PERSONAL SUBMISSION

to

The INQUIRY into the CHILD PROTECTION SYSTEM

in the

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CONTENTS

1. **Contact Details** p3

2. **Introduction** p3

3. **The problem of capacity in the NT CP system.** p4

   3.1 *Setting an informed context for discussion of CP overload in NTFC* p4

   3.2 The case for overload at Intake p6

   3.3 The case for overload in NTFC offices p7

   3.4 NTFC "Interim Arrangements" for dealing with CP overload p7

   3.5 "Hidden Rationing" in CP cases allocated for NTFC investigation p9

   3.6 Hidden Rationing and depressed substantiation rates p9

   3.7 Accurately Estimating "real overload" in the NTFC system. p10

   3.8 Are current NTFC CP procedures too ambitious? p10

   3.9 Can "narrowing the gate" at Intake rescue NTFC from CP overload? p12

4. **The NTFC Response to Cumulative Harm** p13

   4.1 What is cumulative harm? p13

   4.2 The IDA & Cumulative Harm p13

   4.3 SDM and cumulative harm p14

   4.4 How rationing of scarce resources impacts on the response given to cumulative harm p14

1. Contact Details

2. Introduction

I have worked in senior roles in the South Australian Child Protection (CP) system for over 20 years. In 2009, whilst still employed by the SA Dept for Families & Communities, and at the request of NT Families & Children (NTFC), I conducted an Inquiry into the NTFC Child Protection Intake Service for the Department of Health and Families, Northern Territory Government. I was in effect an SA public servant "loaned" to the NT government on a temporary basis for the purposes of conducting that Inquiry. The report I wrote has, I understand, been provided by the Department of Health to this current broader Inquiry into the NT Child Protection System. Meanwhile, my most recent advice is that (NTFC) is currently moving to implement all of the recommendations from my report.

I retired from the SA public service in July 2009. In the interests of full disclosure the Inquiry should be aware that since that time I have worked as:-

(a) an occasional consultant with the Children's Research Centre (CRC) in their work with the NT Department, and also with the NSW Department of Community Services, on the implementation of Structured Decision Making (SDM) tools in each of these child protection systems. This experience is germane to the discussion below with respect to the way cumulative harm is handled in the NT system.
(b) A part-time consultant in private practice to NTFC providing advice on a range of CP related topics.

I wish to make clear to this Inquiry that my remarks which follow are made in my capacity as a private citizen who is a frequent visitor to the Northern Territory, and as a person who has significant working knowledge of the NT CP system. My submission is triggered by my personal interest in the issues involved. Neither CRC nor NTFC have asked that I make this submission and they bear no responsibility for the views I have expressed. That responsibility remains solely my own.

My remarks in this submission are focussed on the CP response of NTFC, the statutory arm of the NT CP system. They are intended to extend and develop some selected topics from my 2009 Intake Service review and to take into account some of the developments in the NTFC CP response since that time. In particular I want to comment upon:-

- Capacity Problems & Overload Management, and

- Responding to cumulative harm.

3. The problem of capacity in the NT CP system.

3.1 *Setting an informed context for discussion of CP overload in NTFC*

I want to argue here that overload is a fundamental problem for the NTFC role in the NT CP system. In this respect NT seems to be no different to comparable CP systems in Australia and beyond. I do not propose to spend a lot of time making the case that such capacity problems are real since it already seems to be well established and accepted that this so[1].

I also agree with many who argue that the way forward for overloaded CP systems must involve increased future investment in early intervention, and the diversion of all but the most serious cases away from statutory welfare agencies and toward community based family support services. Having acknowledged this as a preferred long term direction I need to add that, short of immediate, radical and massive investment in such support services in NT, it s unlikely that the overload pressures currently afflicting NTFC are likely to ease in any significant way in the next few years. If I am correct on this, it means that NTFC will need to continue to invest significant energy into developing and improving its resource rationing strategies given the ongoing gap between the resources it requires to meet its core CP responsibilities and the ever increasing level of new incoming CP work into this already highly stressed system.

I further believe that many of those who advocate investment in early intervention, as I do, do not fully appreciate how serious the cases are which are not able to be serviced in NTFC and comparable statutory welfare agencies across the nation.

My personal experience in the SA system was that senior Managers who had worked in the system for years were well aware that there were serious overload pressures affecting their agency. Earnest discussion of the topic at Executive was frequent. However even they were shocked when presented with actual vignettes of the cases that were unable to be serviced in their system on a day-to-day basis. Such cases included situations where penetrative sexual abuse concerns were unresolved and ongoing, and neglect matters where infants lived with maggot infested waste and where serious mental health and disability issues afflicted their carers. These were every day cases, not isolated shock/horror stories unearthed for dramatic effect. The worst case not able to be serviced on any given day was consistently a shockingly serious matter.

I worry that most senior bureaucrats and academics etc remain under-aware of the real gravity of this shortfall of capacity in statutory welfare. The reasons for this lack of awareness are two fold in my estimation. Firstly, it is not easy to access the actual case vignettes that illuminate the agency data. Rather than occasional anecdotes picked up in conversation, you actually need insider advice sourced methodically and regularly from operational staff making these service rationing closure decisions. Secondly, as I hope to show, agency data typically, and tragically, understates the real incidence of overload in such systems.

The implication of the above, from my point of view, is that those wishing to encourage increased investment in early intervention musr first not advocate doing so at the expense of the existing capacity of the admittedly residual statutory welfare system. The plight of those statutory clients that have already fallen through the gaps in the prevention net needs to be taken into account.

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[1] B Lonne, N Parton, J Thompson and M Harries *Reforming Child Protection*, Routledge, , London, 2009, pp 26- 36

These existing statutory high need clients should not be ignored whilst the system is rebuilt and re-balanced via funding early intervention. By definition their needs are already profound, more profound than those of the families in the early intervention domain who are the understandable subject of most of the CP reform zeal arising in current debates.

To thrash a familiar metaphor unmercifully : whilst we are building a better preventative fence at the top of the proverbial cliff, we must not do so at the expense of the broken bodies already lying moaning at the bottom of said cliff. These are the bodies of those who have previously fallen through the fence above. They need an intensive support ambulance in the here and now. A rebuilt fence won't help them.

My anecdotal experience of the NT system is that the above analysis applies in the Top End just as it also does elsewhere in comparable jurisdictions across the nation. The point I am striving to make is that changes in emphasis in the NT system, in terms of more attention being given to early intervention etc, are unlikely of themselves to have much impact on the capacity problems in NTFC for some considerable time. Hence very serious risk drenched matters will continue to be either inadequately serviced or denied any service at all in that system for the foreseeable future while these worthy reforms are pursued.

While most already agree that NTFC has major capacity problems, I am less confident that those who concede there is such a problem fully understand its real extent or its implications for the way forward with service delivery. My own belief is that the agency capacity problems are actually significantly worse than current understandings and that this has profound implications for what it is realistic to expect as outcomes from any additional resources that might at sometime be deployed against the problem.

I hope to develop an argument here that current overload not only means that many serious CP matters are not responded to by NTFC. It also means that those matters which *are* afforded an NTFC CP response frequently get both a delayed one, and also one that is significantly curtailed in practice quality terms.

There are rationing systems in place in NTFC that are upfront and relatively transparent. For instance Intake divides cases requiring investigation into priority classes where children deemed to be in the most danger are classed as needing more urgent interventions than other less endangered "response priority" classes. Obviously all cases would receive an urgent response if capacity issues allowed this. Capacity issues also mean that official protocols have had to be developed to help offices who are unable to investigate all the cases referred to them from Intake. These protocols set out hopefully defensible processes for closing such cases without full investigation.

Alternatively, capacity issues are also addressed in NTFC offices via "hidden rationing" which is local and idiosyncratic, For example, in cases which succeed in being allocated to a worker for a CP investigation, I am advised that capacity pressures mean that corners are chronically cut, required processes are regularly sidestepped and minimum investigative standards are chronically not met. The important point here is that these cases then masquerade misleadingly in current agency data as "proper" completed investigations, when the reality of the interventions made is quite different.

In keeping with this it noted here that:-

- an existing rationing system, ie the so-called "Interim Arrangements for Managing Incomplete Child Protection Reports", in my view inadvertently obscures the actual nature of the rationing that is occurring under this system. *(Refer Section 3.4 below for more detailed coverage of this topic)*

- corner cutting is occurring not only within CP investigation functions, but also in other NTFC functions which compete with CP investigations for finite agency resources. Most particularly I am thinking here of the inadequacy of services to children who have been taken into care

The implication of the preceding is that for NTFC to actually address its overload problems, account will need to be taken of :-

(a) The need for NTFC to work only with the most serious cases, with other cases diverted away from NTFC to non-statutory family support services wherever possible
(b) the need to deliver credible levels of service to those serious cases which remain in the NTFC system. This implies a need to deliver such services at a level which is in compliance with ethical social work practice and acceptable agency minimum standards.
(c) The need to identify a process for arriving at a credible estimate of the actual resources required to deliver required services at an adequate level of service within NTFC.

3.2 The case for overload at Intake

My 2009 Intake Review argued that the NTFC Intake Service was chronically unable to process the level of incoming CP 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 it's most urgent cases (ie Children 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.

The failure to cope with incoming demand at Intake therefore means that significant numbers of children in the NT CP system, who have been deemed at Intake to be at significant risk, do not have any protective response initiated by that system until well beyond the maximum allowable timeframes set by NTFC for such cases. 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 CP reports it receives.

When I reviewed the Intake Service I recommended a number of reforms there associated with:-

(a) re-designing work processes at Intake in order to allow for more efficient processing of CP reports there
(b) reconsidering some existing business rules/processes which add significantly to processing time costs at Intake (eg progressive withdrawal of email/fax reporting mode, reduced use of Inquiries initiated at Intake, review of 3rd report rule etc)
(c) upgrading other aspects of the business (eg upgraded phone system, improved education of notifiers etc)

However, I remain of the belief that such internal reforms *do not* realistically offer the opportunity to solve the overload problem, unless:-

(a) they are accompanied by:-
- further increases in staff establishment beyond those already made since my 2009 Review Report was submitted
- significantly improved job design, and other reform initiatives which would aim to achieve an improved ability in the Intake Service to reliably fill staff vacancies when they arise via an improved ability to recruit, support and hence retain suitably qualified staff

and (b) the ongoing increases in notification numbers are able to be held in check, or even reversed, in the future, eg via diversion, early intervention etc.

3.3 The case for overload in NTFC offices

It remains my understanding that, in 2010, the number of CP investigations referred to NTFC offices for a response, continues to chronically and significantly exceed the capacity of those offices to deliver the required protective response. Most, if not all, NTFC offices continue to use "write-off" processes to close CP investigations without completing required minimum standards for such investigations. These "write-off" protocols are being applied to most of the low priority Child Concern cases, and increasingly to significant numbers of the more serious "Children at Risk" cases awaiting investigative attention in offices.

3.4 NTFC "Interim Arrangements" for dealing with CP overload

Given these acknowledged ongoing capacity problems, in January 2010, NTFC introduced territory wide "Interim Arrangements for Managing Incomplete Child Protection Reports"[2]. These Arrangements aim in part to address Recommendation 38 of my Intake Review[3] which read as follows:-

"Recommendation 38

It is recommended that NTFC, in response to ongoing CP workload issues:-

- *develops a more consistent agency wide approach to responsibly managing workload demands in Child Protection*
- *considers which approach provides optimal risk management benefits in the prevailing agency circumstances*
- *ensures, as part of this, that accountability for capacity based rationing decisions does not rest with operational staff but is instead the responsibility of an appropriately senior level of agency management*
- *ensures that case record keeping is appropriately transparent in terms of distinguishing clinical decisions based on assessed client need from capacity driven decisions based on the need to ration scarce resources across competing case priorities"*

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[2] Internal NTFC document *Interim Arrangements for Managing Incomplete Child Protection Reports*, January 8, 2010

[3] J Tolhurst, *Review of NTFC Intake Service*, p65

I believe the so-called "Interim Arrangements" constitute a move in an appropriate direction. They provide for CP investigations, which cannot be pursued/completed for capacity reasons, to be closed as incomplete matters. The Interim Arrangements do move to address both the pre-existing variability in the agency response to CP overload, and the need to locate responsibility for that closure decision away from operational staff (who do not control staff numbers) and to place it instead with middle management staff (who can control the staff numbers deployed against the problem).

Having said this I note Item 4) b) of the Arrangements which provides for a case to be closed using the Interim Arrangements only "if there are no ongoing child protection concerns ... ".[4] I think this wording is misleading and worthy of some discussion.

The Arrangements exist to handle cases where the required standards compliant investigation is not able to be resourced. Existing CP investigation procedures and standards set out the minimum acceptable components of the NTFC CP investigation process. The purpose of this operational policy is to define what a worker needs to do in order to arrive at a credible view about whether abuse/neglect has resulted in harm, or whether the likelihood of such harm is indicated. Hence I dispute the premise that informs 4)b) – ie that it is actually possible to determine whether or not ongoing child protection concerns exist or not, without conducting a credible (read "minimum acceptable", ie procedurally and standards compliant) investigative process.

Let's set the scene before going too much further. For any case to be referred from Intake it already has had to be assessed at Intake as being a matter which involves reasonable suspicions that significant CP concerns exist, and accordingly, that a CP investigation is warranted. It thereby means that the case has already met the Intake threshold which exists to exclude more marginal matters before they are referred for NTFC office follow-up. When the case is received at the office to be investigated, I submit it is not logically possible to responsibly determine that ongoing child protection concerns are absent, as required by the Interim Arrangements, without a credible investigation.

The Arrangements certainly allow for inquiries to be made that do *not* include sighting the child and interviewing him/her plus siblings plus parents/carers, as required under policy as part of the investigative process[5]. But if it were possible to responsibly conclude that a child's situation is free of concerns without these family interviews etc, surely they would not be included as part of the required investigative procedures in the first place. The fact that they are included in policy, and that similar requirements always appear in the operational policy of comparable jurisdictions elsewhere, is testament to the fact that selected other agency inquiries cannot substitute for a proper defensible investigative process which includes face-to-face contact with key affected family members, most especially the child him/herself.

Accordingly I think 4)c) misrepresents the reality of cases closed under the Arrangements. The cases are *not* being closed because no ongoing concerns exist. Rather they are being closed with *unresolved* CP concerns, because the resources required to responsibly arrive at a "no concerns" conclusion, via processes which include sighting the child and visiting the family, are *not* forthcoming. Hence the cases being closed involve unresolved CP concerns which are merely of relatively *lesser* protective concern than those which are actually allocated for investigation.

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[4] Op cit, p6

[5] Refer NT Policies and Procedures Manual, Chapter 11, CP Investigation & Intervention

The other agency inquiries allowed for under the existing Arrangements presumably merely serve to inform that prioritising process. They certainly cannot realistically serve to eliminate concerns. I am arguing therefore that the Arrangements should actually seek to ensure that:-

- appropriate prioritising has occurred before the closures are approved, so that the system can be confident that the cases being investigated are more concerning than the cases being closed without an investigation, based on the limited information held, and
- it is made explicit that the cases duly closed under them actually still have unresolved CP concerns where regrettably the resources required to resolve those concerns are not forthcoming.

To me it is self evident that all cases so closed by definition have ongoing unresolved protective concerns. The Manager is therefore not signing off on the closure of a matter where everything is fine, ie there are *no* CP concerns -as per 4)c) currently. If that were actually the case there would seem to be no need for special interim arrangements at all. To repeat, the point is that real protective concerns persist in these closures. The Arrangements should face up to that reality. In their current form, the Manager is merely signing off on a clinical judgment from operational staff that there are no concerns and s/he agrees with this worker assessment. It means that accountability for the decision still effectively rests on the clinical judgment of the operational worker. As things stand that is not fair because the system has denied the worker the resources s/he requires to responsibly arrive at that judgement. The Manager should sign off on that fact – ie that real CP concerns persist, and why they do. This would thereby absolve the worker of the responsibility for any post-closure harm that may subsequently befall the child(ren) involved, who have been denied the service the system says they need, noting that denial of service has been made on capacity grounds, not clinical ones.

To repeat, 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. The decision to close without investigation is therefore a rationing decision affecting cases with *unresolved* CP concerns. 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 .

3.5 "Hidden Rationing" in CP cases allocated for NTFC investigation

I have been advised by operational NTFC staff that it is a very regular event for CP investigation cases to be closed, and for a substantiation decision to be entered, without required investigative procedures/standards in the NTFC CP Manual being complied with. The reason that this occurs is that, under workload pressure, workers cut corners in order to finish the case at hand so that other investigations which are already overdue for attention do not wait any longer for a response.

If the above is true it is obviously indicative of a failure of the NTFC Quality Assurance system to ensure that investigations are completed in a procedurally compliant manner. It is surely plausible to assert that this sort of corner cutting might well arise in the sort of capacity stretched circumstances in which NTFC currently finds itself, when structures and staff to reinforce methodical QA across the system are arguably lacking. It is certainly consistent with the situation I encountered over time in the SA system where comparable capacity issues applied.

3.6 Hidden Rationing and depressed substantiation rates

Another impact of hidden rationing in CP investigations is that substantiation decisions are less informed because investigations are more superficial. Substantiation rates tend to become depressed in such systems. When a worker is confronted by the need to make a decision based on incomplete/inadequate evidence the obvious tendency is to err on the side of not substantiating. In overloaded systems workers are further encouraged in this direction by the knowledge that there is greater pressure to provide ongoing interventions on cases that have been substantiated. When a subsequent report is received at Intake on a case which has previously been investigated and not substantiated, it is the natural tendency of Intake to view that new notification more sceptically than would be the case if a prior substantiation was on the record. Accordingly, the preceding describes a plausible dynamic where corner cutting in investigations suppresses the future likelihood of new reports being screened in for another investigation. Via this dynamic the real incidence of serious CP demand can be understated over time because capacity issues have been under-managed in this way.

The preceding is obviously a speculative analysis about factors impacting on "real" overload levels in the NT system. I acknowledge that I cannot provide definitive evidence that this is what is occurring in NTFC. But it is surely reasonable to assert that, if what I am suggesting in terms of "hidden rationing" does happen, that the number of completed investigations in the current data actually overstates the capacity of the agency to conduct investigations which meet acceptable minimum quality standards. Logically the number of procedurally compliant investigations that can be completed within existing staff resources *has* to be fewer than the number which appear as completed investigations in the current agency data. And arguably more compliant/completed investigations would result in higher substantiation rates, and higher rates of re-notifications being subsequently screened in at Intake.

3.7 Accurately Estimating "real overload" in the NTFC system.

So how big is this "real overload" problem in NTFC? It is an important question if the agency is to judge how many extra staff it needs to operate more credibly in terms of meeting its core business obligations.

There is, I submit, an efficient way to obtain a very good estimate of the resources needed to do this. It logically involves calculating the unit cost of conducting a Child Protection investigation by measuring what a procedurally and standards compliant process actually consumes in terms of staff time.

The methodology involves actual measurement of a sample of cases where the workers involved ensure that existing procedures and standards in the NTFC CP Manual are adhered to. It would be important to ensure that the sample was a representative one (in terms of abuse type, case complexity etc) and included a spread of cases across the range of NTFC office settings – obviously conducting an investigation in a remote community 300k from the office consumes worker time in a different way than would an equivalent investigative process conducted in urban Darwin. An appropriate balance of experienced and inexperienced staff would be another factor that would need to be controlled.

Such a unit cost study would require an investment of resources, either internal or outsourced. But it does not need to be an elaborate investment and case sample sizes do not have to be burdensome to produce a statistically powerful outcome. Accordingly a suitably modest survey could arguably produce, within a few months, a credible unit cost estimate of the actual worker resources required across the territory to deliver a credible investigative response to all CP investigation cases. Then it

would be a simple calculation to use this to estimate staffing number requirements based on the incidence of cases assessed at Intake as requiring investigation, duly adjusted for suitable allowances per worker for leave entitlements, attending staff meetings, training requirements etc.

I believe that such an estimate would provide a very sobering calculation of the actual numbers of staff required to address NTFC's existing CP investigation responsibilities. Clearly I believe that the hidden rationing via corner cutting plus official rationing (eg via the "Interim Arrangements") will be revealed by such a unit cost study to be much greater than an under-informed scan of current agency data would suggest.

If I am correct, the calculation would provide for much more robust discussions with Treasury in the future about NTFC's real staffing needs , and the numbers required for it to defensibly address its core CP business responsibilities.

Clearly the same methodology could be applied to children-in-care cases, and to other areas of CP work (eg Intake processing) to calculate what level of staffing is required to meet current procedural requirements in those areas of the NTFC CP business.

Such calculations can also be used to temper the expectations of politicians who hope that approving one or two extra staff positions here and there across the system will resolve the presenting capacity problem. Unit cost based data is likely to be more powerful in shaping those political expectations the sort of case data currently accessible to NTFC management. In a broader system sense, such unit cost/required staff calculations allow for better informed strategic planning about the balance of resources required across the statutory and non-statutory child welfare system, and what the implications might be for any ongoing under-staffing of statutory welfare services in that system. Clearly, to return to an image cited earlier, what I am signalling here is that when an agency complies with its own Manual the "worst case not attended to" on any day in NTFC is likely to be an even more gravely concerning situation than even the most un-blinkered senior analysts might currently expect. This is because compliant investigations take longer than non-compliant ones which involve key processes being omitted. However the compliant response arguably then delivers a more effective service with more better client outcomes .

I am unaware of any methodical study of the estimated unit cost of standards compliant CP activity having been carried out in any Australian jurisdiction, although the efforts of the Woods Royal Commission in NSW arguably constitute a worthy exception. I suspect this probably reflects the temerity with which administrators of statutory child welfare agencies are typically infected when discussing their real capacity issues with their political masters.

3.8 Are current NTFC CP procedures too ambitious?

I am confident that many people, faced with the crippling overload that prevails in NTFC, will advocate that existing CP procedures & standards, as detailed in the NT Policy & Procedures Manual, should be revisited in order to reduce the cost of transacting CP business in the agency.

Rationing devices like the "Interim Arrangements" are, in effect, a temporary device which "authorises" the sidestepping of some required procedures in order to address this overwhelming demand.

I am firmly supportive of Management assuming responsibility for the introduction of rationing protocols like this, because, as mentioned earlier, it locates responsibility for the curtailed non-procedurally compliant response with management rather than with the hapless worker who would

otherwise gets the blame when an adverse event arises in an underserviced &/or prematurely closed case.[6]

However temporary rationing protocols are a different thing than to having an agency revise its level of required servicing downwards in its operational policy Manuals. I believe that an inspection of the current NTFC Manual reveals required procedures that are only reasonable. It is very much a stretch to argue that they are excessive in terms of the contact and care they require of workers in their relationships with families. They in fact set out the sort of interventions that actually allow workers and families to meet with each other, and even develop something akin to respectful relationships with each other. I note that it is these sorts of requirements that are sidestepped in most early closure rationing protocols.

Many critics of modern child welfare systems have noted the absence of relationship based practice in actual service delivery in these systems.[7] They point to the negative outcomes that are associated with the only superficial interactions that typically bedevil the worker/family interface in such systems.

I think that CP practice that was more rigorously compliant with existing Manual requirements would involve staff spending more time in direct contact with families. I believe that this will produce superior outcomes for its clients and less job dissatisfaction in its staff. I would not support the ongoing acceptance of lower standards than those in the current Manual. It would be folly in my mind to push further down market by lowering current standards. Rather I would argue that in order for NTFC to fulfil its mission a staffing complement commensurate with Manual compliant practice is both the minimum starting point, and something that would be significantly higher than existing levels of client service.

3.9 Can "narrowing the gate" at Intake rescue NTFC from CP overload?

Often, a first step that is advocated when agencies are struggling with CP overload is to review whether the Intake service is appropriately excluding matters that should not be considered to be meeting the threshold for a statutory CP response. NTFC has concluded that its Intake service would benefit from the introduction of structured SDM tools at Intake to ensure an appropriate setting of that Screening threshold, and more consistent interpretation of it by different workers. As mentioned, I have been involved in the SDM initiative that is designing that tool for NTFC and preparing staff for its implementation.

Because of the acknowledged variability in current decision making at Intake it is difficult to predict what the impact of the SDM Screening Tool will be on the numbers of cases screened in for NTFC CP investigation. My own guess is that that the implementation of this tool will bring about some reduction in the numbers of cases assessed as requiring NTFC investigation. Certainly the tool design process has attempted to set standard definitions that would clearly exclude cases which do not involve relatively imminent risk of relatively significant harm – at least to the extent that the Act allows scope for reasonable discretion of how serious such cases need to be to be screened in.

Having said that, it is my impression that Intake staff currently strive to set a reasonable threshold using their own professional judgment. I personally doubt that current screening assessments at

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[6] I use the term "hapless worker" advisedly. I have personally conducted too many Adverse Event Case Reviews over my years in practice where my argument that the system was culpable rather than the worker has been discounted by those eager to believe the deficits were instead in the usually under trained, under supported person to whom the case was allocated, despite the obvious impossibility of that person having time to address the demands inherent in the case in the question, not to mention the rest of his/her excessive caseload.

[7] Lonne et al, op cit, p139

Intake will be found to have been unduly inclusive when they are compared to post SDM assessments.

Accordingly I do not expect that the SDM Screening tool can realistically be expected to make a major contribution to solving the agency's CP capacity issues via a significant upward re-interpretation of the existing (pre-SDM) Screening threshold. Instead I think it is far more likely that Intake decision making will be more consistent using the tool but any movement of the threshold after SDM implementation is most likely to be a relatively subtle phenomenon. I am arguing that overload will persist as an issue for NTFC after SDM has been implemented.

4. The NTFC Response to Cumulative Harm

I note that comment on this topic is made in the recent *"Interim Progress Report into NTFC Intake and Response Processes"* prepared by the NT Children's Commissioner, in terms of *"the strong focus* [in NTFC Intake processes] *on imminent risk along with a relatively weak imperative to consider risk relating to cumulative and potential harm"*[8].

I think it is important to clarify how cumulative harm is handled by soon-to-be-introduced SDM Intake tools, namely the SDM Screening Tool and the SDM Response Priority Tool.

4.1 What is cumulative harm?

Bromfield and Miller define it follows:-

"Cumulative Harm may be caused by an accumulation of a single adverse circumstance or event, or by multiple different circumstances and events. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and well being."[9]

There are other definitions in use but the consistent thrust of these definitions seems to be that cumulative harm refers to the pattern over time of repeated harmful events which may not all be serious events when seen in isolation.

4.2 The IDA & Cumulative Harm

In his Interim Progress Report the NT Children's Commissioner notes with concern that the Initial Danger Assessment (IDA) in use in the NTFC Intake Service has a focus on imminent risk at the expense of giving due recognition to cumulative harm[10].

I think this is deserving of some clarifying comment. When a report is received at Intake it is the worker's responsibility to consider the recorded history of prior reports held on the Case Record system (ie CCIS) as well as the content of the report in question plus, in some circumstances, the information gathered from inquiries initiated from Intake to other agencies or persons considered likely to have information critical to the assessment of the report.

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[8] NT Children's Commissioner *"Interim Progress Report into NTFC Intake and Response Processes"*, 2010, p29

[9] Bromfield, L. M., & Miller, R. (2007). Specialist Practice Guide: Cumulative Harm. Melbourne: Victorian Government Department of Human Services, accessed at www.aifs.gov.au/nch/research/menu.html

[10] NT Children's Commissioner *"Interim Progress Report into NTFC Intake and Response Processes"*, 2010, pp20, 21

The key point here is that information about the child's history of concerns can be gathered from any of these sources with CCIS usually being the richest source of information about patterns of prior abusive behaviour. The worker is obliged therefore to look beyond just the most recent reported incident when making a decision to screen the case in for investigative follow-up. Cumulative harm is not ignored in that process. It is part of the screening assessment process.

Once the Screening Assessment has been completed, all screened in cases then compete for the finite resources of the agency in terms of the urgency of the response to be offered. This next step in the Intake process is generally labelled the Response Priority (RP) Assessment. The IDA exists in the system in order to guide this Response Priority assessment process which translates as the assessed urgency of the required office investigative response.

The context for this assessment – as noted earlier (in Section 3.1, p4) - is that any system would obviously prefer to offer an immediate response to all cases referred to it for investigation. However, typically the agency does not have the resources to offer this urgent (ie 24 hour) response to other than a small proportion of cases. NTFC, like most comparable systems, makes the necessary decision to triage its finite resources toward those cases rated as most urgent first, followed by longer response priority tolerances for less urgent cases.

The logical basis for assessing urgency is one of determining which children face the most compelling and urgent danger issues. Hence the focus of the Initial Danger Assessment is on the imminent harm issues noted by the Commissioner. It is a tool which was explicitly designed to identify factors which might put a child at imminent risk of harm, ie in danger. Accordingly it is not surprising that the Commissioner found that issues related to imminent harm were prominent in it.

4.3 SDM and cumulative harm

The arrival of SDM in the NTFC Intake system means that the SDM Screening Tool will provide a structured process for determining whether a case is to be screened in or out. Currently this decision is made via an unstructured process using the Intake worker's professional judgment. The SDM Screening Tool relies on the Intake worker reviewing the same sources of information as the current unstructured assessment process in order to determine whether the child's situation involves a pattern of prior events which indicate cumulative harm. SDM requires that the worker works through a structured process to make determinations about the "fit" of the case with standard definitions provided with the tool. Again the case history on CCIS is the most critical source of advice about prior patterns of concerning parental behaviours. Standard definitions in the SDM Screening Tool guide the worker in the assessment of recurrent or patterned parental behaviours across the range of possible abuse/neglect scenarios. In this way SDM incorporates cumulative harm in its Screening assessment processes.

Once a case has been screened in, the next step in the Intake process is the application of the SDM Response Priority (RP) Tool which determines the level of urgency of the office response. This tool will replace the IDA when SDM is implemented.[11] Again, it is the prospect of imminent harm which informs the SDM RP rating.

4.4 How rationing of scarce resources impacts on the response given to cumulative harm

The point of the preceding is that it is primarily in the Screening Process, which occurs immediately before the IDA is currently applied, where issues of cumulative harm are picked up in Intake

[11] Note that while the IDA was designed to inform the RP assessment in the pre-SDM Intake system, my Review found that Intake staff reported that it was often one of the last things they completed, and that in practice they made their RP assessment without using the IDA to inform it. The IDA is held in low repute by Intake workers. (For additional discussion refer pp39, 40 of my Intake Review report).

Assessment processes. Cumulative harm issues are not evident in the IDA (or in SDM RP) because RP is a process based on using imminent harm, not cumulative harm, to inform the urgency assessment involved.

My experience is that cases involving cumulative harm will generally be placed in lower urgency RP classes by the IDA, or by SDM RP. This is as you would expect given that cumulative harm is generally understood as involving a series of lower level events which occur in a harmful pattern over time (refer earlier discussion under section 4.1). They do not put children in immediate danger in the same way that serious physical or sexual abuse can. The effect of this is that in a capacity stretched system most NTFC offices will allocate their highest RP cases first, beginning with the most urgent 24 hr Children in Danger cases. If office capacity is exhausted on these higher RP classes, then it is predictable that cumulative harm cases will be over-represented in those cases which are closed without investigation under the Interim Arrangements rationing process.

Cumulative Harm cases would not miss out on an NTFC response if NTFC capacity was adequate to provide a credible response to all cases assessed as needing an investigative response. It is therefore reasonable to expect that unless capacity issues are able to addressed, the response to cumulative harm cases will continue to be compromised. When any sort of case is classified as relatively low risk it will inevitably be a prime candidate for early closure.

It would be technically possible for NTFC to intervene into this dynamic if it chose to. It could, for instance, take the view that a certain amount of staff resources in NTFC offices should he held aside to be devoted to cumulative harm cases. This would be a sensible device if one was actually convinced that a cumulative harm case was a legitimate higher priority for investigative attention than another case where the RP indicated that the child was in more imminent danger. The practice reality is that cumulative harm cases will generally be recognised as legitimate but lower priorities for action when another case is waiting that involves a child in more imminent danger

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 (ie 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 (SDM) 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.

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