CHAPTER 7

The Statutory Intervention Process, Part 1 – Intake and Investigation

Introduction

This chapter describes the findings of the Inquiry regarding the intake and investigation functions of the child protection system in the Northern Territory. These functions and some of the statistical information regarding them were briefly described in Chapter 5 in the context of the broader child protection system (also including family support and out of home care functions).

Intake

Access to child protection services in the Northern Territory (Northern Territory) is through one narrow communication gateway. This gateway is officially known as the Central Intake (CI) service. The service is operated by Northern Territory Families and Children (NTFC), a division of the Department of Health and Families (DHF). There is provision for the intake function in the Care and Protection of Children Act 2007 (the Act) and operational details of the service are outlined in the NTFC Policy and Procedures Manual (NTFC Manual).\(^\text{433}\)

Statutory basis for the intake function

The Act includes powers to enable the Minister for Child Protection to act to protect children from harm and exploitation. The Act provides the Minister and the CEO (of the administering Department, now known as the Chief Executive, or CE) with authority to:

\[
\text{Protect children who are in need of protection... (Section 24(b)).}
\]

Under the Act, people who believe that a child ‘has suffered or is likely to suffer harm or exploitation’ are required to report to the police or to the CEO through his/her delegates.\(^\text{434}\) The definition of harm provided in the Act is as follows (Section 15):

\[
(1) \quad \text{... any significant detrimental effect caused by any act, omission or circumstance on:}
\]

\[
\quad (a) \quad \text{the physical, psychological or emotional wellbeing of the child; or}
\]

\[
\quad (b) \quad \text{the physical, psychological or emotional development of the child.}
\]


\(^{434}\) Care and Protection of Children Act 2007, Section 26(1)[a][i].
(2) Without limiting subsection (1), harm can be caused by the following:
   (a) physical, psychological or emotional abuse or neglect of the child;
   (b) sexual abuse or other exploitation of the child;
   (c) exposure of the child to physical violence.

The definition of exploitation is defined in the Act as follows (Section 16):

(1) ... sexual and any other forms of exploitation of the child.

(2) Without limiting subsection (1), sexual exploitation of a child includes:
   (a) sexual abuse of the child; and
   (b) involving the child as a participant or spectator in any of the following:
      (i) an act of a sexual nature;
      (ii) prostitution;
      (iii) a pornographic performance.

The Act enables the CEO to take specific action. For example, he or she may ‘make inquiries about a child if the CEO receives information that raises concerns about the child’s wellbeing’ and that, ‘on completing the inquiries, the CEO must decide whether any further action should be taken for the child...’ (Sections 32(1) and (2)). The CEO and the police may then investigate ‘to determine whether a child is in need of protection’ (Sections 35 and 36). The CEO may also provide information to the informant (Section 29(2)(a)).

The only specified action in relation to the intake function that is required of the CEO is that ‘The CEO must record the receipt of a report...or a notification about a report...in relation to a child’ (Section 29(1)).

The intake service provides a critical function being the only official gateway for the provision of statutory child protection services apart from the option of reporting to a police officer (Section 26(1)(b)) who must, in turn, notify the Department (Section 28). This being the case, it is essential that the intake service is able to effectively and expeditiously process incoming reports and notifications, assess them for the level of risk and urgency, and pass the information along to child protection officers in the various regions to assist with formal investigations. To effectively operate, the intake service needs to gain the trust, respect and understanding of the various stakeholders, particularly members of the public and professional groups such as the police, health workers and teachers.

Background to and description of centralised intake

In 2003-04, the then Family and Children’s Services (FACS) program launched a child protection initiative – the ‘Caring for our Children’ Reform Agenda. A key component of the reform was the development of a centralised intake (CI) process or call centre to cover the whole of the Northern Territory. Prior to this, abuse and neglect notifications

435 Central Intake (CI) is sometimes referred to as CIT in Departmental documentation and therefore the initials may be used interchangeably through the report.
could be made directly to regional FACS offices. There had been a number of concerns about the decentralised notification process, including service variability across the Territory and, in particular, different decision-making thresholds, out-of-hours staffing problems, the difficulty in record keeping, and response timeliness.

The centralised service commenced in November 2006 and was extended to the entire Territory in June 2007. The primary function of CI is to respond to notifications or reports about actual or suspected harm to children and, where necessary, to conduct an inquiry into the report (Section 32). There is a single telephone number, consisting of two active lines, to cover the entire Northern Territory, with the call centre located at the Berrimah Police Headquarters.

The CI is co-located with the Child Abuse Taskforce (CAT) a joint program operated by the police and NTFC and focused on joint agency responses to serious cases of child maltreatment, including extra-familial sexual abuse. Up to March 2009 there were eight intake workers in the CI along with two team leaders and one Manager. An after-hours team had four permanent and two casual staff members. Two further intake workers were added following the tabling of the interim progress report in January 2010.436

The intake process

According to the Department of Health and Families submission, the following are the key elements of the statutory child protection intake and investigation process:

1. Report – notifier provides information to the Department of their concerns about harm to a child/young person
2. Central Intake Team – the team gather information from their own inquiries, as well as Police and other experts
3. Threshold Assessment – the case proceeds to investigation if concerns are assessed as constituting harm, and there is sufficient information to proceed. For these cases, an initial danger assessment is conducted, which considers vulnerability issues, actual harm, and risk of harm. There are three possible outcomes of the Initial Danger Assessment: child concern (formal investigations to commence within 5 days), child at risk (investigations to commence within 3 days), or child in danger (investigations to commence within 24 hours)
4. Investigations are conducted by the local NTFC Office, police and/or Child Abuse Taskforce:
   a. Interview child
   b. Interview parents or carers, relatives and others where necessary
   c. Medical assessment
   d. Police investigation
   e. Ensure child safety
   f. Conduct full danger assessment

436 Children’s Commissioner Northern Territory, Interim progress report into intake and response processes.
5. Outcome – harm/risk of harm is unsubstantiated or substantiated. A Safety Decision is made, with three possible outcomes: (a) safe; (b) conditionally safe; or (c) unsafe

6. Finally, a decision needs to be made as to whether a protective order needs to be obtained from the Family Matters Jurisdiction of the Local Court and/or whether a child needs to be placed (or to continue) in some form of out-of-home care in order to ensure their safety.

As an alternative to a child protection ‘outcome’, intake workers can ‘outcome’ a case as requiring family support – this involves the creation of an NTFC family support case; or, they can ‘outcome’ a matter as requiring a protective assessment which is a classification used for adolescents referred by the Youth Justice Court or Centrelink; or, as a notification requiring ‘no further action’ or ‘Screened out’, perhaps because of insufficient information being available; or they might simply note the matter but not take further action. A flow chart for the current intake process can be found in Appendix 7.1.

The NTFC Manual provides for the use of a risk assessment tool in CI called the Initial Danger Assessment (IDA). The IDA is comprised of a list of items that are essentially decision-making prompts. There is no formal scoring system associated with the instrument with workers required to form a subjective judgement based on the pattern of responses. The IDA is intended to inform a response priority assessment and the ‘outcome’. When the IDA ‘outcome’ is determined, all child protection matters – those in one of the three risk categories – are forwarded to an appropriate work unit (regional office or CAT) for allocation to a child protection worker or police officer who undertake an investigation that includes the completion of the Full Danger Assessment instrument.

Intake and response performance data

Data on intake and investigation processes in the Northern Territory can be found in Chapter 5 of this report. This includes notification, investigation and substantiation numbers and rates, sources of reports, the numbers of children involved, types of abuse and neglect, and the status of the children in terms of Aboriginality. In this section we review the performance data relating to intake and investigation.

Number of matters processed to ‘outcome’ within the 24 hour target

Table 7.1 Time to finalise notification outcomes

<table>
<thead>
<tr>
<th>Total notifications recorded 1 Jul 2009 and 31 Dec 2009</th>
<th>Number of notifications with outcome approval date within 24 hours</th>
<th>Number of notifications with outcome approval date more than 24 hours</th>
<th>Number of notifications without approval date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3462</td>
<td>1094 (32%)</td>
<td>2365 (68%)</td>
<td>3</td>
</tr>
</tbody>
</table>
The data in Table 7.1 reveal that less than one third of notifications to CI are processed to ‘outcome’ within the 24-hour target period. This CI backlog appears to be a chronic one which should have been improved following the addition of two new workers to the intake team. Jay Tolhurst, in a submission regarding an internal review of NTFC intake in 2009, makes the following observation:

My 2009 Intake review argued that the NTFC Intake service was chronically unable to process the level of incoming [child protection] demand in a timely way. That reportedly remains the case in 2010, despite recent increases in the Intake staff establishment. It means that Intake still cannot reliably meet its 24 hour processing time standard for other than its most urgent cases (i.e. ‘Child in Danger’ cases). Children in Danger cases comprise only a small proportion of all reports received. All other cases, including numerous serious matters deemed to require an investigative response from an NTFC office, are typically not processed at Intake within that 24 hour period. It means that often cases which the system expects will have interventions commence within a defined number of working days will not even receive advice from Intake that these cases exist until that period has already elapsed. 437

Recommendation 7.1
That Northern Territory Families and Children either extends the ‘outcome’ timeframe from 24 to 48 hours for matters that do not appear to require an immediate response; or retains the current 24 hour target but intake workers make an initial assessment based only on the information to hand, as is the case in some other jurisdictions.

Urgency: Within 18 months

Number of child protection matters awaiting allocation for investigation

The interim progress report noted that as of 31 October 2009, there were a total of 785 ‘outcomed’ child protection matters that had been referred to work units (regional offices/CAT) for formal investigation for which there was no record of the investigation having commenced. This delay in actually commencing investigations was identified in the interim report as being one of the three that ‘stand out as having the most immediate and significant bearing on the safety and wellbeing of children’.438 The Inquiry requested updates of this data during the course of the Inquiry.

The Department provided data concerning unallocated child protection cases as of the beginning of each month from January 2010 (Table 7.2).

437 Submission: Jay Tolhurst.
438 Children’s Commissioner Northern Territory, Interim progress report into intake and response processes, p.29.
Table 7.2: Child protection notifications awaiting investigation (no CCIS entry to indicate commencement of investigation)

<table>
<thead>
<tr>
<th>Date (2010)</th>
<th>1 Jan</th>
<th>1 Feb</th>
<th>1 Mar</th>
<th>1 Apr</th>
<th>1 May</th>
<th>1 Jun</th>
<th>1 Jul</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigations not commenced</td>
<td>776</td>
<td>778</td>
<td>809</td>
<td>766</td>
<td>797</td>
<td>786</td>
<td>870</td>
<td>797</td>
</tr>
</tbody>
</table>

The bulk of such unallocated or ‘not commenced’ matters as of 1 July 2010 were from the Casuarina office (318), the Katherine office (116) and the Palmerston office (138).

Further data on these unallocated matters indicates that the vast majority have been waiting in excess of 11 days.

Table 7.3: Urgency ratings for outstanding child protection matters awaiting investigation on 1 July 2010

<table>
<thead>
<tr>
<th>Urgency rating</th>
<th>Investigations not commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1 - Child in Danger</td>
<td>29</td>
</tr>
<tr>
<td>Cat 2 - Child at risk</td>
<td>151</td>
</tr>
<tr>
<td>Cat 3 – Child Concern</td>
<td>690</td>
</tr>
<tr>
<td>Total</td>
<td>870</td>
</tr>
</tbody>
</table>

The majority of the outstanding investigations relate to matters that have been initially classified as ‘child concern’, however, a significant number involve the two higher risk classifications.

The Inquiry is also aware that many of the child protection reports sent to some regional offices are being processed by an approach that involves the calling of notifiers for further information and, further to advice that alternative actions were in place, closing the cases. This means that many of the children ‘outcomed’ as needing a full investigation are not receiving one unless they are at immediate and significant risk. This approach is certainly better than not investigating at all, and may be acceptable as an emergency measure, but it is not acceptable as normal practice according to the NTFC Manual. It means that the very high numbers of children awaiting an investigation in Table 7.3 above are in fact, an undercount.

The significant and chronic backlog of matters awaiting allocation to case workers for formal investigation represents the most glaring failure of the current child protection system to ensure the safety and wellbeing of children in the Northern Territory. It is apparent that most of the children involved are from the lower risk categories and would not be at immediate risk but it is equally likely that a small number would indeed be at significant risk. The Department owes it to the children and to those who have been concerned enough to notify the authorities about their concerns, that these cases are investigated as speedily as possible so that those at immediate risk can be identified.

The Inquiry is deeply concerned that the large backlog of investigation matters continues to exist many months after the problem was identified and specific recommendations to address the problem were made in the Interim Progress Report on intake services.\textsuperscript{439}

\textsuperscript{439} ibid.
Recommendation 7.2
That Northern Territory Families and Children immediately develops and implements a strategy to clear up the backlog of unallocated child protection investigations whilst ensuring all notified children are safe. Furthermore, that Northern Territory Families and Children develop a longer term sustainable approach based on a resource allocation model to ensure that such backlogs do not re-emerge.
Urgency: Immediate to less than 6 months

‘Outcome’ risk classifications

Table 7.4: Child Protection Investigations commenced in each year by urgency

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child In Danger</td>
<td>209</td>
<td>200</td>
<td>227</td>
<td>314</td>
<td>330</td>
</tr>
<tr>
<td>2. Child At Risk</td>
<td>508</td>
<td>396</td>
<td>496</td>
<td>638</td>
<td>784</td>
</tr>
<tr>
<td>3. Child Concern</td>
<td>613</td>
<td>748</td>
<td>836</td>
<td>976</td>
<td>1528</td>
</tr>
<tr>
<td>Total Investigations</td>
<td>1330</td>
<td>1344</td>
<td>1559</td>
<td>1928</td>
<td>2642</td>
</tr>
</tbody>
</table>

Turning to the issue of the actual ‘outcome’ risk classifications, Table 7.4 shows a marked increase in the numbers in each risk classification over the four year period 2003-04 to 2008-09. Category 1 matters increased by 59 percent to 330; Category 2 matters by 54 percent to 784; and Category 3 matters increased by close to 250 percent to 1,528. These data confirm that the recent very large increase in notifications is predominantly made up of children in lower risk categories. The implication is that the intake process is being swamped by matters that do not necessitate an immediate response but do require time to process.

Other ‘outcome’ categories

Two other major outcome categories are ‘protective assessment’ and ‘family support’.

Table 7.5: Number of new protective assessment cases opened in each counting period

<table>
<thead>
<tr>
<th>Number of Protective Assessment Cases Commenced</th>
<th>2004-05</th>
<th>2005-06</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>124</td>
<td>141</td>
<td>238</td>
<td>329</td>
<td>413</td>
<td></td>
</tr>
</tbody>
</table>

The Department reported that, in the four year period 2003–04 to 2008–09 there was a significant increase in ‘protective assessment’ cases opened (usually for youth at risk) from 124 to 413 cases (see Table 7.5). However, only 20 such cases were opened in the
6 months to 31 December 2009. The Department reported that this significant reduction is the result of a narrowing of the protective assessment criteria and that such cases are now more likely to be classified as child protection matters.

The Department has informed the Inquiry that it does not collect data on the completion of protective assessments.

Table 7.6: Number of new family support cases commenced by year

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>486</td>
<td>497</td>
<td>506</td>
<td>425</td>
<td>500</td>
</tr>
</tbody>
</table>

The Inquiry requested data on assessments ‘outcomed’ as family support cases. It is apparent that the number of matters ‘outcomed’ as family support has remained relatively steady at close to 500 for each of the past four years and, 187 cases were opened in the six months to 31 March 2010 (see Table 7.6).

A submission from a NTFC work unit would appear to confirm that there are legitimate concerns about existing family support services:

> due to the overwhelming caseload of CP work, FS referrals are rarely acted upon and consequently intake workers are disinclined to put up a notification as a FS referral because they know it is unlikely to receive attention.440

Given the poor levels of response to Category 3 (child concern) matters, it would be reasonable to suspect that matters ‘outcomed’ as requiring family support (i.e. of less urgent concern) may also be poorly served, particularly as there are no accountability requirements.

The Department has indicated that, as of 30 June 2010, there were 220 open family support cases. Of these open cases, 73 or one third of the total have no evidence of activity recorded in the previous two months.

It should be noted that in the 12 months to 30 June 2010, of all the concerns outcomed as family support cases that came to the attention of the Department only one matter was referred from the CI to external family support services.

Recommendation 7.3

That Northern Territory Families and Children formally reviews its internal family support program. This should result in a clear practice framework and accountability measures including the collection and reporting of service data relating to family support.

Urgency: Within 18 months

440 Submission: NTFC Therapeutic Services Program.
Response timeliness

The Department has been reporting on ‘response timeliness’ for some time now. This refers to the number/percentage of investigation responses (undertaken by child protection workers in the work units and CAT) to the initial risk classification ‘outcomes’ that meet the required time frames for actioning. For example, the formal investigation for Category 1 matters should commence within 24 hours of a notification being received; for Category 2 matters the target is 3 days; whilst for Category 3 matters it is 5 days. It is not clear what the 24 hour response actually refers to. The Manual notes that:

If a report requires an immediate response, that is, has been assessed as a Category 1 – Child in Danger, it must be allocated to the appropriate NTFC work unit promptly, to enable an investigation to commence with 24 hours of the receipt of the report.\(^{441}\)

However, 7.7.1 of the Manual refers to the following Practice Standard:

The outcome of a Child Protection report will be determined and approved by the team leader and allocated or referred to an appropriate regional NTFC work unit or other service provider within 24 hours of receipt of the report.

The first statement suggests that the report must be allocated to enable an investigation to commence within 24 hours but the second requires simply that the report be allocated or referred within 24 hours. The first statement places the onus on both the CI and the work unit to refer the matter and commence the investigation within the required timeframe whilst the responsibility in the second statement rests solely with CI.

Data in Table 7.7 indicate that there appears to have been an improvement in response timeliness for Category 1 but not for the other two categories.

| Table 7.7: Percentage of investigations that commenced within the stipulated time frame |
|------------------------------------|---------|---------|---------|---------|---------|
| 1. Child In Danger                | 78%     | 72%     | 73%     | 74%     | 83%     |
| 2. Child At Risk                  | 61%     | 46%     | 52%     | 49%     | 48%     |
| 3. Child Concern                  | 34%     | 32%     | 30%     | 25%     | 23%     |

From the evidence, Category 1 response timeliness has improved over a four year period from 78 percent to 83 percent but for the other two categories there has been a marked decline (Category 2 is down from 61 percent to 48 percent whilst Category 3 is down from 34 percent to 23 percent). Interim data for the 6 months to 31 December 2009 show that there have been small improvements in timeliness in all three risk categories (Category 1 = 85 percent; Category 2 = 53 percent and Category 3 = 26 percent).

However, there is a serious problem with this measure as it is currently reported. ‘Timeliness’ is calculated only for those matters for which an investigation has actually commenced. As this report illustrates, there is a very large backlog of cases – 870 as of

1 July 2010 – yet to be allocated to a child protection worker for investigation.

The report on Baby BM revealed that in that case a matter requiring investigation had not been allocated for investigation for over five months and that in some cases unallocated matters are simply ‘written off’.442 As currently reported, the timeliness measures, particularly for risk Categories 2 and 3, do not reflect the degree to which the Department has been unable to expeditiously investigate notifications of harm to children.

It might be noted that child protection departments around the country have varying response targets for the commencement of investigations. For example, the Department of Human Services in Victoria has a 2 day target for urgent matters and a 14 day target for non urgent ones443.

Recommendation 7.4
That Northern Territory Families and Children immediately reviews the response targets for the commencement of investigations for the various risk categories and considers whether other targets may be more realistic. Once updated policies/guidelines have been agreed, ongoing timeliness data should be calculated on all matters that have been ‘outcomed’ (processed by Central Intake) not just those for which an investigation has commenced.
Urgency: Immediate to within 6 months

The Interim Progress Report on Intake and Response Processes
In November 2009, the then Minister for Child Protection, the Hon. Malarndirri McCarthy, requested that the Northern Territory Children’s Commissioner prepare a report on the operation of the intake and response services of NTFC to be completed in December 2009. This request was made in the context of a number of highly publicised events involving deaths and injury of children who had allegedly been reported to NTFC as being at risk. The Minister requested the report pursuant to section 260(1)(e) of the Care and Protection of Children Act 2007 (the Act) which:

• reviews the effectiveness and timeliness of Intake processes within NTFC;
• reviews the capacity of the NTFC Intake system
• identifies and reviews assessment tools and processes, having regards to the public comments and cases referred to above
• reviews the capacity of the intake system to respond to matters proceeded to investigation; and
• reviews the processes in place to manage unallocated child protection investigations.

On 5 January 2010, the Children’s Commissioner received a letter from the new Minister for Child Protection, the Hon Kon Vatskalis, requesting that the work done to that point be submitted by way of an ‘interim progress report’ as a broad-ranging Inquiry into the child protection system had been commissioned which would cover similar ground. The letter requested that the final report into the intake system be provided along with the full report of the Board of Inquiry.

The Interim Progress Report was tabled in the Legislative Assembly in January 2010 and made available to the Board of Inquiry.

Summary of findings

In summary, the Interim Progress Report found that:

- The timeliness of NTFC responses to initial classifications of risk had improved in the past year. In 84 percent of cases, formal investigations of reports classified by the centralised intake service (CIT) as being in the highest risk category (‘child in danger’), had commenced within the 24 hours target timeframe. For the two other risk classifications (child in danger and child concern) response timeliness stood at 58 percent and 33 percent respectively. Altogether in the 11 months since the new Act had been commenced, a total of 1,190 cases had not been actioned within the target time frame.

- Although detailed data were not available, it was apparent that CIT was struggling to meet its 24-hour ‘outcomes’ target (that is, determining a preliminary risk classification within 24 hours). At the time of that investigation (October 2009) 370 cases were awaiting an initial assessment ‘outcome’.

- With respect to effectiveness, it was noted that no generally accepted measures are available. However, there had been a raft of publicly-aired complaints about the operations of the CIT and specific allegations that misclassifications had led to the injury and deaths of children. A lack of feedback to notifiers, especially mandated professionals, was the most frequent complaint.

- It is clear from the 69 percent increase in notifications in the space of a year that the CIT experienced capacity problems. The investigation revealed that the CIT, with a notional staffing team of eight, had been operating with a daily average of less than five people and, on occasion, with as few as two people. During this period, NTFC also found it difficult to recruit appropriately-qualified staff to CIT, particularly at professional level 2 or P2’s.

- There had been a number of criticisms of the assessment tools and processes in use in the CIT, particularly the inability of the tools to assess for, and identify, issues of both cumulative and potential harm. Discussion took place on the need for a major shift in the focus on child protection away from what was termed a forensic orientation to one which is more support-focused, early intervention.

- The Operations Manual lacks guidelines on the identification of infants at risk of harm, and on appropriate responses. In some cases, infants from clearly high-risk families were not afforded a high risk classification because they were currently being cared for in hospital and therefore not currently at risk. It was recommended that NTFC develop a specific initiative around the longer-term safety, wellbeing and stability of infants and young children who are brought to its attention.
Data provided by NTFC revealed that there was a large backlog of cases awaiting assignment to a caseworker for investigation. At the time of the report there were 785 such cases which had received an initial outcome classification suggesting a child may be at risk but for which formal investigation had not commenced. There were 345 cases from one urban office in this category.

NTFC managed these backlogs in a variety of ways, including the temporary reassignment of staff, the creation of trouble-shooting teams and, on occasion, the ‘writing-off’ of some cases that had been awaiting investigation.

The report concluded that the three most pressing concerns involved:

- problems with instrumentation and assessment processes
- the need for effective support and intervention services to which at-risk families could be referred and,
- underlying workforce issues that have directly led to the serious response delays.

It was noted that the Inquiry into the child protection system would be more sharply focused on the detail of many of the issues addressed in the interim report and on integrating information received from written and oral submissions. A key issue raised but not explored in detail, is the question of whether the centralised intake model adequately meets the needs of concerned members of the public and professional notifiers who live in rural and remote areas.

Because of the nature of the interim report, six draft recommendations were made:

- That NTFC immediately review its training program for CIT staff members to ensure that all workers receive training in core child protection issues, critical decision making and cultural awareness as part of their orientation program for working in CIT
- That NTFC immediately review its training program for CIT staff members to ensure that all workers receive training in core child protection issues, critical decision making and cultural awareness as part of their orientation program for working in CIT
- That NTFC give urgent consideration to the findings of a recent review of Intake Services undertaken Jay Tolhurst (2009), and in particular those recommendations addressing efficiency concerns
- That the staffing level of CIT be increased by two full-time workers and a systematic review of caseloads and other workforce needs in CIT be undertaken by NTFC
- That NTFC consider the development of an initiative focused on the longer-term safety and wellbeing of infants and young children who come to its attention. This could be modelled on the ‘One Chance at Childhood’ initiative of the Department of Communities in Queensland but should also include guidelines for case classification at Intake as well as ongoing case management
- That NTFC policies and procedures be amended to reflect the principle that the opinions of medical and allied personnel who have worked directly with infants and young children and their caregivers, should be afforded ‘special consideration’ in assessing the risk status and wellbeing of children and when intervention decisions are made
As the particularly chronic workforce issues faced by both the CIT and some NTFC work units and are having a serious adverse impact on NTFC’s ability to ensure the protection of children, it is recommended that NTFC act immediately to address the backlogs involving initial assessments and case allocations and, to prioritise implementation of recruitment and retention strategies developed by their internal review team.

The Case of Baby BM

At the time the intake report was commissioned by the Minister, the Children’s Commissioner was also asked to prepare a report on a specific case, Baby BM. This matter involved allegations that the intake process had failed to appropriately identify and act on the risk to an infant who subsequently died. Staff members at the Royal Darwin hospital had notified the Department at the birth of BM believing that he was at risk given the parental history of alcoholism, mental health issues and domestic violence.

This investigation report determined that there was a long family history of notifications and investigations over a period of five years. However, no children had been removed and it was unclear whether formal assistance had been provided. Of particular concern was that a notification had been received concerning harm to the infant’s five-year old sibling, five months prior to the infant’s birth. This notification had been ‘outcomed’ as a child protection matter (child concern) requiring further investigation but, at the time of the infant’s birth, the case was still awaiting allocation to a worker for investigation.

At the time the notification for the infant was received, the intake workers processed it as an ‘intake event’ only and passed this information along to the Casuarina office where the original matter was still awaiting allocation to a worker for investigation. The girl’s case was still awaiting investigation when the infant died aged eight weeks.

At the time of the infant’s death it was widely reported in the media that the infant had died as a result of abuse. However, the Northern Territory coroner issued a statement the next day to the effect that a preliminary autopsy had determined that there was no evidence of obvious injuries, trauma, broken bones or abuse. The death was formally referred to the Northern Territory Coroner for investigation.

In reviewing the BM matter it was determined that:

- serious issues relating to the quality of the information being passed along to child protection authorities had emerged
- the current assessment processes appeared to overlook the problem of chronic risk and cumulative harm
- the opinions of medical personnel were not satisfactorily taken into account in the making of assessments
- there did not appear to be a protocol for guiding the responses of caseworkers to ensure the safety and wellbeing of infants and children, and
- the workloads of caseworkers, court evidentiary requirements and the lack of available placements were also identified as having a direct bearing on the decision-making processes.

444 ibid.
The report on BM made the following recommendations:

- First, that NTFC policies and guidelines be amended to reflect the principle that the opinions of health and allied personnel who have worked directly with infants and young children and their caregivers, should be afforded special consideration in assessing risk status and intervening to ensure the wellbeing of children.
- Second, that NTFC develop specific guidance for the assessment of notifications involving infants and very young children that draws attention to their particular vulnerabilities and needs and that prompts consideration of a parent’s capacity to ensure safety and wellbeing.
- Third, that NTFC ensures that the new decision-making instrumentation to be used in its Central Intake service is specifically configured to identify and to prompt for appropriately protective responses to issues of cumulative harm.

The Inquiry endorses the recommendations from the two reports from the Office of the Children’s Commissioner: ‘Report in respect of Baby BM’ and ‘The Interim Progress Report on Intake and the response process’ and calls for their timely implementation as per Recommendation 7.5 below.

Recommendation 7.5

That the recommendations from the two reports from the Office of the Children’s Commissioner: ‘Report in respect of Baby BM’ and ‘The Interim Progress Report on Intake and Response Processes’ be implemented as a matter of priority, subject to any over-riding proposals from the current Inquiry.

Urgency: Within 18 months

Written and oral submissions on intake and response services

The Inquiry received a large number of submissions that addressed issues relating to intake and response services. The submissions were largely, but not exclusively, critical of current structures and practices. However, there were also many suggestions for improving the system.

Difficulties in making notifications

A number of submissions indicate there were major differences of opinion over the roles and responsibilities of various professionals and that, in some cases, relationships between CI and some notifying professionals had become marked by hostility and mistrust.

One group of professional staff indicated that they had stopped making notifications over the telephone because of the hostility that marked the interactions and doubts were expressed about whether the notifications were being appropriately registered. Their use of written notifications had led to further tensions with CI which, in December 2009, had requested that notifications only be made verbally and, allegedly, returned written notifications in a punitive manner to the professional workers who authored them.
One confidential submission suggested that the directive to a particular group to only make notifications verbally was seen ‘as indicative of a desire to take notifications from that group ‘off the books’445. The concern that not all notifications are registered appropriately is one that came up in a number of submissions.

It should be noted that an internal NTFC report on Intake services by Jay Tolhurst suggested that the practice of sending written or faxed notifications was adding to the inefficiencies in CI because intake workers always had to attempt to call the notifiers back to request further information.446 Regardless of the causes, any breakdown in the relationship between CI and a major referring group must be of serious concern.

Some submissions refer to difficulties in actually getting through to the intake line, a problem also noted in the Interim Intake report447. A submission describes the experiences of one person who attempted to make notifications:

I add my own experience of being unable to contact the Central Intake team on a number of occasions and receiving recorded messages that I should call back later because the line was overloaded. I believe that these minor issues would be resolved if structural issues of the crisis in child protection were addressed.448

A school principal also comments on the practical impediments that he faces in making notifications:

School Leaders are keen to fulfill their responsibilities toward children. The cumbersome nature of present requirements, if refined, will help them to do this in a more positive and strategic manner. The Mandatory Reporting sign-off requirements presently in place are too unwieldy and need to be refined. 449

Other submissions noted that the processes of making a notification are onerous and take a long time. Some drew attention to the fact that there were only two phone lines and one often had to wait on line for long periods of time. One submission noted that it is difficult to get a positive response after 4:21pm, the notional public service closing time.

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445 Submission: Confidential.
447 ibid.
448 Submission: Dr Rosalie Schultz. see comment above.
449 Submission: Henry Gray.
Another submission addressed the risk to young people where there are long delays in processing notifications. Long response delays may not just be an administrative matter but a matter of life and death:

Why are staff at intake level not actively referring people to non-government sectors or police etc for more immediate support. Leaving matters un-attended for months after we have explained the process to children re: notifications and the fact that the police and or NTFC will likely question them re-traumatises young people. Where I ask are the needs of the young person considered in this? They are not. Meanwhile mental health teams are left to manage the risk that follows with such interventions. If NTFC is to function effectively, Referrals have to be responded to immediately. 450

**Unhelpful bureaucratic requirements**

Some submissions refer to the unrealistic requirements for detail which, if not available at the time, may lead to CI refusing to take the notification. In one case a witness stated that they were unable to complete a notification about an infant at risk because they did not have the exact address of the mother who was living in the ‘long grass’. The police were called and reportedly responded immediately, locating the woman and the child.

Several submissions make reference to a requirement that follow-up calls from professionals or members of the public relating to open cases (already processed through CI and investigated) also needed to go through CI. One referred to:

> The inability to go directly to case workers and having to go back through the 1800 intake number often is detrimental to a child’s safety.451

Sunrise Health Service Aboriginal Corporation commented on a particular matter:

> FACS visited the community the day before looking for a child. To report that I had seen this child, I was asked to go through the intake team again. - The next day I was contacted by... FACS; the case worker was going on leave and asked that any further issues be forwarded through the intake team. Nothing further has happened.452

Several submissions suggested that where reporters had information on new developments in an open case (i.e., one that had been substantiated) they should not have to go through the whole intake process again.

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450 Submission: Hannah Moran.
451 Submission: Crockford and Carolin (see comment above).
452 Submission: Sunrise Health Service Aboriginal Corporation.
Recommendation 7.6

That Northern Territory Families and Children develops guidelines to the effect that professional notifiers with follow-up information on an open case (i.e. a case formally under investigation or a matter that has been substantiated) have the option of directly contacting the relevant regional office rather than needing to be processed through Central Intake.

Urgency: Within 18 months

Third report rule

Some submissions, including that from DHF, noted that word has got around that in order to secure a response from CI multiple notifications had to be made to trigger the so called ‘third report rule’. This stems from an NTFC Manual guideline which mandates an investigation into child protection in circumstances where, regardless of the ‘outcome’ classification, three notifications have been made over the course of a year. One submission notes that:

The process to make 3 reports before action/investigation of a known family is contrary to the reporting requirements.

The Manual does not provide the reasons for instigating the ‘third report rule’ but it is likely that the intent was to trigger an investigative response to matters involving cumulative harm where individual events do not reach the investigation threshold. However, given the chronic backlog of matters awaiting investigation it is unlikely that any such intention of the ‘third report rule’ is being met.

Internal processing of notifications

A number of submissions were received that raised questions about the efficiency of the actual processes involved.

Earlier this year a new data entry screen was developed for CI which is called the ‘Intake event’. This screen was designed to speed up processing and cut duplication. Several submissions mentioned that, although this may have been the intention, the data screen does not appear to have made an appreciable difference and may even have made the process longer.

Jay Tolhurst who undertook a review of intake services for NTFC in 2009 made a number of recommendations to address inefficiencies in the processing of notifications. In his submission to the present Inquiry he suggests that NTFC should reconsider:

existing business rules/processes which add significantly to processing time costs at intake (e.g. the progressive withdrawal of email/fax reporting).

453 Submission: DHF.
455 Submission: Crockford and Carolin.
456 Submission: Jay Tolhurst.
NTFCHas indicated that they are in the process of actioning the efficiency recommendations made in the Tolhurst report and supported in the interim progress report undertaken by the Children’s Commissioner457.

Some submissions addressed issues relating to collaborative work with the police and how some collaborative requirements resulted in unacceptable delays. Observing that some guidelines require consultation prior to making an intake decision, one submission notes:

> The working relationship with police has created practice issues... NTFC response should not be dependent on police action, but rather clear on protection of the child. This relationship also creates lengthy delays in intakes being outcomed and forward to local offices.  

Another submission from a statutory worker drew attention to the fact that some internal referral processes are so cumbersome that they leave young people at risk because many internal referrals are not dealt with expeditiously.

Data supplied by DHF indicate that there is a large number of matters under investigation by the CAT North for which a case has been opened but the investigation has yet to be completed. As of 31 March 2010 there were 391 such matters recorded by CAT North and another 69 for which an investigation had been completed but not ‘signed off’. NTFC has indicated to the Inquiry that these data may not reflect incomplete investigations but rather follow-up casework that has not taken place or that has not been entered on the data system. Either way, these data need to be formally reviewed and action taken to clear the apparent backlog.

Recommendation 7.7

That Northern Territory Families and Children and the Northern Territory Police review the large numbers of apparently incomplete investigations from CAT North to determine the accuracy of the data and whether action needs to be taken to address the apparent backlog in completing investigations.

Urgency: Within 18 months

Management and supervision of workers

In the written and oral submissions there is comment about the management of the CI. Some noted that there had been a significant turnover of team leaders as well as intake workers in a short period of time whilst others broadly suggested that there are deficiencies in the management of the service.

The Interim Progress Report on intake noted that pressures in CI had led to a falling-away of normal supervision arrangements - a number of submissions made reference to the fact that formal supervision was rarely provided for intake workers and is not considered to be a priority.

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457 Children’s Commissioner Northern Territory, Interim progress report into intake and response processes.
458 Submission: NTFC employee.
Other workplace management issues raised in submissions include a poor induction and orientation program being provided for new workers. Some suggested that morale in the Cl was low – ‘It’s not a happy place, for many reasons, and it is a tough job...It is quite grim, and that’s all you do all day... You are weighing up risk all day so there is pressure there...It is a very cold place...It is not a safe place to work’.459

Workplace issues are explored in more depth in Chapter 12.

**Qualifications of intake staff**

The issue of staff qualifications for working in Cl came up in a number of submissions. In the Children’s Commissioner’s interim report460 it was observed that the practice standard for intake staff was that they are required to be at the P2 level but that P2 staff are in a minority because of chronic recruitment difficulties. The NTFC Barkly submission states:

> The reality is that intake is such an important job that it should consist of the most experienced staff who know the right questions to ask and can identify what is and is not Child Protection and how seriously it should be treated (triage).

Other confidential submissions stated that a role as important as intake needs to be undertaken by very qualified and experienced staff members and several noted that problems multiplied when poorly experienced and non-professional staff began gathering information for assessments.

The Department accepts that it is having significant problems attracting staff, noting:

> Central Intake has great difficulty in attracting and retaining staff and currently has a number of vacancies. Additional positions have been approved but remain unfilled. Central Intake has only been at full strength for one week since 1 January 2009.

A client of one NGO was reported as making the following comments:

> They keep putting new people on you...you really need some of your best workers on intake so that they can assess things properly from the start not ‘cleanskins’ ...that’s what they used to be called...you want good quality people that know what to look for and what to ask and can make good assessments straight away.461

One submission maintains that NTFC should consider employing general staff members in Cl who are trained as call centre operators rather than insisting on professionally qualified staff members.

Clearly the issue of attracting and retaining staff members is a critical one that at some level underlies most of the practice concerns outlined in this report.

460 Children’s Commissioner Northern Territory, *Interim progress report into intake and response processes*.
461 Submission: Danila Dilba.
Training of CI staff

The Children’s Commissioner’s Interim Progress Report noted that most (but not all) of the CI staff members had received some training in areas of child protection practice, but there did not appear to be a systematic approach to ensuring that all CI staff had the specific training required to undertake the work.\textsuperscript{462} For example, only two of the staff members at that time had received training in ‘critical decision-making’, a core skill for the intake task. It was recommended that NTFC undertake an immediate review of the training program for CI staff to ensure that the appropriate training was provided.

Specific types of training were recommended in some submissions. For example, some health workers called for:

Consistent and appropriate training for intake staff to ensure that notifications are taken in a timely and courteous manner. Some anecdotal evidence to explain this point includes: staff member making a notification on a Friday afternoon at 4.00pm was told that it was an inappropriate time to make a notification and that she should call back; staff member made to feel that her concerns were frivolous.\textsuperscript{463}

One recommendation in the Interim Progress Report on intake states:

That NTFC immediately review its training program for CIT staff members to ensure that all workers receive training in core child protection issues, critical decision-making and cultural awareness as part of their orientation program for working in CIT.\textsuperscript{464}

This recommendation is strongly supported by the current Inquiry and the Inquiry believes it must be addressed without delay.

Training of notifiers

A number of submissions make reference to the fact that there needs to be a more effective education program for those who are expected to notify, not just those who receive notifications. In one submission it is states:

Minimal training provided to the community in relation to the current Mandatory reporting responsibilities in the community. This leads to ill informed reporting processes at times. Especially, health and educational staff need to be trained more intensively re child protection matters.\textsuperscript{465}

A number of submissions express concerns about community expectations, education and knowledge of how to access the system, the allocation of public resources, and cultural awareness. For example:

\textsuperscript{462} Children’s Commissioner Northern Territory, \textit{Interim progress report into intake and response processes}.
\textsuperscript{463} Submission: Palmerston Child and Family Health Nurses.
\textsuperscript{464} Children’s Commissioner Northern Territory, \textit{Interim progress report into intake and response processes}, Draft Recommendation 1.
\textsuperscript{465} Submission: Tangentyere Council.
Indigenous and non-Indigenous communities lack understanding about [child sexual abuse] and mandatory reporting obligations in the Northern Territory. It is widely accepted that [child sexual abuse] is extensively under-reported. There is a need to educate communities about what is/not sexual abuse; what is/not acceptable behaviour; and what role communities can play in protecting children. There have been no funds allocated to do this, yet there is a well-funded plan to support mandatory reporting of [domestic violence]. NTFC needs to educate Indigenous and non-Indigenous communities about [child sexual abuse] – what it is, how communities and individuals can prevent it, and mandatory reporting obligations.

On the need for a broader educational perspective, AMSANT observes:

The Office of Aboriginal and Torres Strait Islander Health [OATSIH] has funded a series of workshops on the detection and management of child abuse targeted to clinicians working in Aboriginal primary health care. These have been well received. Education in this area needs to be provided regularly given rapid staff turnover and a high proportion of locum /inexperienced staff due to workforce shortages. Aboriginal Community Controlled Health Services (and other services) need to be assisted to orientate their staff in this area.

There is some confusion over the specific requirements of notifiers and a need for more specific training in complex matters:

We understand that any staff member is required to report if reasonable ground[s] to believe abuse has occurred. However, we are advised not to investigate so as not to ‘taint the evidence’. As a result, the information we gain is often limited. From experience we have learnt that when later called to be a witness and cross examined in court we are left in a difficult position. What are our obligations in relation to collecting and recording information?

It should be noted that the need for a ‘public awareness campaign’ for Aboriginal people about child sexual abuse was a key recommendation of the Little Children are Sacred Report. The Northern Territory Children’s Commissioner pointed out that although there had been a specific Northern Territory government commitment to ‘a wide-spread and sustained educational campaign’ this had yet to eventuate.

Specific suggestions around training include the following:

(The) Development of a ‘checklist’ or flowchart to assist other clinical staff as to when a FACS notification should be made, including any interim referral pathways.

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466 Submission: Gerri Grady.
467 Submission: Residential School.
468 Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, Ampe Akelyernemen Meke Mekarle “Little Children are Sacred”, Recommendation 94. See Chapter 6 for more detail.
470 Submission: Palmerston Child and Family Health Nurses.
One submission from within NTFC made the observation that:

NTFC currently has no allocated staff or dedicated positions available to offer Community Education or mandatory reporting sessions. 471

Jay Tolhurst who makes extensive comment on the operations of CI and who undertook an internal review of CI for NTFC, also made reference in his submission to improved education of the notifying public as a key element in improving the efficiency of the intake system.

**Cultural competence of intake workers**

A number of submissions addressed the issue of cultural competence. One of the NTFC work groups observes:

Consideration needs to be given to recruiting more Aboriginal staff to the Central Intake Team to assist with making assessments on reports about Aboriginal children in remote locations. Perhaps the Aboriginal Community Resource Worker team that is based at Central Intake could be co-opted to provide this function. 472

An experienced statutory worker who is familiar with the process, observes:

Most of the orientation consisted, and I imagine it remains the same, of people being given a map of the Health Centres, Aboriginal Communities and Police Stations. No orientation was given about the history of the Stolen Generations or the formerly ‘welfare’ system. 473

The Children’s Commissioner’s Interim Progress Report recommended that cultural awareness training should be an orientation requirement for any worker at CI. 474

**Critical issues relating to the effectiveness of and confidence in Central Intake**

**Differences of opinion over the risk classifications made by Central Intake**

Many submissions and community service providers addressed the question of different perceptions of the level of risk experienced by notified children and the particular thresholds being used in CI to determine harm.

Perceptions that the NTFC uses high thresholds for intervention have also been raised in the two reports prepared by the Children’s Commissioner for the Minister for Child

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471 Submission: NTFC Training and Development Unit.
472 Submission: NTFC Darwin Remote Office.
473 Submission: Confidential.
Numerous NGOs and external professionals have expressed their concerns about the decision-making processes, especially the high thresholds being applied which exclude many children who remain at risk. For example, thresholds for acceptance into the child protection system as recognised by remote Aboriginal Health Workers are not recognised as meeting the threshold at the Intake point.

Being told that the report doesn’t warrant being entered on the system.

Being informed that the behaviour is normal for Aboriginal people, such as teenage girls wandering the streets late at night, and as such does not constitute harm.

Lack of response from the Department on issues of serious concern frustrate a number of organisations. This is frequently expressed in the submissions. According to Save the Children, the organisation:

repeatedly notified on some families due to serious concerns for the safety of children with little or no response from the Department unless the issue is elevated to senior levels. No notification we have made on a town camp has resulted in children being removed to safety despite at times serious violence and neglect issues.

Many practitioners with a long history in child protection work found the assessment and screening process confusing, particularly ‘threshold’ assessment on the part of the person managing the intake. This same frustration was expressed by Tangentyere Council in their submission:

Notification was made to NTFC by staff regarding two siblings. CP informed staff that children were not high enough risk for them to investigate, staff requested Targeted Family Support Scheme (TFSS) pick up the case and we were informed that children were too high risk for their team, resulting in no service delivery and a non-actioned notification. Children fell through the gap.

One experienced NTFC worker made the following observation:

What someone gets charged with torture for in the Eastern states we accept as ‘normal’ in the Territory, and this higher threshold of neglect has been confirmed by staff at [NTFC]. It becomes demoralising on a daily basis to witness the needless death and suffering that Territory children live with and know that there is no point in notifying [NTFC] as the notification will be closed at Intake.

There were numerous complaints that CI had refused to recognise that particular children had been harmed or were in danger of being harmed or to accept recommendations that a family needed family support services.

475 ibid.
476 Submission: Centre for Remote Health, Charles Darwin University/Flinders University.
477 Submission: Relationships Australia.
478 Submission: Confidential.
There was an allegation this young girl was hit around the head and three people decided NTFC needed to be involved. She had over 10 previous notifications and many substantiations of harm. It goes through from the community as a child at risk but when it is finalised it comes out as ‘insufficient information’ because there is no evidence of harm.479

Schools and health services repeatedly reported serious concerns of child safety. For example, one professional reporter provided a detailed outline of a chronically neglected child raised by parents with serious drug and alcohol problems. Despite a long history of reporting the case, a number of years passed before the boy was actually taken into care.

Repeated phone calls were made to FACS ... We were repeatedly told that there was not enough evidence to act on.480

Frustration was also expressed in a submission from Sunrise Health Service Aboriginal Corporation: of the two cases reported to the intake team, one was not considered serious enough to follow up despite evidence of neglect and emotional abuse by the step parent. This type of poor response was a common theme in the submissions, particularly when reporting involved volatile substances and abuse481 and, for example,

One consequence of the marginalisation of child neglect (‘child concern’) is that child neglect referrals tend to get accepted only when the situation is entrenched and not easily responsive to intervention...482

Counsellors also report that there is a view that neglect of children is regarded by NTFC workers as less serious or concerning than sexual or physical abuse. Parents are reportedly saying ‘why bother ringing NTFC’. A remote clinic nurse intended to report a baby with continual illness and infected scabies but for whatever reason did not report this.483

Medical neglect is another form of abuse that is rarely followed up by [child protection services], and those that are investigated briefly happen only after repeated calls to intake by paediatricians and paediatric nurses. Medical neglect occurs when a child with serious medical conditions is not taken to paediatric appointments despite multiple phone calls and reminder letters sent by the hospital. They also miss appointments with other specialty Departments and allied health. Some of these children are in care484

Another submission from a medical practitioner raised similar concerns providing examples of chronic medical neglect involving non-compliance with medical advice in situations involving ‘significant growth concerns’. The practitioner maintains that the Department ‘appears reluctant to respond to such cases’.

479  Hearing: Confidential witness.
480  Submission: Confidential.
481  Submission: Confidential.
482  Submission: Nettie Flaherty.
483  Submission: Relationships Australia.
484  Submission: Paediatric nurse.
Other submissions expressed anxiety at the Department’s lack of response to notifications of children who need to spend long periods of time in hospital but do not receive visits from family. In such cases there are concerns about abandonment or neglect yet such matters do not meet the imminent or actual harm criteria for triggering a formal assessment.

(There is a) Huge emphasis on tangible harm at intake...This means that children with disabilities or children with behavioural problems, or children where there is no substantive evidence of harm, are not accepted as clients at intake level.\textsuperscript{485}

Reports from schools regarding children who are not physically abused but are neglected, and living in substandard conditions are ignored by the Department.\textsuperscript{486}

Given the widespread dissatisfaction over decision-making in CI it is not surprising that one confidential submission called for the establishment of a review function for notifications.

The case examples referred to here are a small sub-set of the large number of submissions that addressed this issue. Many of these submissions were marked confidential and/or contain details that may have led to the identification of particular children, so they have not been cited. Clearly, there is a significant gulf of misunderstanding between NTFC and professional notifiers with respect to what constitutes harm to children and what circumstances call for a protective response. Of particular concern to the Inquiry have been the examples from health and education professionals from across the Territory who claim that the Department has routinely refused to act on notifications where there is abundant evidence that children are being harmed.

It should be noted that any discussion of intervention thresholds needs to consider the context of practice in the Northern Territory and disparities that exist between the Northern Territory and other states. Generally poor living standards in remote areas, the devastating impacts of alcohol/kava, marijuana and gambling, the decline in traditional cultural practices, the history of forced child removal\textsuperscript{487} and the significant shortage of Aboriginal foster carers along with the adoption of the Aboriginal Child Placement Principle, all contribute to the creation of a complex practice context in which there are conflicting imperatives and some policy confusion. Additional complexities exist in understanding and working with Aboriginal people with a complexity of living arrangements such as those in the Northern Territory eg Town camps, long grass, outstations, homelands, rural and remote. Intervention standards in use elsewhere, could, if adopted locally, lead to many more children and families coming under the purview of NTFC which does not have the resourcing to adequately deal with current numbers. A paediatrician captured some of the complexities and the difficulties faced by child protection workers:

\textsuperscript{485} Submission: NTFC employee.
\textsuperscript{486} Submission: ANTSEL.
\textsuperscript{487} Human Rights and Equal Opportunity Commission (HREOC), ‘Bringing them home’ report.
Neglect is one of the main problems I deal with as a Community Paediatrician. There are no clear definitions of neglect, and it is subjective to decide when a child is being harmed due to ‘non intentional’ neglect. Nearly all children living in remote communities and on town camps may be included in this category. Allowances must be made for culture, different child raising practices, poverty and disempowerment. It is difficult to know whether a relativism approach is required (standard of care compared to other children within the same community), or absolute approach (same standard applied to all children regardless of ethnicity, location etc). This makes it difficult to know right from wrong at times, and as professionals we have little training in this area. There are no clear guidelines as to which children should be notified, and this remains variable between clinicians resulting in a lack of consistency. Often new, and visiting staff, have a lower threshold for notification, as once you have worked in this area for some time many things may become ‘normalised’. (There are) lower thresholds for reporting in the Northern Territory – we see the normalisation of the abnormal.488

Concerns such as these and numerous other examples of different opinions regarding risks and responses, highlight the pressing need for policy clarity, clear guidelines, clear understanding of professional roles, and compelling mechanisms for interagency collaboration and training.

Key recommendations contained in this report around interagency roles and collaborative practice (see Chapter 11), if implemented, should contribute substantially to addressing problems that arise in the assessment of risk.

**Cumulative harm**

Many, but not all, of the differences of opinion concerning risk pertain to the differences between actual and imminent harm versus cumulative harm. Cumulative harm ‘refers to the effects of multiple adverse circumstances and events in a child’s life. The unremitting daily impact of multiple adverse circumstances and events on the child can be profound and exponential’489. Particular episodes of abuse or neglect (for example a child witnessing domestic violence) may not in themselves reach the threshold that triggers a statutory intervention but the cumulative impact of many such episodes may result in serious harm to a child’s development. Cumulative harm is often (but not exclusively) associated with neglectful parenting.

Most risk assessment instruments and decision-making processes in child protection services focus on particular harmful events and on the urgency requirements in terms of response. That is, the emphasis is on issues of urgency and imminence not significance of harm. These response elements are necessary ones but in overloaded systems they may become the only areas of focus and thus children who are being seriously harmed but whose circumstances do not require an immediate response, do not get the protection and support they deserve. Recent Northern Territory reports such as the report on Baby BM highlight this problem490. In the Baby BM case, the Commissioner observed:

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488 Submission: Dr Clare MacVicar.
490 Children’s Commissioner northern territory, Report in respect of Baby BM.
There is a common theme in all the notifications received by NTFC which suggest that AJ (BM’s 5-year-old sister) is likely to have been exposed to numerous incidents of family violence, alcohol and drug usage, inappropriate sexual behaviour, shouting and verbal abuse from the adults, all over a long period of time...It would appear that this chronic pattern of behaviours and risks may not have been given due consideration when the case severity was being assessed and that each notification was looked at as an isolated event rather than as part of an ongoing pattern.\(^491\)

A number of similar examples were provided for the Inquiry in confidential submissions.

The Department itself is well aware of the problems with the current assessment focus and it might be noted that the relative neglect of cumulative harm has been identified in other jurisdictions around Australia. For example, the Victorian Ombudsman in a recent report on child protection services in that state observed:

> Throughout my investigation, it has been apparent that the Department’s capacity to respond is so stretched that cumulative harm to children has not been given the priority and attention it should. \(^492\)

The submission from NTFC Therapeutic services captures the assessment dilemma:

> If a notification doesn’t meet the threshold to raise a child protection investigation (CPI) it doesn’t get an intervention – deemed ‘no further action’ or ‘no abuse or neglect found’ because although there is clearly something going wrong in this family it does not yet meet the statutory definition of child abuse. Yet this is where the work should be focused – with early intervention and preventative supports put in place so issues are resolved at an earlier stage and further abuse and neglect is prevented.

The submission from Tolhurst (author of the internal review of intake services) addressed the question of cumulative risk in some detail. He observes:

> I think a preferable agency response is that which NTFC is currently developing where lower risk cases (which will often involve cumulative harm) are diverted from the system without investigation and connected directly to family support services where they exist. Note that this Diversion Response (i.e. DRF) is a process undertaken in the NTFC office, not at Intake.

> In my view Intake is not the place to make system changes to address cumulative harm. That is because current and future [Structured Decision Making] screening processes are configured to capture these cases reliably. The problem in the cumulative harm response is not at Intake. It is in the resources available to respond to these cases in NTFC offices, and the accessibility/availability of community support services to which the families involved can be connected.

\(^{491}\) ibid., p.13.
\(^{492}\) Ombudsman Victoria, *Own motion investigation into the Department of Human Services Child Protection Program*, p.11.
The Inquiry agrees that the fundamental problem does indeed relate to the availability and quality of services to which families can be referred for assistance (see Chapter 8), but that the problem of identifying cumulative harm also remains an issue for CI.

The intake service is the gateway to those services that do exist and if cumulative harm cases are not being identified then no assistance will be provided, especially in those complex matters that may require a statutory intervention. Moreover, many of the submissions provide examples of cases involving cumulative harm in which the present harm to children is significant and their developmental prospects are undeniably compromised, yet they did not receive an investigation.

From 1 July 2010, NTFC began introducing what is termed the Structured Decision-Making (SDM) system – an empirically-based assessment set of tools that can be used at various points in the statutory process and which has been adopted in some other states. The first step was to introduce the system to CI, including a new initial assessment tool. The SDM system provides for a clear, step-wise decision-making protocol and it is understood that it has been specifically configured to screen for issues of cumulative harm. However, Tolhurst observes that despite an increased emphasis on cumulative harm risk factors using new tools, such as the SDM Response Priority Tool, the prospect of imminent harm still informs the SDM Response Priority rating.493

The children who drift

Related to the issue of cumulative harm is the issue of children who are receiving less than optimal parenting by a variety of caregivers and whose developmental potential is seriously compromised, but who are rarely picked up by child protection systems.

The Inquiry heard about a number of such children who slip through the usually effective extended familial support networks that operate in most Aboriginal communities. Some children may be looked after in a basic fashion but not provided with the love and care they need. For example, the Inquiry heard about the ambivalence evidenced by some carers when required to look after a grandchild following the death of the child’s parent (their own son or daughter) in an episode of domestic violence. It also heard from a teacher who was concerned about the care of a nine-year-old student who was related to the family with whom he lived. She did a home visit and discovered that whilst the other children slept inside the house, he was required to sleep by himself on the veranda.

The High Risk Audit494 reviewed a case in which an infant was passed between relatives to other community members and eventually handed on to the police by people who did not know the identity of the child. The Children’s Commissioner’s annual report495 has also drawn attention to such children who might be accepted by a community but do not have anyone in particular to parent them. In some cases there may have been reports to child protection services alleging neglect, but these have not resulted in an assessment that has identified the lack of attachment to any particular person or people.

In discussion with community members around the Northern Territory, the issue of ‘wrong way’ babies was raised on a number of occasions. These are infants that result from parental unions that violate the complex ‘skin’ or moiety prescriptions of

493 Submission: Jay Tolhurst.
494 Northern Territory Department of Health and Community Services, Northern Territory Community Services high risk audit: Executive summary & recommendations.
traditional cultural practice. It was suggested that such children may be at increased risk of being rejected by a biological mother and passed on to relatives who may not have a commitment to providing the necessary parenting and support that children need. The Inquiry was also told about other infants that might be at increased risk of abandonment – in addition to children with a disability, these include what were termed ‘grog babies’ (conceived in the ‘wrong way’ whilst the mother was under the influence of alcohol) and ‘conscience babies’ (rejected by the biological mother because she had a ‘bad conscience’ about the circumstances around the conception of the child).

Although the terms ‘wrong way baby’, ‘grog baby’ and ‘conscience baby’ were brought up spontaneously, it is unclear how widely the terms are used, the number of children to which they apply, and the degree to which such children are at increased risk of neglect. That such terms exist at all suggests that assessment and investigation processes must be sensitive to the possibility that some children may be provided with the basic necessities of life but not the vital attachment and engagement so necessary for healthy development.

Recommendation 7.8

That Northern Territory Families and Children ensures that its investigation processes and instruments are sensitive to the possibility that notified children (particularly for reasons of neglect) may be provided with the basic necessities but not be meaningfully bonded with a caring adult or adults, and that they can experience significant developmental harm as a result.

Urgency: Immediate to less than 6 months

Potential harm

A number of cases involving potential harm, rather than actual or imminent harm, have come to the attention of the Inquiry. These generally involve infants who are currently safe (for example, they may be in a paediatric ward in hospital) but are due to be discharged to a parent or parents with serious substance abuse problems or histories of serious domestic violence. Complainants were told that the Department could not assess such children as being ‘in danger’, or ‘at risk’, as no harm had occurred. For example:

There has been concern that the NTFC response to children referred by health staff as being at high risk of child abuse has at times not been adequate. These are obviously difficult situations e.g. child abuse not substantiated therefore NTFC Child Protection Services do not have statutory powers to intervene. However in such situations, health care staff would recommend a high level of case monitoring and family support, and this has not occurred. There have also been situations where child abuse has been considered likely by health care staff but not agreed upon by [child protection services] staff, which again has resulted in inadequate action to ensure the best outcomes for these children.496

496 Submission: Royal Darwin Hospital, Paediatric Department.
In one case widely reported in the media, an infant was severely harmed some weeks after being notified, on a number of occasions, as potentially at risk when he was discharged. In that case, the Department apparently deemed that the child’s situation did not reach the threshold for a child protection investigation and a request for a family assessment was refused.

Clearly, such matters involving potential risk do fall within the statutory role of the Department – ‘any adult is required to report a matter in which a child ‘has suffered or is likely to suffer harm...’ (s. 26) – however, the Department is reluctant to become involved. To some extent this may be a result of the resource implications.

The Interim Progress Report on intake services recommended, that the Department:

- consider the development of an initiative focused on the longer-term safety and wellbeing of infants and young children who come to its attention.497 The initiative could be modelled on those of other child protection Departments around the country. It is imperative that such a program be established for infants and young children in the Northern Territory and the Inquiry notes that NTFC has indicated that they are in the process of implementing such a policy.

Recommendation 7.9

That Northern Territory Families and Children urgently implements an initiative focused on the longer-term safety and wellbeing of infants and young children who come to its attention. This might be modelled on the ‘One Chance at Childhood’ initiative of the Department of Communities in Queensland but should also include guidelines for case classification at intake as well as ongoing case support and management.

Urgency: Immediate to less than 6 months

Protecting unborn infants and neonates at risk

The issues of providing protection for unborn infants or for neonates were raised in a number of submissions. Concerns arise where a pregnant woman may be engaging in high risk behaviours such as the serious abuse of substances, to the extent that such behaviour may harm the unborn child. There are frequent situations in which the behaviour of a pregnant woman and/or her mental health or disability status suggests that she may not be able to provide adequate care and protection for her infant.

No formal powers are provided in the Act for the Department to act in matters involving harm to unborn infants or potential harm to neonates but there is a practice guideline to the effect that the latter may be noted by case workers so that case planning may proceed. The NTFC Manual notes that:

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Reports made before the birth of a child that identify risks to the child after their birth should be recorded on CCIS and referred to an NTFC work unit for follow-up if appropriate. The purpose of recording these reports is to allow assistance and support to be provided to the family to reduce the likelihood of being harmed when born.\textsuperscript{498} The Department was unable to provide information about any case in which such planning has taken place.

The Inquiry was made aware of cases in which babies had been born to very young mothers who were themselves under protection and who were engaging in high risk behaviours. Despite being aware of the dangers facing the newborns and, in one case, being advised internally by senior personnel to take action prior to a child’s birth, no preventive actions or preparatory planning had taken place. A related recommendation is included Chapter 10.

**Assessment based on ability to respond**

It has been observed that a major influence on the initial assessment processes in the Northern Territory is the availability of services and options to which vulnerable families can be referred.

Where such services do not exist or are hard to locate, there are subtle pressures on the decision-making process which can lead to poor assessments. For example, if an Intake worker is aware that family support services are not available for families (as is the case in many remote communities), they may be more likely to pragmatically assess a lower-risk notification as ‘no action required’. Likewise, a Central Intake worker may be aware that there is a large backlog of unallocated cases in a particular region and thus be inclined to avoid higher risk ‘outcome’ classification which would add to the already over-stretched case loads.\textsuperscript{499} The Victorian Ombudsman’s report also made reference to the ‘conditional’ nature of risk assessments and how the context for a decision affects the outcome.\textsuperscript{500} According to the report, different decision-making standards operate in different regions of Victoria.

A number of submissions addressed the organisational issue, for example:

> Assessment of intake (is) sometimes based on capacity of office to respond.\textsuperscript{501}

Part of the justification for centralising the intake function was that the assessment process could be standardised and focused on objective indicators of harm to children. This problem might be improved with centralisation where greater oversight and common training can be provided but the influence of response capacity factors cannot be entirely removed, particularly in the Northern Territory where family support, therapeutic and out-of-home care resources are so stretched.


\textsuperscript{499} ibid., p.21.

\textsuperscript{500} Ombudsman Victoria, *Own motion investigation into the Department of Human Services Child Protection Program*.

\textsuperscript{501} Submission: NTFC employee.
The need for a significant investment in the development of family support and intervention services is addressed throughout this report (see in particular, Chapter 6).

**The role of the courts**

It has been observed that the role of the courts is also a significant background factor in the decisions that are made by child protection workers including those from CI. The Children’s Commissioner noted that:

> The Family Matters Court is involved in the determination of protective orders where children are found to be at risk and the thresholds of proof for abuse and neglect adopted by the court indirectly affect the way NTFC staff frame the tasks and present documentation. Court processes are heavily influenced by evidence and such evidence is more readily found in cases involving physical and sexual abuse. Inevitably, such processes help to frame an NTFC worker’s understanding of what constitutes risk and what evidence will be needed to obtain formal protection orders.  

Discussions focused on the decision making process and the role of the courts, suggest that addressing problems with assessment tools and procedures, in the absence of other reforms, will not be sufficient to solve the problems confronting the NTFC intake service. Consideration needs also to be given to the reform of court processes together with legislative reforms if significant reforms to the way the system of child protection operates in the Northern Territory are to be achieved. Some of these issues are addressed in Chapter 10.

**Lack of feedback to notifiers**

A consistent complaint in both the written and oral submissions is that notifiers do not receive feedback on the notifications they make. They often do not know whether NTFC has deemed the notification worthy of investigation and whether the child they were concerned about remains at risk. There are numerous examples in the submissions from individuals and organisations, of which the following are a sample:

> An e-mail following notification is occasionally received from Central Intake to say the case has been passed on to the office in Alice for further investigation (or the case is not being further investigated), but there is often no further information about who the case worker is, the outcome of the investigation or whether the concerns were substantiated. I am rarely contacted by the case worker for more information.  

> One of the difficulties I have encountered over the years is when reports are lodged feedback is rarely offered. While appreciating issues attaching to privacy, school disclosure often brings issues to light. Not knowing how matters are progressing leaves reporting agencies in the dark.  

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503 Submission: Dr Clare MacVicar.

504 Submission: Henry Gray.
The participants of a survey were disconcerted by the lack of feedback from child protection workers...[They] also commented that many cases referred to the child protection agency were not investigated, but no information was given as to the reason for this. Professional staff will make a notification and they often feel as though they are not taken seriously, there is no follow-up with the worker of the family. I am not clear if this is a systems issue, resource issue or that staff do not have the capacity or skills to assess cases. The Central Australian Aboriginal Congress reported on a particular case involving a teenager at high risk. The lack of response left the young person at risk and the organisation not knowing how to proceed. They concluded: Currently, intake assessment is a one way street with no feedback or inadequate feedback to referring organisations.

There is specific provision in the Act for the Department to provide feedback to notifiers (s29:2) and the NTFC Manual also provides for this to be done for ‘Reporters who are making a report in their professional capacity’ (section 7.3.4). There is no reason why most reporters cannot be provided with basic information about the response classification that has been provided and the work unit to which a matter may have been referred. The many submissions received on this matter suggest that such feedback is given very little priority in the current system and has led to a significant loss of trust.

When the system is plagued by long response delays as is currently the case such that many notifications are not investigated for months, some information relating to the formal investigation is unavailable. Again, where such delays exist and meaningful outcomes cannot be relayed to notifiers, their confidence in the Department is affected.

As the submission from Dr MacVicar suggests, professional notifiers also expect NTFC to consult them to discuss responses to particular cases and to provide assistance with case consultation. This level of collaboration can and must happen if notified children are to be adequately protected.

For example, in section 7.3.4 of the NTFC Manual sentences such as ‘Reporters who are involved in service provision for the child and/or family may be provided with information should be re-phrased as ‘Reporters who are involved in service provision for the child and/or family should be provided with information.

**Recommendation 7.10**

That Northern Territory Families and Children develops an indicator based on the provision of feedback to notifiers to be used in reporting on performance

**Urgency: Within 18 months**

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505 Submission: Marie Land.
506 Submission: Catholic Care Northern Territory.
507 Submission: Central Australian Aboriginal Congress.
Centralised versus decentralised intake

Perhaps the most critical issue relating to intake services in the Northern Territory is whether the current centralised model is achieving its objective of providing for a reliable and responsive gateway for the provision of statutory intervention services for vulnerable children across the Northern Territory. The centralised model was established as part of a reform package in the mid-2000s following concerns about the regional office-based intake model that had operated to that point.

Examples of concerns from individuals about the centralised intake model include the following:

The centralisation of the intake system leads to a remoteness of service, and a sense of alienation of people outside Darwin. I do not know whether this has affected the quality of service, but our perceptions have deteriorated. 508

Unless ...office has a localised intake system, I have little hope that (a) thing will change. Darwin based intake workers do not have local knowledge, which is essential for accurate assessment of children, and timely handover to the child protection team... 509

A number of NGOs also expressed concerns about the centralised model:

A centralised intake system has limitations as it becomes a risk aversion process rather than a people based way of approaching very complex family problems. By relying on their checklists and rules they may miss the obvious, and are not able to accommodate local nuances and situations. 510

Being able to discuss ongoing concerns around the intake process face to face would be useful. On some occasions there has been a sense that the Darwin based system is not familiar with our geographical remoteness and there is a sense of disconnectedness as opposed to partnering us in our work. 511

Intake staff have no local knowledge or experience and therefore assessment for Alice Springs clients is poor, for example they may not prioritise cases due to lack of local knowledge and then high risk cases fall through the gap. 512

The submission from staff at Alice Springs hospital, where many child protection concerns are identified, make the following observation:

Centralisation of NTFC intake has been detrimental. Decisions and prioritisation are made without local knowledge of [the Central Australia] area or the families...

A number of statutory workers themselves were also critical of the centralised model, for example:

508 Submission: Dr Rosalie Schultz.
509 Submission: NTFC worker.
510 Submission: Catholic Care Northern Territory.
511 Submission: Relationships Australia.
512 Submission: Tangentyere Council.
We need an...Intake/referral system that is local, inclusive of other service providers and has the ability to be flexible depending upon the size and the resources at a local community level.513

And...

Is anyone considering why the public want to de-centralise the intake process. Presumably the most common response would be to add a local face to the intake process. The fact is that most intakes come in by phone with very little face to face contact. Another reason might be to add a local flavour to the process. We live in the same town/area therefore you know what I am talking about.514

Not all the submissions were critical of the centralised intake model. For example, the Territory Opposition submission observes:

A responsive and effective central intake system is crucial...

The submission from the Strategic Projects unit of NTFC comments as follows:

The current problems with Central Intake System should not be seen necessarily as a result of centralising the function. Some of these problems are related to issues like inadequate staff capacity to meet enormous increases in reports that would arguably carry more risk if the function were devolved to local offices where a staffing shortage could mean that there is literally no one to perform the function.

The submission from NTFC Barkly contained a number of observations on problems with the previous de-centralised intake model. These include:

Duty Intake workers were usually rostered on for 5 days at a time – when it was their turn, they still had to manage their own case work as well. There was no one to take over their work while they were rostered on

Duty Intake workers avoided phone calls

Duty workers were often sick when they were rostered on. This caused hostility between workers as others not rostered on have to fill the void

Local on-call staff were much busier with no gate keeping

Clients and other professional[s] will approach NTFC staff after hours or at staff homes to make notifications

Staff get no down time – particularly Indigenous staff who are approached because of their connections

The police will phone staff at home – this was the practice for years in Tennant Creek prior to the centralised intake system.

513 Submission: NTFC worker.
514 Submission: NTFC Barkly.
The majority of people who gave evidence in camera and who commented on the centralised intake model, were critical, particularly those witnesses who were from rural and remote areas. One professional stated that they no longer used the central reporting line as they had lost confidence in NTFC.

Options for the re-development of the intake system to help address the concerns of people in rural and remote areas are outlined later in this report.

**After hours service**

There were many submissions that commented on the after-hours service operated by NTFC in Darwin. Most comments were critical and suggested that the current service model did not meet the needs of rural and remote areas. For example:

> Having to go through Darwin after hours is unsatisfactory. They don’t understand local context and issues of child at risk and sometimes assess a situation as not urgent and leave the patrols having to come up with alternative and unsatisfactory solution[s].

Several submissions and witnesses gave examples of notifications being made after hours only for the response to be, for example, ‘there is nothing we can do’.

The Alice Springs Hospital submission referred to an incident:

> Where central intake have refused to take a notification because it was a Public Holiday.

It should be noted that NTFC is undertaking a formal review of the After Hours services including planning for a new responsive after-hours system:

> (NTFC is) developing a proposal for provision of an Out of Hours Child Protection Service in Alice Springs. After Hours service responses to carers also need to be considered in order to provide 24 hour support to carers to ensure that they receive timely advice and follow up for any critical incidents or crises.

**Formal investigation of child protection ‘outcomes’**

Although much of the comment in submissions focuses on CI and the initial responses to a notification, some have commented on the actual process of formal investigation by child protection workers after CI refers a matter to a work unit.

As noted earlier, the outstanding problem here is the huge backlog of cases awaiting allocation to a worker for investigation. As of 1 July 2010, this backlog stood at 870 matters. Data provided by the Department suggests that the backlog has remained consistently high in the past year and urgently needs to be addressed.

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515 Submission: Tangentyere Council.
516 Submission: DHF.
Tolhurst, in his submission, makes the following observations about the delay in undertaking investigations:

This continues to leave children at risk of serious harm un-responded to for unconscionable periods. It also continues to frustrate notifiers who have reported their concerns in good faith and who, as subsequent days pass, cannot see evidence of any on-the-ground NTFC response to their concerns. The above, in my view, and that of many NTFC staff, is contributing to a widespread loss of community confidence in the NTFC response to the [child protection] reports it receives.

In the Interim Progress Report on intake, the Children’s Commissioner identified the backlog and the ‘serious and chronic workforce problems’ that underlie it. The report, highlights the backlog as one of the three issues with the most ‘immediate and significant bearing on the safety and wellbeing of children’ 517

Caseloads and workforce are addressed in Chapter 12 of this report and specific recommendations are made to address these underlying issues that contribute to many practice problems. However, regardless of the causes, the investigation backlogs present a serious threat to the safety and wellbeing of vulnerable children in the Northern Territory and need to be addressed as a matter of urgency.

A draft recommendation in the Children’s Commissioner’s interim report states, in part:

that NTFC act to immediately address the backlogs involving initial assessments and case allocations... 518

A specific recommendation regarding the pressing need to clear up this backlog is made earlier in this chapter.

Who undertakes the investigations?

Concerns were expressed during the community consultations that remote area issues are managed by staff in urban areas. The Darwin Remote team, responsible for providing services to remote areas outside of Darwin, raised questions in their submission about who actually undertakes the investigations of notifications relating to children in remote areas:

There is a recognised need for specialist local based services - [the] fly-in fly-out approach currently adopted by NTFC to service remote communities does not provide the necessary regular, consistent intervention for children and families and impacts negatively on building the necessary working relationships with families and the wider community.

Recommendations relating to a new community-based intake model are summarised later in the current chapter and are provided in Chapter 11.

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517 Children’s Commissioner Northern Territory, Interim progress report into intake and response processes, p29. The Report was tabled in the Northern Territory Legislative Assembly, January 2010.

518 ibid., draft recommendation 6.
Police and the Child Abuse Taskforce

Formed in June 2006, the Child Abuse Taskforce (CAT) is comprised of NTFC workers, Northern Territory Police and the Australian Federal Police. It provides a joint investigative response to reports of serious child abuse matters, particularly where there are multiple victims of child sexual abuse and multiple offenders. The work commenced with the investigation of offences committed on remote communities and this has continued to be the central focus of CAT activities. CAT commenced with four police officers and four NTFC workers. DHF have observed that there are currently 13 Northern Territory police officers, 4 AFP officers, and 9 NTFC personnel in the CAT North (Darwin based) along with 4 Northern Territory police officers, 2 AFP officers and 3 NTFC personnel in CAT South (Alice-Springs based). Furthermore, they note that police greatly outnumber NTFC personnel in the CAT teams and thus the focus tends to be on pursuing criminal investigations rather than broader child protection interventions.

The DHF submission went on to note that both branches of CAT have worked with 282 children whilst investigating alleged sexual assaults in Northern Territory communities (between 1 July 2009 to 28 January 2010). This has resulted in 99 arrests and 26 court summonses.

With the possible conclusion of the Northern Territory Emergency Response, the planned withdrawal of AFP officers over the next 18 months (January 2010 – June 2011) has been identified in the Northern Territory police submission as a serious concern for the ongoing viability of the CAT teams.

Recommendations made by the independent review of the Northern Territory Police role in CAT to further enhance its effectiveness were made around governance and some operational issues – particularly the Northern Territory Police involvement in the NTFC Central Intake process.

The proactive work of CAT in raising the profile of child protection in remote communities is important, and consistent with the strategic directions identified in the National Framework for Protecting Australia’s Children, as well as recent scholarship.

Information-sharing

Issues relating to the process for working collaboratively between Police and DHF were directly raised in the Northern Territory Police submission. In particular, concerns were raised about lack of information sharing between police in CAT and NTFC workers in CAT. One submission drew attention to procedural problems noting that child sexual assault matters could not be investigated by NTFC until police had interviewed the child (either on their own, or jointly with NTFC staff). The problem raised was that:

519 C Gardiner-Barnes, email, 25 August 2010.
520 Submission: DHF.
521 Submission: Northern Territory Police.
522 Ibid.
...unless the police were presented with a report where there was good collaborating evidence, or a good disclosure by the child and there was a good chance of a criminal conviction, then there often seemed no urgency by police to investigate. In cases such as these, sometimes reports could not be actioned by NTFC staff for months after [it was] allocated because of the above practice of NTFC officers waiting for the matters to be first investigated by police. 524

The same submission went on to offer ways that CAT teams could operate more effectively by reviewing and clarifying the criteria for cases to accept. The legislative mandate of NTFC does not clearly extend to cases of extra-familial abuse where parents are acting protectively – yet such cases were alleged to have been accepted by CAT teams 525.

In their submission, the Northern Territory Police recommend that CAT teams be expanded to include representatives from Department of Education and Training (DET) and Remote Health. They argue that the co-location and addition of DET and Remote Health representatives as permanent members of CAT teams would provide a multi-agency critical response to communities at high risk of child abuse. The call for an enhanced interagency response, particularly in remote areas, is considered in more depth Chapter 11.

One submission526 identifies that what they perceived as a large amount of funding for the CAT meant that NTFC workers in the CAT team were under-employed and doing largely unnecessary work on cases where there was no legislative mandate (i.e., cases of extra familial abuse where the parents were clearly protective). This was seen as being an unfair intrusion into family life when there is no evidence of caregiver abuse/neglect, and creating an unfair differential between other NTFC workers who were not part of a CAT team.

**Community engagement**

Given the educative/preventive role of CAT, community engagement needs to be a critical part of CAT work. However, engagement needs to be based on a sound community partnership model. The Northern Territory Police submission recommended that a community partnership problem-solving model is developed and implemented as part of a sustainable community engagement strategy for protecting children in remote communities. This is consistent with calls for community development approaches to child safety in Aboriginal communities527 (see Chapter 6) as well as the remote community child protection model outlined in Chapter 12, and is supported by this Inquiry.

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524 Submission: NTFC worker.
525 Ibid.
526 Submission: Confidential.
527 Higgins, *Community development approaches to safety and well-being of Indigenous children*. 
Recommendation 7.11
That the Northern Territory Government in considering the impact of the phased withdrawal of AFP by the Commonwealth, ensures that adequate planning and funding is in place to respond to the issues of serious abuse in remote areas.
Urgency: Immediate to less than 6 months

Recommendation 7.12
Given that a number of issues have been raised in submissions touching on strategic goals, resourcing, communications and governance, that a joint review of CAT is undertaken by Northern Territory Families and Children and NT Police during the first phase of child protection reforms resulting from this Inquiry.
Urgency: Within 18 months

Other issues involving the police and child protection
A number of other issues relating to police/NTFC investigations and responsiveness were brought up in submissions. These included problems around the sharing of information, the alleged reluctance by NTFC to refer matters (such as those involving domestic violence) to the police for investigation; and the alleged failure of the police to contact NTFC when they come into contact with young people apparently in need of protection. For example, the NAAJA submission made the following observations:

It is NAAJA’s view that when Northern Territory Police arrest a child who is alleged to be committing offences and for whom no responsible adult can be located, a police officer should be required to immediately initiate an investigation to determine whether a child is in need of protection. In NAAJA’s experience, often what occurs is that a police officer will instead arrange for a support person to be present when the child is interviewed (the Youth Justice Advisory Committee maintains a register of persons appropriate to be support persons). The problem with this approach, however, is that police are not responding fully and effectively to the issue of whether a child is in need of protection. It simply delays appropriate action being taken at the earliest opportunity to determine whether a child is in need of care, usually until the child without a responsible adult appears before the Youth Justice Court.

In the discussion of youth issues in Chapter 8 there is a call for the development of a child protection youth strategy to include collaborative inter-agency strategies to address the needs of vulnerable young people.

528 Hearing: Witness 52.
Sex offenders and community safety

The Northern Territory Police submission to the Inquiry made reference to the fact that in October 2006 there were 64 reportable sex offenders on record with 8 living on remote communities. Three years later in November 2009 there were 192 reportable offenders with 60 living on remote communities. They added that there are currently 90 other offenders in custody many of whom will become reportable offenders upon release. The potential risk to children in the communities is a significant one, particularly as there are few formal monitoring mechanisms available. The submission went on to suggest a number of approaches being used elsewhere to monitor the behaviour of offenders including the Child Protection Watch Team approach which was recently trialed in NSW529.

The Inquiry notes that there has been a great deal of work put into the development of community safety plans (CSPs) as a component of the Local Implementation Plans in the 20 growth towns530 and Northern Territory Police have informed the Inquiry that CSPs are currently under development in 6 remote communities. It is the view of the Inquiry that management strategies for sex offenders on release should be included as part of such plans in each of the 20 growth towns to include coverage of the associated outstations and homelands.

**Recommendation 7.13**

Given that there has been a significant increase in the number of ‘reportable offenders’ on the sex offenders register, and that many such offenders are paroled to their home communities, that the Northern Territory Government ensures there are resources available to maintain the effectiveness of the Reportable Offender Management Unit and to implement a community-based ‘child protection watch’ scheme linked with the development of Community Safety Plans.

Urgency: Within 18 months

Inappropriate practice relating to investigations

In the course of the hearings, the Inquiry heard a number of allegations relating to investigative processes. Most of the allegations were difficult to verify as those making the claims could not identify the clients involved, or the specific case workers.

However, the Inquiry notes that a former staff member of NTFC alleged that, in some cases, staff in a particular work unit appeared to arbitrarily ‘write-off’ cases referred for investigation (i.e. closed them without formal investigation) because of the long periods of time that had elapsed from the receipt of the notification from CI. The issue of ‘writing-off’ matters is raised elsewhere, both in submissions to the Inquiry and in previous reports. ‘Write-offs’ appear to have occurred both in CI and the work units. Reference to this practice was also made by the Children’s Commissioner in his interim report.531


531 Children’s Commissioner Northern Territory, *Interim progress report into intake and response processes*. 

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Jay Tolhurst, referring to directions to ‘write-off’ cases, states that this is ‘a very regular event’ and makes the following observations:

To ask workers as part of the Arrangements to say that there are no concerns when the matter has not been investigated is to ask them to arrive at a conclusion that is not based on the agreed minimum required interventions set in policy for making that determination. Policy requires interventions which involve sighting the child and a series of family interviews etc to arrive defensibly at such a view. Workers are therefore not properly able to say un-investigated situations are concern free...It is a decision for which management should be transparently accountable. Operational staff involved should not bear any risk for the future implications of the closure.532

Another allegation of inappropriate practice relates to action being taken in lieu of an investigation. The former employee, mentioned above, alleged that on several occasions, children were removed from families in remote areas without any on-the-ground investigation of the circumstances. That is, the action was taken on the basis of the original notification, not following an official investigation and in contravention of the Act. The following allegation is in the submission from a paediatrician:

Many of the indigenous children notified live in remote locations. It appears that NTFC is reluctant to fly workers out to these locations to do investigations. Sometimes it appears that the police are used to remove children, rather than a proper investigation being carried out.533

There were also complaints about culturally biased and otherwise misinformed assessment processes:

Child protection assessments and investigations are often based upon the opinion of one or two ‘whitefellas’ in the community that may or may not have a proper knowledge of these particular children and young people, leading to ill informed and subjective decisions.534

New assessment instrumentation

The submission from the NTFC Strategic Projects Unit referred to the new instrumentation to be introduced for family assessments –The Family Strengths and Needs Assessment (FSNA). The tool has been introduced in the Targeted Family Support Service operated by Congress in Alice Springs. According to the NTFC this tool might also be used by:

all agencies working with vulnerable families, including NTFC and that it will support collaborative responses to those families.535

The tool is not yet in formal use within NTFC but use of the new SDM intake tool commenced on 1 July 2010.

532 Submission: Jay Tolhurst.
533 Submission: Dr Clare MacVicar.
534 Submission: NPYWC.
535 Submission: NTFC Strategic Projects Unit.
Consultation with notifiers

There has been some comment on the need for a collaborative approach to the investigation process. It stands to reason that a professional who notifies a matter might be consulted during the investigation process but this does not always appear to be the case. For example, the paediatrician, reported earlier, observes:

An e-mail following notification is occasionally received from Central Intake to say the case has been passed on the office in Alice for further investigation (or the case is not being further investigated), but there is often no further information about who the case worker is, the outcome of the investigation or whether the concerns were substantiated. I am rarely contacted by the case worker for more information.536

A confidential submission by an NTFC worker reinforces this point and suggests that the collaboration should go beyond investigation information to actual case planning:

It is vital that the allocated worker completing the investigation (has) much contact the referrer to gather background information (about) the incident. With regards to confidentiality one must consider whether the referrer needs to know the outcome of the incident, however one would hope that other agencies working with the family, schools for example are involved in developing the case plan.

Save the Children make a similar point in their submission:

There is also concern that FACS responses to families are inadequate. There is little partnership evident with other community groups and a continued devaluing of the cultural knowledge of workers…

There are existing guidelines in the NTFC Manual537 around the gathering of information from other professionals as part of an investigation along with details of the authority to do so, but there is very little on consulting with the referring professional and/or other service providers who may be familiar with the case in order to come up with more valid and useful information. It is noted that certain professionals ‘are legally required to provide the information requested by NTFC.’ 538 However, the Manual contains little about the importance of engaging other professionals in a collaborative way during the investigation phase. Given that many cases in the Northern Territory involve children and families in remote areas and that professionals on location (such as health workers, teachers and the police) may be well placed to comment on issues such as risk and protective factors, this is a major oversight. The promotion of collaborative forms of practice is a major theme of this report and the imperative of collaboration needs to be written into sections of the Manual covering initial assessment, investigation as well as case planning. It is noted that issues relating to interagency collaboration and information sharing are addressed in Chapter 11.

536 Submission: Dr Clare MacVicar.
538 ibid., 11.6.2.
Recommendation 7.14

That the Northern Territory Families and Children Policy and Procedures Manual be formally reviewed with a view to actively encouraging workers to adopt a collaborative approach to practice with respect to intake assessment, investigations and case planning.

Urgency: Within 18 months

Engagement with family

The need to engage positively with family members at various stages of the statutory investigation process is noted in the NTFC Manual but there is not a great deal about engaging the extended family as part of the assessment process. The need for such an approach has been canvassed in a number of submissions, for example:

Assessment does not appear to be satisfactorily engaging with all family members and other services with a solid understanding of the child and the family.

Tangentyere Council also advocates for:

Regular, frequent and appropriate case meetings with families occur throughout investigation, and occur at a place and in a fashion that is determined by the family.

Other submissions observe that engagement with family and extended family was needed at all decision-making points of the statutory process. For example, the analysis of one case by Danila Dilba led to the following observations:

As with other case stories there was no concerted effort from the child protection workers to engage with the family, at each critical decision making point, and discuss how best to support the children. The policy environment in the Northern Territory seems to place no importance on family group conferencing or other mechanisms for families to be at the centre of the decision making process. Enshrining the rights of families to participate in decision making and resourcing these processes should be a priority for child protection legislative reform in the Northern Territory.

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539 ibid., 11.5.
540 Submission: Tangentyere Council.
541 Ibid.
542 Submission: Danila Dilba.
Recommendation 7.15
That the Northern Territory Families and Children Policy and Procedures Manual be reviewed and re-worded to embed the principle that engagement and collaboration with the family and extended family should be considered part of normal child protection practice where the child’s safety is not compromised.
Urgency: Within 18 months

As noted earlier there are often differences of opinion about the level of risk in a particular case, a frequent scenario being that external professionals believe that a child is at high risk but cannot convince CI that this is indeed the case. Such differences extend to the actual investigations undertaken by NTFC. Examples of such cases are provided in the submissions. For example:

Case workers were becoming so de-sensitised by the level of neglect in Indigenous families that they were inadvertently lowering the bar in what they would substantiate as child abuse/neglect.\(^{543}\)

Such concerns should be at least partially addressed by the re-calibration of the intake instrumentation used in NTFC to include specific references to neglect and cumulative harm (commencing 1 July 2010), the introduction of broader family needs and strengths tools, and a significant investment in the development of support and intervention services for families at risk.

Qualifications and experience of staff
A number of submissions were received that called attention to the fact that some staff members undertaking investigations were not qualified to do so. This was confirmed by some confidential submissions received from NTFC staff. A number of referring professionals also expressed concern about being interviewed by administrative rather than clinically-trained staff members. This issue is addressed in more detail in Chapter 12 which specifically addresses workforce issues.

Recommendation 7.16
That Northern Territory Families and Children evaluates current intake and assessment functions to determine the skills, qualifications and training that are required and whether these are functions that need to be performed by P2 classified workers.
Urgency: Within 18 months

\(^{543}\) Submission: NTFC worker.
The focus on substantiation rather than the needs of children and families

Submissions noted that the current emphasis, and national data reporting requirement, is for each investigation to lead to a ruling on whether a case is substantiated or not. This can lead to a skewed, forensic approach that focuses more on the technicalities of whether harm occurred rather than on meeting the actual needs of families and children\textsuperscript{544}. For example, relatively minor harm may have occurred in a particular case (requiring a substantiation), but a more useful outcome of an investigation in the case might be determining what level of support or therapeutic intervention the family/parents need to create a safe environment for children therefore avoiding future notifications.

Unnecessarily restrictive legislation

A number of submissions refer to the fact that under the new Act there is no direct mandate for the provision of assistance outside of an abuse/neglect substantiation. For example, a parent complained in a submission that when she requested assistance, the Department responded that help could only be offered to ‘derelict’ parents, not those who sought out help. This parent also stated, ‘I have continually sought assistance to no avail.’

Several other parents told the Inquiry that they sought assistance from FACS around the management of their children only to have their children removed from them. One parent observed that ‘it had to reach a crisis point before FACS was forced to provide some assistance’\textsuperscript{545}.

It might be noted that the Act does allow for assistance to be provided where a matter has not been substantiated as well as in matters where there has been no notification. For example, the CEO ‘can take actions for the wellbeing of children generally (including actions with the voluntary participation of parents and for children who are not necessarily in need of protection’) (Section 41). However, in an over-stretched system which has difficulties responding to those at immediate risk of harm, it is unlikely that much attention and assistance will be provided for those who need help as a preventive measure.

The issue of voluntary assistance to families outside of statutory investigations is explored throughout this report.

Developing a model of intake, investigation and assessment for the Northern Territory

The broad intake and assessment model being presented in this discussion is based on research commissioned by the Inquiry and undertaken by the Australian Institute of Family Studies (AIFS), the numerous submissions received by the Inquiry relating to this topic, the service delivery data provided by the Department, and consultations with communities, the reference group and various child protection experts from across the country. The model is consistent with the primary thrust of the national child protection framework and reflects a move to a model which places emphasis on early intervention and the provision of family support rather than a more forensic approach.\textsuperscript{546}

\textsuperscript{544} Submission: NTFC Therapeutic Services.
\textsuperscript{545} Hearing: Confidential.
\textsuperscript{546} Council of Australian Governments, Protecting children is everyone’s business.
In broad terms, the approach outlined here supports the NGO sector and a range of
government agencies to assume a more prominent role in assessing and responding
to the needs of vulnerable children and families whilst ensuring that DHF and NTFC in
particular, have the means to provide statutory child protection where this is necessary
to protect children from harm.

The AIFS review of assessment and intake models operating in various Australian
jurisdictions and overseas is provided in Appendix 7.2. In undertaking the background
research on assessment and investigation models the Inquiry did not identify any existing
models that could be adopted in the Northern Territory but did identify a number that
had strengths and features that might be usefully adapted.

There are a number of key issues that need to be considered in the development of intake
models for child protection in the Northern Territory. These include the following:

- A small population spread over a large geographic area, primarily remote, with
  limited professional services and supports in local areas
- A large population of Aboriginal children living in circumstances of concentrated
  disadvantage
- The historical context involving dispossession and the forced removal of some
  Aboriginal children leads to a deep sense of mistrust and injustice
- A high proportion of children are experiencing abuse and neglect
- Many families are vulnerable to future problems, such as inability to meet their
  child’s needs, but may be able to do so with support
- A lack of coordinated state-wide services and supports for high risk and vulnerable
  families
- The only state-wide visible entry point into services is through the centralised
  child protection intake services. There is no visible entry point directly into
  services and supports for high risk and vulnerable children and families.

These issues have culminated to a system in which:

- Child protection services are unable to respond to demand
- There are significant delays in response time
- Many children are not receiving services despite risk
- High risk and vulnerable children are not receiving services despite need.

Statutory child protection is designed to be an intervention of last resort, in which children
are protected after they have been abused and neglected or are at high risk of very
serious harm. Child protection should be understood as just one part of an integrated
service system that also provides services and supports to families to prevent abuse and
neglect. Figure 7.1 is based on the models described in Chapters 3 and 6. It represents
the broad categories of services and supports that should be available to families as part
of an integrated service system.
Figure 7.1: Integrated model for child protection services

Most families are at the bottom layer of the pyramid, but with increasing need they rise up the pyramid such that there is increasing involvement of services culminating in the statutory authority assuming the responsibility for meeting a child’s needs. From the lowest layer and upwards:

- Most families are meeting their children’s needs. They will benefit from formal and informal supports available to all families.
- Some families are meeting their children’s needs, but are vulnerable to future problems. They will benefit if they are supported with targeted assistance to prevent problems from occurring.
- Some families are not meeting all of their children’s needs, but are open to receiving support and can meet their children’s needs if they are provided with assistance.
- Some families are not meeting all of their children’s needs, but may be able to meet those needs with assistance. They are not open to receiving support, but will comply with statutory involvement.
- Some families cannot or will not meet their children’s needs, or cannot make the changes to meet those needs in the child’s developmental timeframe. The state is in loco parentis and is required to facilitate children’s needs being met.

The fundamental challenge is to design an integrated system of services and supports that leads to early identification of children and families at risk and referral of these families to early intervention services and supports. Overall, the thrust of an integrated system of services and supports would be formalised referral pathways that mean families can access supports and services no matter what level of need they have and
that they will not need to require a child protection referral to access general family supports. If families are not willing or able to provide for the needs of their child despite the use of strategies such as family-decision making models, more intrusive forms of intervention can then be used. An integrated service system does not prevent referrals being made from child protection to child and family service hubs or universal services to child protection, yet it does change the primary referral pathway into these services.

To meaningfully discuss intake processes we need to consider them in the context of broader structural changes being proposed for the child protection system in the Northern Territory. These changes are more fully explored in later chapters.

**Integrating intake, assessment and investigation into child protection services**

This section explores the potential applicability of the broad model of child protection intake, assessment and investigation as part of an integrated system of services and supports for child safety and wellbeing in the Northern Territory. Rather than focus on structures, we take a step back and identify the functions of services in the child and family safety and wellbeing agenda throughout the integrated service system and who is best placed to perform them in the Northern Territory. The issues raised include:

- referral pathways
- professionals and services well-placed to make assessments, and
- the nature or purpose of the assessment.

Different models for undertaking investigations into child abuse and neglect are also considered.

Consideration of this broader safety and wellbeing agenda offers families a non-stigmatising and non-threatening pathway to access services. A population health approach offers services to all children and families, more of those services plus therapeutic services to vulnerable children and families, through to indicated services for those deemed to require them, through to what is traditionally known as child protection and out of home care. This model reduces the involvement of the statutory authority for vulnerable children and families such that the overwhelmed child protection services are no longer the initial point of referral and assessment.

**Universal services available to all children and families (level 1)**

**Referral pathway**

Universal services are those which every child and family can access regardless of whether or not there are specific vulnerabilities. As with any provider of services for children there is a need for workers in this field to know how and when to access services higher up the pyramid, and in particular when to access the child protection system.

In a subsequent chapter we discuss that a strengths and needs assessment instrument must be developed, and it would be useful for universal services. Such a tool needs to be standardised and suitable for professionals and community members with varying
qualifications and experience to assess a child and family’s strengths and needs. As a population approach applied to all children, the assessment instrument would need to be brief and relatively non-intrusive, such as a screening instrument.

The focus of the AIFs review described in Appendix 7.2 was to examine assessment instruments for abuse and neglect, thus no example of universal strengths and needs tools were evaluated. However, the Common Approach to Assessment, Referral and Support (CAARS) developed as part of the National Framework for Protecting Australia’s Children may warrant investigation.

Any assessment instrument used in the Northern Territory would need to be purpose-designed or modified to ensure it is culturally sensitive and takes into account social and structural inequity.

**Services and supports for vulnerable and high-risk children and families (levels 2-3)**

**Referral pathway**

At present, there is a variety of services and supports for vulnerable and at risk children and their families. However, as described in Chapter 6, coverage is variable and largely operator dependent, with some communities having some services and others without. There is no coordinated Territory-wide approach to developing a service and support sector for vulnerable and high-risk children and families, and as a consequence there is no coordinated state-wide visible referral pathway into these services.

In addition to allegations of child abuse and neglect, the CI is acting as the primary visible referral point for vulnerable and at risk children and their families. However, it is unlikely to know what services and supports are available within local communities, making it difficult if not impossible for intake workers to make appropriate referrals. Moreover, as described, the CI is overwhelmed by the number of notifications it receives and is unable to keep up with even the urgent matters it receives. Realistically, the current system cannot provide a reliable referral service for families who need assistance short of statutory intervention.

Many of the reports currently made to CI could be referrals made, with the families’ knowledge, directly to a regional family support referral centre; or families could self-refer. To achieve this goal the primary (most visible) referral point for vulnerable and high-risk families would need to shift from CI to the community. This is a similar concept to the operation of Child FIRST in Victoria, Gateway Services in Tasmania and more recently in NSW. In remote areas, the Community Child Safety and Wellbeing teams would assume a similar function.

Despite a vulnerable child still being at risk of harm from, say, neglect, referring a child and family to a recognised safety and wellbeing centre should satisfy mandatory reporting requirements (with appropriate adjustments to the legislation). This dual track referral system diverts referrals from statutory child protection, where they are inadequately addressed, to support oriented services. In Tasmania this formally occurred on the 1 August 2009. New provisions were made in the *Children Young Persons and their Families Act 1997*.

547 ibid.
(Tasmania), providing the option for mandatory reporters to report their concerns about the care of a child to the non-government Gateways service (a community-based intake service), and that such a report fulfils mandatory reporting obligations.

By way of summary, the proposed centres or ‘gateways’ will address the need for a visible referral pathway in the urban areas — the alternative model in remote areas will be through the local Child Safety and Wellbeing team.

**Professionals and services well-placed to make assessments**

There is currently a shortage of skilled child and family welfare professionals within the Territory. A few specialist services are being provided in remote and very remote communities on a fly-in, fly-out basis, for example, the NTFC Mobile Outreach Service for trauma victims. However, for the most part, the only professionals within the communities who come into contact with families are those who form part of universal government services, such as police officers, teachers and health workers.

The proposed interagency team model, described in the chapter on interagency collaboration, provides an opportunity to develop local community-based responses that draw upon those professionals within the communities in partnership with members of the community. This approach has similarities with the description of the community-based child protection teams operating in countries affected by armed conflict or natural disasters as it is developed because of a unique set of needs and circumstances and mobilises the resources at hand.548

For community-based models to be effective, a staged approach to implementation that builds skills and capacity of community members to provide services is essential. For example, the province of Manitoba in Canada built the capacity of community-controlled non-government agencies through the secondment of the existing government child protection practitioners to the newly established services for a two-year period while the fundamental shift in practice and organisational culture was achieved.

In the major urban centres there could be an intensive effort to develop service hubs. The Tasmanian Gateway Services were developed in the four-year period after 2006 following two reviews that identified the lack of non-government child and family services as contributing to an overwhelmed and ineffective child protection service.549

**The nature or purpose of assessment instruments**

The purpose of the assessment is to assess whether children’s needs are currently being met: ‘What are the strengths and needs of this family looking after this child?’ That is, they would have a family service orientation with a therapeutic focus comparable to the child and family welfare approach in many European countries.

For children whose needs are not being met, the assessment will also need to determine (a) whether the family can meet the child’s needs with assistance; and (b) whether the family is open to receiving support. If the outcome of either (a) or (b) is negative, then a referral must be made to statutory child protection services. If the outcome of (a) and

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548 See Appendix 7.2.
(b) is affirmative, then the role of child and family service hubs will be to provide the services and supports or connect families to the services and supports that they require to meet their child’s needs.

An assessment instrument for use with vulnerable and high-risk families would need to be suitable for professionals and community members with child and family welfare experience or training.

As previously discussed, any assessment instrument used in the Northern Territory would need to be purpose designed or modified to ensure it is culturally sensitive and avoids holding parents accountable for social and structural inequity. Existing consensus-based assessment instruments which incorporate theory in their development, could potentially be adapted to fit the Northern Territory context. Given that NTFC has invested in the SDM system of tools, the Family Strengths and Needs Assessment being investigated for use in ‘Differential Response’ services may provide a common assessment tool for secondary level family assessments.

**Children requiring statutory intervention for their protection (levels 4 & 5)**

**Referral pathway**

At present, there is a large group of vulnerable and at risk children and families who require a therapeutic response and for whom child protection responses are not appropriate. Many of these children are currently reported to child protection services through the CI.

Referral to a statutory child protection service is stigmatising and threatening to families. Regardless of the ability to take on the number of such referrals, it is questionable whether statutory child protection services can effectively engage families in voluntary therapeutic interventions anyway. Child protection practitioners face an overwhelming demand for their services and role confusion as they try to fulfil the multiple obligations of investigation, surveillance and monitoring of risk to children whist, at the same time, therapeutically engaging families to support and assist them in a process of change.

The culmination of these factors is that child protection intake services are the primary, and most visible, referral point for professionals concerned about a child. This means that families must be assessed by an agency that provides a coercive (involuntary intervention) to access the voluntary support service they require. This situation acts as a deterrent to families seeking support and creates inefficiencies with families being assessed by multiple services.

European countries with a family service orientation still retain a legal response for families in which a coercive intervention is required (i.e., families not open to receiving support) and for children who require legal redress as they have experienced serious maltreatment (sexual abuse, severe physical abuse and criminal neglect). However, the proportion of families requiring such a legal response is relatively small. For example, as outlined in Appendix 7.2, research shows that only 7 percent of cases reported to a Confidential Doctor Centre in Brussels required a judicial intervention and incidence of re-abuse was low after receipt of services.  

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Narrowing the scope of child protection

There are opportunities here to reframe and more narrowly scope statutory child protection services by removing all voluntary service functions. Child protection would focus solely on families requiring a coercive intervention and the protection of children who have experienced serious maltreatment (sexual abuse, severe physical abuse and criminal neglect) that require forensic investigations. This would help to address the current role confusion between families who need assistance who can and will engage with voluntary services and those who need to be compelled under law to change their behaviour or have their children removed.

Statutory interventions are generally more costly than voluntary interventions. In addition, there is inefficiency in assessments being undertaken by child protection for families subsequently referred to voluntary services, which in turn undertake their own assessment.

It is possible that a more narrowly scoped child protection service could result in cost savings. Any cost savings could be re-invested into voluntary child and family support services for vulnerable and high-risk families. It is important to note that any changes designed to reduce the scope of statutory child protection services to coercive interventions and criminal investigations could not be safely carried out without having a robust, well-funded and supported alternate voluntary service response and visible referral pathways for high-risk families.

Different types of assessment: Intake and investigation

At present, there are two types of assessments made by child protection services prior to a substantiation decision: an initial screening assessment made by intake staff based on information provided orally (primarily by phone); and a comprehensive assessment made as part of an investigation, which generally requires a child and their home environment to be sighted and discussions held with parents.

At present, initial screening assessments are performed by a centralised child protection intake team. In regional centres, investigations are performed by child protection practitioners. In remote areas, investigations may be conducted by child protection practitioners who are part of mobile child protection teams transported into the community, or by local police based within communities.

A more narrowly scoped child protection service would have a less prominent intake function, as child and family safety and wellbeing ‘gateways’ and teams would be the primary referral point for vulnerable and high-risk families.

The role of narrowly scoped child protection services would include:

- investigating allegations of sexual abuse, serious physical abuse and criminal neglect and presenting evidence before the courts
- presenting evidence before the courts requesting orders be made to require parents to participate in an intervention (e.g. drug rehabilitation) or to remove children from the care of their parents
- to provide for children who need to be placed with carers other than their parents because of protective concerns, and

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Lonne et al., Reforming child protection.
• to facilitate, where appropriate, the restoration of removed children to the care of their parents or the transition to independent living.

Where the harm or risk to any child falls below the ‘significant harm’ threshold, the CI would, where appropriate, refer the family and/or child for further assistance.

There would be a continuing need for investigations to be made by professionals who are in a position to see and assess the child and their family. The following discussion addresses assessments made during an investigation.

**Professionals and services well placed to make assessments and carry out investigations**

With the proposed model, CI and NTFC will still undertake the assessment and investigation role, although there will be standing inter-agency, inter-disciplinary teams to assist with determinations around complex cases.

The police currently undertake some remote child protection investigations but most are undertaken by fly/drive-in workers from urban centres. Around the country there are a number of existing models of investigation that formally involve police officers and health professionals who are able to conduct forensic medical assessments. In the Northern Territory the CAT located in both Darwin and Alice Springs provides an inter-agency investigation service for complex child sexual abuse matters and they call on the expertise of specialist forensic medical specialists as required. However, there are no formal inter-disciplinary assessment/investigation models for broader child protection concerns.

There are limited professional services and supports based within remote communities other than police officers, teachers and health workers and the Community Child Safety and Wellbeing teams proposed in this report will be a means for facilitating collaboration amongst these. However, formal statutory investigatory functions in remote areas present a number of difficulties for the teams given that most members of the teams will be resident in the communities and, given concerns raised in some submissions, may be uncomfortable in this role. There may therefore be some need for external child protection specialists (such as represented by the mobile Child Protection Team currently operated by NTFC) to assist the police in such investigations, in consultation with the Community Child Safety and Wellbeing teams.

**The nature or purpose of assessment instruments**

The purpose of the assessments undertaken by child protection services at different stages of the child protection process would be to confirm whether abuse and neglect has occurred (along with a response urgency rating), the extent to which the child has been harmed as a consequence of this abuse and whether children are able to safely remain in the care of their parents. Thus the nature of the assessment would be focused on abuse and neglect and an assessment of future risk of further abuse and/or neglect.

Given the dual pathways advocated in the proposed model, the assessment instrument/s must be able to identify matters which should be referred to centralised intake where appropriate. There would also need to be robust training and accountability programs to ensure that the application of the tools is consistent.
As previously stated, assessment instruments used in the Northern Territory need to be purpose-designed or modified to ensure they are culturally sensitive and avoid holding parents accountable for social and structural inequity (e.g., where children are vulnerable due to a lack of adequate housing in the community), thus a consensus-based instrument which is theoretically informed may be more suitable than an actuarial instrument which is based on statistically valid measures.