CHILD PROTECTION INQUIRY

Submission provided by **12 March 2010**	Deborah Morriss

Personal Statement

I do not have any reason to have my submission classified as confidential or anonymous, I do however wish to state that my submission is based on my own professional opinion and experience gained over the course of a ten year career in FACS/NTFC.

Given the nature of the client group and program area, normal business is caring for children and young people at the tertiary end of the system therefore some of the cases have attracted media and political attention and/or are identifiable.

In the event that the Board of Inquiry see possible breaches of confidentiality or during the course of the oral submission require information which may be of a sensitive nature or identifying of individual clients, I would expect that the appropriate action is taken to protect client information and me as the contributing author and an NTFC employee.

My primary focus area will be **Out of Home Care** services, specifically my subjective experience in the development of a residential care program within the child protection system. I will also include my views concerning a variety of areas of practice raised for discussion by the Board of Inquiry.

Professional Background

I entered the Child Protection system in 1999, spending approximately two and a half years in both the Child Protection and then Substitute Care Teams.

In 2004, I developed the Family Support Framework for Family and Children's Services (FACS) Planning and Development Team. The framework was designed to be used as a tool to guide the development and provision of an improved service system in the NT. I continued to work with non-government agencies around the management of FACS funded service agreements in that role.

My experience over the past five years has been to develop a Therapeutic Model of Residential Care within the Child Protection System to cater for some of the most complex and highest needs children and young people in Out of Home Care in the Darwin and Alice Springs urban areas. My role extended into implementation and then the management of the program.

Specialist Care Program Overview

The Specialist Care Program was introduced in Darwin and Alice Springs on 1 November 2005. Although the initial intention of the model was to intensively support primary carers, there was a shift to include a 24/7 residential care model that provided rostered carers and youth work staff. This shift was due to no placement availability for the most complex, extremely high needs and at risk young people entering the system.

Primary carers are provided a substantial remuneration package; this reflects the case intensity and the extra commitment necessary. Primary carers are expected to make themselves available to respond when a young person needs them. Regular house meetings are an obligation to ensure ongoing case management, assessment and review and to provide the required level of support to carers and young people.

The Specialist Care Program has been committed to practicing from a Strengths Approach and following the principles of Trauma-Informed Care. The program has also been greatly influenced by the Response Ability Pathways (RAP) Circle of Courage model, which is based on resilience principles to address needs for belonging, mastery, independence and generosity.

The aim of the Specialist Care Program is to provide young people with the opportunities they need to gain a sense of security and belonging in a stable, therapeutic environment. The building of trusting, supportive relationships with carers and staff are seen as essential elements in teaching young people more adaptive coping skills and the achievement of long-term behavioural change.

The Specialist Care Program uses Therapeutic Crisis Intervention (TCI) as a crisis prevention and management system, the skills learned are seen as essential to appropriately responding to and supporting young people to cope with their emotions. This approach is evidenced based and widely used in residential programs across the US, the UK and Australia. The program has accredited trainers in TCI.

Specialist Care Program Data

The Specialist Care Program has made a significant contribution to the Out of Home Care system over the past four years. Initial client referrals in 2005, were 7 young people and by May 2007 there were 21, the number rose to 27 by May 2008. Two large sibling groups (5 and 4) have skewed client numbers, the benefits of intensively supporting carers and to reunify siblings or keep them together has reinforced the achievement of best practice principles within the program.

A total client number of referrals entering Specialist Care is 36, made up of:
ATSI: 21 = 9 male & 12 female
Non-ATSI: 15 = 9 male & 6 female

Current Ages: 18x4; 17x4; 16x9; 15x3; 14x3; 13x3; 12x3; 11x2; 10x2; 9x2; 8x1.

A total of 11 young people have left the program to date.
ATSI: 6 = 0 male & 6 female
Non-ATSI: 5 = 1 male & 4 female

Ages when leaving: 18x4; 17x2; 16x4; 15x1.

Where they went: 7 returned to family
2 referred to Adult Guardianship / Disability Services
1 Independence
1 Supported Accommodation

The majority of young people entering Specialist Care have been approaching adolescent years, are disconnected and have a range of complex needs.

There are a couple of young people who choose to return for support when they require. The Specialist Care Program has successfully provided a safe base, trusting relationships, predictability and consistency in their young lives.

Along with the fluctuating numbers of clients the program saw significant growth and comparative numbers in placements, primary carers, respite carers, houses and 24/7 rostered placements.

What we have learned over four years

- There are more often no easy or simple solutions
- Nothing is black or white
- There is no right or wrong
- Working through trauma takes time
- Behaviour is about need
- Safety is paramount as is creating a safe base
- Hanging in there is essential
- There is always a power imbalance
- Relationships are fundamental
- Genuine engagement and connection is crucial
- Most young people have no sense of a future
- How much our responses/interactions contributes to an outcome
- Our appropriate responses to traumatised young people are not automatic/ second nature, we have to:
    1. think before responding to behaviour
    2. not go into automatic parenting from our own experiences
    3. not respond from a position of authority
- The 'blocks' to progress and succeeding for young people is often a fear of failure and exposure of vulnerability
- Parallel practice is needed for successful outcomes
- Best practice = consistently challenging attitudes of punishment and authoritarian practice
- Programs should be creative, flexible and responsive to changing needs
- Therapeutic care is an ever evolving response to a young person's individual needs
- We all need to have some fun!

Specialist Care Program Challenges

Pressure to care for young people who required secure care which meant that the model was not effective for this cohort of clients. The priorities became, duty of care and managing the competing risks for the safety of young people, staff, carers and NTFC.

The use of Security became necessary to provide a sense of safety to all, including the young people themselves.

No appropriate risk assessment tool for young people in Out of Home Care.

Unsafe and inappropriate environments for the secure care clients.

No authority to 'contain' or 'secure' young people and any policies or processes dealing with the use of restraint.

No specialist clinical input from child and adolescent specific professionals.

Limited to no support services for young people and their family's in the secondary to tertiary end of the system.

Cross program collaboration and shared responsibility for high needs clients remains an ongoing frustration.

People at all levels have limited understanding about what is involved in managing and maintaining a 24/7 residential program within the child protection system.

No capacity or resources to fully implement the TCI System into practice or for the few individuals to keep up with the provision of essential and ongoing training for staff and carers.

No specialist professional supervision, support or professional development available for professional staff.

Specialist Care never 'fitted' easily into the system, there has been an ongoing struggle to maintain a culture and value base congruent with the practice model.

Specialist Care has stretched employment and human resource rules to maintain creative and flexible care options for several high-risk young people.

Move from Contractors to Employees has posed significant issues relating to the program model, impact on young people, employment, management and support of staff and increased responsibilities for mentoring and training.

NTFC restructure into five branches. Out of Home Care branch is disconnected from OoHC teams and business in child protection offices. Different priorities and practice.

Realignment and limited funding as well as costs being spread across the Out of Home Care system.

Additional responsibilities and pressures to open an Emergency Care House.

The Sue Gleed report affects morale and hope for the future of the program.

Observation that the Specialist Care model was too expensive and not demonstrating throughput or successful outcomes.

The mixing of high needs/risky young people without clinical input, carefully assessed matching options, highly skilled staff and professional support processes in place could significantly increase risk for all.

Small client numbers in Specialist Care became an increasing tension between program teams who wanted to make referrals. There was also a perception that it was not fair for 'some' to get more intensive support and resources while 'others' were provided little support/intervention.

Change in leadership meant no ongoing commitment to the Specialist Care model and opportunities to increase therapeutic care.

Secure care and step-down therapeutic care will not be available for approximately 18months to 2 years.

New strategic directions were set to provide more equity and services to a greater number of children and young people in the system.

A perception that Specialist Care had grown strong best practice principles and the elements of more intensive support to placements and carers within the system would ensure a higher quality of care to more young people in the system.

Concern about having non-professional and inexperienced staff supervising and co-ordinating services to young people, carers and staff.

Ongoing struggle for congruence as various competing needs arise for yp, staff, carer, program, organisation and my personal/professional ethics collide.

Living Anglin's, Pain, Normality and the Struggle for Congruence (Anglin 2002).

High needs/risk cases, I thought should be keep within NTFC, the current directions however and the SCP experience in the past year leads me to rethinking this view.

Further Thoughts

The past 12-18 months have been the most difficult in memory.

The restructure, new branches are not working.

NTFC structure is growing heavier at the top.

Leadership – issues include styles, approaches and experience in managing people, communication, having shared values and a shared vision. The difficulty of having conflicting priorities and taking the helicopter view.

Financially driven decision-making, managing unmanageable budgets. Where do you put limited resources? Decisions impact directly on children and young people.

The Coronial Hearings added significant pressure on individuals and the system, there is still a lot to do to improve practice and compliance issues.

Recruitment and Retention of staff in NTFC.

- We lack experience from the top down.
- People move up too quickly.
- No one wants to work with clients and their families anymore, everyone wants to be the expert, provide advice, assessment and training (cross program).
- The growing of non-professional positions/workforce increases risks.
- Retention of long-term experienced employees needs attention.

NTFC Human Resource – is not a fair or transparent process, there are often no definite or clear outcomes, and there is a perception that HR is there to cover the back of the Department.

Changing focus and priorities in practice:

- Family Preservation
- Re-Unification
- Permanency Planning
- Differential Response Framework

CREATE – a valuable and under used resource for young people in the system. There needs to be sufficient funding provided to ensure access and representation of all young people in and who have left the OoHC system.

Leaving Care preparation needs to be a priority case plan goal in OoHC teams. Specialist Care supported a Youth Development Coordinator to develop a competency-based program and begin providing services to young people.

Leaving care work should also be a non-government responsibility to ensure young people are engaged in community support services.

The role of Secure Care, Therapeutic and Residential care in the current system.

- Concern about there not being adequate funding for quality services, and professionals for the Secure Care/ Therapeutic step-down facilities.
- Experienced professionals and best practice models are essential to preventing systems abuse and further trauma to young people if residential care is to be provided within the system, as well as outside.

For profit caring organisations need agreements, standards and registration (much more accountability and demonstration of skills/training etc).

Recruitment and remuneration for carers – they need to be paid for caring and the competency-based system would add value to their role, quality of care and provide professional development opportunities.

Government versus non-government provision of services:

- We should invest in our local services; we all compete for the same people in a limited market (all cross program partners gov and non-gov).
- Attracting large agencies from South will provide the same challenges for practice; models will need to be responsive to the NT context and environments.
- Quality services cost, you get what you pay for! We need to ensure adequate funding, this should be determined by experts who can make sound comparisons in like services elsewhere.
- We need to invest in good relationships, share training, mentoring etc so we can share knowledge and practice wisdom within our people/organisations.

Aboriginal Placement Principle – While I am sure there are people more experienced and conversant in this area, the SCP has several successful case examples that could be presented to demonstrate ethical dilemmas and creative care options offered to a number of Indigenous young people in recent years.

Case Management: There are many examples of good practice in offices. It seems however that inexperience and insufficient support systems contribute to more authoritarian approaches, issues of 'ownership', reactive and poor practice.

Regular and structured supervision is vital to good reflective practice; resources would be wisely spent in having dedicated, experienced supervisors mentoring staff.

Legal:

- Perception that there is a fight for the sake of winning and not what is in the best interests of the child or young person.
- Young people need to be heard and their wishes seriously considered.
- Youth Justice Court does not respond swiftly enough. Young people suffer ongoing anxiety from matters dragging on for weeks/months without an outcome.
- Young people start to believe there are no legal consequences for serious offending.
- Being remanded in a Juvenile Detention Centre is not a good/positive experience for a young person.