solutions**:

1. Having secure and sufficient income, and more time available, means that carers have much more mental energy left over to spend on the children in their care. The stress of juggling things like school pickups, not losing income from unpaid leave, paying bills etc, while normal for most adults, mean that many parents or carers cannot provide the extra care most children in the child protection system need. From what parents and other unpaid carers tell me, additional supports would make a huge difference in their lives. Additional supports could include:
    1. i. Supplemental income or even a salary. This would need to be a meaningful amount, in order to ensure families are well above the poverty line.
    2. ii. Financial support for life-improving supports, such as payment for cleaning, garden maintenance services, medical bills (for the carers), or even groceries. This could extend to paying for counselling or therapy for parents, siblings, and other carers.
    3. iii. These costs would be much lower than the cost of a residential placement, while being likely to offer much higher relational availability for the child within a family-based placement. It would also mean potential foster/kinship carers would not be asked to make the same huge sacrifices they are currently called on to make. In some (perhaps many), this reduction in stress would allow biological parents more mental reserve to be the parents they want to be.

2. Providing biological parents and foster/kinship carers some paid-for in-home help could be helpful in reducing day-to-day stressors, without requiring the whole cost of a residential placement.
    i. These models have been effective in aged care, based around the aged care assessment teams (ACAT). A similar assessment service could operate in the child protection space. At present these practical financial supports are not offered or provided for most parents and carers which, like when not available in aged care, then results in much more expensive options being required (eg. residential care).
3. This support could and should be considered early intervention.

- **Problem**: Residential care (resi) is expensive, and yet its effectiveness is continually undermined. When a placement breaks down (ends prematurely/suddenly) this incurs extra costs, both financial, and to the child. These include:
    - Emergency accommodation
    - Emergency services call outs
    - Inpatient admissions
    - Emergency department presentations
    - Children go to jail with a high likelihood they will return to jail as adults, leading to ongoing costs to society throughout their lives, including the loss of productivity and tax revenue.
    - Building/repairing a stronger home, and maintaining it.
    - Buying a new property
    - Recruiting and training new staff
    - More staff being required to maintain safety
    - Fewer children in a placement
    - Restarting therapy with new carers and therapist
    - Maintaining a resi while a child is in jail
    - Greater likelihood that this new resi/setup will also end prematurely.
    - The child loses trust again

1. Some real examples of this include:
    i. a child moves to youth detention so residential carers are no longer paid. The carers who know the child then leave to find new jobs so they can afford to feed their own families, and the child comes back to a new care team and becomes more dysregulated, leading to placement breakdown and further time in detention.
    ii. A child is doing very well in a single tenanted placement, but is destabilised by a new co-tentant This begins a cycle of placement breakdowns resulting in more expense over time for emergency accommodation and establishment of new placements.
    iii. Care providers feel they can’t pay for team training, or even team meetings, and so staff become demoralised and leave. This increases the likelihood of placement breakdown and increases the overall cost of caring for a child.
    iv. A resi receives a new cotenant with no notice to staff or other children. The placement breaks down because they fight or scare

each other because none of them have been given the time to get to know each other.

- **Possible Solutions**:
  a. Ensure staff are paid when children are unavoidably absent from the home, for example when in youth detention, or even when the home has been damaged (due to the child, or from external forces such as storms)
  b. Ensure team-building time and training time, including shift handover time is budgeted for in contracts and paid.
  c. Keeping children in care connected to those who care for them is critical for reducing rates of recidivism.
  d. Avoiding sudden changes of accommodation. Allow children time to get used to new accommodation and co-tenants. Avoid sudden changes of co-tenants, and when change is impossible to avoid, allow children time to get to know each other. It is unreasonable to expect new housemates to suddenly get along, just as it is unreasonable for adults.
  e. Ensure that all changes in accommodation are given as much notice as possible of the changes and ensure this is communicated in a timely way. Most people, adults and children, would need many meetings over weeks before fully trusting another person, even if they do not have a trauma history. This is much harder for those who have been traumatised, and ideally they would have more time to adjust to changes.
  f. Placements could remain open even if a child has not slept there for some time. Even if a child has not slept there, having no clear 'home' to return to is immensely frightening and destabilising for most people, making it more likely the young person won't sleep at the next place, because they won't trust it is safe and reliable. Any alternate placement could be found in consultation with the young person, after concerted efforts to determine how their life experiences are contributing to them not sleeping at the current house.

- **Problem**: No one has the time to think about the whole system and work out why it is struggling. A child in care is part of an incredibly complex system. However, in spite of the immense financial and time cost of care, there is little provision for time to be spent considering how to improve functioning to minimise cost over the longer term.
- **Potential solutions**:
  1. Increasing the number of clinicians with [redacted]
  2. Increase the number of Child Safety Officers
  3. Reducing the caseloads for each clinician so that they have time to adequately support these complex children and systems.
     i. Historically the [redacted] case load was half what it is now. Much of the work that would help the system function to the best of its capability is no longer possible.
  4. **Reducing the case loads of each child safety officer for the same reasons.**

- **Problem**: First Nations people are over-represented amongst children in care, and do not receive the support required to prevent them being removed from their families, or support them once they are.
- **Potential Solutions**:

1. Integration of Aboriginal and Torres Strait Islander Health Workers in every [redacted].
   i. To be meaningful this would require sufficient workers to spend meaningful time with all children, particularly those in care. This would likely mean more than one worker in many teams. The appropriate workload should be determined by Indigenous people themselves, as other health service expectations are likely to be unhelpful in some circumstances.
   ii. In order for Aboriginal and Torres Strait Islander Health Workers to have a meaningful voice in the system it would be helpful if they were to be appointed and paid as senior team members, with clearly available opportunities for career progression. This could be beneficial regardless of 'on paper' experience and qualifications as the health system is not set up to value the voice of junior team members at present, and this is more relevant for minority groups including Aboriginal and Torres Strait Islanders.
      a. This would also help reduce staff vacancies
   iii. More cultural practice advisors could be employed within Child Safety, with pay and conditions set to minimise the likelihood of positions remaining vacant, in numbers sufficient to ensure every child has a cultural plan. Similarly it would be helpful if these staff were appointed as senior team members with commensurate opportunities for pay and progression.
   iv. Job descriptions could be written in consultation with local elders and community groups to avoid a situation where no one is qualified to fill them.
2. Children at risk of being removed from their families could receive the supports suggested above, prior to being removed, and/or afterwards if necessary.

- **Problem**: Many children in care feel as if they have no voice, and have an experience that no one understands their situation, this is despite an 'on paper' emphasis on informed consent.

➢ **Potential solutions**:

1. Graduates (or care-leavers) of child safety out of home care could be employed in the child safety service centres to give voice to some of their unique experiences. This could follow a similar model to peer workers in mental health services (government and non-government). This may share some similarities with the model for cultural practice advisors within service centres at present. Representatives within the Office of the Chief Practitioner are also likely to helpful.
2. It may be helpful to consider a similar concept for foster/kinship carers, and indeed biological parents who have left the system and contributed to it.
3. Funding positions for graduates/care leavers of out of home care within [redacted] teams could be very helpful. Indeed this may be one of the most helpful places to employ people with lived experience of the System, where they can be safely supported, and their voice can be amplified to help the system to function better.
4. Children need a consistent person throughout their time in care and beyond. CSOs cannot currently perform this role as they change or leave so

frequently. Solving this problem requires greater institutional commitment to staff retention, which would likely need to include significantly higher salaries, and positions allocated to First Nations workers for First Nations children. This could happen within Child Safety, or within the NGO sector. However, this is unlikely to be amenable to routine tendering for contracts as the market will lead to the lowest possible salaries and conditions which would not be conducive to staff retention. Continuity/retention is more important for this purpose than almost any other, with the aim of giving the child an experience as close to an 'always there' biological parent as possible.

- **<u>Problem</u>**: Sometimes children are placed (for example by magistrates) with carers the Department has not (and will not) formally approved. Child Safety is constrained in being able to support these carers in any way.
- **Potential Solution**:
  1. Options to make it easier for Child Safety to support carers, regardless of whether they are approved or not, would help keep the wellbeing of the child in mind and keep them safe while child safety considers its options.
     i. This may require procedural or guidance change within Child Safety.

- **<u>Problem</u>**: Siblings of children in youth detention are at much higher risk of becoming children in care, and being incarcerated.
- **Potential Solution**:
  1. Ensuring all siblings of a child in care or youth detention receive support, financial and otherwise, regardless of their involvement with child safety or the justice system.

- **<u>Problem</u>**: All children in care have had difficult life experiences. While not all children develop 'mental illness', many go on to live impoverished lives, including in jail.
- **<u>Potential Solutions</u>**:
  1. It takes time to intervene in a way that will make a long-term difference. It takes lots of energy.
     i. Therefore, funding for more staff in each ████ team, coupled with lower caseloads is likely to bring about improved outcomes.
     ii. Similarly, reduced caseloads (and more staff) for Child Safety Officers is likely to be helpful.
     iii. Historically ████ has had lower caseloads (half what they are now), but funding has been reduced which means the quality of the work is also reduced.
     iv. No agency other than ████ is currently in a position to provide this thoughtful, wrap-around perspective that unites different service providers and carers.

- **<u>Problem</u>**: Little is known about long term tangible/functional outcomes for children in care.
- **Potential Solutions**:

1. Development of a plan to collect <u>and share</u> data on longer term functional outcomes of children who have been in care is vital.
    i. Real change could be created from having independent data gathering that extends beyond statistics to qualitative research that includes the long term functional outcomes of the children of children in care.
        a. this might include educational attainment, employment attainment, strength of attachment with their own children, rates of substance use, relational security etc.
        b. this would need to extend well into adulthood.
    ii. Only with this data will we ever know whether we are really doing a good job of caring for children.
    iii. Ideally this would happen in a sensitive, relationally connected way, beyond surveys and numbers.

- **<u>Problem:</u>** The priority age group for [redacted] is 5-17, yet:

➢ **Potential Solutions**:

1. We know early intervention is vital. Earlier intervention often means less money and resources need to be expended for a given change to occur. Targeting the 0-4 age group may help facilitate lifelong change which will mean less expenditure over a young person's lifetime.
2. Transitioning from care is often a highly distressing and high-risk time. Including age 18 in the priority group may allow [redacted] to support this very difficult time in a child/young adult's life.
    i. Mental health services for young people across Australia are increasingly extending into the 'youth' space – up to age 25. This is because many young people fall through the cracks in the health system due to the funding and resourcing divide between 'children' and 'adults'. The evidence clearly shows that graduates of the child protection system are more likely to fall through these cracks and end up in jail, unemployed, or worse.
        a. There may be an opportunity to provide mental health care through [redacted] or a linked service that could continue into early adulthood.
        b. There should be practical support beyond mental health care, past their 18th birthday. This should extend well beyond the current post-care support/financial structure.
            a. The costs of this service provision should be weighed against the costs of housing care leavers within the correctional, criminal justice, and homelessness systems.
                i. This would require robust data collection and modelling.

[redacted]

- **<u>Problem</u>**: More children are being placed in residential care. These children are often the most distressed and most complex in the state. [redacted] funding and staffing have not kept pace with this increase in complexity; indeed, the reverse is true.

➢ **Potential Solutions**:

1. Increase funding and full-time equivalent staffing within all [redacted]
    i. Include specific funding for identified positions for speech therapists, occupational therapists, and psychologists.
    ii. Ensure every team has at least one First Nations health worker [redacted]
    iii. Consider whether more [redacted] service hubs would be helpful to maintain team cohesion and prevent teams becoming too large to maintain a supportive and thoughtful team environment.
2. Explicit links with the local [redacted] would be helpful.

In summary, a key adjustment required within the child protection system is to view its purpose as raising children (real care), rather than just protecting from harm. Their needs must be central to the mission of the Department, rather than a single need (protection from harm). All children have the right to develop and thrive, as well as not being harmed. As Article 27 of the UN Convention of the Rights of the Child states "Children have the right to a standard of living that is good enough to meet their physical and mental needs. The government should help families who cannot afford to provide this."

Yours Faithfully,

[redacted]