Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF JULIAN HUXLEY WATCHORN

I, Julian Huxley Watchorn of [redacted] in the State of Tasmania, Clinical Psychologist, do solemnly and sincerely declare that:

1. I make this statement in my personal capacity.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3. I have read the witness statement of Dr Kim Backhouse (Chief Executive Officer of the FKAT) made to the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (**Commission**) and affirmed 8th June 2022 (**Backhouse Statement**). I agree with the Backhouse Statement, and refer to and adopt paragraphs 17 -27 and 89 - 93 of the Backhouse Statement for the purpose of this statement.

BACKGROUND AND QUALIFICATIONS

4. I have the following qualifications:

   (a) Bachelor of Science (Psychology and Computer Science) from the University of Tasmania, awarded in 1991;

   (b) Bachelor of Science (Honours) (Psychology and Computer Science) from the University of Tasmania, awarded in 1993; and

   (c) Doctor of Philosophy in Clinical Psychology from the University of Tasmania, awarded in 2001.

5. I am a clinical psychologist registered with the Australian Health Practitioner Regulation Agency and a member of the Clinical College of the Australian Psychological Society.

6. I have been in private practice for approximately 25 years in Hobart. For all of that time, a significant amount of my work has been involved in working with children, young people, parents and carers in the out of home care sector. I have conducted family assessments for Child Safety as well as provided psychological support to children and young people in the out of home care sector, often referred by Child Safety. My private practice has included the

treatment of various psychological issues including trauma, depression, and anxiety as well as undertaking medico-legal assessments in Child Safety and Family Court matters.

7. Since 2015, I have been contracted by FKAT to provide support and systemic advocacy to carers as well as designing and delivering training programs to foster and kinship carers across the State.

8. More recently, my work at FKAT has focused on:

   (a) developing trauma-informed therapeutic models of care for both carers and children and young people; and

   (b) supporting informal kinship carers around the State.

9. I am also the Chair of the Family Based Care Providers' Group (**FBCP Group**). I have been involved with the FBCP Group since 2019 as a representative of FKAT and Chair since early 2020.

10. I discuss the role and function of the FBCP Group at paragraphs 41 to 47 below.

11. Attached to this statement marked **JW-01** is a copy of my curriculum vitae.

FKAT ADVOCACY AND SUPPORT OFFERING

The role of FKAT

12. FKAT provides support and assistance for foster carers, kinship carers and people interested in becoming carers within Tasmania. I refer to paragraphs 17 to 27 of the **Backhouse Statemen**t.

Funding and membership base

13. FKAT is funded by the State government to provide support and assistance to carers within the out of home care sector. My understanding is that there are approximately 1,200 foster and formal kinship carers in the out of home care sector in Tasmania. Roughly, 50% of the carers in the sector are engaged by the Department of Communities (**Department**), and the other 50% are engaged by non-government out of home care providers (**agencies**).

14. In the past two years, there has been increasing demand in FKAT for support from informal kinship carers. There are no accurate figures on the numbers in the State, but I would estimate that there are thousands of informal kinship carers in Tasmania. Informal kinship carers often don't have access to training or support and some have reported to FKAT that they struggle with the demands of caring for the children or young people in their care. Commencing this year, FKAT has received Government funding to provide training and support for informal kinship carers across the State.

Advocacy and support offering

15. FKAT offers a range of supports to carers, from providing resources and information to providing advocacy and emotional support, such as assisting with the challenges of a young person with challenging behaviours.

16. In more complex matters, FKAT provide strategic support in relation to significant matters such as 'care concerns'. This is where an issue of concern has been raised in regards to a carer's ability to adequately and safely care for a child. This may be where there have been allegations of psychological or physical abuse raised against the carer.

17. The assistance that I provide to carers through FKAT can be in these cases of a more complex or serious nature, in what is titled a 'Care Concern' process. I may guide the carers through the process, whilst ensuring that the Department is open and transparent with the carer throughout the process.

18. Where a care concern is raised, an investigation will be undertaken by the Department, either by Child Safety staff or senior Departmental staff. In some investigations, the child or young person in care may be removed temporarily or permanently. I am aware that the Department are developing new guidelines and protocols in this area, which are yet to be made public.

19. In practical terms, I assist carers in these care concern situations by liaising with senior staff from the Department or agencies, such as:

    (a) the Manager for Out of Home Care for the State;

    (b) senior practice consultants in Child and Family Services;

    (c) the Child Advocate; and

(d) representatives from other agencies.

Sometimes the agencies themselves may also contact FKAT to assist in a case they are dealing with.

Training for carers

20. The training FKAT provides to carers has evolved. We used to provide a range of different training programs. A key training workshop was on trauma-informed care, conducted over two half-days. This training has been delivered over the past four years but is now being replaced by the Trust-Based Relational Intervention (**TBRI**) model.

21. The training enables carers to better understand trauma and its impact of children and young people, and how to respond in a trauma-informed manner.

Trust-Based Relational Intervention

22. FKAT has been collaborating with the Department on developing a model that comes out of the United States called TBRI. TBRI is a therapeutic care-giving model that trains carers to provide effective support and treatment for at-risk children. TBRI has been applied in orphanages, courts, residential treatment facilities, group homes, foster and adoptive homes, and schools. It has been used effectively with children and youth of all ages and all risk levels.

23. Within TBRI, there are three factors that are recognised as needing to be included in any program designed to treat complex trauma. These are:

    (a) the development of safety;

    (b) the promotion of healing relationships, and

    (c) the teaching of self-management and coping skills.

    These elements parallel the three evidence-based principles of TBRI, namely:

    (i) Empowerment (Attention to physical needs);

    (ii) Connection (Attention to attachment needs); and

    (iii) Correction (Attention to behavioural needs).

24. Attached to this statement marked **JW-02** is a copy of a journal article on TBRI.

25. Within the TBRI model, it is critical for carers to be aware of their own emotional state, attachment style, and emotional availability. Studies have found that the attachment style of a primary carer predicts the child's attachment style. Sometimes carers can have unresolved childhood or early adult histories of their own and are inadvertently triggering maladaptive behaviours in the children they are supporting.

26. For example, a woman who had the stillbirth of an infant may guard her feelings unknowingly so that she doesn't experience the distressing loss again. These individuals, though fully available for their child's physical needs, may find it difficult to be emotionally available for healing connections with their child.

27. An adult's attachment style can change and one objective of TBRI is to provide steps that adults can take to facilitate positive changes in their attachment styles.

28. When a young person reaches teenage years, they are often on a path of becoming more independent and exploring self-identity, and as a result seeking some separation from their carer. They may wish to reconnect with their family of origin. This can be a challenging time for the carer and the young person, and the emotional changes accompanying this may lead to the young person being highly dysregulated. This is a time when carer needs to be well skilled.

29. Formal TBRI trainer training is offered by the TBRI Institute in the United States. There are staff from the Department and agencies who are currently undertaking the 'train the trainer' course.

30. FKAT has collaborated with the Department to provide initial TBRI information sessions to carers. I have been liaising with Lionel Walters, the State Manager of Out of Home Care in the Department in the development of this.

31. Earlier this year, the Department commenced delivering information sessions around the State on TBRI to foster and kinship carers, as well as staff from the Department and agencies. These information sessions will lead into the more comprehensive training sessions, covering the three key principles of the TBRI model.

32. The program is very practical and the feedback from carers has been positive. Initial sessions have been conducted by Lionel Walters, but as more staff are trained, there will be more trainers to conduct the training. Training will be provided not only to carers but also Child Safety and Out of Home Care staff.

33. Our strong recommendation is that the Department of Education (DoE) will also eventually become involved in the program. The merger of Department of Communities and the Department of Education may enhance this process. Carers frequently need to discuss with teachers information on the trauma background and signs and symptoms of trauma of the child or young person in their care. If carers and teachers were speaking the same language, via the TBRI Model, this process would be greatly enhanced. There have been to facilitate this with DoE but to date have been unsuccessful.

Attendance at FKAT training and mandatory training

34. Carers respond well to the training modules conducted by FKAT, but not all carers participate because it is not mandatory.

35. I have completed two State-wide surveys of foster and kinship carers, one in 2015 and one in 2018.

36. Attached to this statement marked **JW-03** are copies of 2015 Carers Survey Report and the 2018 Carers Survey Summary Report.

37. One of the issues we were seeking feedback on was that of mandatory training of carers. Results from the 2018 Survey revealed that 75% of respondents reported that they would support the accreditation of carers, 74% would support minimum mandatory training requirements, and 78% would support mandatory registration of carers.

38. I see the need for a change to a system of registration that requires mandatory training and professional development.

39. Under that model, some training might still be optional, such as quite specific training on topics like foetal alcohol syndrome disorder. More general topics, however, like trauma informed care, would be compulsory.

40. We believe that as the TBRI program develops, we can move towards it becoming a mandatory component completed by all foster or kinship carers.

THE FBCP GROUP

41. The FBCP Group has been running for several years. The 'Strong Families Safe Kids' strategy references a whole-of-service system and community approach to protecting vulnerable children, including a focus on increased collaboration between the non-governmental and governmental sector. The FBCP Group provides an opportunity for partners to share information regarding their organisation, culture and area(s) of expertise. The group seeks to identify and discuss practice and capacity trends in the work area, share and discuss policy where applicable and look at practice issues that are specific to the provision of out of home care. Coming together enhances the working relationships with one another.

42. During COVID-19, the FBCP Group's activity increased significantly to address the specific challenges inherent with COVID-19 and expectations and responsibilities of agencies and carers, including vaccinations and Covid-safe practices.

43. Attached to this statement marked **JW-04** is a copy of FBCP Group Terms of Reference.

44. When the pandemic arrived in 2020, there was a need for more frequent collaboration across the sector to manage and address the dynamic challenges presented by COVID-19. During the pandemic, we conducted monthly meetings. We are now continuing with bi-monthly meetings as well as one planned face to face meeting each year. I have been in the role of Chair for the past two years working in collaboration with the Manager of Out of Home Care. The group continues to work on current issues in the out of home care sector, including developing a carer's register, the need for more recruitment of carers, placement matching, and the future training needs of staff and carers.

45. While participation is voluntary, all agencies involved with family-based care in the out of home care sector are involved in the FBCP Group. This includes the Department of Communities, Baptcare, Catholicare, Life Without Barriers, Key Assets, Glenhaven, Kennerley, FKAT, CREATE, and the Tasmanian Aboriginal Centre.

46. Representatives from the Department also attend the FBCP Group meetings, including team leaders and centre managers. Dr Kim Backhouse and myself attend representing FKAT.

47. I have found that the FBCP Group has been an excellent vehicle for facilitating greater collaboration across the out of home care sector. With more collaboration comes more transparency and consistency between the agencies ond how they approach certain issues. We are also hopefully moving towards more collaboration in relation to training across the agencies. For example, if one agency is conducting training and they have spare spaces, they might allow carers from another agency to join the training session.

THE CARERS

Entering the system as a carer

48. There has been a history of a conflictual culture between foster carers and Child Safety. There has been also been an historically held perception by some Child Safety staff of carers solely being 'babysitters'. Fortunately, the perception of the role of carers is changing, with the Department now seeking to recognise them as key members of a child or young person's care team. However, an adversarial climate is still evident for many carers.

49. There is a mandatory training and screening process for people who want to become foster carers. Carers complete an initial training program called Shared Lives which is conducted by the Department and the agencies. As part of that training there is also a component of observation and assessment of the carer. Through this process, some people may be identified as being unsuitable to undertake care for a child, or at least unsuitable to undertake care immediately.

50. Where a potential carer is deemed unsuitable by either the Department or an agency, in the past they have been possibly able to apply at other agencies and be accepted. This is an issue that has been raised by the FBCP Group. We are trying to bring in a system where these people can be identified across the agencies.

51. The Department maintains centralised records, but out of home care agencies and FKAT, though the FBCP Group, recognise that these need to be more

accurate and more frequently updated. If an individual is not accepted by one agency, and then a month later applies to another, the system may not pick that up.

52. With the introduction of a registration system, hopefully the ability to assess and monitor existing carers will also increase. Currently, we have carers who have been in the system for a considerable time, but this does not necessarily guarantee that they have maintained the skills and ability to adequately care for children. We also having an aging population of carers.

Recruitment of carers

53. It appears that since 2021, the Department has stopped recruiting its own carers. The reason for this is not clear. I feel there is a fundamental problem in a service provider (i.e., the Department), also having a governance role for the whole of the sector, including their own services. That is part of the reason why I have previously suggested we establish an external, independent assessor and arbitrator in the out of home care sector. I discuss the role of an independent assessor at paragraphs 95 to 98 below.

54. One of the issues that the FBCP Group has considered recently is the need for additional funding to enhance recruitment across the sector. The out of home care agencies are struggling to recruit new carers at present and there is a dire shortage of foster and kinship carers in the sector.

55. It also seems problematic that considering our limited resources, agencies are at times competing with one another to recruit carers.

56. The FBCP Group have tentatively explored alternative models for state-wide recruitment of carers. For example, in Victoria, applicants are directed to a central gateway and then distributed equitably amongst the agencies, with consideration given to matching the child to the carer. I think it would be a useful model to at least consider here in Tasmania.

Adequacy of intake process and placement of children with carers

57. Generally, I do not think carers always receive sufficient information to be able to create an appropriately safe environment for a child who is placed in their care. However, I think that the new Case in Care Plan model, where the

Department is seeking to have carers as a more active member of a care team will enhance communication between all parties and greater information provision when a child or young person comes into care.

58. There is potential for risk of abuse and harmful sexual behaviour in out of home care when carers are not given adequate information about a child or young person coming into their care. For example, the young person may pose a risk to other children in the family home or, because of their past, be at risk of being abused.

59. When a child is first placed into a carer's home, carers report that the Department might report to them, 'we can't tell you about the child's background, because it is confidential information'. I know of one historic case in which a child engaged in harmful sexual behaviour with another child on the first night that they were placed in a carer's home. This was a terrible situation and may have been prevented if the carer had been given more background information on the risk the child posed, if that information was available.

60. Understanding a child's background helps carers to identify the child's trauma symptoms and triggers. Assumptions about the level of trauma a child has experienced can be fairly accurate, but triggers can be very specific, for example, one child's trigger might be a raised voice whilst another's may be silence. It would be so much easier for all parties if the carer was given accurate information about the child's past trauma before placement if that information is available.

61. I am not aware of any standardised screening tools being utilised in Tasmania to assess children for past trauma symptomatology. I do see the need for a comprehensive assessment of a child's health and wellbeing in a timely manner when they come into care. This appears to not always be the case. I suspect the cost of such assessments is a barrier to implementation.

62. Early clinical screening is important to assist carers to understand what psychological or health supports are required for the child and how quickly those support needs to be provided. Often there is a delay in psychological intervention with children and young people in care because symptoms of trauma are not recognised. For example, foster carers have reported that when a child is presenting challenging behaviour, a frequent response form

their Child Safety Officer (**CSO**) is that this is 'just normal behaviour' when in fact it may be the behaviour of a highly traumatised individual.

63. I have had other reports from carers where a child has been in care for six to twelve months and has been struggling at school. Then the child undergoes a vision test or a hearing test and everyone realises they cannot see or hear properly. Because they may have grown up in a neglectful household, regular health assessments may have never been undertaken before they came into care.

64. In Tasmania, we do not have enough carers to have an adequate form of 'placement matching' between children and carers. Even if we introduced a registration system that included information that can be used for placement matching this would not be effective because there are simply not enough carers in the system.

65. I think the pathway for better care and less risk could be found with thorough initial health, psychological and educational assessments. Recommendations about placement, on the basis of that assessment, could then be made. The recommendation should consider things such as:

    (a) Is the household suitable for the child?

    (b) Is the carer suitable for the child?

    (c) What are the risk factors for the child or young person?

    (d) How can we mitigate those factors?

66. There are certainly financial barriers to the implementation of an assessment process of this kind. But we need to recognise that there is benefit in having intense intervention upfront. I think this is reflected in the operation of the NDIS which does provide early intervention services aimed at the individual who will need less assistance over time. Intensive initial assessments can result in fewer services required over the longer term. Currently, many reports from carers in the out of home care sector suggest it is the opposite, in that assessments are not undertaken until the child is exhibiting such severe difficulties that the carer is almost at the point of saying 'I can't have them in my care'.

67. The sector has had some discussion about models to deal with this issue and this has been discussed with the Department during the Out Of Home Care Reform process. One possible model involved the child being placed with a temporary carer initially. People may not like the idea of a temporary carer, but I think there are aspects of this model that are effective. The child might be placed with the temporary carer for something like four, six or eight weeks. During that time an assessment could be undertaken before a permanent placement is decided. If the child is assessed as needing to move to another carer, we will know they are moving into a hopefully long-term care arrangement that is most suitable for them. For this model to work effectively, however, we would need more carers.

Ability to deal with children who have experienced significant trauma

68. In my experience, many carers don't have the requisite skills to be able to manage children who have experienced significant trauma. I think there are a lot of challenges associated with this and these challenges are heightened when the carer has other children in their care. Some children with trauma struggle with other children in the home, and that can be a significant trigger for them.

69. In addition to the TBRI pilot program discussed above at paragraphs 22 to 33, in my role at FKAT, I have been assisting the Department to develop a pilot trauma-informed therapeutic model of therapy for children with trauma. As part of this model, we are exploring the use of:

    (a) The 'Sleeping Dogs' model developed by Ariane Struick; and

    (b) Eye Movement Desensitization Reprocessing (**EMDR**).

70. The Sleeping Dogs method is a treatment to engage chronically traumatised children and prepare them for trauma treatment. The method provides a framework (the Sleeping Dogs Barrier Tool) to make a structured analysis of the possible barriers in the child's history and circumstances and develop a customised treatment plan with practical interventions to overcome these barriers so the child can engage and complete trauma processing. This would be led by Child Safety staff to help children to prepare for and engage in trauma processing.

71. Attached to this statement marked **JW-05** is a copy of Sleeping Dogs Case Conceptualisation Form.

72. EMDR was developed in 1989, claiming to rapidly resolve trauma memories, with greater speed and effectiveness than other therapies. Because EMDR stemmed from an accidental discovery, and because no one could initially explain how it worked, it was initially regarded by many people as controversial. Much research followed, and there are now more studies demonstrating the greater effectiveness and efficiency of EMDR in resolving trauma compared with any other treatment. A single incident trauma can generally be resolved within a few sessions.

73. During EMDR the client is guided to deliberately bring into conscious awareness of the sensory memory, their thoughts, and the accompanying emotions and bodily sensations relating to a traumatic event. This is quickly followed by the client following the moving fingers of the therapist. The client's eyes move rapidly for a brief period, around 30 seconds. This produces a distinctive and naturally occurring pattern of electrical activity in the brain, which causes the stored trauma memory to quickly change.

74. During the eye movement the therapist does not talk or offer suggestions. The client does not try to change any aspect of the memory, and is asked to just notice the experience, to observe their memory, emotions, bodily sensations and thoughts. At the end of each set of eye movements the client is then asked to report their present experience. It may be that the sensory memory becomes less detailed or less vivid, and clients often report that the memory has become quite distant. Commonly the emotional or bodily sensations reduce in intensity quite quickly. If other associations are observed, they are shared with the therapist. Further sets of eye movement follow, until the memory is recalled as a distant event, with minimal current distress.

75. The client is then asked to associate a more useful thought to the now more distant trauma memory, and further sets of eye movements follow. The EMDR process is complete when the new perspective feels true even when the old memory is recalled. This entire process may take as little as ten minutes, or as long as a one-hour session. Where there are several different experiences underlying the client's difficulties, it may take several sessions to fully resolve them.

76. Attached to this statement marked **JW-06** is an information leaflet on Trauma and EMDR.

77. I see EMDR as an excellent treatment therapy for assisting children and young people affected by trauma and who experience significant emotional reactions or triggers. It includes techniques that can be used to effect without need for the individual to discuss the traumatic incident. EMDR processing aims to reduce the emotional intensity of a child's traumatic symptoms. Where triggers carry significant emotional intensity, it is common for a child to become emotionally overwhelmed and either act out or shut down when they are triggered.

78. We are still developing the specific referral pathway for children to engage in this trauma therapy model. We will need to have psychologists or other mental health providers who are EMDR trained to be practitioners in this model, some of whom we have already identified. These are professionals in the private system.

79. We are expecting that this model will provide time and cost efficiency. If we prepare children and young people for therapy, we will have a more productive therapeutic process. We are envisaging 8 weekly EMDR sessions in this program to be run initially as a pilot.

80. Overall, TBRI combined with the Sleeping Dogs and EMDR will provide a 'wrap around' model of trauma informed service and support for children and young people, reflecting the key components envisaged in the trauma informed model of care:

    (a) Phase 1: Stabilisation (which will include the TBRI training for carers and support staff, and Sleeping Dogs preparation for therapy);

    (b) Phase 2: Processing (EMDR); and

    (c) Phase 3 Integration (that will again be facilitated by the TBRI Model delivered to carers and staff).

Ability to deal with children who have disability

81. Specific supports for children with disability in out of home care seems to be largely provided by the NDIS. Currently, the Department is trying to assist

carers engaging with the NDIS. I am aware that there was some consideration of having a specialised NDIS role within the Department but I am not sure if that has occurred. Often it falls to the carer to navigate the complex and challenging NDIS system to access the support needed for children with disability in their care. Without assistance from the Department, sometimes it can become so challenging that carers may give up.

82. From a clinical experience, children with disabilities, especially intellectual disability are at an increased risk of abuse including child sexual abuse. Whilst not necessarily within the out of home care system, I have worked with many adult clients of childhood sexual abuse. Many of these clients have an intellectual disability or a significant mental health condition.

83. Children with disability are a vulnerable group in the community. A child with intellectual disability may be more susceptible to grooming. Children with intellectual disability are less likely to understand and recognise abuse. They may not necessarily recognise that what occurred to them as a child was sexual abuse, but later in adulthood that may realise that it was.

84. A survivor of childhood sexual abuse may not have been exhibiting a significant traumatic response following the abuse. But once a child reaches their teenage years and starts talking to their peers, they might suddenly understand the nature of their past abuse. The impact of this realisation may be significant at this time.

Ability to deal with cultural specificities

85. Government agenciés including the Department are aware of the Aboriginal Placement Principles, but culturally sensitive placement of children can be a challenge considering the shortage of carers in the State. There is, however, a strong expectation on out of home care service providers and Child Safety to ensure children with Aboriginal identity are assisted in engaging with their culture. This is particularly the case where there is likely to be a transition from foster care to guardianship.

86. I am aware that the Department was considering introducing a specific Aboriginal cultural liaison role internally, but I am not sure if this has eventuated. I do feel that this would be very beneficial as it would hopefully

help develop better communication and collaboration with Aboriginal representative agencies and service providers.

Changing placements

87. When the Department identifies the need to change a child's placement and move them to a new carer or return to live with their biological family, it is frequently reported from carers that the Department will stop any ongoing contact or communication between the child and their previous carer. Carers report that they are told by the Department that they are being too personally involved or that they have become too attached, if they are seeking to maintain a relationship with a child or young person who has previously been in their care. In my view, we should be trying to replicate a healthy family system which includes contact with extended family. Previous carers can still be considered an extended family member and may be able to provide respite care to support the primary carer or in some cases biological family.

88. Frequent changes to a child's placement may reinforce a poor attachment style for the child. It may also reinforce negative self-beliefs, such as 'I'm not loveable', 'I'm not going to be here long', 'Mum or Dad are going to leave me'. It would be reasonable to assume that frequent changes of placement and the reinforcement of negative beliefs may increase a child or young person's vulnerability to abuse including sexual abuse.

89. Sometimes these poor attachment styles or negative beliefs are not evident until a carer seeks respite or goes on a holiday. I have heard of cases where a child might have been in the carer's household for several years. Everything appears stable and then the carer takes a brief holiday for a week. This triggers the child's negative beliefs and attachment issues and they have an extreme emotional response that may put the placement at risk.

90. There are ways these triggers can be ameliorated. For example, I dealt with one case where the previous year a child had completely broken down when one of their foster parents went on a holiday. The next year, we created a clear plan and structure to the parent's holiday. We made a map which showed everywhere the parent was going, when there would be check-ins with the child, and when the parent would be returning home. The child was able to

visually see that the parent was returning, so while there were still some difficulties, it lessened the triggers and emotional response of the child.

Permanency of placement and transitioning to guardianship

91. Over the past twelve months there has been a review of the requirements for transferring legal guardianship of children and young people in out of home care from the Department to carers. In a new working draft, there is now a more detailed list of around 15 items that the Department must deem as satisfied before they will approve a carer becoming the legal guardian of a child in their care.

92. I think this is ultimately a well-informed process but there are issues with how the Department is approaching the complexity of the assessment/approval process that may make it difficult to reach the criteria needed for approval. I see many cases where children and young people want guardianship in order to feel a sense of certainty and permanency with the carer and the carer's family.

93. There appears to have been little transparency around this process for carers. I have had reports from carers who have been told by the Department that they are good candidates for guardianship, and that the transfer will occur quickly and smoothly. Then, 6 or 12 or 24 months later, the carers are told that they do not meet the guidelines or that it will take more time for the process to be completed. Sometimes it is because they have not met certain criteria which they were previously unaware of. This is problematic, because if the Department does not actually communicate such requirements for guardianship to the carers, the carers cannot do anything to address them.

94. I think this reflects an historic lack of collaboration and transparency between the Department and carers. This is an historic cultural issue within the Department where we have seen a conflictual relationship between some Child Safety staff and carers. I have many carers who have had difficulties with the Department and who are standing up to the Department and pushing certain issues that they see are important for the child or young person in the care. Unfortunately, these carers can often be seen as 'trouble-makers', and a conflictual relationship becomes entrenched.

THE DEPARTMENT-AGENCY RELATIONSHIP

Need for overarching out of home care standards and independent oversight

95. I believe there should be an implementation of overarching out of home care standards in Tasmania. I believe that these standards should be aligned with national guidelines.

96. In addition, I see the need for an independent external assessor to evaluate the adequacy of the standards adopted and whether they are being met. Otherwise, the Department is effectively assessing themselves on their own standards and protocols.

97. Ideally, that independent body would also assess whether all agencies are meeting the out of home care standards. I think the main barrier to this occurring is that the Department and agencies may not agree to it. While the FBCP Group is shifting to a more collaborative approach, they still operate in a competitive market.

98. Ultimately, however, I think the introduction of out of home care standards and an independent oversight body to assess and monitor those standards is a necessary step.

The Child Advocate

99. I believe that the Child Advocate serves a valuable role and that the current Child Advocate, Sonya Pringle-Jones, is doing an excellent job. I do think that some carers question her independence, in cases where she is assessing the Department whilst also being employed by them.

100. One of beneficial aspects of the Child Advocate's role is her ability to access file information. The Child Advocate has access to the Department's files and while she cannot necessarily tell parties directly what is documented about a particular case, she can use that information to guide nay process.

101. For example, let's consider if a care concern is raised about a carer. The Department may say that they have been trying to work with the carer and resolve the issue or concern. The carer might then come to FKAT and tell us that the Department has not raised any concern with them previously, and this has 'come out of the blue'. It is helpful to have someone like the Child

Advocate who can review the file material to get a more accurate picture of what has actually occurred, regarding the interaction between the carer and the Department and the validity of the concerns that have been raised.

Interaction between the Department and carers

102. I see the conflict between carers and the Department as a cultural issue both within the Department and amongst carers.

103. The level of hostility is less than it has been in the past, but it still continues to occur and we continue to see an adversarial relationship between some Child Safety Officers and some carers. I think we need a cultural shift here that may take some time to change.

104. There is still a culture of distrust, which fits with a broader lack of collaboration and transparency between Department and carers which I discuss at paragraphs 93 to 94 above. The Department will at times withhold information from carers and might argue that it is confidential. In my view, however, if sharing the information would reduce risk for the child, priority has to be with the interests of the child, not the confidentiality of information.

105. Under the current changes to the Case in Care Plan, the Department is seeking to have more collaboration by, for example, making carers more engaged in care team meetings. A Care Team is an ongoing collaborative team of key people important in the life a child or young person. These people work together as a team to identify, plan and meet the child or young person's needs. The Care Team (run by Child Safety) includes the child or young person, and their family members, caregivers, professionals and other important people in their lives.

106. The CSO is expected to establish a Care Team for each child within 6 weeks of the first legal order (interim or final). The CSO must arrange subsequent meetings of the Care Team every 6 weeks for the first 12 months; and then at a frequency decided by the Care Team.

107. Each team member is responsible for working as part of the group to develop plans, set goals, make decisions, carry out tasks and share resources to achieve the best possible outcomes for the child or young person. I do think that the culture is slowly changing to reflect carers being seen as important, if

not the most important person in that child or young person's life, whilst they are in care.

108. It is unfortunate that in some cases, an adversarial culture can become quite entrenched. From the perspective of the CSOs, they may be struggling to manage a number of difficult relationships with at times 'challenging' carers. When they have a challenging relationship with a carer, they might start to become defensive or withdraw somewhat from communicating with that carer. Sometimes the CSO might report that the carer is aggressive and that they cannot deal with that carer. CSOs might perceive that some carers make their role more problematic or increase their workload.

109. From the carers' perspective, because they have difficulty at times communicating with CSOs, they may see them as the enemy. A commonly reported scenario is a carer asking for help from the CSO, perhaps in the form of a referral to an allied health professional due to the challenging behaviour of the child or young person. They do not receive that help, the challenging situation at homes continues, they ask again, and still the suggestion is not supported. This builds up until the carer is so overwhelmed that they do become emotionally dysregulated. The CSO might even make an assessment that the carer is emotionally unstable, and that the child should be removed from their care.

110. Another cultural problem that I believe causes tension between the Child Safety staff and carers is how staff perceive and understand the role of the carer. Sometimes CSOs might interpret certain statements made by carers as evidence that that carer is now 'too personally involved' or 'attached' to the child. My response to that has been that if the carer was not personally involved or attached to the child in their care, I would be very concerned because it is exactly that attachment that the child needs for their healing and ongoing emotional and relational development.

111. To put it simply, this demonstrates a long-held belief by many foster carers that some Departmental staff still view the carer's role as that of a babysitter. This is a sad and unfortunate situation. The babysitter mentality is reinforced by the way Child Safety staff don't respond well to carers who push and advocate for the child or young person in their care.

112. Whilst I am not aware of any cases, this may ultimately lead to a reticence from carers to communicate concerns to Child Safety that may lead to a lack of awareness of potential risks for the child or young person.

CSOs

113. These cultural issues may partly influence why historically, carers have reported a high turnover of Child Safety staff. It appears that some CSOs will leave due to burnout or the stressors of working in an adversarial system. If CSOs can't establish and maintain long-term relationships with carers and children, this creates difficulty. I have had carers report that the child in their care has had something like six CSOs in the last four years. This turnover of staff has a detrimental effect on the development and longevity of relationships between the CSO and the child, and the CSO and the carer.

114. In my view, CSOs need to be better trained in trauma-informed approaches to care. Being a CSO is a very challenging role. If many of the CSOs do not have adequate prior work experience, there needs to be quality supervision and a Department that is mindful of avoiding CSOs being overworked or becoming burnt out.

115. I do not know how many children are assigned to each CSO, but I know that there are vacant positions in Child Safety which would suggest the workload for current CSO's is high. This has been reflected in the length of time it takes for some CSO's to respond to a carer's requests. This might in turn lead to a CSO not having enough time to have their 'eyes on the child' in a consistent enough manner to know what is happening for that child and anticipate any potential risk.

SPECIFIC ALLEGATIONS OF CHILD SEXUAL ABUSE OR OTHER CARE CONCERNS: THE PROCESS

Prevalence of allegations

116. Based on anecdotal information, allegations of child sexual abuse against carers in out of home care do not occur very often. There are more reported allegations of inappropriate care, physical abuse, and psychological abuse.

FKAT's role

117. Where an allegation is made, FKAT's role is to support the carers. It is Child Safety who will support the child and who are directly responsible for the child or young person's wellbeing.

118. I refer to paragraphs 89 to 93 of the Backhouse statement, which discusses the range of support provided by FKAT to carers who are facing allegations of child sexual abuse.

Department's response to allegations

119. Again, based on anecdotal information, there are many allegations made against carers that are found to be false. This factor needs to be considered and incorporated into how we respond to such allegations.

120. Carers report that the Department's typical approach in circumstances of abuse including sexual abuse is to remove the child as soon as an allegation is made. This is problematic because there is a danger that once that child is removed, they may never go back to that carer even if an allegation turns out to be false. Research and training may need to be undertaken to better enable assessors to understand what factors need to be considered in determining if abuse has occurred. This would lead to allegations being managed and responded to in a more sensitive and considered way.

121. Where there has been an allegation of child sexual abuse, there may be a number of complex and sometimes competing issues that need to be sensitively explored, whilst at the same time protecting the child or young person.

Interviews with children

122. The Department may need to consider the approach taken in interviewing the child or young person in some of these cases. In my view, interviewing needs to be conducted in a structured, clinical way and in an appropriate setting. I hear reports from carers, however, of children being interviewed by Child Safety staff in an unstructured manner. The way in which children are interviewed and tell their story is very important for gathering accurate information.

123. I am not an expert in this process, but if a child has spoken to several people about an incident before they are more formally interviewed, how do we know whether what they say in the interview hasn't been influenced by this? On the other hand, if a child changes their story or decides to recant, we need to be looking to the clinical research which says that while people may change their story, this does not mean that the abuse did not occur.

124. It has often been reported by carers that children may be interviewed at school by the CSO who attends unannounced. Child Safety have explained to some carers, that the reason for this is that they do not want the carer to know about the interview and therefore influence the child in what they have to say or not say. I think the Department needs to take a more considered, transparent and forensic approach to such situations, with staff having adequate skills, training and experience.

Department's response to unsubstantiated allegations

125. Even where there may be a false or unsubstantiated allegation, there still may need to be follow up assessment and support by the Department. While it may be that the allegation of sexual abuse cannot be substantiated, there might still be risk factors that we are unaware of and that we need to investigate further. For example, a young person may have made false allegations but he or she may have psychological problems that mean they make false allegations again or that they might be at risk of abuse. Referral to a psychologist may be needed in these circumstances and a closer monitoring of the young person's well-being and behaviour.

Role of clinical psychologists in response to allegations

126. I feel that the Department needs to adopt a more forensic approach in its responses to allegations. It does not currently seek assistance, either internally or externally, from clinical psychologists when investigating allegations. The Department has waxed and waned with respect to employing their own psychologists. The Department has senior staff members, clinical practice consultants, who assist in these more serious investigations but I think this could be complemented by clinical psychologists working within the Department.

127. However, even if such roles existed within the Department, there is a broader problem in Tasmania in that we do not have enough appropriately trained clinical psychologists. I am constantly being asked by carers 'who is a psychologist I can see who is available?' Lots of psychology practices have closed their books and do not even have waiting lists anymore. I think it is an issue that needs to be considered at a broader level otherwise we can develop programs or make referrals that cannot be met with appropriate professionals. Because there is limited public child or adolescent mental health services across the State, there are very few options available.

Ability of CSOs and school staff to deal with children experiencing trauma

128. The lack of clinical psychologists does not mean it should be left to a CSO or a child's teacher to determine whether a child is suffering from serious trauma. School staff and CSOs currently do not have a sufficient understanding of psychological trauma to be able to assess the child's behaviours and symptoms. I hope that the rollout of the TBRI program will go some way to addressing this factor.

129. Trauma informed care seeks people to consider what is behind certain behaviour and understand their causes. Otherwise, we often make simple assumptions based on the presenting behaviour which can be unhelpful.

130. Just as FKAT provides trauma training to carers, it would also be beneficial to conduct similar trauma training at schools for teachers, social workers and support staff. This would mean carers and teachers are using the same language and concepts, which would assist with better collaboration between carers and teachers, and lead to better identification of issues with respect to the child.

Need for an independent arbitrator

131. I have discussed the need for an independent and external assessor above at paragraphs 95 to 98.

132. I also think that the role of the independent assessor could act as a tribunal to resolve significant care concerns. The independent arbitrator could be

composed of professionals equipped with a range of skills to assess these situations and review processes and outcomes.

133. I believe an independent tribunal is important because they would have the power to obtain all the information that may be relevant to a case, and in turn provide well-informed and independent decision making.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at
on 8th June 2022

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