

SUBMISSION FROM THE CENTRE FOR REMOTE HEALTH TO THE INQUIRY INTO THE CHILD PROTECTION SYSTEM IN THE NORTHERN TERRITORY.

1. The functioning of the current child protection system including the roles and responsibilities of Northern Territory Families and Children and other service providers involved in child protection.

(ii) The Intake and Assessment systems, including mandatory reporting.

The Centre for Remote Health has been funded by the Department of Health and Ageing Office for Aboriginal and Torres Strait Islander Health (OATSIH) to deliver a two day training course 'Responding to Child Abuse and Neglect: What Primary Health Care Practitioners Need to Know'. Details of this training course are provided (below) under responses to point 3 of the Terms of Reference. Over 180 participants from government, non government and the Aboriginal Community Controlled Health sector have attended this training:

-40% were nurses

-25% were Aboriginal Health Workers or Aboriginal Community Based Workers

-15 % were Allied Health Professionals.

A number of issues have been raised in the workshops that raise concerns and/or identify problems with the current functioning of the child protection *service* (that is NT Families and Children). These issues are summarised below, and have previously been provided to the Department via their representative on the Project Advisory Group.

Feedback from two day short course.

The following section provides feedback as reported by participants.

Particular concerns expressed by **Aboriginal Health Workers** (AHWs) in remote areas:

- The need for the 'system' to acknowledge that whilst AHWs understand that everyone has an obligation to report harm, it is the usual practice (in teams that work well) for the Remote Area Nurse (RAN) to make the notification. This trend

in reporting occurs for a number of reasons: cultural complexities which make it difficult for AHWs to be 'the notifier' having a particularly strong influence.

However, AHWs also noted a downside of RANs being responsible for notifications. Given the large numbers of locum nursing staff, particularly in Central Australia, when a RAN is the person making the notification, he/she is the person the child protection worker will most likely speak to, but is probably the least knowledgeable about the community and family. AHWs see this as a real problem in developing safety plans for children and young people;

- AHWs also raised the issue of thresholds for acceptance into the child protection system: they are concerned that many issues they see as child protection issues are not meeting the threshold and thus not being responded to;
- Similarly, AHWs were also concerned regarding the impact of increasing numbers of child protection workers being recruited from interstate and internationally. The role of an AHW in other jurisdictions is either more restricted or non-existent, so child protection workers new to the Northern Territory do not appear to understand the role of AHW. This lack of knowledge about the role of the AHW is complicated by a perceived lack of any orientation about AHW skills, knowledge and role provided to child protection workers. As a result many child protection workers are not availing themselves of a crucial resource in planning for children. To address this problem, the AHWs stated they would like to participate in the orientation and induction of child protection workers (including intake workers).

In relation to the process of **making a report** the following issues were raised by a variety of health professionals:

- The length of time for the phones to be answered by the Central Intake Team;
- Being told that their report doesn't warrant being entered on 'the system';
- Being told that the reported concerns are normative behaviour for Aboriginal people (for example, kids wandering about late at night) and therefore does not constitute harm even though the reporter believes harm is occurring;
- Being told that they are not 'experts' so their 'opinion' does not count;
- Participants questioned the competence of intake workers who, in their view, only wanted to know the 'bare minimum', which was experienced by the reporter as a gate-keeping mechanism to keep the report 'out of the system';

- Not being provided feedback about whether the case was accepted or not;
- Concerns, especially from areas outside of Darwin, that the threshold for acceptance of neglect notifications had risen (that is, that what used to be accepted now no longer was). A typical example was a case where young children (often infants) were being regularly left with reluctant extended family members, while the parent 'went drinking'. Reporters, acting on concerns expressed by these family members were being told that since the child was not at significant immediate risk, the child was 'safe' and so their notification could not be accepted.

In relation to the practices of **local offices** the following issues were raised:

- Concerns about lack of communication and reluctance to share information with the primary health care team by local child protection offices ;
- Cases being closed without case workers advising the primary health care team, who, in many cases, had made the initial report;
- In one region concerns that when NTF&C workers visited clients in the hospital they no longer record the visit in the hospital file (this used to be the practice) so no hospital staff no whether their concern is being acted upon by the local NTF&C office.

It is important to note that a (lesser) number of participants provided positive feedback about their relationship with the local child protection service. This relationship was characterised by child protection practice that actively invited primary health care staff to be involved in the development of safety plans for children and regular communication about the progress of the case.

3. Support systems and operational procedures for all workers engaged in child protection, in particular staff retention and training.

(iv) Staff training and development opportunities

The Centre for Remote Health (CRH) a joint Centre of Charles Darwin University and Flinders University, has provided post-graduate education for rural and remote medical, nursing and allied health professionals since 1999. The gap between undergraduate

education and the advanced and extended role of health and community service professionals in remote areas has been long recognised by remote practitioners. It was in response to this need that the suite of post graduate courses that form the *Remote Health Practice* program was developed. The curriculum for the *Remote Health Practice* program has been developed by the Centre for Remote Health in partnership with *CRANApplus* (formerly the Council of Remote Area Nurses of Australia-CRANA), Services for Australian Rural and Remote Allied Health (SARRAH), and with the Australian College of Rural and Remote Medicine (ACCRM). The content of the courses specifically respond to the needs of remote practitioners and the reality of remote practice. An underlying principle of course development within the Centre for Remote Health is that courses are *needs based*. That is, the courses respond to needs, standards and competencies identified by industry, the professions and remote consumers.

In 2007 the Centre for Remote Health recognised the need for specific training and education for remote child protection practitioners, and for Primary Health Care staff. In 2007/2008 we began course development to address the needs of the broader multidisciplinary child wellbeing workforce via a 2 day workshop, as well as a speciality Graduate Certificate stream within the *Remote Health Practice* program for child protection practitioners. The curriculum content was presented to a series of multidisciplinary focus groups in Central Australia during 2008 to ensure course content was relevant and addressed practitioner needs.

This initiative was consistent with a number of inquiries and reports including the *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007* (the *LCAS Report*) which emphasised the need for enhanced training and support for child protection and primary health care workers.

The Graduate Certificate in Remote Health (Remote Child Protection Practice)

The *LCAS Report* highlighted high levels of staff turnover within the Family and Children's Services branch, which would inevitably compromise the capacity of the organisation to provide ongoing professional development opportunities for its workforce. Although there is limited Australian literature, studies that have explored this issue

indicate that enhanced opportunities for professional development (Lonne & Cheers 2000) and increasing collaboration between child protection agencies and universities may help to address worker stress and retention of front line staff (Hodgkin 2002). There has been a growing acknowledgement in the literature that rural and remote social work and human services practice is different from urban practice (Cheers et al 2005) and that remote child protection practice may differ from that in urban and even rural settings. Social work, and other professional, education is predominantly urban based, and there is little content that reflects the realities of service delivery in remote areas (Green 2003).

Ongoing education and training opportunities are required to respond to a workforce that includes the professional stream of workers (social workers and others) and Aboriginal Community Workers who frequently have no post secondary school qualifications but bring considerable cultural knowledge to their work. The Centre for Remote Health has a commitment to providing entry to practitioners who demonstrate ability to complete higher study but may lack formal educational pre-requisites and whose current position requires them to develop advanced conceptual and practice skills. This may include current Aboriginal Community Workers employed within the Family and Children's Services program.

Child protection practice has become more complex and demanding over the past decade. In 2005, the *West Australian Child Protection Training Report* noted that much current training focussed on processes and procedures and highlighted a number of training issues which required greater attention. In addition to the issues identified in the *LCAS Report*, the West Australian report included education and training issues related to the complex ethical, moral and professional challenges involved in child protection work. The West Australian report also identified the need for development of expertise in assessment, critical analysis and decision making, and knowledge of the impact of the family and social context on children. Knowledge of child development, cross cultural child rearing practices and reflective practice were highlighted as being critical to sound professional practice. A number of international and national inquiries have confirmed the need for further attention to these areas of knowledge and practice, whilst also drawing attention for the need for better communication and interagency working.

In broad terms the curriculum framework for post-graduate study at the Centre for Remote Health includes:

- A population health approach to child health and wellbeing in remote practice with a focus on the remote context and the social determinants of health and wellbeing;
- Communication and cultural skills to enable practitioners to engage effectively with children and families in remote areas and to practice as culturally safe workers with and ongoing commitment to strengths base and inclusive practice;
- A focus on the professional, legal and ethical roles including working with others, reflective practice, ethics and power, legislation and critical thinking; and
- Child protection practice skills including enhanced assessment skills and a focus on organisational aspects of service delivery.

The course is taught on line with students attending on campus twice in Alice Springs for *intensives* throughout the period of study.

The first two topics within the Graduate Certificate are multidisciplinary and students are afforded the opportunity to learn with, from and about other remote practitioners, and from the outset students are oriented to a primary health care approach to practice.

Requests have been made to the Northern Territory Department of Health and Families (NTDH&F) for support to assist with the feasibility study, subsequent course development and for practitioners to enrol in the post graduate course of study. This support however, has not been forthcoming. There are precedents within the department for supporting staff to participate in postgraduate study. The 'employed model' of study supports NTDH&F staff financially and with study leave to enrol in postgraduate Diploma level courses in Child and Family Health, Renal Nursing and Midwifery offered by Charles Darwin University. Similar support is planned for Remote Area Nurses to enrol in the Graduate Diploma in Remote Health Practice offered through the Centre for Remote Health.

In the meantime, a partnership has been established by the Remote Health division of NTDH&F whereby the Centre for Remote Health delivers a component of the 'Pathways' orientation program. This program is called 'Transition to Remote Area Nursing' and

supports nurses new to remote primary health care clinics to undertake a 13 week program conducted by the Centre for Remote Health. The Department funds the attendance, travel and accommodation, and fees for participation in a three week intensive workshop delivered by remote health academics and experienced remote health practitioners. The intensive workshop includes contextual orientation to Remote and Indigenous Health, and skills and knowledge in remote advanced nursing practice and pharmacotherapeutics. Department staff who consolidate their skills and knowledge over the following 10 weeks receive credit towards subsequent enrolment in the Graduate Certificate in Remote Health Practice. This credit means that staff who take up this opportunity are not only supported to receive preparation for immediate practice, but are financially supported for equivalent to 50% of the Graduate Certificate. To date, the program has been conducted in Alice Springs and 20 department staff have participated. In 2010, the program will be offered in Darwin in addition to two further intakes in Central Australia.

The Graduate Certificate focussing on remote child protection practice has now been approved by Flinders University, and students will be able to enrol from 2010. A similar phased approach to supporting preparation for child protection workers new to the Northern Territory and subsequent continuing education is therefore possible.

The two day short course 'Responding to Child Abuse and Neglect: What Primary Health Care Practitioners Need to Know'.

This two day short course has been available since late 2008. In the second half of 2009 the Department of Health and Ageing (Office of Aboriginal and Torres Strait Islander Health) contracted the Centre for Remote Health to deliver this two day short course to remote practitioners around the Territory. The primary target group was primary health care practitioners, but participants have come from a range of disciplines and areas of practice. There is no cost to participants, and staff employed in PHC organisations have their travel and accommodation costs reimbursed by OATSIH.

In addition to ensuring participants understand their legal obligations and are able to identify cases possible child abuse and neglect, the short course has a strong focus on developing an understanding of the child protection *system*, by which we mean the primary, secondary and tertiary services that go to enhance the wellbeing of children and

families, as well as the child protection *service*, by which we mean the role of NT Children and Families. The course stresses the importance of:

- early identification and intervention within the primary and secondary service system for children and families who may be struggling as activities which may prevent child abuse and neglect;
- the need for plans which include clear timelines for 'moving to the next step' which may include notification to the child protection service;
- and the need for co-ordinated, multi disciplinary approaches when working with children and families.

On the second day of the workshop representatives from the Sexual Assault Referral Service and/or the Mobile Outreach Support Service and NT Families and Children attend for an informal Question and Answer session.

Workshops have been held in Darwin, Nhulunbuy, Wadeye, Katherine, Tennant Creek and Alice Springs. Over 180 people have attended this workshop, and feedback has been overwhelmingly positive.

In addition, this year we have begun training five Indigenous co-facilitators (including three from NT Families and Children and one from the remote Maternal and Child Health Team) to assist with the delivery of these courses.

The workshop, and the process of co-facilitator training, is being evaluated (both immediately following, and three to six months post training) by staff employed within the Centre for Remote Health Primary Health Care Research, Evaluation and Development program.

The evaluation of the program to date has identified that participants have emphasised the importance of inter-professional networking and collaborating on problem solving activities in relation to case studies. For example respondents commented:

' More importantly for me was gaining an insight into what RANS and other health professionals are facing in terms of decision making in complex contexts'

'Exposure to other points of view on CP seemed to clarify my opinion of the right thing to do in a reasonable manner..'

Although this workshop is targeted at non-child protection staff, a small number of child protection workers have elected to attend, and their feedback has focussed on enhancing their understanding of the problem solving approaches and views of primary health care staff and the ways in which this could enhance their ability to work with primary health care teams.

During the workshops a number of critical issues were raised, and at the conclusion of workshops this feedback was provided to the NT Families and Children's representative on the Project Advisory Group. The issues as raised are summarised above under the response to the first point of the Terms of Reference.

Conclusion

This submission has included direct feedback from frontline primary care workers about the current functioning of the child protection service and system. This feedback can inform future child protection system development.

The Centre for Remote Health has developed accredited postgraduate training for remote child protection workers which could improve the appropriateness, effectiveness and staff turnover within this critical group of professionals. This is especially the case in a context of high staff turnover and the need to recruit staff without remote experience from both interstate and internationally.

The issue of inter-agency collaboration remains a key issue in child protection and child health and wellbeing practice. Interprofessional education and training opportunities are a key strategy to enhance worker ability to practice collaboratively.

It is critical that staff receive both *encouragement* and *support* to access further education and training. The current partnership between the Centre for Remote Health and the Remote Health division of the NT Department of Health and Families to support their nursing staff transition to remote practice is a model that may be useful for child protection workers.

In addition to formal postgraduate education, we have run and evaluated workshops for the broader primary health care and community services workforce with a focus on early identification of, and intervention for, child health and wellbeing issues including child abuse and neglect. These have been successful, are subject to ongoing evaluation and strongly appear to be worth of ongoing support from relevant responsible funding bodies.