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TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

MS K McMILLAN SC, Counsel Assisting
MR M COPLEY SC, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

BRISBANE

..DATE 7/11/2012

Continued from 6/11/2012

..DAY 32

THE COMMISSION COMMENCED AT 10.01 AM

COMMISSIONER: I'll note the appearances as yesterday.

MS McMILLAN: Yes.

COMMISSIONER: No-one had a big win yesterday. Everyone still has to work for a living.

MS McMILLAN: Presumably. We're all here, present and correct. Well, I don't know, present, anyway.

COMMISSIONER: No character references this morning, Mr Hanger.

MR HANGER: Yes.

MS McMILLAN: During perhaps the morning break I'll have assembled the statements that I was proposing to tender earlier in the week. Everyone has kindly advised me they have no objection to them being tendered without those witnesses being called so I'll assemble those in the morning break and tender those.

COMMISSIONER: All right.

STATHIS, STEPHEN affirmed:

COMMISSIONER: Good morning, doctor. Good to see you again?---Good morning.

Yes, Ms McMillan?

MS McMILLAN: Yes, thank you.

Dr Stathis, have you prepared a statement in relation to this inquiry which was affirmed by you on 17 October this year?---Yes, I have.

Momentarily it will be handed to you. Dr Stathis, is this your statement?---Yes, it is.

Yes, all right. Are the contents true and correct?---Yes, it is.

Dr Stathis, there's no reason that couldn't be published, is there, on the website?---No.

No, thank you. I tender that, Mr Commissioner.

COMMISSIONER: Dr Stathis's statement will admitted and marked exhibit 115.

ADMITTED AND MARKED: "EXHIBIT 115"

COMMISSIONER: Ms McMillan, are you going to qualify the doctor's membership of the advisory panel?

MS McMILLAN: Yes, I will.

COMMISSIONER: Thank you.

MS McMILLAN: Yes, thank you. Perhaps would you direct then that that could be published as well?

COMMISSIONER: I will direct that Mr Stathis's statement can be published.

MS McMILLAN: Thank you.

Dr Stathis, you've indicated your role as clinical director of the child and family therapy unit at the Royal Children's Hospital?---Yes.

You hold a degree of bachelor of medicine and surgery. Correct?---Correct.

You're a fellow of the Royal Australian and New Zealand College of Psychiatrists?---Correct.

You hold a certificate in child and adolescent psychiatry? ---Yes.

You're a member of the faculty of child and adolescent psychiatry and the faculty of forensic psychiatry?---That's all correct.

Yes, and you're also a fellow of the Royal Australasian College of Physicians and you've been awarded a diploma of tropical medicine and hygiene in Liverpool in the United Kingdom?---That was a fun six months, yes.

I imagine there's a large call for tropical medicine in Liverpool?---There used to be.

And masters in clinical epidemiology, Newcastle, New South Wales?---That's correct.

You hold an associate professorial position with the University of Queensland since 2007?---Yes.

All right. Dr Stathis, have you also been appointed to the advisory committee assisting the commissioner in relation to this inquiry?---Yes, I have.

You have attended a forum of Friday of last week. Correct? ---That is correct.

All right, thank you. Now, Dr Stathis, have you got a copy of your statement with you?---I do.

Doctor, if I just ask you, CAFTU is perhaps the acronym, isn't it, for what you are the director of?---Yes.

As you say in your statement, CAFTU is obviously the specialist tertiary mental health services for people aged 13 and younger. Correct?---Yes.

It's one of the few in Queensland, isn't it?---There's only two. CAFTU services Queensland north – approximately north of the Brisbane River to the Torres Strait and the Mater Children's Hospital have their own unit which services Queensland south of the Brisbane River.
As you say, it's a 10 bed in-patient acute care facility for children and young people up to 13 years. There's a family admission suite and then you have a consultation liaison service. Correct?---That's correct.

You say that – obviously, 10 beds, you must have to give priority at times to particular young people and children?---Yes.

You say that priority is given to psychiatric emergencies, including psychotic symptoms or suicidal thoughts or behaviour or mental health problems of a severe or complex nature?---Yes.

You also emphasise that the in-patient unit uses a collaborative approach to treatment that involves clients, families and other service providers. So I take it, for instance, if there's a child in care it might be the foster carer you involve?---Absolutely, yes.

I take it that a collaborative approach is thought if not desirable, essential, because often the presenting problem with the child may well be emanating, or if not emanating, largely contributed to, by the family of origin or indeed where their current placement is?---Yes, and as I mentioned later in the affidavit to demonstrate that, we essentially insist that all parents or carers of children admitted into CAFTU participate in our triple P program which we run on Wednesday mornings.

That, I take it, is because you see it as essential, obviously, that what may well have contributed to the young person needing to become an in-patient is as a result or could well be ameliorated by the family being worked with?---Yes, and strengthening parenting we see is an invaluable part of our treatment.

Doctor, you say in paragraph 9(c) that in 2012 of the 80 admissions up to 4 October 6.5 per cent of children were in foster care on admission. Can I just ask you, do you know whether they were under short or long-term orders?---I don't have that detail with me.

Right, okay, but 7.8 per cent of children were discharged

back into the Department of Communities, Child Safety and Disability Services. Now, that's obviously a slightly higher figure than those who were admitted. Are they the same cohort of those children?---It's the same cohort, and the difference is that one child, possibly two - one child came in and then because of the issues that we found during their admission we informed the department and then they were discharged into the department's care.

So I take it that's through assessment and treatment those issues are - - -?---Yes. We have a mandatory reporting regime, obviously, and we felt for that child that we needed to inform the department and the department had a similar view and found substantiated abuse and took them into care.

You say 19.5 per cent of children - so that's of the 80 admissions, I take it?---Yes.

Had a history of substantiated abuse or neglect. Are you able to say as best as you can what sort of abuse it was? ---No. We don't really have - I can't give you the percentages. The majority would be some type of physical abuse, occasionally sexual abuse and possibly neglect, but I don't have the figures to break down the types of abuse.

Do you keep those figures, although you may not have them with you?---We could find those figures, because if you looked at the history we would be able to document what type of abuse was found.

Could it be established without too much difficulty?---I'm sure I could do that for the commission, yes.

Yes, perhaps could you do that in time?---Yes.

Thank you. 10.4 per cent, you say, of children were notified to the department with concerns about abuse or neglect?---Yes.

Is that what is termed, perhaps, the child concern report? ---Yes.

Yes. So it hasn't reached the notification level, but it's still a concern report?---Yes.

Now, is this correct, that children up until about 12 or 13 tend to be voluntary admissions to the CAFTU unit?---Yes. As opposed to the adolescent unit where the adolescent unit is at the Royal Children's Hospital, between the ages of 14 to 18 you get increasing incidences of, say, psychotic illnesses. So those children often have to be kept under the Mental Health Act. That's not the case for children. So most children under the age of 13 are admitted voluntarily and with the parents' consent. Could I mention though that under the current Mental Health Act we are unable to seclude a child unless we place them under the act.

Just explain that a little bit more, if you would?---What that means is if a child becomes distressed or demonstrates challenging behaviour in the unit and we are required to put them in what we call closed time out, which is we put them in a room and close the door, though there is a window in the door and we are monitoring them continuously; because we close the door we prevent egress from the room, under the act we actually have to treat them as an involuntary patient.

Because you're secluding them?---Because we are secluding them.

Right?---And we have received advice for that. What that means, in practicality, is that they are secluded under the act for the time that they are secluded - they are admitted under the act for time they are in seclusion. That may only be for 10 minutes, but the paperwork needs to be completed.

All right. So in terms of that, then, I take it that would you think it was appropriate that there perhaps be some recognition in the Child Protection Act about measures that might need to be taken for children who are in care or in need of care, that there be some proscription, if you like, about rights and responsibilities in relation to seclusion, for instance?---I think that would be helpful. It is an issue because of course we do suggest that parents at home monitor children, and sometimes have to close a door and prevent a child from egressing a room. That can be good parenting if it's done in the appropriate manner. But under the Mental Health Act we cannot do it if the child is admitted into hospital. We would prefer that we didn't

have to put the child under the Mental Health Act because we don't feel that that is what the act is for, but under the current provisions of the act on how it's written we actually have to make them an involuntary patient.

COMMISSIONER: So you want to access the procedure but not via the act?---Yes, which is what, in reality, parents do all the time at home.

MS McMILLAN: And as you say, that might well be good parenting to do that?---That may well be good parenting.

In terms of restrictive practices, obviously there are specific measures - again, the Mental Health Act - I take it are there times where that is appropriate for children and young people do have some sort of restrictive practices?
---Yes. It depends on what you define as restrictive practices, and that's the issue. Under the act putting a child in closed time out is indeed a restrictive practice, which is why we have to be put them under the act to do that. We now do not use physical constraints in CAFTU and we certainly - we attempt not to use what could be called chemical restraints if at all possible.

And at the moment I take it you don't have to you come under the aegis of the Mental Health Act if you do need to use chemical restraints of some sort?---No, we don't.

Right, okay. Again, do you think that would be appropriate to have some recognition of that and perhaps again some responsibilities in the act, or do you think that should really still be within your discretion?---No, I think that should be within our discretion. Can I say we let parents know when they come into CAFTU that on occasions we might have to give the child and oral pill, or in the extreme case an injection to try to calm them down. And we almost always would do that with parental consent. And indeed, we inform parents if some type of medication was required to calm the child down.

All right. And is there - in foster care, for instance, who do you get the consent from?---The department if the department - if that's the case, yes.

All right. Now, I want to just concentrate a little bit more on the adolescents. I know that you're not in the adolescent unit, but I take it you have a close working relationship with them. So that 14 to 18-year-old cohort, is it correct that - and you talk a little bit about this further in your statement - it's a particularly challenging clinical picture, if you like, that these young people because particularly those who've had a history of, for instance, substantiated abuse or neglect, you have the impacts of those sort of traumatic experiences, don't you; you have the issues that beset all adolescents in terms of

challenging, for instance, limit-setting and challenging behaviour generally; and you say that it's about, what, age 14 that a number of the psychotic illnesses become symptomatic. Is that right?---Yes. So it's a volatile mix. You've got the developmental trauma; you've got the adolescent issues, as you said, of individuation and identity; and you've got the emergence of severe mental health problems, which are less common in children.

What are those sort, are they schizophrenia, for instance?---Yes, psychotic illnesses; drug-induced psychoses; severe major depressive episodes; eating disorders, although unfortunately we are seeing a lowering of the age of eating disorders. Right now we have a few people in CAFTU with eating disorders. But the incidence increases during adolescence as well.

What is the youngest age you've got of children with eating disorders in CAFTU?---Gosh, we would have had nine-year-olds, 10-year-olds in CAFTU with eating disorders.

All right. So if I can then just turned again to your - the consultation liaison service - just trying to work out how all these interlock. As you say, it provides mental health input to all specialist services at the Royal Children. So as I understand it, it provides support where for instance they may have comorbid illnesses?---Yes. So the child and family therapy unit actually has two sub-units. The best known as the in-patient unit, which is often just called CAFTU; the second is the consultation liaison, or CL service, which I'm also the director of. The consultation liaison service provides support for the Royal Children's Hospital, so you may have children with a past history of mental health problems; you then, let's say, have a serious burn or have cancer; they may have an anxiety disorder and they're having bone marrow transplant and they're going to be in isolation for weeks, so we provide assistance to those children and we also provide assistance to the families of the children, to the parents. On occasions we have parents coming into hospital staying with their children, and they themselves have a history of severe mental health problems. You can understand stress of a very unwell child might trigger a mental health problem. And those parents are not willing to go to the Royal Brisbane Hospital for treatment, so we will go and treat them as best we can within the hospital.

Right, okay. Thank you. So you then turn in your statement to the child and youth forensic services, young people in the youth justice system. You say at paragraph 12 that:

> *27 per cent of all Queensland children who have been victims of substantiated harm and had contact with the child protection system subsequently offended and became involved in the youth justice system. Approximately one in six - 17 per cent - had been in the care of the department prior to detention.*

---Yes.

That's a very significant number?---Yes, it is very high.

And you say that, "Young people in the youth justice system ranked among the most socially disadvantaged in the community and are at an increased risk of mental health and substance misuse issues"?---Yes.

You say, "In Queensland a high proportion of these young people identify themselves as being Aboriginal and Torres Strait Islander; approximately 50 per cent of mental health, alcohol, tobacco and other drugs - MHATODS - identify as being indigenous"?---Yes.

All right. So that's obviously a very high number, given the indigenous population, particularly youth population. Have you got particular views about why that is so high? ---Yes. To step back we first of all - MHATODS is the service that I was the consultant forth over 10 years. I did a survey of young people in the Brisbane Youth Detention Centre and we found about 75 per cent of females and about 65 per cent of males screened positive for some type of mental health of drug and alcohol problem. In other words, co-morbidity is the norm rather than the exception. We also found the stats show that about half of indigenous young people are in the youth detention - half of young people in the youth detention centre are indigenous. Indigenous youth are over-represented in all youth justice systems right throughout Australia. Queensland has the second highest rate of indigenous young people in the youth justice system after WA, I believe, though New South Wales comes a close third. There are a lot of reasons why that is so or a lot of hypotheses given. It may be that indigenous youth have a history of significant disadvantage more so than non-indigenous youth. They have higher rates of drug and alcohol problems unfortunately and they come from backgrounds characterised by greater incidences of itinerancy, poverty, neglect which is reflected in the child protection statistics. These all are associated with increased rates of delinquency and forensic activities.

Which means coming into contact with the youth justice system?---Absolutely, yes. It's also been - and I don't have a view on this, but it's also been suggested that there is a lower threshold at which indigenous young people are given - are remanded in custody versus non-indigenous young people and that's something that's being debated. I don't have a view on that but that has certainly been put forth.

That's a view that's, I think, common, is it to adults as well?---It is.

They come to the notice perhaps more to police than perhaps non-indigenous parts of the population?---Yes.

All right. So you say that Queensland Health has set up two services in South-East Queensland. There's MHATODS and the Child and Youth Forensic Outreach Service. Now, they both operate within the Brisbane Youth Detention Centre?---No.

Just MHATODS?---MHATODS operates within the Brisbane Youth Detention Centre so they are confined to the Brisbane Youth Detention Centre. The Child and Youth Forensic Outreach Service, CYFOS, is the community arm of adolescent forensic services.

Yes, and it operates now, as I understand it - who are the stakeholders in CYFOS?---There are two stakeholders in CYFOS. The first are CYMHS, Queensland Health or Child and Youth Mental Health Service which is the acronym for CYMHS. If a child is a current client of CYMHS, then we can provide a specialised forensic assessment and treatment for that child and the family.

Yes?---That's the first stakeholder. The second stakeholder is Youth Justice Services. For children within the youth justice system under our current memorandum of understanding we can provide a mental health assessment of someone within the youth justice system but under the MOU we are not funded to actually provide forensic assessment and treatment. Now, that's not just semantics. It's one thing to provide a mental health assessment, that is, a determination by a skilled mental health clinician whether that child or adolescent is suffering from an acute mental health problem. It's another thing to provide a detailed forensic assessment and treat them and we're not funded to do that.

So, for instance, what you're saying is an assessment by a clinician but you're not funded to provide an assessment, for instance, to a court - - -?---Absolutely.

- - - about what might be appropriate treatment for that young person?---We are certainly not funded to provide an independent psychiatric assessment or psychological

assessment to the court. We're not funded to provide a forensic treatment plan for that young person. A simple example might be that, for instance, we have an MOU with Caboolture court - the courts at Caboolture and if there is a young person there that they feel might be suffering from a psychotic illness or acutely depressed or suicidal, they will call us. We'll go out, we'll see the young people and form a view, but that's about as far as we can go under our current MOU.

So there's no ability, for instance, for you to provide that assessment or a more detailed one for the court?---No.

No?---We will provide that assessment to the Youth Justice Services.

Yes, so it would seem somewhat ludicrous that, for instance, there are often forensic assessments for adult offenders given to the courts for sentencing and/or treatment but there's no facility to do that for youths? ---No, there's no - we don't - we're not funded to provide pre-sentence reports or independent reports. Occasionally certainly in my experience whilst I was in the detention centre for 10 years they would ask for a treating doctor's report, but a treating doctor's report is very different to an independent forensic psychiatric assessment.

All right. In terms then of CYFOS's role the Department of Child Safety is not a stakeholder. Correct?---the Department of Child Safety is not a stakeholder, that's correct.

So let's say, for instance, a child is an in-patient of CAFTU. They're discharged back into the department's care. CYFOS can't assist that child currently, can they, in terms of outreach unless that child is, for instance, a client of youth justice or already a client of Child and Youth Mental Health?---Yes. The majority of children who are discharged from CAFTU would be discharged back to their local Child and Youth Health Service because for admission into CAFTU you would have to have a severe and complex mental health problem.

Right?---So in that example the majority of children would be referred back to a CYMHS clinic and if they required forensic services, then CYMHS is a stakeholder. The difficulty we have is that it's not uncommon at all for the department to contact CYFOS with a child who has quite worrying violent behaviours, sexualised behaviours. They're in foster care. Sometimes they're in foster placement with other children and there's clear concerns about the safety of that child and the other children and the foster carers, but they are not under any youth justice orders and particularly if they're under 10 when they can't be and they haven't been accepted into a Child and Youth Mental Health Service because they don't have a severe and

complex mental health problem. For those children we have nothing to offer and in fact there are no services in Queensland in terms of forensic services in Queensland for those children.

So, in other words, unless that psychiatric presentation, for instance, becomes so problematic that they either come to the notice of the authorities with offending or it becomes so severe and complex that they get admitted either through CYMHS, as you say, and indeed perhaps into CAFTU, there is nothing available for them?---Nothing, and in fact what could happen is if a child - I'll give you an example. Let's just say we've got a 15-year-old child who has severe sexualised behaviours in foster care. They also have a depressive episode. They're seen by CYMHS. They're accepted as a client of CYMHS and they're treated. Six months later their depressive episode is well treated and they're discharged from CYMHS. We cannot continue to see that child.

COMMISSIONER: Sorry, what is CYMHS?---Child and Youth Mental Health Services, Mr Commissioner.

MS McMILLAN: Given the sort of situation you're describing, that's not an issue that's going to disappear after six months, is it?---Look, sometimes it will for a discrete depressive episode but what's not going to disappear or is unlikely to disappear after six months is the violent or sexualised behaviours which has likely been embedded within long-standing developmental trauma, for example.

So it would seem absolutely essential that the department should be a stakeholder so that you're able to offer that assistance to these young people?---That's my view. The department needs to be a stakeholder but also there needs to be then with that increased funding.

Dr Stathis, have you read the submission made to the commission by, amongst others, Dr Connors, one of your colleagues Dr Wilson, Mr Philip Trudinger - - -?---Yes, I have read that.

Yes, all right. There's a submission dated 28 September this year. In it - and I'll just read it out to you for those who don't have it in front of them.

They say about adolescents, "The current child protection systems seem to have little place for adolescents and young people. Significant concerns about the welfare of these groups seem to get the regular response of a child concern report from the regional intake service." Just pausing there, would you agree with that?---I would agree.

"The rationale behind this response is that these older children are able to make their own decisions and/or that the report is a result of parent-adolescent conflict. This approach attempts to normalise the behaviour and does not take into account the true nature of the conflict, which not infrequently is one based in abuse and neglect. Children in this group are getting younger, with children as young as 13 years of less." Now, firstly, what do you say about the rationale that these older children are able to make their own decisions and/or report that it's a result of parent-adolescent conflict?---I don't think those older children can make those decisions.

Do you think that rationale, though, is what is the basis of that?---It has been stated that, yes.

By what, the departmental officers?---Yes.

To your knowledge?---Yes.

"This approach attempts to normalise behaviour, it's said, and does not take into account the true nature of the conflict, which is not infrequently based in abuse and neglect." Would you agree with that?---Yes. Longstanding abuse and neglect over many years, I think.

All right, and, "Children in this group are getting younger, with children as young as 13 years or less," what do you say about that?---I don't have the - anecdotally, I would agree. I don't have - there may well be evidence out there to demonstrate that.

"As well as those who are not taken up by the child protection system, there are many children under child protection orders who display extremely high risk behaviours that could end in their harm or death through accident or deliberate means." Would you agree with that?---Yes, I would agree with that, and as a psychiatrist I would also say that their behaviour puts them at risk, increasing risk, of other severe mental health problems as well.

All right. Well, it goes on to say, "These young people have significant emotional and behavioural disturbances and are difficult to engage with"?---Yes.

"They often self-medicate with drugs and/or alcohol." Correct?---Yes.

"Develop inappropriate, at times violent, emotional attachments and often refuse supports with accommodation and health services"?---Yes.

It says, "The group does not fit well in the child protection service model and often all services, including the Department of Child Safety, Queensland Police, Health and Education are at a loss how to help these children"? ---Look, these are very difficult children, and if you don't mind, I actually would have referred to these children back in my affidavit in paragraph 46.

I was going to ask you about that, yes. Perhaps now might be convenient?---Okay. I'd mentioned back then, and I might just quote from it and then I'll elaborate. "Young people who exhibit problematic behaviours of a violent or sexual nature are difficult to manage in standard foster care placements." The example that Jan Connors used is more broader than that. I was more focused on a forensic example, but it's the same, broadly, group of children. "These behaviours frequently cause placement breakdowns which lead to adverse outcomes for young people." I go on to say that my view is that there is a need for highly specialised treatment planning for young people who require residential foster care placements to reduce the risk of them requiring an even greater level of intervention, which may be then movement into the youth justice system. "A therapeutic foster care model in which different tiers of intensive therapeutic interventions are provided to children and adolescents has been found effective. No such model exists in Australia." Mr Commissioner, can I apologise, I made a mistake there. No such model actually exists in Queensland. In fact there are some very good models down south. Berry Street in Victoria published a paper back in 2007 about therapeutic foster care and they have demonstrated that it actually works. The big difference between therapeutic foster care and say current foster care that we have here in Queensland is in therapeutic foster care the foster carers are seen to be part of the interventional team. So they are just not someone who just looks after the children, they are seen to be integral in terms of treatment of the children.

COMMISSIONER: So they differ from what we call intensive foster caring here?---Yes. It's probably a step beyond that. Intensive foster caring, usually the children in the foster placement are given intensive interventions within the community, and that's good.

MS McMILLAN: Do you mean Evolve, something like Evolve? ---Well, Evolve - yes.

Yes?---For instance, Evolve might be seen broadly - - -

Yes?---There's lots of different models and Evolve could be seen broadly within that model, but for therapeutic foster

care the foster carers themselves are seen be part of the therapeutic team. They usually only have one or two children in their care and it's the next step above that.

COMMISSIONER: Would they need special training and interest - - -?---Absolutely, yes.

They would be harder than usual to find, wouldn't they? ---Yes.

And retain?---Well, yes, so one of the – they are difficult to find. They're very special people.

Yes?---That's one of the reasons they only have one or two children within their care. They're actually paid more, which reflects the increase in specialisation of their skills and their needs and they do also get a much greater wraparound service. As I've said, Berry Street has done a nice report summarising that and I'm happy to provide a copy.

Would you? That would be helpful, thanks, doctor?---Yes.

MS McMILLAN: In terms of that, in this submission, "Consideration be given to adolescent specialist teams and multi-agency consideration is given how to best manage high risk young people." So you've indicated this is a – well, I won't say "solution", but some proposal in terms of this highly specialised foster placement. Otherwise, for young people who, as you indicate at paragraph 43, that long-term specialist in-patient care is obviously for children under 12 – sorry, that's for children who remain in hospital, but you also say that there's no step down facility that provides longer term treatment and rehabilitation. So if CYFOS had the department as a stakeholder, then you would be able to provide assistance for children who are in the care of the department, wouldn't you?---Yes.

The advantage of CYFOS is it is mobile, isn't it?---Yes.

Indeed, it's the case, isn't it, with adult psychiatric care there are mobile teams attached to, for instance, PA, Mater and indeed your own hospital. Correct?---Well, we don't have – they're known by a range of names and acronyms within the community, often, MIT teams, mobile and sensitive treatment teams, and that's well known within adult services. We don't have any MIT teams in child and youth mental health services. So these are teams who will go out and actually see children in their homes, at the schools, and do acute mental health assessments on them in their environment. The child doesn't have to come to us, we go to the child or the adolescent. That's very common in adult services. It's been around for years. We don't have them in child and youth services.

You would think, would you not, that particularly in a cohort, say adolescents, that might be some of the most difficult part of the population to engage with, that would be very desirable?---Yes, and also, when you think about it, particularly for children who are in youth justice services or in the care of the department, they see lots and lots of different people. They go from one office to another office to another office to another office, and often their mental health clinician is just one in a whole line of people that they have to see. If someone can actually go out to see them I think – I know that would increase their therapeutic relationship and I believe that that would be in their best interests.

Indeed, whilst it might be said obviously there would be some more expense involved in that than the current model, do you say that it's perhaps swings and roundabouts, because if these children aren't receiving treatment, children and young adolescents, they're likely to perhaps come to the notice of authorities if it's not treated or enter the adult mental health system, et cetera?---Yes, and there is another issue as well, is the advantage of mobile intensive treatment teams is they can go out and see someone in the community and if they believe that person is at acute risk, they're suicidal, they're acutely psychotic, they can actually place them under the act there. As it stands, parents now – they ring me up, they ring our intake officer up, and if the parent can't get the child to come to us the parents have to try to get a justice examination order to put the child under the act, they have to ring the police. It's incredibly stressful for the parents and it can often fracture the relationship, which might already be tenuous, with the child.

This allows us - ie, mental health services - to determine in the community at the time whether a child should be placed under the act and receive appropriate mental health treatment in a safe environment.

There is some funding, is there not - is it Medicare specialists or - do you - - -?---There are Medicare locals - - -

Sorry, yes?--- - - - that we are looking at who have some funding and there are plans afoot to see whether we could engage with Medicare locals around some funding. Ideally, though, funding should come, in my view, from Queensland Health to provide what I believe is an essential service.

Thank you. In terms of just the residential care that you're aware of for young people who may not be able to be placed with foster carers or the foster care placements have broken down because of challenging and/or aggressive behaviour, what do you understand is the standard of professional or training that these carers generally have? ---My understanding is that the training could be improved. I believe that was recommended by the Forde inquiry, and of not sure how that has been rolled out. I want to say, though, that it's a very stressful job, looking after children 24-7, say, in a hotel room, but obviously I believe the staff could have better training. Can I also say a step - and another issue, I guess, I'd just like to bring it up because it also is the next step from the therapeutic foster care that I mentioned. There are a group of children who just are very, very difficult to manage and those are the children that you were referring to the regularly abscond. They don't stay at home. They know that they can just walk out of a home. They're not under the youth justice system. There's nothing under the current legislation that we can do to keep them in that placement. They often engage in quite significant and dangerous drug and alcohol substance misuse. They engage with toxic peer groups. They put themselves at significant risk. We see this time and time again. My view is - and I've talked with police officers, they feel that their hands are tied under the current legislation.

COMMISSIONER: Unless they commit a crime?---Unless they commit a crime. Unless they commit a crime. And under the Mental Health Act there's nothing much we can do. I mean, and I've talked with police, they bring these children in intoxicated to the emergency departments. A good example is if they've been sniffing petrol or something, you can get acutely intoxicated very quickly when you sniff glue. You can make all sorts of statements about being suicidal and wanted to kill yourself and seeing little green monkeys or whatever and hearing voices. You bring them into the department of emergency medicine at the Royal Children's Hospital. After half an hour they're lucid; they denied any suicidal intent; they're not psychotic. We can't hold

them under the Mental Health Act. There's nothing we can do. They can walk right outside the door.

MS McMILLAN: And commenced to do the same thing?---And commenced to do it again down at the Valley, which is 500 metres down the road. And many of these children are out in the distant suburbs and the foster parents are concerned. Their parents are concerned but there's very little we can do. And often these young people have engaged in that behaviour again and again and again. And under our current legislation there's nothing there for them.

COMMISSIONER: So what's the solution to that? What should the system do about that?---Well, in the UK they have - under their legislation they have secure children's homes. Under their legislation what they're able to do is legislate under what might be seen as the child welfare or child protection system to actually house children against their will to home. So that if they leave behind they can actually be brought back.

COMMISSIONER: Because that would be an offence or something?---I don't know the details of the legislation and I don't think it's an offence in terms of their youth justice system, but - - -

It would be a breach of -so it would be a contravention that was enforceable against them by some authority?---Yes, of some act, exactly.

So it would give - leaving would be a trigger that would activate coercive action to intercept and return?---Yes.

And they were kept their for their safety and the safety of others?---Yes.

Because there was simply no other alternative - - -? ---Yes.

- - - all those having been tried and repeatedly failed in the past?---Yes.

And the only other less attractive option is to abandon them?
---That's right. Which is what is happening now, effectively.

And they become then part of the homeless subclass? ---That's correct. The abused homeless subclass.

Yes, the most vulnerable - - -?---The most vulnerable.

And they have to compete with whatever meagre resources they have available to them, such as welfare payments? ---Mr Commissioner, the resource is their body and that's

what they use. So with the secure children's homes these children can be housed, but it's therapeutic as well. It's a therapeutic model. They're not just stuck in a home, it's a therapeutic model where - and I guess that's the step above the foster care placement model that I just mentioned, the therapeutic foster care, where in therapeutic foster care it's voluntary, these - it's the next step up where these children are housed against their will, technically - - -

For their own good?---For their own good. They're provided vocational training, they're provided social supports, they're provided other types of therapeutic interventions. They're not just locked up. And in fact, some of these homes, their homes without - there's no walls, it's not like a prison.

No?---It's a home but the kids know that if they leave they're going to be brought back.

There's a consequence?---There's a consequence.

MS McMILLAN: And - - -

COMMISSIONER: An enforceable one. So how many would you think would be a viable number to house in a place like this?---Look, in the UK and Wales where this has been rolled out they have 15, 17, something like that, and the homes - there are varying sizes, but you might have five, eight children in different wings and their scattered throughout the country.

And is their entry needs or behaviour-based? That is, do they gain entry to these places because of their behaviour, regardless of the cause; or if their behaviour is due to some other need, like mental illness or intellectual impairment or some antisocial personality? Would that put them in a different subsection?---No. My understanding is that most of these children are admitted into the homes because of their behaviour - - -

Yes, okay?--- - - - their challenging behaviours, which include a lot of - which often does include delinquent behaviours, for example.

Yes?---But whilst they're in the placement they're offered a complete health check-up, a mental health check-up, and those needs would often be managed.

And that they'd be needs-specific?---Yes.

So it's their behaviour that gets them access to their needs being met?---Absolutely.

In a way that they might not opt for but which is good, both for them and the overall community?---Yes.

How long would they stay in there?---I don't know the details, but I would consider it would be months.

Yes?---6 to 12 months, possibly. I don't know the details. I do know - and forgive if the ages aren't quite correct - I think they're around 10 to 17, but I understand that in the UK system under their legislation if a child is under 13 or so there needs to be special ministerial consideration for that.

Yes. In England they've got the additional constraint of the Human Rights Act and the Rights of Children there in England and in Europe generally is much more expensive than it is here?---Yes.

So they'd have meet all those requirements as well?---Yes. Though the legislation has clearly worked because it is rolled out.

It would be cheaper than residential?---They've done the costings and it's much cheaper, and the outcomes are better.

And better?---It's better than housing and child with 2:1 carers in a hotel room down at Logan, for instance.

Yes, who do the best they can to contain them unsuccessfully?---Absolutely.

They fight bravely but not very well?---Yes.

All right.

MS McMILLAN: And they don't receive any therapeutic assistance in that model, if you can call - - -?---No. I mean, they may receive some type of therapeutic assistance, ie, they have to go to see their youth justice worker if they've got orders, of course, or they might have to see their CYMHS worker, but if they walk out and then unavailable, then they don't turn up.

So I take it implicit in your evidence then is that you think that sort of model, the UK and Wales one, has some real benefits to offer for a particular type of young person?---It's a subclass but it's a class that causes tremendous angst for police, child safety workers, health workers, education. I mean their needs are multidisciplinary, trans-disciplinary right across the board.

COMMISSIONER: It's not uncommon in other sectors of the community. It's often 10 per cent of the population need 90 per cent of the attention?---Yes.

Let me go to this question though to you: what we're discussing here seems to me to be giving these children for their own good and for good reason - and there are plenty of humanity arguments that would justify it, but we're giving them something. The state is giving them something that children living at home with their families and their parents would not get so we're creating a different class of child, aren't we?---We've already got a different class of child. I would argue that the difference in the class of child is already there. We're not creating it. We're actually trying to - I use the word "rescue". I don't want to sound - - -

You don't want to go back to the rescue movement?---Yes, exactly, but we are trying to manage what is already a different class of child. I don't think there's any creating being - - -

All right. I will accept that but pose this instead: those children will be getting services not available to children at home with their parents?---No, those services are available to children at home with their parents if they need it. The stark reality is I've got two children at home with me. They don't need the services that these children need.

Yes, but, see, my 16-year-old, if I had one, could walk out of home, not go to school, do what he or she liked, roam the streets like this cohort you're talking about and there's no legal power in me or anyone else to bring them back?---No, but they don't. They could but the vast majority don't.

Yes?---The vast majority don't or occasionally they might walk out for a while, realise the consequences and don't do it again, but these are children who are consistently, persistently engaging in this dangerous behaviour and invariably come from backgrounds characterised by developmental trauma, abuse and neglect.

So there's a dual motive here. It's for their benefit but also for society's benefit?---Yes, it's for their benefit because they're putting themselves at significant risk.

It's for society's benefit because I believe if you crunch the numbers, it's cheaper and you're preventing or you're trying to prevent a subculture.

And you should save money down the line from the juvenile and adult criminal justice system.

MS McMILLAN: And mental health system.

COMMISSIONER: And mental health system?---And mental health system.

MS McMILLAN: And the fact that they may then have children with that cycle continuing?---That's right, yes.

Can I just ask you just in terms of those issues, I take it you know Dr Elizabeth Hoehn?---I do.

All right. Now, in her statement she talks about:

> *Extensive research -*

this is page 5 for anyone who wants to follow it -

> *has demonstrated the importance of the early years of a child's life, especially the first three years in laying the foundation for healthy development and resilience. The brain changes throughout life but it's in the changes in the first three years of life that will have the greatest impact on expressing the brain's potential.*

Are you aware of that extensive research?---Very well.

Is it, in your view, fairly much accepted within the psychiatric world that that's correct?---Absolutely; no question.

All right. She says later, amongst many other things:

> *Crucial pathways needed for neuropsychological processes such as attention, learning, memory, recognising and regulating emotions, impulse control and speech and language develop during these first three years?*

---Yes, I'm aware of two really important studies, if you don't mind me elaborating.

COMMISSIONER: No, please?---The first is the Bucharest Early Intervention Project which is now over 10 years old and what they did is they actually took children who were in institutions in Romania and put them into foster placement and they - but it's different from the foster placements we have here. They trained these foster mums up. They paid their foster mums a good wage. It's a

European model. These kids were taken and placed in the foster placements. Now, they did it randomly which sounds like an ethical dilemma but the reason they could do that is Romania had no foster placement ethos anyway so they came in and said, "We've got this amount of money. We can't look after all kids but we can randomly assign children," and they assigned them from birth onward and this is what they found. They've followed these children up. This is good foster placement. If the children were placed in foster care before the age of two, they had significant improvements in IQ; in a whole range of mental health issues. EEG changes showed that their brain was recovering, so to speak. After the age of two no change; didn't matter; good foster parents, good foster mums, good foster dads; didn't matter.

Irreversible?---Irreversible, and they've continued that study on. Because now it's a longitudinal study, we're getting increasing evidence that this is the case. You're got two years. You've got two years. Dr Hoehn said three. I respect Dr Hoehn, but from the Bucharest study you've got two years. If you don't act within two years, the door's closed.

Doctor, can I ask you something that I have been pondering about for some time? To me I see it as one of the major dilemmas of our system to grapple with in a way that's acceptable, ethical and respectful of all interests and it's the unborn child whose pregnant mother drinks to the point of risking harm to the child. At the moment "child" is defined as an individual from zero to 18 and we have other ethical medical dilemmas with what you do - what can be done should be done in respect of an unborn child at various stages of development in utero, but from a child protection perspective the legislation says that you can offer the mother support and she can have it if she wants it but it's a really a matter for her and you monitor the child's development to see whether it's at risk at birth. If it's determined that the child is at risk at birth, then the state intervenes, but from the evidence I've heard before by that time the damage has already been done to that child. There was a way to protect the child. The child protection system is powerless, lacking authority to exercise any protective function in respect of that child, and virtually has stood by and watched irreversible damage being done to that child who at birth will then from that time until death have a disadvantage or a disability which the state then will have probably an ongoing responsibility for?---Mm'hm.

Has your discipline grappled with this problem from your own perspective and do you have any solutions when you bear in mind that the child is most at risk of the over-drinking, over-drug-taking pregnant woman in the first trimester?---Mr Commissioner, the nexus there is: how do you resolve child protection issues with what is actually a

primary health-care problem which is the drinking and the smoking. And I don't - it's a difficult issue because we use foetal alcohol - FAS - - -

Yes, that's what I was thinking?---Okay. We know that the damage occurs in the first trimester; in fact, probably the first six to eight weeks post-conception. The issue - and can I just say although FASD - I'll divert just for a minute, and this is stats from Canada - we're all concerned about FAS and FASD in our indigenous population, and so we should be, but the evidence is the greater - if you look at the numbers, the largest number of children born with FASD is that of white, middle income women; no question. That's Canadian statistics. Because you get a lot more white - you think about it, it's the first six to eight weeks gestation. Often these women don't even know they're pregnant, and they'll have a binge because that's what they do, and that's when the damage happens. But this is the problem that we have, is if you're going to change the definition of "child" to be at conception, which is what you'd have to do - - -

Yes?--- - - - that would have a whole bunch of medicolegal issues: what are you going to do for terminations? You're terminating a child under the act, for instance.

Precisely?---And what are you going to do? Are you going to lock these women up to prevent them from drinking?

That's what prompted me to ask you the question when we were talking about the adolescents?---Yes.

In principle, what's the difference? If we had somebody - another adult doing irreparable harm on an ongoing basis to an entity who has on one view some rights to life, at least, that need to be respected; but compete with the parental human rights to choose - - -?---Yes.

- - - how can a state in a liberal democracy properly intervene in that situation and meet all the requirements of each of the relevant ethical rights-based philosophies? I think there's two answers to your question. The first answer is we can't in a liberal democracy. We can't. Because if you live in a liberal democracy you have to give people the right to choose.

Yes?---You can't have your cake and eat it too. We could live in an autocratic society and if you drink, to get locked up; but we don't, we live in a liberal democracy, so you can't. I think what you need to do is drive - this needs to be driven from a primary health-care model where older indigenous women - as has happened in Fitzroy River in WA, older indigenous women drive this and they basically shame you, and particularly shame the men if they drink. Because I can tell you if your partner is drinking himself silly every night, you're not going to be able to stop yourself drinking if you've got a history of alcohol abuse.

It's your environment?---Exactly, it's the environment. You can't legislate for that. You can legislate for some things in the environment; I have a pool fence at home, you can legislate to that, that's an acceptable risk. You can legislate - I wore a seat belt when I drove here -you can legislate for some things, but - - -

You can legislate for brains?---Exactly. And so I think the answer unfortunately is there is nothing you can do you want to live in a democratic society.

But yet, if we take that same child to point of birth, the state does step in but the damage is already done?---And that's the society that we live in, and I don't have - unfortunately I don't have an answer for you. We either change the way that we live as a society - ie, change our democratic rights - - -

All we watch Humpty Dumpty fall off the wall and then pick up the pieces?---Unfortunately, yes. The second answer to

the question, though, is - and you made a comparison with the adolescents - there is a difference. The unborn child can't choose; the adolescent is making their choices, and that's where we're stepping in.

And again, though - sorry to have this medicolegal debate with you - but again, the law would say at some point adolescents can choose to make a bad choice and are responsible for the consequences of having done?---Yes.

And the system owes them no further protective responsibility, they're on their own?---I think that's where we can reform. I mean, the law says 18 - 17 in Queensland, but that's another matter - 18, and then you're an adult. I think you have to make some type of cut-off. We all understand that cut-offs are artificial, but you have to make a cut off: it's 18 and its birth.

Well, yes, it's 18 by definition, but then Gillick responsibility or Gillick competence or autonomy is sitting in there as well?---Yes.

And if they can make choices about medical procedures, they can make choices that they are responsible for at some earlier point than 18, and the question is whether if you are making those choices the state should continue - what is the justification for the State continuing to protect somebody who is making bad adult-type choices repeatedly and is not in need of protection?---There's a few answers to that question. First of all Gillick competency in itself is a spectrum. I assess Gillick competency at the hospital; it's one of the things I do.

Yes?---It's one thing to ask a 14-year-old if they want their appendix out; it's another thing to ask for a 14-year-old to understand the complex developmental trauma that is driving them to make bad choices. They can't do that. They can't do that. The other thing about Gillick competency - I'm a doctor, not a lawyer - is my understanding, and I've talked with - when you look at Gillick competency per se it's a decision to do something, make a decision to have something. These children are actually doing the opposite; they're making decisions not to do something, not to have a good education, not to actually be safe. I guess you could argue the opposite, they're making a decision to be unsafe. But I don't think - that's not what Gillick was on about.

No?---So I would argue that Gillick competency probably is a side issue in relation to these children. They don't have the capacity to make those choices.

But on top of that the law regards them as having the capacity and the responsibility for committing a crime? ---Yes, the law does have - - -

Before they're 18?---Before they're 18, yes.

So there is a confusion and there's a lot of complex things that need to be worked out there. And again, I've got to do it from a child protective point of view, not from an overall societal point of view?---Yes. I guess the law says that whether the person knew that they ought not to have committed the offence, that's one of the cornerstones of deciding capacity, whether they ought not to have known - whether they ought not to have committed the offence.

Yes?---A lot of these young people, when you sit down and when they're safe - and this is the thing, Mr Commissioner - is when they're in the detention centre they actually settle down. These young people who live really dangerous, unsafe lives in the community, to get them into the detention centre, they settled down. And in fact, what I often do is if they are good medication, the good drugs, I take them off their medication and I watch them and in an environment in detention where they can't run away but it's an environment characterised by security, by firm boundaries, by the lack of access to illicit substances - because there's almost no illicit substances in due detention centres, as opposed to gaols - those kids, they settle down. They're not choirboys or choirgirls, but they settle down, so in that type of environment they actually improve. I would then argue that they don't have the capacity to make pro-social safe choices in the environment they find themselves in, in the community.

So they are unsafe and unprotected within the definition of our current system?---Absolutely.

MS McMILLAN: So doctor, just coming back in part, Dr Hoehn also says that, "Healthy relationships build healthy brains; conversely, abusive and neglectful relationships and traumatic experiences will have a profound and damaging impact on a child's developing brain." I imagine you'd agree with that?---Yes.

So for these children, who may well have experienced very significant trauma and abuse and/or neglect, their brains haven't developed properly from - - - ?---Yes.

Extrapolating from that, therefore they don't have the capacity to make safe choices?---That's right.

Is that really what you're saying?---Absolutely, and when you think of it, it's not just psychological. Professor Kamitamoda in Japan has done a lot of research in the association between early abuse and brain development and what she's found is harsh - she's found a number of things. One of them is harsh corporal punishment in the first three years of life actually reduces the volume of parts of your frontal lobe by 20 per cent. These kids have small brains that don't work properly.

COMMISSIONER: Because they were over-disciplined?---Harsh corporal punishment, beatings and things like that. Not over-disciplined, but what we would class as abuse, physical abuse.

Right?---These kids have small brains. They have small temporal lobes. Harsh verbal abuse, persistent verbal abuse, actually causes the temporal lobe to actually be bigger, but if you look at through SPECT scans and special scans the temporal lobe is bigger but it hasn't developed properly. So we know now that abuse, broadly speaking, in the first years of life cause brain changes and the parts of the brain that are affected are the parts of the brain that looks at impulsivity, decision-making, memory, abstract reasoning. Now, if you lose those type of things you're going to get children who are impulsive, who make bad choices, who do not learn from the bad choices, who have poor memory. We know this.

MS McMILLAN: Regulating mood states?---Absolutely.

And interpersonal functioning?---Yes.

COMMISSIONER: What sort of trauma? I mean, I know you said before that abuse will lead to it, but what sorts of other trauma? Witnessing domestic violence, is that one? ---Mr Commissioner, I'm not sure about that. I do know that she's looked at adult women who were sexually abused and they found early - during early - well, right across the age spectrum.

Yes?---She found, for instance, that adult women who were sexually abused have changes in the hippocampus. The hippocampus is a part of the brain in the medial temporal lobe that kind of connects to cortex, the front lobe, with the limbic system, the fright and flight system, and it has a number of jobs to do, the hippocampus. It looks at impulsivity and it looks at - it also modulates memory. These women had hippocampuses that were poorly developed and smaller.

So is what you're saying that you've got to get the kids early to make them resilient or impervious or not porous to

all the traumatic events and things that are going to happen to them throughout their life?---We all exhibit trauma. We're all – life is traumatic.

Yes?---But broadly speaking these children have had more trauma early on than the average child, the average person, so they are at greater risk, yes.

So if you remove the trauma, remove them from the setting of the trauma, whatever it is, at what age would they need most protection, or between what ages would they need most protection?---The current evidence shows between the ages of zero to three, as Dr Hoehn said, though in the Bucharest project they actually went down to 24 months. Can I say, it was even lower for speech and language problems. I think it was 15 to 18 months.

All right, so if we can give them a protective, developmentally friendly environment up till three can they withstand a different environment, much more coercive, intrusive, traumatic, for longer as a result of the benefits that they had pre three?---Their brains and themselves by definition therefore have a greater capacity for resilience. You can't – as we've discussed, you can't do anything under our current legislation until the age of – until they're born.

Yes?---These children might have genetic vulnerabilities that place them at increased risk of a wide range of behavioural problems. We know, for instance, that substance abuse has a genetic component too, yes, so there are genetic vulnerabilities and they also have had vulnerabilities prior to birth, but what we can do is protect them after they're born and give them a better opportunity.

If we do that until they're three they've got more of a chance of surviving what else comes?---Yes. Well, if we do that by three we're giving the brain a better chance, a better opportunity, to develop normally.

It processes the trauma that it sees more normatively and copes – their coping mechanisms - - -?---You could argue that. If your anatomy hasn't been distorted then you're more likely to be able to – if you have a normal anatomy you're more likely to cope with trauma.

All right. I wonder if you can help me with this. I've heard as a Family Court judge and from many witnesses here and I guess there's a consensus of view that children need stability and security. Accepting that to be true, on the hierarchy of their needs, though, where would that stand by comparison with a need to be reunited with natural parents?---I think what we're talking about is permanent placement.

Yes?---Yes. Let's just say – yes, okay. I have a view, and it's a view that I would say the majority of child psychiatrists in this state also have.

Right?---I think if we look at permanent placement – and I am an advocate for permanent placement, but I think there needs to be three plans. The first plan is that children need to be identified early. You can't do a permanent placement late. It needs to be early. Well, you can do permanent placement late, but the damage might already have been done. It needs to be early. So you have to have a system that identifies children at risk, and the first thing you need to do is put an enormous amount of effort into managing that mum and trying to keep the child in the family. You can't just pull a child from their natural mum. That's not fair and I don't accept that. So we need more resources and more effort into trying to maintain that dyad, the family dyad. So that's the first plank, is a system of early - - -

Intensive support?---Well, yes, intensive support which has to be done on a basis of early identification.

MS McMILLAN: And through the health model?---Yes.

Right?---It could be through the health model, yes.

Well, you say - - -?---Primarily through the health model, I'd say.

Because it's non-stigmatising, for a start?---Absolutely.

Also it's available even in remote communities, health. Correct?---Yes.

Thirdly, you're talking about some of those issues about drinking, no doubt there's sexual health issues, education, contraception?---Absolutely, and I entirely agree, particularly if we're looking at indigenous communities where we want the least stigmatising route. So that's the first plank.

Okay. The second?---The second plank is if it does not work the child needs to be taken and permanently placed elsewhere. That's my view.

COMMISSIONER: How long will you give it to work?---We've got two years, three years, based – if you want the evidence, three years based on the evidence. You don't have a long time, okay.

Okay?---I mean, you could have permanent placement later, of course, but I'm talking about children who are identified - - -

At birth?---At birth or soon after.

Soon after?---Okay.

Yes?---But for that to work as well that second plank has to have foster parents who also have been trained and educated up and they see it as a vocation and they're paid well too. They're given one, two, three kids, a few kids, and this is their family. I don't care whether you call it adoption or permanent placement or whatever. This is their family until 18 or beyond, okay. This is their family. That's the second plank, but there's a third plank, and the third plank is we can't forget the mums, or often it's the girls, whose kids have been taken from them, because I've worked in a detention centre. These children, and I'll use the word "children" - - -

Children - - -?--- - - - who are having children - - -

Child parents?---Yes. They want the child. They will say they want the child because they want someone to love them. That's the irony. They want the child to love them, and it's because they've never been loved. "So I'll have a child and they can love me." Now, if all you do is take that child from them and you stigmatise them and you crush them, they're just going to have another child.

To replace the love that they didn't get from the first one?---To replace – because that's the only way they've found love. So the child who's having the children has to be nurtured themselves so we can't forget the third plank because if you leave out the third plank, you're just going to have them having more and more children. That's not in the child's best interests and it's not in the child's child's best interests either.

So does that mean you include the child parent in the life of the child who's now living in another family?---I don't think so.

No?---That's my view. Others might have a different view.

MS McMILLAN: Why, because it's destabilising?---Yes, I think it's destabilising. You're putting that child in another - I'm talking about the birth, the child that's just been - the baby, the toddler - into another family. If you're giving them permanent placement, that's their family. It causes - and I've seen this. It causes a lot of confusion.

COMMISSIONER: Yes, and rivalry between the parents with decisions?---There's rivalry, there's triangulation and at some level the mother whose child has been taken from them I think believes that they - - -

There's still a chance?---Yes, there is a chance somewhere there and it just causes too much confusion. I believe that that mother should be able to have the opportunity to reunite with her child when they're 18 or later on, but, no, I don't think - I think if it's permanent, it's permanent, but you can't forget the mum.

So look after her?---You need to look after her.

And deal with the emotions that she's been going through because of the loss of the child permanently or at least until the child is an adult and focus on renewing the bond and the tie then, not beforehand?---Yes. Now, I know that there are concerns about this. There are concerns about - - -

There are concerns about everything, doctor?---Yes, there are concerns but I think these concerns can be addressed. There are some concerns I think are very difficult to address, ie, FAS and what to do prior to birth, but I think these concerns can be addressed. There are concerns in the indigenous community. We all know about the stolen generations. In fact we've had stolen generations since back in 1865 under the Industrial and Reformatory School Act. That was a stolen generation that's been forgotten, okay, but I think the stolen generations was state-sanctioned removal of children on the basis of race. That's wrong. I mean, we all know that, terrible, but this is not state-sanctioned removal of children on the basis of race. This is state-sanctioned removal of children because they are at risk. Now, the reality is that they're more likely to be at risk in the indigenous community and that's something we're going to have to grapple with, but I think we can manage that. There are other concerns about certain children who will be left out, yes, but that's already happening in the foster system and I understand that there's probably other legislative changes that would need

to be done but that can be.

Originally the Industrial and Reformatory School Act was to protect society from the delinquent children from the industrial revolution?---That's right, absolutely, but the delinquent child was also - was defined under the act as someone who lives with drunkards, someone who wanders in the community, someone who sleeps outside or someone who has an Aboriginal parent. That was under the act.

MS McMILLAN: Doctor, who in your view should decide about this permanency placement? You will have seen in the submission from Dr Connors and others there's an issue there about who should be making this decision because clearly it's such a draconian measure to remove a child from their parent. Whilst there's obviously a need often to take urgent action on the short term like a temporary assessment order or court assessment order. Who should be doing that? Should it be in consultation with a psychiatrist because we do know, don't we, that child safety officers generally don't have training in developmental stages and probably have not had the education in terms of these brain-development issues and probably one can't expect them to have it in detail?---Yes.

So how do you decide that?---First of all, I would say it's not a draconian measure.

All right. Let's just say some people might regard it as draconian?---Yes, and I'd argue it that it's not a draconian measure, but I think, first of all, ultimately it must be done through the courts, the Family Court, because it needs to be done under legislation. It needs to be done through the courts, but I think if there was some type of process analogous to the SCAN teams that we have - I'm saying "analogous". I think there are issues with SCAN, but analogous with the SCAN team, ie, a multidisciplinary team. That probably wouldn't include education because most of these children would be too young but would include health. It would have to include health because health would be the people most likely to have notified the department anyway. I think it would have to be health and the Department of Communities that would make the decision and I think - and then the person though who would lead the team, in my view, would have to be - would either have to be a psychiatrist or someone in the Department of Communities who is very senior and might - it might be a social worker or psychologist or someone very senior who has a lot of experience in the area.

Or could this be a model that if you go to look at any long-term orders but particularly these where there's already a provision in the Child Protection Act for a Children's Court magistrate to have recourse to an expert, say, someone like you?---Yes.

Now, we understand that's not taken up very often and someone such as yourself is not going to have the capacity to be available readily necessarily, but do you think there's some merit in there being a consultant psychiatrist such as yourself able and overseeing, for instance, the passage of these cases through?---I think that's a good idea . In other words, we're asking someone to provide an independent assessment to the court. I think that's a good idea.

Yes, and if it's not you, perhaps one of your colleagues who you supervise, a registrar?---Yes, I think that has merit.

COMMISSIONER: We have got up to three years, as you say. It's not a decision we have to make right here?---And don't forget the first plank.

No, because the first plank - we're still working on that as long as we can?---Absolutely.

MS McMILLAN: It's been suggested that, for instance, urgent orders and no doubt these newborn ones - the apex should be inverted that the most experienced child safety officers make these sorts of decisions in cases, whereas the more inexperienced are doing the long-term ones where there's less interface and less necessity to make often urgent decisions. Do you think that's a good idea? ---Absolutely; it's a weighty decision the experienced people need to make.

COMMISSIONER: Some might argue the chief executive should sign off on it.

MS McMILLAN: Do you think that there is - yes, sorry - merit also in there being some sort of postgraduate training for child safety officers so, for instance, they receive some formal education, if I can put it this way, and training about, for instance, brain development, developmental stages of children?---Yes, look, we don't have any courses in Queensland specifically for that that I'm aware of. I'll put it on record I'm on the board for ACT For Kids and we're actually looking at a partnership being with James Cook University in Townsville particularly to develop a course around that.

All right. What's Headspace? There has been some recent funding from the Commonwealth in relation to that?---Yes, Headspace is a new system of mental health care that's been rolled out federally which is - looks at a youth mental health model which, generally speaking, is looking after young people between the ages of 12 and 15 to 25 who have mental health problems, though probably not of the severity that we see with CYMHS.

So it's a step down, if you like, from that very complex

and serious - - -?---Yes.

All right?---20 per cent of adolescents in Australia will have some time during their adolescent a mental health problem; not that they necessarily need to see a psychiatrist but would benefit from some type of counselling and Headspace offers that.

What do you know about the Queensland Mental Health Commission? Do you understand that that's on the drawing board?---Yes, that's on the drawing board and we're currently having - it's going to be based under a New South Wales model and I'm not entirely - I'm not sure of the provisions of the commission at this point in time. It's still being developed.

And how much it would intersect with, for instance, child protection?---Yes.

Yes, thank you. I have nothing further with this witness, Mr Commissioner.

COMMISSIONER: Thank you. One final question from me before I ask Mr Hanger to examine you: when we talk about child protection, what's the protection principle? What are we protecting?---In terms of what are we protecting with the child?

Yes, what protective needs the child have?---If you look at Maslow's triad, I mean, first of all children need protection in terms of food and shelter.

So we protecting their survival?---So we protecting them - yes so we are protecting them - will use the bio-psycho-social approach.

Right?---So we protecting them biologically, we are making sure that they get enough food to grow and they're sheltered from the elements. The next step up is that they're also provided, from a psychological and social base, a healthy social and psychological environment, because humans are more than a body and so we need to protect them psychologically and socially, which is why we look at the significance and concern, say, in neglect. Neglect of a child is not simply that they're not just getting enough food or they're not provided with sufficient shelter; that they're being neglected socially as well.

And if we protect them properly what's our goal? What's the goal of the - - -?---Our goal, I guess, is that they are able to live productive, optimal lives.

As functioning adults?---As functioning adults within society.

And they're fully socialised, so they don't commit crime or anything like that and they play a positive role in the community?---Well, I'd say not that they don't commit crime, but it reduces the risk of them.

All right. Now, under the current legislation harm is defined as a significant detriment to one of the wellbeings?---Yes.

Wellbeing itself is not defined, but it seems to have the same - it would be synonymous with welfare?---Yes.

It's just a more modern word for welfare. And it's physical, psychological and emotional?---Yes.

And one of bases of state intervention - it's only harm-based, it doesn't matter about the cause; self-harm could be a cause under the legislation, I think - but if there's a significant detrimental impact on your psychological or emotional wellbeing as a child or an unacceptable risk of that - - -?---Yes.

- - - then the state has power to intervene?---Yes.

My concern is if the risk of emotional harm is the basis for intervention: (1) how does anybody correctly assess that initially; and then how does the risk of emotional harm become the basis for ongoing intervention and permanent placement?---Yes, that's a good question. It's a

hard one. First of all of course we know now - and I've given evidence from Professor Tomotha - that emotional harm causes physical harm. You get small brains. So emotional harm will cause a small brain and it's probably going to have more - will have longer detriment than a bruise.

Right?---So emotional harm is physical harm. The difficulty we have is you can't look in the brain to see that.

Can't see it?---So there are models, though. We can look at attachment, for instance. We can measure attachment. That's not my area of expertise, it might be a good idea to talk to Dr Hoehn about that. But we have good measures of attachment and we know that children who have been emotionally harmed as young children have poor attachment, they have avoided attachment styles, ambivalent attachment styles, disorganised attachment styles. That's a de facto measure of harm, so to speak.

Yes?---So there are measures that we have of emotional harm.

But the CSO isn't going to have the gauge in their back pocket?---No.

So you can see a bruise, you can say, "That's physical harm and that could be caused by abuse;" you see unhygienic, badly clothed, terrible living conditions, you can say that's neglect?---Yes.

But to say that's emotional harm or that is the consequence of emotional harm, what are you looking for? Bad behaviour could be, but yet bad behaviour could be just bad behaviour?---Yes. It could be poor attachment, which is a bit different from bad behaviour.

Yes?---I guess the first point is not all, but the majority of kids who are harmed emotionally are also going to be harmed physically - not all.

Yes?---But it's part of a package. Most parents who emotionally harm their kids are likely to at some level be physically harming them.

Even the idea of emotional abuse is hard to get your head around. I mean, yelling at, you know, ridiculing, that could be; but that happens everywhere all the time to kids?---Yes.

If you play soccer, your parents are on the sideline tell you how to do it, playing a better game than they ever did themselves. But that's not emotionally abusive?---No. And that's where it gets tricky because there's no black and white here, there's a lot of grey, which I think is why to make these big decisions you need a multidisciplinary team

and you probably need one or maybe even two - using the model - two independent assessments.

So you might have a forensic investigation but a multidisciplinary assessment?---Yes. Particularly of these very young children who can't tell you what's happening themselves.

You want to know what their prognosis is, too, don't you? Because if the aim is to reunite, given that that's what fostering is supposed to be, fostering is supposed to be a non-permanent thing?---Yes.

Then if the aim is to reunite, as long as the attempts to do so does no more harm, then you need to know how they're going to cope with that instability that's going to come with the failings, because parents' lives are not like that, they might fluctuate like that?---Yes.

Some weeks they're good, some which they're not?---That's the reality, and that's why I think that those parents, they need to remain at least in the system, so to speak, so that they can be monitored.

Yes. Okay, sorry. Now, Mr Hanger.

MR HANGER: Doctor, most of the questions I was going to ask you have been asked by my learned friend Ms McMillan. There are just a couple of things there. As I understand it now, the latest research also indicates that abuse can be carried on into the next generation by the genes. Could you tell us something about?---Yes. So what we're talking about is epigenetics.

Yes?---It's not an area of expertise of mine. Prof Brett McDermott, who is giving evidence tomorrow may have more to say on that. But what it basically means is we thought that genes didn't change; you were born with the genes and they're never going to change. We now know that trauma - early trauma can actually change genes; change gene expression, and that's fascinating because it means on both sides - if you've got a child who's been traumatised, that their genes are going to change; but on the other hand as well if you can then give a child a good enough upbringing you might change those genes back. There are other genes that are associated with safe substance use. We note that genes turn on and off. We never knew that before. We thought you had the gene for life and it was there for life and that's what happened, but we know now that there are certain - for want of a better word, and argues it loosely - psychotic genes. We all have psychotic genes. And if you smoke marijuana for roughly 18 you turn these psychotic genes on; if you don't smoke marijuana - cannabis - until after 18 or so, those genes turn off at around the age of 18 or so, to reduce the risk of psychosis. That's just one

example.

So you can be carrying a gene that may result in psychosis being precipitated and the taking of marijuana is likely to precipitate that?---It would be one of a number of genes. And of course it's kind of a tipping point, isn't it, if you get enough genes then your risk of psychosis increases. That's just one example. It's not an area of my expertise, but those are just some broad examples that I know of.

Okay, thank you. And is it the case also that abuse in early childhood - abuse at any time shortens telomeres of the - - -?---Yes.

And can you tell us about that?---Yes. Once again, that's to do with epigenetics. I so abuse shortens these little things called telomeres on the chromosomes.

COMMISSIONER: Sorry, what they call?---Telomeres.

Can you spell that for the record?---Now you're got me.

Sorry?---T-e-l-e-m-e-r-e, I think.

MR HANGER: I thought it was Omere?---Telomere, T-e-l-o-m-e-r-e.

What's telomere?---So these are little bits on the chromosome, okay, that modulate behaviour, for instance, and modulate the way that we – I'm trying to explain – modulate the way that we cope with stress and trauma.

COMMISSIONER: They're coping mechanisms?---They're kind of, yes, and because, of course, when you're under stress, for instance, you will produce certain hormones which allows you to cope with stress, or certain hormones, of course, actually can make the stress worse. I mentioned about the hippocampus, and this is where the telomeres come in. Early trauma causes us to flood our bodies with cortisol. Cortisol is really damaging to the hippocampus in the brain, high levels, when you're zero to three years of age. So that's kind of – that is a good example of where those telomeres – early trauma can change the telomeres which will then have long-term implications later on in life.

MR HANGER: I have heard, and I put this anecdotally but you may be able to tell me there's some research on it, that girls who are abused, sexually abused, as children are likely to choose a mate who will sexually abuse their child, strange as it may seem?---Yes, look, I've heard that, but it's not an area of my expertise so I wouldn't like to – I don't - - -

Let's leave it?---Yes.

Let's leave it, yes, thank you. I have nothing further, thank you, sir.

MS McMILLAN: Mr Commissioner, can I just hand up to assist you, because no doubt it's all very clear to you what Dr Stathis has just indicated, but pages – the last paragraph on page 6 and over to page 7 of Dr Hoehn's statement gives a very good exposition of that epigenetic link.

COMMISSIONER: Okay.

MS McMILLAN: So that might - - -

COMMISSIONER: Well, I haven't read that statement yet.

MS McMILLAN: No, I haven't tendered it yet.

COMMISSIONER: That's fine.

MS McMILLAN: But I just thought if you wanted to have it now just to look at those couple of paragraphs that might also just assist.

COMMISSIONER: All right, thank you.

MS McMILLAN: The bottom of – last paragraph of page 6 and then on to page 7.

COMMISSIONER: Now, Dr Hoehn, she's not giving evidence?

MS McMILLAN: Yes, she is, tomorrow morning.

COMMISSIONER: Okay. All right, thank you. Sorry, Ms Stewart?

MS STEWART: Good morning. Lisa Stewart from the Aboriginal and Torres Strait Islander Legal Service. Mr Stathis, can I just take you to paragraph 28 of your statement?---Yes.

In there you've highlighted the importance of co-admission of children alongside their primary care providers when entering residential care units. From my understanding of what you've written there, the rationale of that approach is to negate any attachment disruptions?---Yes.

That's something we're particularly interested in, in contact and reunification considerations and how to minimise the impacts on a child. Jan Connors, who is going to be giving evidence this afternoon, has identified some similar proposals in a slightly different context, that she supports a collaborative approach between carers and the children and more support and contact around reunification process. What I'm interested from you is can you just provide some more detail about the benefits of more co-admission approach in the residential care units context?---Yes. This was given in the context of admissions to CAFTU, so given the fact that positive parenting is embedded the importance of positive parenting should be embedded in managing children with mental health problems. What we ask is that parents or carers with these problems are co-admitted so that we can, first of all, in CAFTU, watch – look at their parenting. We can monitor their parenting twenty four-seven. We can educate them about how they could better parent their child and we could demonstrate ourselves how to better parent the child, because our nursing staff are extremely skilled in this area. So within the child and family therapy unit we see this as a very important approach. I'm not quite sure of the - - -

Is it an approach that's adopted already, the co-admission of a carer and a child in the CAFTU?---Yes, we do this.

Okay?---In fact, we almost insist it for – in relation to this paragraph, we insist that for residential cares. What that means, of course, is a child who is under the care of the department who is in residential care.

Yes?---The reason is many of the carers have had very little experience in parenting and so we want to try to upskill them as best we can. Now, there has been an argument that that shouldn't be our role. We spend an inordinate amount of time and resources upskilling carers that should already have that level of expertise.

Just on that, what is your understanding about the level of qualifications that a residential carer needs or should have?
---Well, I understand from the Ford inquiry – didn't they recommend at least at cert IV or a diploma?

COMMISSIONER: Yes, they recommended it?---I think so. That would be – and the government looked at rolling out the recommendations. I don't – my sense is that a lot of these carers don't have that level of expertise.

MS STEWART: Okay. There's a few things that came out of your evidence that I'd just like to explore a bit more, firstly around – there was some discussion around intervening prior to a child being born?---Yes.

I'm not quite sure if you're aware of section 21 of the Child Protection Act around unborn children. I can just pass you up one?---Sure.

It's essentially that if the chief executive reasonably suspects that a child will be in need of protection after it's born there's a number of things that can take place, but specifically in relation to Aboriginal and Torres Strait Islander parents consent is needed?---Yes.

There's also a role for the recognised entity there?---Yes.

I'm not sure if you're aware of the role of the recognised entity under the Child Protection Act, but they consult and participate in significant decisions relating to Aboriginal and Torres Strait Islander children?---Yes, I'm aware of that.

I suppose what is specifically important is that consent is needed. Do you believe in light of the discussion that we've had this morning that if that particular provision is properly utilised that – well, do you believe that we're properly utilising that position?---It's hard for me to comment. I don't know the examples well enough to comment on that.

Okay, well, I suppose in relation to the discussion around foetal alcohol syndrome and how to meet the concerns and plan the appropriate intervention to a mum without, I suppose – while, you know, respecting civil liberties?
---Yes.

Do you believe that would be an appropriate provision that

could - - -?---Yes, I think that that – using the recognised entity?

Well, section 21A?---Yes.

Because that occurs before the child is born?---Yes, this is for unborn children.

Yes, we have a culturally appropriate service that has an option under the act already to engage with the mum with consent?---Yes.

Then we could possibly negate some of the concerns that - - -?---If you could engage the mum with consent, yes. I think the issue is consent, yes.

Yes, the issue would be consent, and I suppose it's informed consent. At the moment I don't know if there's a clear picture to the inquiry about how that's utilised. I think it perhaps could be more difficult to get consent, you know, a week before the baby is born when you've got a child safety officer at your door trying to engage and get your consent?---Yes.

That's probably - - -?---It would be easier if it were through health, for instance.

How do you see it occurring through health?---As I've said, I'd say that that would then have to be a primary health care model rather than a child protection model, which is less stigmatising.

If I can just take you to another part of your evidence about the permanency planning?---Yes.

In light of the historical factors that have impacted Aboriginal and Torres Strait Islander children that have resulted from the stolen generation, what special considerations do you think need to be considered when we're talking about permanency planning for our children? ---Well, first of all, permanency planning if at all possible should be with another indigenous family.

Under the Child Protection Act at the moment - - -?---That already - - -

Yes, we have got the specific provision, section 83, the hierarchy of placement options for Aboriginal and Torres Strait Islander children?---Yes.

But we've heard that there's a severe shortage of foster carers that are Aboriginal or Torres Strait Islander so a number of our children are not placed with Aboriginal foster carers. So if you look at making that a permanent arrangement, what in your opinion - - -?---Well, it may well be that if there was permanency there, we may get higher numbers of people willing to take that on. The other issue is - and I'm thinking this through - given the importance of community within the indigenous community - - -

Can I just get you to talk from your experience from, I suppose, a psychological point of view around identity and culture? What would be the impact on a child that loses that from, to put it politely, the unintended result of permanently placing a child with a non-Aboriginal kin or foster carer?---I think it would depend partly on the child, partly on the sensitivity of the non-indigenous carers in terms of allowing the child as they grow up to explore their indigenous heritage, allowing them to participate in cultural activities, allowing them even if possible to learn the language, if possible, so it really - so it does depend on the sensitivities of the carers involved. What I do know is that for indigenous adolescents exploring and understanding their identity is a tremendous source of support for them. I see that in the detention centre. So I don't see it as an all or nothing. It would be, of course, preferable that a young person is placed in terms of permanency with an indigenous family. If it was handled sensitively - and there are issues involved, but if it was handled sensitively, they could be placed with a non-indigenous family if, for instance, that non-indigenous family also had close connections within the indigenous community, but it's not the best situation.

No, and I suppose there are two things that come from that because if we've got a child under a long-term guardianship order, they're going to have a case plan and incorporated in that case plan would be a cultural retention plan, but a child that's adopted probably wouldn't have those safety nets?---Yes. The key is permanency. I don't want to

debate adoption versus long-term guardianship. I think the key is permanency here and it may well be for - I'm just thinking off the top of my head here. It may well be safe for the indigenous community that long-term guardianship is more appropriate in terms of permanency, but the key is permanency, not so much what you're going to call it. Now, I'm not a lawyer. I understand there may be differences legally calling it one thing or another. As a psychiatrist, the key is to develop secure attachments and for the child to feel safe in the environment that they're placed.

COMMISSIONER: The legal difficulty is permanency is a state of being, whereas adoption would sever parental responsibility and long-term guardianship wouldn't?---Yes.

So that's the distinction?---That's the difference.

The bigger call is to sever parental responsibility - - -? ---Yes.

- - - because you could probably sever the parental tie or the bond, assuming that you had attachment and bonding? ---Assuming you had in the first place.

In the first place, yes?---Yes.

MS STEWART: Just perhaps one last point: in your evidence you spoke about intensive zero to three would be the best age to work intensively and you spoke about children having children?---Yes.

Correct me if I'm wrong about how I understood your evidence, but if that child is removed from that child, it should be in care till 18 and there would be no contact with the mum. Just correct me if I've understood that? ---That would be my preferred position, yes.

What's the rationale behind that, keeping the mum out of the picture like that, and how does that - - -?---For permanency. I'm talking if the child is placed permanently.

Yes?---Look, my view is it causes confusion in terms of the attachment.

For the child or for the mum?---For the child which is why the third plank is you have to support the mum too.

Okay. Just a second. I will just put one last thing to you and you can just express an opinion on it?---Yes.

We're aware of things that happen in the community and one thing that we're aware of that's not a Queensland based case is where a baby was removed from mum. She was an Aboriginal woman and placed with foster carers and it was a

fantastic placement. It was stable and all needs were met? ---Were those foster parents indigenous?

No?---Okay.

No, but there were no issues with the foster care. It was a stable placement, emotional needs, everything was met, but still what arose from that was an identity issue when she started to realise that she wasn't white and that then led to the discovery of searching for your own identity, getting in touch with your culture because you need to be in touch with that culture, retain and build on it and nurture it in order to hand that down. That's a part of being Aboriginal?---Absolutely.

What would you say to that?---This is what I was going to say beforehand. Aboriginal communities live in communities much more - have a stronger community base than, say, the non-indigenous communities and so, first of all to answer your question, yes, that indigenous girl should be allowed to explore an revel in her culture. I think it's very, very important in terms of her identity; absolutely no question. The paradox is if she does that, she may, of course, come in contact with her mum. Her birth mum I mean.

Do I take it from how you've expressed that that's not a good thing?---Well, I've learnt in medicine never to say all or never, yes. I don't mean to sit on the fence here. My preferred view would be that there is not a - that the child - in permanency the child doesn't have regular access to their birth parents. In reality that will occur, particularly in the indigenous community. Let's just put that on the table. I think that is something that may have happened in the fullness of time. If that happens, then I think you have to manage that. You can't suddenly say, "You can't go to this festival" or "You can't associate with this group of people because your birth mum is there." You need to handle that sensitively and with commonsense. So if that happened particularly in the indigenous community, then you're going to have to handle that.

Can I just get you to address me on one last thing? As an adult in that situation, would you agree that that child going into an adolescent and then an adult would be experiencing grief and loss?---Yes.

How does manifest itself?---Well, in a number of ways. Of course you could see a load mood, affective lability, moods going up and down, which happens in adolescents anyway but may more so, symptoms of anxiety, school refusal, drug and alcohol use, increasing risk-taking behaviours, separation from parents which once again is normal within - for adolescents but to a greater extent than normal and at that stage they may also be actively looking for their parents. Can I make it clear when I said about that I didn't think

that the mother should be involved - the parents should be involved in their lives, I'm talking about sanctioned involvement at an early - you know, during childhood, but if an adolescent 15, 16 of 17 is saying, "I want to find my birth mum. I want to try to understand what it means," especially in the indigenous community what it means, "Who I am," then you're going to have to handle that sensitively and once again - and we use it glibly, don't we, but we say, "What is in that child's best interests?" and if you have a stable placement that looks like it's going to become unstable for the primary reason that the child wants to find their birth mum, I would say as a therapist, "Then you should take that seriously," but it's not something that's sanctioned by the state. It's something that you take on a case-by-case basis for what must be in the child's best interests.

Nothing further, Mr Commissioner.

COMMISSIONER: Thanks, Ms Stewart. Mr Capper?

MR CAPPER: Yes, nothing further.

MS McMILLAN: Just one issue, doctor. You have a particular interest and expertise in gender identity disorder, don't you?---Yes.

Can you just explain briefly what that is?---Gender identity disorder is a psychiatric diagnosis in which a child who is born of one gender identifies as being the opposite gender, ie, if you were born as a male, you actually identify as being a female.

And you do have a particular interest and expertise in it, don't you?---Yes.

Do you find that that makes up a proportion of the children that you see who are in the child protection system and any correlation?---It's a good question. I'm not aware of any correlation except this: in my view, there are probably, for want of a better word, two types of young people suffering from GID, gender identity disorder. The first lot are children who are born a birth gender and the parents come to me and they say, "From the age of three or four little Johnny always wore dresses; always wanted to be a girl; asked to be called Jill; would wear female clothes and female underwear; would get incredibly distressed if he had to dress as a boy to go to school." That's a clear case of GID and if that progresses to adolescence, that probably is not going to desist. That's childhood GID. There is another subset called adolescent gender identity disorder. Many of those are adolescents who also had childhood gender identify disorder but another proportion is - and these are almost invariably females - girls who have been sexually abused and many of them are - well, when

I say "many", I have a handful of these and of those handful I would say a couple have a history, are current or were current or were clients of the department and for those individuals I don't - we're still working through what GID means. I think the confusion about their gender identity is also confusion around their sexuality. Sexuality is different from gender and I think it's more attached to questions of their identity in terms of their abuse rather than their birth gender.

So Ms Holly Brennan who gave evidence on Monday from the Family Planning Queensland Organisation indicated that young adolescents and young people who have sexual orientation issues - and I know that's different from gender identity disorder but might identify as being bisexual or homosexual, et cetera?---Yes.

(1) she says that's not necessarily a fixed orientation? ---Yes, that's correct.

Would you agree with that?---Absolutely.

And (2) that they are much more in need of support than the general cohort of adolescents, for instance, and (3) particularly if they're in the child protection system, they are very much in need of therapeutic assistance. Would you agree with that?---Yes, and from a mental health viewpoint those young people that you describe, as well as young people with gender identity disorder have very high rates of mental health problems. In my area of GID in adolescents - for adolescents with gender dysphoria, significant symptoms of gender identity disorder, up to 80 to 90 per cent have mental health problems so, yes, I would entirely agree.

And again they are not going to be assisted out in the community unless at the moment they come to the notice under Juvenile Justice or they are so acute that they come under Child and Health Youth Mental Service. Correct? ---Some of those young people would be able to be managed - if you're just looking at their mental health problems, would be able to be managed by private psychologists, private practitioners or possibly even in Headspace.

Right, yes, thank you. I have nothing further with the doctor. Might he be excused, Mr Commissioner?

COMMISSIONER: Doctor, thank you very much for the time that you have taken to give you evidence and your statement. It's very much appreciated?---Thank you.

WITNESS WITHDREW

MS McMILLAN: Might we just have a short break before Dr Connors gives her evidence, Mr Commissioner?

COMMISSIONER: Five minutes.

THE COMMISSION ADJOURNED AT 12.07 PM UNTIL 12.17 PM

THE COMMISSION RESUMED AT 12.17 PM

COMMISSIONER: Yes, Ms McMillan.

MS McMILLAN: Mr Commissioner, it occurs to me that it might be helpful if I tender for identification Dr Hoehn's statement.

COMMISSIONER: Yes.

MS McMILLAN: Because I may well take Dr Connors to it, and because I also took Dr Stathis to it in great detail - or some detail - so I'll just tender for identification his statement. If no one's got any objection I'll tender it now.

MR HANGER: I've got no objection.

MS McMILLAN: I'll tender at formally now.

COMMISSIONER: Dr Hoehn's statement will be exhibited and marked 116 and it will be published.

ADMITTED AND MARKED: "EXHIBIT 116"

MS McMILLAN: Yes, thank you.

CONNORS, JAN MARY sworn:

ASSOCIATE: For recording purposes please state your full name, your occupation and your business address?---Dr Jan Mary Connors, I'm a paediatrician at Mater Children's Hospital.

COMMISSIONER: Good morning, doctor. Welcome. I should be clear before we start that the doctor and I share friends and acquaintances and sometimes run into each other socially.

MS McMILLAN: Thank you, Mr Commissioner. I was going to say it wouldn't be that Dr Connors had treated you.

COMMISSIONER: If she had, it didn't work.

MS McMILLAN: Given her youthful years, I meant.

Dr Connors, have you prepared a statement in relation to this inquiry which was affirmed on 2 November?---Yes, that's correct.

All right. Have a look at this document. Secondly were you one of the authors of a submission dated 28 September 2012, some 55 pages?---Yes, that's correct.

All right. And lastly have you prepared deidentified case scenarios that you refer to in your statement?---Yes, that's correct.

And it's correct, isn't it, you wish for them not to be published because they may well identify to the child or the family involved who they are, effectively?---Yes, that's correct.

Yes, thank you. Dr Connors, just to clarify, your actual statement and the submission could be published? There's no difficulty with that?---Yes, that's fine.

But it is the case studies that you're of the view that they should be effectively suppressed?---Yes.

COMMISSIONER: I'll give them separate numbers. The statement of Dr Connors will be Exhibit 117

ADMITTED AND MARKED: "EXHIBIT 117"

COMMISSIONER: Her submissions will be exhibit 117 and - sorry, 18?

MS McMILLAN: Yes.

COMMISSIONER: Yes, the statement is 117, the submissions, 118.

ADMITTED AND MARKED: "EXHIBIT 118"

COMMISSIONER: And the document not to be published, which is case examples, will be exhibit 119.

ADMITTED AND MARKED: "EXHIBIT 119"

MS McMILLAN: Doctor, can I just ask you that in terms of giving evidence, if questions are asked of you by anyone in relation to those cases, you are of the view - I might in fact identify, would you please indicate that so that measures can be taken in terms of the live streaming at the transcript?---Yes.

All right, thank you. Doctor, if I can firstly then take you to your qualifications, could you just outline those, please, for the inquiry?---I've been a medical practitioner for about 30 years and a paediatrician for 10 years. I've been working in child protection in one way or another for about 13 years. My predominant area of paediatric practice is in child development and behavioural paediatrics. I've been working specifically in child protection for about 10 years and been the director of the child protection unit at the Mater for approximately six years. My expertise in child protection spans from community to a tertiary centre and the forensic end of child abuse investigation. As director of the child protection unit at the Mater we cover

the span of child protection from the antenatal period through to 18 years of age, so it's quite a broad experience in child protection.

Thank you. And doctor, can I just ask you, do you have a copy of your statement with you?---Yes, I do.

All right, thank you. Now, just otherwise in terms of your qualifications, you've got a masters of public health. Correct?---Yes, that's correct.

A masters of forensic medicine through Monash University? ---I'm currently enrolled in a masters of forensic medicine.

Right, I'm sorry. You've completed certain modules in it? ---Yes.

You're a fellow of the Royal Australasian College of Physicians?---Yes.

Member of the Paediatric Society of Queensland?---Yes.

Member of the Australian Association of Infant Mental Health; member of the International Society for the Prevention of Child Abuse and Neglect; member of the Chapter of Community Child Health: and member of the special interest group in child protection for the RACP, that's the college, isn't it - - -?---Yes, that's correct.

- - - of paediatricians. And currently the Queensland representative of that group. And your statement otherwise includes your experience. Correct?---Yes, that's correct.

All right, thank you. Now, can I ask you if we could go to that submission, thank you, that was provided to the inquiry. In terms of the acknowledgments at page 5, just if you could perhaps elaborate, Associate Prof Kerry Sullivan, who's a staff specialist, is it your understanding that he is a man with some probably 30-odd years' experience in child protection work?---Yes, he has an extensive clinical expertise.

All right. And Mr Phillip Trudinger, he's a clinical psychologist, you understand, with also at least probably 10, 15 years in child protection?---At least that, yes.

And Dr Sue Wilson, she is a very experienced child psychiatrist?---Yes, particularly in the area of infant mental health.

All right. Of some, probably, what, 20 years' experience? ---Yes, I would think so.

Yes?---I'm not sure exactly.

All right, doctor, if I can ask you then if we can go specifically to the submission. Firstly page 9 over to page 10, "De-skilling of the child protection workforce: at the second paragraph on page 9 Prof Munro's report highlights the value of a highly trained professional workforce. While there are many individuals with whom DCS" - you mean the Department of Child Safety here - "who are highly skilled in this work, they are not supported by a structure that recruits staff with no human services qualifications." What do you mean by the human services qualifications?---Specific tertiary training in the areas of social work, psychology, those sorts of areas of training that deal particularly with the psychosocial issues that child safety workforce are dealing with.

And you go on to say that, "The tendency to assess child protection cases with a superficiality which does not match the complexity of the issues under consideration can be seen at many levels." And you cite in the paragraph below that children where harm has been substantiated and in need of protection are often - are left at home under an intervention with parental agreement - an IPA. So you say, "Alternatively families may be linked in with a support service through referral for active intervention - RAI - but with very little, if any, assessment around the capacity is to engage with services." So is what you're saying really as you go into the paragraph nextly that there's a band-aid approach without really examining and understanding the underlying problem that has given rise to the acute situation?---Yes, that's my experience, that the assessment process seems to be quite rapid and without a lot of depth looking at why families have got to the point that there at. And there will be recommendations made for certain issues that may need to be addressed, such as substance abuse or mental health issues, if they are identified, but there doesn't seem to be a very comprehensive assessment about what the capacity of the family is to actually take part in services that can support them, to engage in those services and to affect change. And so quite often the impression is that there is a tick-box of recommendations to meet needs but no real assessment about whether the interventions that are going to be suggested a little work. I think often we see in families where there is really generational dysfunction, the issues have been going on for a very, very long period of time and supports that are put in a very time-limited.

While we see families can sometimes respond in that short period where there is a service involved, as soon as that service pulls out things start deteriorating again, so any gains that are achieved are often not sustained. So what that means is children - things improve, the services are there, the services pull out, things deteriorate, children are back into the child protection system again. There's some families where other agencies such as health or education have been trying to work cooperatively with the families for a period of time and not been able to engage these families and so there's a lot of knowledge about the families and the difficulties that they have, yet that doesn't seem to be taken into account. Quite often families - it's just going through a cycle of just repeating the same intervention again and again, so they will have multiple IPAs with no evidence of any sustained change.

Perhaps is there really inherent in that then not an appreciation that there may not be an ability to change those factors, to inter-generational issues?---Yes, that's right. I mean, I think in some cases - the other part of the assessment is the speed at which the assessments occur. So the department - a notification will be raised, the department will do their assessment, they will identify some issues, plug in some services and then they're out, so it's then over to an NGO who may be involved for a few months, and in some of these families it's fairly clear that these issues are very unlikely to resolve in such a short period of time. So it's quite often possible to predict where it's going to lead to, that they are going to come back into the system, and I guess the feeling for many of us is that if we can predict that why can't we do something to stop that re-entry back into the system down the track.

I suppose for the children, as you say, things improve for a while and they deteriorate, or indeed it might be that they're reunified and the reunification breaks down. Is that your experience as well?---Well, I think that's the other side of it, is if the assessment by the department is that the children are removed, you know, if that can be a short-term under a TAO while they're doing their assessment and then - again, the example I've given is where the house is found to be unhygienic and not appropriate for children to be living in. The children are removed, the family are given a certain amount of time to remedy that. It's remedied, the children are put back, and that's about it for that occasion, with no real look at why did the house deteriorate to that point in the first place and therefore how can we stop it happening again. So it seems to be quite often fix the immediate obvious problem but not look at the family as a whole over a period of time, with the background knowledge that many agencies know, to actually get a solution that is going to be effective in the longer term.

In fact, the input from other providers, if I can put it this way, such as health or education, will not necessarily occur unless it reaches, for instance, a SCAN level or what's called an ICM, isn't it, an inter - a meeting that can be convened, because in doing their assessment is it your experience that the department don't necessarily contact health or education to glean other background data?---They do to a certain extent.

All right?---So if we look at what happens outside of SCAN, the department will try to get some information, and so through the health system we will be - there will be 159 requests under the Child Protection Act asking for release of information that might be relevant.

Yes?---But under the 159 release of information the information that can be provided is fairly limited and certainly there's not really the ability to give a lot of interpretation with that information. So it might be a request to tell the department has this child attended our hospital, has the child come to the Mater Children's at any point of time. So we can sort of say, well, "Yes, they have on these occasions," or, you know, "This is their medical condition," but if we don't know the background very well it's limited as to how much we can give meaningful information to the department. So in the circumstances where we are aware of the family and we feel there's complexity, we're able to refer to a SCAN team meeting, but only if the information we have is at a level where a notification is going to be raised.

All right?---So it has to get to that level first. The ICM meetings which allow a lower level of concern that hasn't reached a notification, so according to the department is a child concern report, we can take a case to that meeting, but it's really quite ineffective, because they can only be discussed on one occasion and there's sort of this one opportunity where all agencies can bring information which then goes to child safety. It's not a meeting designed to actually look at a good support service for children.

Indeed, it's also the case, isn't it, that one of these ICM meetings, the department doesn't necessarily have to alter their view?---Well, the understanding of an ICM is on the basis that it's not there to challenge the child concern report, and so it's made fairly clear that that's not one of the outcomes. If we are wanting to take it to an ICM because we think there may be more information to raise it to a child protection notification, that's really not the reason they want it there. Having said that, if more information comes through that meeting that becomes more concerning that information needs to be reported back through the regional intake service and the regional intake service will again assess the information and decide - and review that new information to see if it warrants being raised to a notification.

How timely is that - - -?---If that – sorry.

Sorry, Dr Connors. How timely is that?---Not at all. First of all, we can't take it to a meeting until we get the outcome from the RIS as to whether it's a child concern report or a notification. Now, in theory that's supposed to be within five working days. Recently we've had child concern reports that have taken five weeks before we've been told what the outcome is. In cases that we're very concerned about we will agitate until we get an outcome, but in those ones that aren't quite that concerning we need to wait. We then need to wait for the next ICM meeting, so that could be another two-week delay, and then the agencies, the other agencies, it depends on how much notice they get before the meeting. It could come in the night before the meeting and they've got that night to basically get whatever information they can and there's one bite of the cherry, you get one chance to table that information.

COMMISSIONER: Why would it take five weeks to get the screening?---It's hard to know. I think – and I guess the RIS need to answer that question, but some cases - - -

You didn't get it – they don't tell you why it took so long?---Not particularly, no. In some cases it's because they're doing further checks and maybe doing some pre-notification checks. The ones that take that long are probably the cases of lower concern. So whether they're just being de-prioritised - - -

Prioritised?--- - - - within the system - - -

MS McMILLAN: But I take that for you, say, for instance, as a health provider, to raise a matter that you want to take to an ICM, it must have reached a reasonable level of concern, mustn't it?---Yes. Like, any report - - -

It's not a decision you take lightly?---No. Certainly we – it's only those cases where we would feel very concerned about the welfare of the child and that we're concerned that it's not a child – that it hasn't become a notification. Having said that, officially we can't take it to an ICM simply because we're worried it's not a notification. So we have to be able to justify that there may be other information. So if it was just health and child safety and the result comes back as a CCR and there's no reason to believe police or education would have any information, we can't do anything about that.

So you can't action any further, if you like, up the chain, particularly through SCAN?---Well, no, not through SCAN. The only way we could do that would be – and, look, we do this not uncommonly. Our first port of call would be ring the manager of the RIS and say, "We're concerned about this outcome. Could you have a look at it?" and try to have it reassessed that way. Ultimately what we are told is that

it's their core business and it's their responsibility. If we were very concerned we would escalate it further within the department. However, there's a limit to how many times you can take that approach so it would really be extreme cases of concern where we would escalate it that much. To a certain extent we're told it's not our responsibility and to leave it with Child Safety.

But in pages 18 and following in the submission you indicate - the submission indicates that on reviewing the 2004 CMC report much weight was put on the protection of children through a robust and accountable multiagency approach which is really what SCAN is, isn't it?---It's what SCAN was.

Was, right, okay. Then you further indicate in the submission:

> *The policy and procedure manual was written by all core member agencies providing a guide to SCAN teams to promote consistency which had been missing previously and then further on DCS appointed coordinators of all SCAN teams across Queensland. Unfortunately the new model was not fully embraced by the new DCS. The idea that the DCS was the lead agency meant that they alone were to make decisions about the safety of children.*

Now, just pausing there, is that really in your view where the wheels fell off, if you like, where DCS were of the view that they were the lead agency and they alone were to make decisions about the safety of children?---Yes.

And previously, am I correct in saying, the way in which it had worked was it tended to be more of an informal process as to who was the chair, if you like, of SCAN meetings and it was usually the most senior practitioner, and I mean by that it might be a police officer, it may be a paediatrician, depending on who was at that particular SCAN team?---Yes, there was some - and I guess that was the issue with SCAN back then prior to the 2004 inquiry, that there was lack of consistency and in some sites it wasn't really working at all. At other sites, say, there could be police leading it. Certainly at the Royal Children's Hospital and at Mater Children's it was led by Health so there were variations on the SCAN model at that time.

In your view, did it work well largely?---I think it worked well overall. I certainly think it needed some improvement and I wouldn't want to go back to that original model. At that time I think we held onto cases far too long and there was no clear identification of which cases were the best cases to talk about and I think that's the challenge. At the moment there's really very little guideline as to what cases would do best at a multiagency meeting and so I think to continue with a multiagency meeting of some sort there needs to be work around which are the cases that we can effectively improve outcomes for children with by utilising services of fairly senior experienced members of various departments and so it is a reasonably resource-intensive team when you look at the people that are sitting at the team, but at the moment I think it's really a waste of their time quite often. The reason for having those senior people is to utilise their experience and their expertise so that their opinions about safety and wellbeing of children is acknowledged, whereas under this model we're told very clearly we are not to have those opinions. Now, having said that, there are teams that ignore that sort of corporate line, if you like, and are working very, very well, but there is still - - -

When you say, sorry, the "corporate line", do you mean - is it your understanding that is the line, if you like, from the department?---Yes, that is my understanding. I think under the new policy and procedures there's a very limited ability for the utilisation of the other core members to the best of their ability to feed into advice about the safety and wellbeing of children because the closure criteria means that the cases can be closed before we have any information back from Child Safety as to what their assessment is. So if we don't know what they've found, it's very hard for us to feed into that. Now, having said that, there is a provision that - so it will close there is a provision that they will then bring back an outcome when they finish, but that is often after it's all done and dusted so they may come back and tell us what their outcome was but there's no way we can then feed into that.

Or change the view?---Yes, that's right. So they may have finalised their assessment on the basis that the child is engaging with Mental Health Services, whereas we would be able to tell them that in fact the child isn't attending Mental Health Services. Yes, they've been referred to Mental Health Services, but by then to feed back that information the department have finished and have finalised.

Then from really what you're describing it's a fairly futile exercise in many cases?---In some sites. There are other sites that very much work to the best interests of the child and allow a free and full discussion; are very appreciative of the expertise of clinicians at the table. However, I would say that's because of the goodwill of the people, not because of the structure of the system.

I was going to ask that. It seems to very much then from what you have described - the success of it really rests on the personalities involved and how they function together? ---Yes.

Is it the case that prior to the most recent iteration of SCAN that they had formed an important educative facility? So, for instance, if you had a young, fairly inexperienced child safety officer, if they had someone like yourself or Dr Sullivan who are very experienced paediatricians, that often performed a fairly important educative role for them? ---Yes, I mean, I think that the other side of SCAN was the relationship building that occurred between the different core members and that ability to have Child Safety staff attend for their case so that not only was there an educative process there but it also meant that you could put a name to a face and that sort of thing and that actually makes a really big difference. So you could have then members of - you know, outside of SCAN you could have - it's much easier then to pick up the phone and say, "Listen, can I just talk to you about something?" I think in SCAN teams that work well those relationships have been

built.

In fact, is a further import, if you like, of that - working well is that particularly for, say, a young, inexperienced child safety officer if the matter has been to SCAN, that also no doubt perhaps gives them a level of reassurance that the right decision may have been made because they have the input of, say, someone such as yourself, maybe the police, maybe education, particularly if they're making a very difficult decision?---Yes. Look, I think that certainly should be the case. One of the issues though is that the communication that occurs within the SCAN team - in some sites there have been real issues with that communication going back to the officers working with the children. So a lot of very good quality information and expertise is provided at the SCAN team but the CSO doesn't necessarily get that information.

Fed back to them?---Yes, so that's certainly something that can be very frustrating for the SCAN team when it comes back for review two weeks later and the question from the CSO to the team is the information we gave two weeks ago.

Right?---So, you know, that's another layer of complexity of making sure that if you've got a multiagency approach, any information sharing that occurs there actually translates into the case management.

How practical would it be for those child safety officers to be there at the meeting who are responsible for that particular case?---Look, I guess it depends on the workload at the time and it also depends on the approach of the manager of that Child Safety Service centre where the SCAN team meeting is occurring. I guess my experience has been that there's some managers who are not really supportive of SCAN; who see it as just an extra layer of paperwork; feel very happy that they can get the job done without having to have that meeting; who don't want their CSOs to be using their time sitting in on an a SCAN team meeting. There are other officers - Child Safety Service centres that very much value the SCAN team and encourage their CSOs to attend whenever they possibly can.

Now, some of the recommendations made about SCAN at page 20 - you obviously recommend 8.1.2. When I say "you", I mean yourself and those who collaborated on it. The team representatives come together as equal partners. That obviously makes sense from what you've just indicated.

The further recommendation is, "SCAN meetings are coordinated and chaired by an independent body." Who would you have in mind is being appropriate to do that?---I'm not sure what the answer to that is.

Right?---Certainly the Children's Commission perhaps.

All right?---If that was possible for them to take that on, but I'm not really sure of whether that is an appropriate suggestion. But I think one of the problems in having the coordinator and coming from the child safety service centre, particularly when you have a SCAN team which is quite resistant to the full sharing of information, that the coordinator really acts on behalf of child safety, so.

And Other Collaboration at 8.2 and the recommendation that's made there, what do you understand -if I can put it this way - are the road blocks to getting good quality information? Is it perhaps a lack of understanding of the confidentiality issues, or what is it that means that there's not a proper flow of useful information?---I think at the moment with child safety setting themselves in the position of the lead agency, they receive information into them, but being the health component of a complex situation, we provide them information; they will feed back some information for us, but we need to know what Education knows and we need to know what Police know so that we can put together a response and supports for the family that are appropriate and well thought out. And the best way to do that is to have everybody together, and that's where the multi-agency approach works the best; whereas certainly even just recently I had a response from one child safety service centre when the referral to SCAN saying, "You can't refer a case to SCAN just to share information." Well, until we share the information you don't know what is needed in the way responses and support and what you can provide or suggest.

Or what the risk is, one would think?---Yes.

So from what you say really there should be a proper ability of each of the agencies to share what they view as useful information prior to and including the SCAN meeting, wouldn't it be?---Yes.

Because as a paediatrician I imagine one of the important roles you have is interpreting that information?---Yes.

So if you're putting together information about schooling - and you in fact give an example in one of your case studies, don't you, about a child who was failing to thrive, putting it at the very least, and there were good signs in Education that this was happening - as a paediatrician you'd want to pull that together, wouldn't you, and say, "Well look, developmentally this child should be at this age. There isn't any physical reason why

they're not achieving." And you have a very important interpretive role, don't you?---Yes, that's right. And what used to happen in full discussion at the SCAN table was we would identify that child needs a medical assessment or a developmental assessment and we would do that assessment with the full knowledge of the background of the family and what the concerns are; what we tend to get now is a referral from child safety with a couple of lines giving us very limited background on the child, the child will then come to their assessment, perhaps brought by a child safety support officer who's transported the child to us, they can give us no history, very little information, and so what we can achieve them in doing an assessment about that child is extremely limited.

Perhaps if I take you to - at the moment case 4, Mr Commissioner, in the studies - this was a child referred to SCAN; Education was concerned that the parent of the child had presented the child with significant medical concerns and a health plan which had severe restriction on that child's life including, one would think, very intrusive issues such as tube feeds via an abdominal stomata at school, long periods in a wheelchair and no play with other children. Apparently there'd been no ability to verify that the medical practitioner and because there were inconsistencies in what the child was doing and saying, Education became concerned. Correct?---Mm'hm.

Dr Connors, you tell me if I'm asking you anything that you think will identify too much about the child. But the point was it went to SCAN and it was screened as a child concern reports. Correct?---Yes. This case was prior to the current SCAN team so the point of this case was we could talk about this case while it was a child concerned report, which enabled us will work together to develop a plan which would make sure that that were these restrictions reasonable, where they not? We could offer a service to assess the child, and because of then the fact there was failure to engage, child safety were able to then identify that there was risk of significant harm and raised into a notification.

I was going to ask you that. And indeed it seems like there was a good outcome for the child?---Yes.

That the restrictions were effectively lifted, et cetera? ---Yes.

But is your point that under the SCAN model that wouldn't be able to be resolved in that manner because it wasn't elevated at the time of all of those levels of concern - - -?---Yes.

- - - at a notification level?---Yes.

Thank you?---That's right.

Now, in terms of the skilling, going back to the workforce, page 10 of your submission, "Support be given to the establishment and retention of highly skilled child protection workforce for clinical judgement based on this expertise is valued over screening tools." Now, in your view should there be some sort of postgraduate course or training which would include for child safety officers, an understanding of developmental - for instance - stages for children?---Yes. I mean, I think certainly formal training across a broad area is essential but I think what's missing even more so is the actual experience and in building an actual workforce that's got experience from mentoring and training by being shown on the job how to do and how to assess these complex cases more effectively. You know, I think we see very - probably one of the most difficult areas, I think, is around assessments of newborn babies and potential removal of babies soon after birth. You've got a very short timeframe to make an assessment. It is obviously a very distressing process for everybody involved, and yet we see very inexperienced child safety officers doing those assessments and progressing with removals. And certainly they're not making the final decision, but they're the person on the ground who is dealing with the parents.

In fact I was going to ask you, there's been some evidence from a solicitor who undertakes separate representation for children in child protection matters that in fact the apex should be upended, that the most experienced workers should be doing things like TAOs and CAOs and including, obviously, newborns; and the least experienced should be on the long-term guardianship orders where there's less day-to-day matters and particularly important, often urgent, decisions made. What would you say about that?---Yes, I think that makes a lot of sense. But certainly that needs to be more mentoring and demonstration of skills to be able to do assessments and to do psychosocial assessments. And the other area is interviewing of children, which a lot of the CSOs seem to have very little training and experience in. And again, that's something that comes with ideally watching somebody with the skills to do it, show you how to do it. And I don't think you get that from tertiary training courses, although obviously they're important too.

COMMISSIONER: And from what I've gathered from other witnesses as well is yourself, do you really need to be focusing on the infants, on the ones who are one to three and around that, their developmental needs, that's what their highest need is right there and then?---Yes.

And you need to understand the stages of development to do that, presumably?---Yes. I think to a certain extent child safety know that those things are important.

Yes?---But then it's to be better integration with other experts who can actually feed the correct assessments to

them, rather than expecting child safety are going to do with the assessments. You know, it's not uncommon that child safety will go out on a home visit and in the report say, you know, "Child well attached," and often my question would be: on what basis that they make that assessment; and what's their expertise in making that assessment?

They've, you know, seen the baby for about five minutes while it's asleep in the mother's arms, or something, or the baby has made eye contact with the mother, and to me that's a huge statement to make.

And it could be misleading?---It could be misleading.

Then perpetuated, because everyone acts on the assumption that it's correct?---Yes, and so while I think they – and similarly with development. They make very quick decisions, often, that they're not concerned about a child's development, whereas we, just hearing the background of the family, would say we actually need to see that child and actually make sure their development is appropriate. So, I mean, it's good that they know what are the issues to look out for, but I certainly am not suggesting that they suddenly become the experts in all those areas.

Yes?---Particularly in the area of attachment. Recently one of the – a senior child safety person asked me could I see a baby who was very, very distressed whenever it was in the child safety office. This child had been removed early in its life so it had had a fairly rocky start for the first few weeks to month and then was taken into care, was unsettled initially and then settled beautifully with its carer, but what was happening was the baby was coming to the office for contact visits, removed from its primary carer, the foster carer, who it had developed a very good attachment with, very happy in that environment, plucked from its primary carer to sit in the child safety office for its contact visit with the biological parent, would cry the whole time it was there, would cry the whole time it was with the biological parent, return to the foster carer happy, and the question was what is physically wrong with this child. Now, clearly it wasn't a physical issue. So even though they know about attachment they couldn't understand that a baby that young, the issue was it was being removed from its primary attachment figure. Now, that was causing distress to the baby, it was causing immense distress to the biological parent.

Parent, because she was feeling - - -?---So to maintain the attachment and bonding – in fact, what was happening was actually undermining that completely.

Well, you might come to the conclusion that the best interests of that child given that was not to have any more contact with the - - -?---Or to allow the foster carer, perhaps, to be there.

Well, that would be the better decision?---To soothe the baby.

Because that would be the root cause of the problem. You've identified it correctly and you've resolved it. On the other hand, on the same body of evidence, a different mind might conclude – might overlook the real cause and conclude that contact is not in the best interests of the child because it's distressing the child, and then that would be the wrong call to make?---Yes.

But equally available on the same body of evidence?---Yes,

that's right. I mean, certainly the issue needs to be about very appropriate contact.

Yes?---Yes.

MS McMILLAN: Whereas just in general parenting terms it's fairly well known, one would think, in the general community, that, for instance, young children, babies of a certain age, removing from their primary carer even to a close relative can cause distress at a particular developmental stage. There's absolutely no issue about the parenting or that family figure, it's simply a stage of that baby's development, isn't it?---Yes.

So, you know, as the commissioner said, the difficulty is that there could be a range of outcomes on those observations. All right. In terms of the multi-agency investigations, number 11, page 24, it's highlighted there that there's a lack of consistency around multi-agency investigations, with no guidelines for best practice and it says that there's several researched based interview protocols which are used in the UK, Sweden, Canada, Israel and United States. Now, you would understand that there's the ICARE interview process which is utilised by the police. In your view, how reliable do you think that is as a model for eliciting information from children?---I'm not sure what quality assurance is done around the ICARE model. My experience is that for particular child protection investigation units not all of the police workforce will be ICARE trained, or if they are trained there's often a member of that CPIU who takes on the role of being the interviewer and improving those skills. So if that person is not there you may have interviews being done by people with far less experience. I think my understanding with child safety is they can do the ICARE course but they don't have to do the ICARE course and a lot of them aren't released to do the ICARE course.

Yes?---Also my understanding is that once they've done it, that's it. So there's no quality assurance about their interviewing techniques or more professional development and support around that. I think it's an incredibly difficult task to be doing child friendly effective interviews and certainly members of police that I've spoken to, the idea of having a specialist interviewing service where you've got maybe less number of people doing more interviews individually and having a lot of professional development and peer review would be something that they would welcome. So I'm less clear about how much of an issue it is within police, but certainly when we see child safety officers, again often very inexperienced, coming up and doing interviews with children, there would be questions about the level of training and support they've had to do that.

If nothing else, there should be a standardised type of training, shouldn't there, across Queensland Health, Child Safety and QPS, one would think?---Well, I guess the decision is who should be doing forensic interviews, if you like. So from an interview point of view certainly, you know, we would just do what we would do in our normal practice with talking to children. I guess in paediatrics we're used to talking to children. Our social workers are trained to be talking to children. So certainly there are skills that could be used, utilised, in training with the other services, but, you know, there are, as we've talked about here, models of training in interviewing which may be worth looking at.

All right, thank you. Is that a convenient time, Mr Commissioner?

COMMISSIONER: Yes, it is.

MS McMILLAN: Thank you.

COMMISSIONER: We'll make it 2 o'clock.

THE COMMISSION ADJOURNED AT 1.04 PM UNTIL 2 PM

THE COMMISSION RESUMED AT 2.03 PM

COMMISSIONER: Ms McMillan?

MS McMILLAN: Yes, thank you, Mr Commissioner.

Dr Connors, if I could just take you back to page 9 for a moment of the submission, it's under the heading of "The Deskilling of the Child Protection Workforce". It says:

> *There has been a demonstrator by an increasing reliance on structured decision-making, SDM tool, and deskilling of the professional workforce.*

Then onto page 11 at the penultimate paragraph:

> *Is frequently followed religiously, the structured decision-making tool, with outcomes that are difficult to understand. Further comments have been made along the lines that the worker would like to come up with another outcome but the tool says, "No."*

Now, could we go to the first case study, please, and again as best as you're able without perhaps identifying the particulars, can you perhaps walk us through that one? ---Yes, I suppose maybe to avoid the particulars of the case but I think that's a typical example. I don't know how much you need me to go through it. Everyone has got a copy of it, I think, but from the point of view of the child that was felt by Health to be at extreme risk with risk of potential suicide where Health was unable to identify really any protective mechanisms - and in contacting the RIS who shared our concerns but said because it was emotional abuse, the tool only allowed it to have a 10-day response, even though it was quite an extreme emotional harm risk and so it was - the conversation was then around, "How do we get around that?" because there was really very little option and quite a senior member of the RIS team expressing her concerns and sharing my concerns but saying, "The tool says 10 days basically."

COMMISSIONER: Can't it be overridden by commonsense? ---Well, that's what we are told, that it can be, but that seems to happen less often and I guess that's - my concern is that we don't see a lot of evidence of overriding with the use of professional judgment. So to get around that case it was referred to police to do a welfare check.

MS McMILLAN: Did that then accelerate it, the police doing a welfare check?---I'm not sure what happened from then but from the point of view of when Child Safety then became involved - I know they did become involved but I'm not sure on what the time frame of that was after that.

Is it that they became involved because the police welfare check would have precipitated that?---Look, in this particular case I'm not sure but certainly if police went out and found anything of concern, they could then put in another report which might mean it will be rescreened and I guess it depends on whether you rescreen it as a risk of physical harm which might get you a quicker response or you go down an emotional-harm pathway again. So it's how you work with the tool rather than really just using what would seem to be pretty obvious sound, professional judgment, and I guess we hear a lot about the time involved in negotiating the SDM tool with reports coming in and I wonder in some cases, as in this one, whether a lot of the time is trying different pathways to get an outcome that a professional child safety worker knows the outcome should be and so they're massaging the tool to get to that. I don't know, but it seems to me there would be a number of cases where on the level of the information that's provided the response is very clear what should happen.

Because it might well be that emotional harm is far more urgent in many cases such as a child expressing suicide ideation or self-harm issues from perhaps necessarily a physical risk. Correct?---Yes, I mean, I think each case needs to be taken on its merits and, as you say, it comes - you know, I think quite often it should come down to the professional judgment based on the information that is provided. One of the struggles is that quite often there seems to be a need for us to be able to demonstrate actual harm when we're not in a position to know that. We may have limited information and so we're - because of our experience and expertise knowing what certain risk factors lead to, we may well be able to go - we are very concerned that there is significant risk of harm and we're often asked to - you know, the outcome will be a CCR because there is no harm demonstrated yet and while I think that's appropriate in some cases, there's other cases where the risk in fact is so significant that it seems very unfortunate that we have to actually wait until the harm occurs.

COMMISSIONER: That seems to be a misunderstanding of the meaning of "harm" because "risk" itself is defined as "harm". So while we talk - I haven't got the act here, but while we talk in terms of past harm, present harm, future risk of harm or risk of future harm, the act defines "harm" as if it includes risk of harm if it's unacceptable. At an unacceptable level risk becomes harm itself, doesn't it? Am I right?---Mm.

Because emotional harm is so illusory - it's not illusory. It's hard to identify; to draw a picture of. In a situation of someone who was suicidal, then clearly she has suffered harm because there's an unacceptable risk of harm, physical harm?---Mm.

So you don't have to worry about the emotional harm. It's the cause. Actually it's driving the unacceptable level of harm to - physical to her life?---Mm.

So interpreted that way it would be an immediate turnaround rather than a 10-day category, wouldn't it? Isn't that how it works?---Well, one would hope so, but I guess this is what we're often confronted with.

Semantics?---The reason, my understanding, for the structured decision-making tool was to have a more consistent outcome rather than leaving it up to - - -

A consistent one rather than a right one?---Well, yes, one would hope it would be both but I think when the SDM tool was put in, to me part of it was driven by accountability and a risk-averse approach for the department so that by using a structured decision-making tool they could account for their decision by saying, "I followed the tool."

Yes, sure?---So I think it wasn't risk averse about harm to children. It was risk averse about the department being accountable for it's decision-making.

Yes?---So by following these tools it can be shown, "Well, if something turns out that that was the wrong decision, we followed the tool and that's where it led us."

Yes, that's what I mean about when I say it's more about doing the thing right rather than doing the right thing and it's probably better to have looked at a model that instead of being structured as being sound. So it's sound decision-making and you might have a tool that helps you with that, but again it's just a tool?---Yes.

It's not the only way to do the job?---Yes, and I think in fact the people who designed the tool - it was supposed to be just a tool to assist in decision-making but very much still based on experience and sound practice.

MS McMILLAN: In terms of training I asked you whether you were on the view that there should be postgraduate training. Do you think it should be actually undergraduate education about, for instance, developmental milestones and issues if you're going to work in the child protection sector?---Look, I'm not sure exactly where in the training it should occur but I think they definitely - workers in the system need to have that broad training.

What do you think of the view - obviously team managers - I mean, you would be familiar with their role. There has been some suggestion in the evidence that there might be good reason to have them accredited so that they have a sufficient level of ongoing training and expertise to guide presumably the less experienced child safety officers under their direction. What would you think about that?---Look,

I think that fundamentally makes sense. Again I think what it comes down to - if you're having somebody in a leadership role, you could have someone who's done a whole lot of courses but actually has had very little experience on the ground and I think to advance into a more senior role where you're making more significant decisions and you're mentoring, it's about what you're experience is, I think.

So certainly matching that with some formal training sounds like a very good idea, but the risk of getting too focused on training and certificates and what have you is that - - -

Without the on the ground experience?---Yes.

Can I then move, page 15, to newborn and perinatal period. You mention about babies at high risk where a TAO will be sought. Now, clearly the hospital can take out a care and treatment order, which is 72 hours long, isn't it?---That's correct.

But it's not your view, is it, that it should be taken instead of a TAO properly obtained? Is that correct? ---Yes. The care and treatment order provision is really quite an extraordinary power for a non-statutory authority such as health to hold and should be used very, very rarely and is really there for the time when something occurs with no ability to plan for it. You know, a child comes into the emergency department with injuries or with a parent who is behaving in a very concerning way so that you are left thinking if this child was to leave the emergency department now they're at immediate risk of harm. That's the provision of the care and treatment order, is it has to be immediate risk of significant harm for us to use one.

So I don't think it should be used as an alternative to appropriate statutory intervention, so that in the circumstances where quite often we know this baby is going to - that a TAO will be taken before the baby - once the baby is born, or in other circumstances, there is high risk and the department will be assessing at the time of birth and will decide very quickly yes or no about a TAO, then it's their responsibility to take the TAO and not default to health, who is not a statutory authority, to intervene.

Have you in practice found that that has happened, that there has been, as you've experienced, a default setting, if you like, where it's been expected certainly at Mater, under your stewardship, if I can put it that way, that the hospital should be taking out the order rather than the department?---Yes, commonly.

Sorry?---Commonly, particularly after hours, when the child safety after hours service are physically unable to attend after hours. We will have children who have come in with significant injuries. There's actually no orders around that child restricting access and the department's response will be, "Well, if they try to leave use a care and treatment order." However, my concern would be that the department have all the information we have and they're not choosing to do that, so really is that the appropriate use of a care and treatment order? I would think we would probably be in breach in the use of it when there's actually ample opportunity for the statutory authority to intervene, so why are we intervening as non-statutory authority? The other issue is - - -

COMMISSIONER: That's because you have the responsibility and risk if you do, I suppose?---Yes. I think the other issue, after hours, as well, while we're on that area, is that quite often after hours if the department does

acknowledge that they are the ones that act, is asking the health practitioners to actually serve TAOs on their behalf. Just recently we had child safety after hours asking a ward clerk to get a family to sign a voluntary care agreement. So it quite often is very inappropriately - the responsibility is shifted to health staff to carry out those functions.

MS McMILLAN: I take it would there be good reason why in your view the hospital and health doesn't want to be put in the position of being the statutory intervention authority? ---Yes, because we're not a statutory authority. I mean, basically we are a health service and we need to maintain our relationship in providing a health service to the family, to the children that we see, and while we're more than happy to assist the department, I think it shifts our position enormously with families. This is particularly so in say hospitals outside of Brisbane where the treating clinician will be the one who will have to do the care and treatment order, and I think that really undermines the treating relationship between health and the family who we are trying to support, and then if we're seen to be ones intervening in a statutory way I think that really undermines the health relationship.

Thank you. We've heard some evidence in other locations that with temporary assessment orders and newborns that it is not uncommon for either the police to be asked, because it's after hours, or indeed hospital staff, to serve TAOs upon a mother who has not long given birth. Do you have any experience along those lines, or is it a contrary experience?---Yes. No, that does occur, and unfortunately assessments and decisions are made over the phone. So it's not uncommon that we will get a call from the maternity ward saying, "We've got a mother who is extremely distressed who has just been told that the department are having the baby removed and they want the hospital to serve the TAO." So, you know, to make those assessments and to inform parents of that outcome over the phone certainly doesn't seem appropriate to us.

One example we heard of, a young intellectually impaired woman who gave birth and the baby was removed and it was left to the hospital social worker to both explain the effect of the order and deal with her distress. How common is it, this sort of situation, where either the police or hospital staff are to your knowledge involved in having to serve and perhaps explain orders to newly delivered mothers, if I can put it that way?---It's not uncommon, let me put it that way. Certainly the request to do it is not uncommon. We don't. We won't do it, so it doesn't happen, but certainly requests for us to do it - you know, yes, it's not uncommon, and it's also around, as I say, the quality of assessments, around that, and it's around the experience of the workers that are coming up. So even if they are there it's again not uncommon that a very

inexperienced worker is asked to come up and serve some sort of order, a TAO, or get a voluntary care agreement signed, and the conversation is very limited. The parents are served, the worker leaves and then the social workers pick up the pieces. Quite often the family don't really understand what has just happened. It has all happened very quickly, and again, it's about often, you know, the experience of the worker who is put into that position. I think it's very unfortunate for the worker as well that they're put in that position.

Indeed, does that resonate with your earlier answer that the much more experienced officers should be placed doing this sort of work?---Yes.

Rather than young, inexperienced officers?---I think there needs to be people available after hours.

I was going to ask that. That's the next issue. Do you remember a time when crisis care was actually manned, and I mean that people were available to attend after hours? Were you - - -?---Yes.

Yes, I mean, was that – some of us show our age by that? ---Yes, quite a bit.

But do you think that was a far better system in terms of facilitating not just this situation but generally after hours child protection issues?---Absolutely. Even just the other weekend a baby with abusive head trauma comes in Friday night. Child safety don't actually meet with the family until some time Monday. That's not uncommon. So they will be managing it by phone, they will have police starting an investigation, but, you know, I would argue that police have their role in the investigation and child safety have their role and they're not completely interchangeable. So you've got, you know, 48 hours plus until child safety actually meet with the family.

If they indicate, particularly through SCAN, that they're the lead agency in child protection matters, then wouldn't logic dictate that they take the lead?---One would hope so.

A recommendation in the submission is the possibility of a TAO being issued prior to the birth of the baby to avoid the flight risk issue. I take it then that would remove some of the distress and lack of comprehension on behalf of perhaps mothers and indeed their family as to what was happening?---I think that recommendation obviously some issues with it.

I think if it would have to be - I think if most parents realised that the baby was going to be removed at birth - so if they were informed that at TAO had been taken - there's a huge possibility they won't come to the hospital to have the baby. And that's putting the mother and the child at significant risk. So I don't know about the logistics of it, but very often everyone knows a TAO is going to be applied for and the baby is not going to be going home with the parents. But under the current situation we still have to wait until the baby is born, which could happen at 2 o'clock in the morning. We have no way of securing the safety of that child. Yes, if before child safety had a chance to act we could use a care and treatment order if they were about to leave and there was no opportunity to do anything else. However, we may not be aware they're going to leave. So, you know, certainly normal discharge these days is less than 24 hours, so there's a very short timeframe in which the baby's security can
be - - -

So 24 hours, is that in the public system?---Yes. It would be quite common for discharge within 24 hours.

I suppose that has implications, too, in new mothers being able to learn some of the basics of parenting?---Yes.

But I imagine that's a feature of funding issues and availability of beds, I imagine?---And, look, it's a common practice for mother's to go home. There is home visiting midwives. If it's a 24-hour discharge there is follow-up at home for a couple of days. And a lot of mothers much prefer that, to be at home rather than the hospital at that period of time.

Do you have any other suggestions on how to resolve what was clearly a very distressing situation in terms of newborns and TAOs? Do you have any other ideas you could offer to perhaps address this?---No, apart from at the time having, as I say, experienced people who can adequately explain to parents why the action is being taken and fully explain to them what their rights are so that they have a full understanding of the process. But also having an understanding of when they will see their baby again, what contact provisions will be made. Often there's very limited discussion about that. At times that can be very difficult if the mother is so distressed. She may not be able to have that discussion.

At that time?---Yes. So, you know, I think it needs certainly a lot of planning and discussion around it so there's good communication. Under the unborn child high risk alerts, if we have those at our hospital within our SCAN catchment we will actually try to have those cases discussed at SCAN so everyone's got a good understanding of what's happening with the family, so hopefully we can do

some planning around it.

And you might be able to, for instance, by that discussion, I imagine, identify another carer - kinship carer or something of that nature - because of the knowledge of the family, for instance?---Yes. Or what supports might be available.

Available?---Yes.

All right. Now, can I ask you, just in terms of saying with those early years, page 16 and 17 of the submission. We've already heard some evidence - and I think you heard at least some of Dr Stathis's evidence this morning - his evidence was that it seems that it's fairly well accepted that attachment issues are crucial because as you say here it impacts on brain development. That's well accepted, I understand - - -?
---Yes.

- - - in certainly your world as well, is it?---Yes.

Paediatrics. And the flip side is as the submission talks about securely attached infants and the advantage they have; the disadvantage is obviously behavioural learning difficulties, but we've also heard that it very much impedes the brain's development. And you'd be aware of Dr Hoehn?---Yes.

Yes. And she, like this submission, talks about, "The foundations for secure attachment are laid in the first three years of life." So in terms of this issue and from earlier in the submission there is that idea that you've raised that if in fact at times the child's interests are subsumed - these are my words - really to the least intrusive option?---Mm.

Now, that being the case, is it your view that where there are issues that are perhaps not resolvable in three to six months with parents, even with support, that one should look at some sort of permanent placement within those first three years?---Yes, a permanent placement for the initial three years, yes. Sorry, I was thinking were you suggesting long-term placement at that point?

No, well that's what I - - - ?---Certainly consistency for the first three years.

Right?---Yes.

And is it your experience that if there is that security of placement, that the child may well then be able to attach down the track to one of their biological parents?---Yes, I think that's what the literature tells us, that if children are able to establish secure attachment in that first three years, their ability to develop future secure attachments

is much enhanced, and so it's probably - rather than having a child going through a roller-coaster of disrupted attachments for that period and then try to do reunifications down the track where you've almost set that up to fail because by then the child will have great difficulty in developing secure attachment. So if it's got right at that point and in that period the family have been supported to deal with issues and it's seen that it's appropriate to then reunify, hopefully you've then got an emotionally healthy child and parents who are in a much better place, and reunification hopefully should go much better, but again needs to be done, as we were talking about earlier, in an attachment-informed framework. So you don't just suddenly go from here to there, that's it's a transition that happens over time.

COMMISSIONER: So the primary need of a child in the first three years of life is stability and emotional, psychological attachment?---Yes.

And so the psychological parent in that first three years has to know how to achieve that, and if that is achieved, then the child after three - again if it's done properly, sensitively - can attach psychologically and emotionally to someone else, including a natural parent who they haven't had the chance to attach to or bond with in the first three years?---Yes.

MS McMILLAN: Can you tell us the distinction between attachment and bonding?---Attachment applies to the child forming an attachment to a primary carer; the bonding tends to refer to the parent who bonds with their child. And clearly ideally you want both to occur, that the child attaches to the parent and the parent bonds with the child and they stay together. That's obviously the ideal. So I think it helps to think of them both separately so that when you're working towards hopeful reunification you can maintain two things: one is the ability for that child to develop healthy attachments, and for that first three years it needs to be a significant other, but I don't believe it needs to absolutely be the biological parent if they can't provide that sound base; if the plan is for reunification, maintaining connections with the biological family I think is important, but it needs to be done in a way that is not undermining the attachment. So thinking of ways to maintain contact through photographs, whole lots of different things. Obviously there will be variations depending on the cases as to how appropriate contact can be. And hopefully there can be very appropriate contact without breaking down that attachment. But the focus needs to be on the primary attachment of the baby.

And do you think from your interaction in general with the Department of Child Safety and these then early years, that that is well understood, the absolute importance that one attributes to that stability of placement?---No, I don't

think so. And I think the other area where it's not well understood is probably the magistry. I think at times the focus appears to be on the needs of the parents to maintain contact with the child and there certainly have been orders made of really quite regular contact which can be quite disruptive to the child at times. So, you know, I think there needs to be a lot of work done around getting attachment-informed processes understood and established really.

So you may have heard I asked Dr Stathis about those issues. If you're making a decision about removal of a very young child for at least, say, till three years or thereabouts or perhaps even longer, there clearly needs to be some very thoughtful and, one would seem, high-level expertise in terms of material gathered either from someone like yourself or Dr Stathis or whomever?---Yes.

Do you think there's merit within the Children's Court of having something where that resort that currently exists to expert assistance is either to someone which is headed by a consultant paediatrician or consultant child psychiatrist? ---I think the fundamental concern about making a decision that a child is not going to be placed with their parents for at least three years means that there has to be a fully comprehensive assessment about that. I think that includes a very in-depth psychosocial assessment which is the domain of the Department of Child Safety which includes assessment of capacity for parents to change, identifying the depths of the problems they have, what resources can be put in there, all those sorts of things, so what can be mitigated and what can't. I think a multiagency approach to looking at all the factors that are playing into that family and particularly - you know, that family may have older children that have been at school and again that's where I think the expertise of a SCAN team structure can be used very effectively and then through that it may be possible to identify that there are particular experts that could be called upon to do an expert opinion to assist the court. So it might be that a psychiatrist might be the appropriate one for a particular case. It might be a forensic paediatrician for another case, but I think by having a group of experts at least consider, "Where are the gaps? Where do we need to get information and assessments?" then we can, you know, hopefully get a much better understanding of capacity to change.

So if you're putting resources in at the front end basically, that is, doing a very thorough assessment, you're making a call at that time: is there a capacity within this family to change to address these issues or is it of such a nature and so chronic that it is unrealistic for them to be able to do that?---Yes, and I think what I tend to get a sense of at the moment is that everything - we need to making decisions and so we're confronted with a set of facts around the birth of a child, decisions are made within a fairly short time frame and then if there's risk perceived, a two-year child protection order will be granted perhaps with constant efforts for reunification across that period of time, but, you know, rather than sort of a rapid response at the beginning really being able to get that right and know that whether it is appropriate to go for reunification or you actually get that stability. I think one of the issues is that often we're looking at babies who are obviously very vulnerable and I think that cohort - very challenging and the consequences of removing newborn babies is obviously a huge consequence and it is driven by that vulnerability of the children. What we don't have are facilities where perhaps we can get a better assessment of capacity to change; parents' capacity to prioritise the child, et cetera. There are very few facilities available that would allow that to happen. There are some but not many.

Such as?---There's St Mary's and - I've gone blank. There's another - Mercy accommodation, but they're all limited in what they can provide. Some will only allow mother and not allow the partner to be there, et cetera, so there's not a lot of flexibility and also there's usually a waiting time until you can get into those facilities. So removal needs to happen immediately, then there's disruption, the child goes to a foster carer, then try to get a residential facility, but they're really quite limited. So, you know, it may be that there needs to be thought given to how to allow those really full and comprehensive assessments to be done and there won't be a one - you know, the one response for everyone. I think everyone is going to have their individual needs, whether they be mental health needs or drug and alcohol needs, et cetera, but I think certainly there needs to be a lot more work done about how to get that really good quality assessment.

And obviously a proper assessment, one would think, of the particular risk given the very high vulnerability of babies and young children?---Yes.

You've had experience, I understand, of the perhaps not proper understanding of the risk to a young baby. Is that correct?---Yes. I mean, again it's around the assessment and at times I guess we're left being very concerned about babies going home where we perceive there's significant risk and sometimes in looking at that there's certain again tick boxes that are ticked to say it's, "Okay. The child's been referred to child health," and all these things are being done, but there's actually no assessment about whether they're going to accept those referrals so, yes, it's a very vulnerable time.

All right. In terms of medical needs of children in protection, page 13, it's predicated that children who remain home could be argued are in need of more with the same support as out-of-home children. Now, with respect, that makes a great deal of sense because they're still in what was the original risky environment, if you like, or in fact substantiated harm environment. Do you think that there's merit in terms of having some child health passport even if they remain at home so that there has been some thorough assessment of them?---I think there's merit in having a comprehensive medical assessment of them. The child health passport, I suppose, is really developed to be able to carry on or carry forward medical information about a child so while they're remaining with their family, they still maintain the background information about a child. So when the child goes to a medical service, the parents are able to say, "This is the family history. This is the child's history." So separating child health passports from screening or assessments about the child's needs, be they medical, be they emotional, I think those - you know,

children who are deemed in need of protection, whether they be at home or in care - certainly there's lots of documentation about the high needs of that cohort. We don't provide a service within Queensland Health for either of those groups. There's no routine or no consistent approach to these children having their medical needs met. So at the moment there's a primary care model so foster carers are asked to take their child to a GP and there are some tools that the GPs can use, but there's never been a lot of support to GPs for that and there's certainly no pathways for prioritising the children should they be identified as having needs. The other part of that is that - sorry, in addition to that some health facilities have used their resources to create clinics for kids in care but it's very ad hoc. The other part of it with our experience is that when we do see these children and do screenings of them and create a health plan, there's not - it's not a given that that health plan will actually be followed. So I think there needs to be greater coordination of the health care of this group with someone who can actually - and I can understand the difficulty. When we've created a health plan, it goes to Child Safety. It will sit on a file.

Even if they are trying to action it I can understand that at times they may have difficulty negotiating the health system. So I think having like a health case manager for the needs of these children, someone who can coordinate the health plan - - -

So where would that person sit?---It could be within health, it could be within child safety. I'm not sure, but there needs to be someone - - -

So someone who liaises, effectively, to achieve those outcomes?---Yes.

That would go for both children remaining in home but also children who are out of come care?---Yes. I mean, the children that are remaining in home I guess – yes, I mean, it certainly should be offered for them; yes.

Thank you. I want to ask you lastly about adolescents, page 14. I take it you share this view, the current child protection system seems to have very little place for adolescents and young people. Now, you may have heard Dr Stathis's evidence too that he was of the view that whilst these children may be, for instance, Gillick competent, they are not competent to make these choices about self-placing, and when they do they're often dangerous and harmful places. Would you agree with the tenor of that?---Yes.

All right, so that you've referred to cases 2 and 3 in those case studies. Again, is the theme that emerges that with adolescents matters seem to be screened often as a child concern report rather than notification, and is that again because that drives the outcome, in the sense that obviously if it's not a notification then one doesn't have the same investigative and other powers that the department needs to exercise?---Yes. I think they're a very difficult group and that group of adolescents with high risk behaviours to themselves and others quite often who are known to the department, a number of these children will in fact be under orders, who are frequently presenting to emergency departments, to police, breaking down placements, et cetera, living on the streets, and I think all agencies feel completely impotent as to what they can do for that group. So they present to our emergency department having engaged in some high risk behaviour, substance abuse or whatever, or having been sexually assaulted or a whole range of reasons, and I guess we are in a position that we then have to release that child once the issues are dealt with, but we have a child with no parent who appears willing and able. The department may be their de facto parent and they're saying, "We can't get this child to stay anywhere or go anywhere," and so we're left with releasing this child into the ether, really. I guess we will report that, in that we have a child who is at significant risk of harm, who does not have a parent willing and able, but at

the same time we don't really have an expectation that child safety can fix it, and so what are we achieving by doing that? We feel very uncomfortable not doing it, but there's sort of, "What do we do with these kids?" So there needs to be some sort of multi-agency approach to this, but whether it sits within the child protection system or sits separately to that, I'm not sure. But I think because of the response to that group of what do we do with this group, that has a bit of a flow-on effect that whenever another troubled teenager is reported it's the same response, it's a CCR, but some of this group are in fact coming to our attention for the first time. There's been no assessment about what is going on for this child. So we need to be sure that those children actually do get an assessment and simply by saying it's parent-adolescent conflict therefore the department isn't going to become involved, and you're a 13-year-old and you've got no parent who seems to want to look after you, I guess our concern is there has not actually been an assessment of why this child has suddenly presented for the first time. So I think by lumping them together we're doing one group a significant disservice and the other group we're not meeting their needs at all, and I'm not sure how we do.

So the assessment that might be say the first time presentations, it may well be that, for instance, if it's a mental health issue, perhaps having child safety as a stakeholder, from Dr Stathis's evidence, of them being able to access that type of assistance would be at least a start, wouldn't it?---Yes. I mean, a lot of these children are known to all services but simply don't comply and continue to have high risk behaviours. I know there's been discussion about can they be sort of forcibly detained.

Securely detained, yes?---I mean, if you looked at if they were putting themselves at that degree of risk and they had a mental health problem, yes, they could be securely detained. What a lot of them have are severe emotional and behavioural problems which are putting them at just as extreme risk.

So perhaps for them there is maybe not the need for some sort of secure detainment. Dr Stathis's evidence was that - a Berry Street model he spoke of, where there's those intensive therapeutic - in maybe a group of adolescents living within a home. Would that be, do you think, to some effect?---Look, yes. I think it's a complex issue. I don't have the answer to it, but I think it's a group that there needs to be a lot of consideration about what sort of model might help them. I don't have the absolute answer. I think, I hope, that if we get it right for the younger children we won't see so many of the extreme behaviour kids down the end. That would be the hope.

I was going to ask you, that really re-emphasises your evidence earlier about the need for getting it right about

the very young children, doesn't it, because one would hope that if that's correct and they're securely attached and their brain develops properly and all of those sorts of basic, fundamental issues, then you may not have children with these sorts of self-harming and perhaps harming to the community behaviours which is outlined in the submission on page 14?---Well, that would be the hope, and certainly the literature talks about some of this adolescent group that break down placements because they actually can't tolerate that closeness in relationships. They don 't want to be in residentials, they don't want to be close to anybody, because of that very disordered attachment that they've had through their life. So I guess if we can avoid that the hope is we would have less of this cohort to deal with.

All right, thank you. I have nothing further with this witness, Mr Commissioner.

COMMISSIONER: Thank you. I've got a question before I ask Mr Hanger to examine. Doctor, the child protection system, presumably its label reflects its function, so if I was to ask you what were a child's protective needs that the system needs to meet, what would you say they primarily were?---Certainly to maintain their physical needs at a very basic level, but also, you know, to keep them from physical harm, from all sorts of harms.

So safety would be one of their needs?---Yes.

Survival is their basic need?---Yes.

So we've got to keep them alive. They need to be kept safe?---Yes.

You can put this in a negative, they need not to be neglected, but that only poses a question rather than answers it. So are developmental needs included in their protection, meaning them - - -?---Yes. I mean, I think ultimately you want a healthy individual as an adult who is healthy not only physically but emotionally as well, and, you know, that their mental health is sound.

So they've got to be nurtured too, don't they?---Yes.

They've got to be socialised?---Yes.

As well as educated?---Yes.

So in the system it intervenes at the point of safety, really. That's what we call it, child safety. We talk about the child protection system but then we talk - the only real tangible element of that is what we call child safety services.

Now, one seems to be a subsystem of the other and neither are properly named because although "protection" is defined to include care, once a child comes to be treated by the state as a child in need of protection which by definition has suffered harm or is at risk of significant harm and no protective parent, it changes. The child gets into the system by being in need of protection but once in the system, subject to support and reunifications and things like that, it really becomes a child in need of care and protection because the way you're protecting that child is actually keeping it away from home?---Yes.

If you take the responsibility of that, then obviously you have to care for that child as closely as a normative family would?---Yes.

So it seems that once the state assumes responsibility for a child because the child meets the statutory criteria, as substitute parent the system stops becoming protective at some point and becomes child-rearing, a substitute-parent system, and there's a conflict between a stable substitute parent on the one hand and the department responsible for implementing the social policy that sees the family as primarily responsible for the wellbeing of a child? ---Mm'hm.

So it has got these rival considerations that it's expected to meet and it's possibly the product of a piece of legislation that's developed ad hoc and from time to time at different points people have thrown in principles that sound good and look like they should reflect the proper policy by they have made an incoherent piece of legislation that's trying to do too much of one thing, not enough of another thing and in the end not meeting a benchmark for anything. So having said all that, what I want to ask you is: is there something you think stigmatising about calling the system Child Safety Services? Does that create a sense within parents and children that makes them not want to use the services that that particular agency offers even though it offers a lot of things they need? ---I'm not too sure how much Child Safety Services does offer a lot of things the family needs really because really their role - certainly since being separated from communities their role is the tertiary intervention and so it's about assessment and we need to act or we refer on to another agency. So, you know, like, would parents want to contact them and ask for help? We know some people do that and it will be referred to services, but it's actually they're referred on to another area outside the domain of Child Safety.

And that's not really the help they want. They don't want to get that help that is offered by Child Safety?---No.

It's the only thing they know so they ring it. Has anyone got the act? I'm going to ask you some questions, if I

can, about the act. Have you got the act there? That's what I rather thought; that it has got all these jobs to do but in reality it only provides a limited number of things that it's asked to do?---I think the children that come into the domain of Child Safety Services, so the point where the need for tertiary intervention occurs, are along a continuum. They don't suddenly get that bad.

No?---I think previously when the old Department of Families had a broader remit, I think, they could actually become involved with families at a much earlier stage where they could refer to services and say, "Look, you know, you've come to our attention. We've seen the family. We've identified these issues and we're going to recommend these supports," et cetera.

Yes?---I think because the system has now - Child Safety Services are at very much the pointy end of the child protection continuum. To get in there the notification needs to be at a level where it's likely that there's going to be tertiary intervention so it's way down the end and that's what they offer. There's an assessment about that. There's going to be intervention or there's not going to be intervention, then they're out and, "Here's someone who might come and help you, but we're actually not going to keep tabs on that because that's not our problem."

Okay. Again that was the sense I was getting, but let's just have a look at the act. I will read out to you the bits that I want to ask you to comment on. Now, the act is administered under the stated principles and the person who administers the act is the chief executive who happens to also be the director-general of the department as a whole, but the chief executive is the person responsible for child protection in Queensland under this piece of legislation. Now, the principles are fine. One of them is the child's family has got primary responsibility and the state has got responsibility if there is no willing and able parent but also we know it has got to also be harmed or at risk of harm before the state becomes responsible despite that principle. Then it goes on to deal in the principles with in protecting a child you take the least intrusive action. That's fair enough?---Mm'hm.

Then it talks about a child maintaining relationships with kin and siblings and parents. That is also fair enough. It then goes on to the principles about exercising powers or making decisions in respect of Aboriginal and Torres Strait Islanders. Now, in section 7 it is the functions of the chief executive that are set out and these are what they say and I would like you to comment on them. So for the proper efficient administration of the act this is the chief executive's functions: (1) provide or help provide information for parents and other members of the community about the development of children and their safety needs. Do you see the chief executive exercising that function in

your experience?---No.

No, (b) providing and helping provide preventative and support services to strengthen and support families and reduce the incidence of harm to children?---I guess whether that comes under Communities and Child Safety or just Child Safety - - -

Does Communities do that?---To some degree the fund services to provide those things, I think.

Yes, and you have identified part of the problem. We have got one department that has got three separate functions and they will have overlapping relevance, but within the overlaps there will be gaps and I'm just trying to identify the gaps. I'm not really asked to inquire into Communities. I'm asked to inquire into the child protection system that is run out of Communities?---Mm.

So the next one is providing services to families to protect their children if a risk of harm has been identified. Again that would be referral at best, wouldn't it?---Yes.

Providing services for the protection of children and responding to allegations of harm. That's their forensic function. Providing and helping provide services that encourage children in their development into responsible adulthood. Would you be able to identify how it exercises that function?---Not readily, no.

Helping Aboriginal and Torres Strait Islander communities to establish programs for preventing or reducing incidences - the incidence, I think - of harm to children in the communities. Maybe you don't know that one. Maybe there are; maybe there aren't. It has just deprogrammed itself. Anyway, it doesn't matter. I have probably made my point. Perhaps at some point in the inquiry we will find out the chief executive realistically can be expected to discharge bearing in mind her predominantly tertiary role.

Yes, well, I don't know about this one. Somebody clearly has to do this, but (i) is, "Promoting a partnership between the state, local government and non-government agencies and families in taking responsibility for and dealing with the problem of harm to children." That's a pretty big remit. Have you ever seen any evidence of that?---Well, whether that's referring to like the whole of government response of engaging other departments through Child Safety Directors' Network, I'm not sure.

Yes, but this is her job as chief executive, to promote that partnership?---Well, I think that the Child Safety Directors' Network answers to the chief executive, and that certainly would bring in the government departments, but I'm not sure.

Then later on in section 159, as I say, she's got all these coordinating responsibilities to carry out as well in relation to out of home care. But anyway, in practice your relationship with the department is one of a very tertiary coercively interventionist part of the system?---Yes.

All right, thanks. Mr Hanger?

MR HANGER: May I say, I'll ask my client to respond to those matters if you are so - - -

COMMISSIONER: Yes, thanks.

MR HANGER: You would appreciate a response to that from - - -

COMMISSIONER: I've actually asked for it. She might have even provided it, but I asked her how she fulfilled each one of those functions.

MR HANGER: Thank you. Just a few questions. Dr Connors, underlying your evidence is a need to focus on the first three years of life and very early intervention with families that have got problems?---Mm.

Yes, okay. You would recommend to Mr Carmody that the relevant legislation be amended so that each of the relevant parties dealing with child protection should have access to the information that they need to make the best possible decision?---Yes.

Yes, and that there should be a sharing between the departments of all relevant information on a needs to know basis?---Yes.

This would greatly facilitate the operation of SCAN?---Yes.

And other bodies interested in - - -?---Well, I think SCAN would greatly facilitate the sharing of the information,

and I guess the other element of the information sharing is the expertise to interpret that information.

You're of the opinion that the SCAN system as it now is should be significantly reformed?---Yes.

Yes, thank you. That's all I have, thank you.

COMMISSIONER: Thanks, Mr Hanger. Ms Stewart?

MS STEWART: Good afternoon. I'm Lisa Stewart from the Aboriginal and Torres Strait Islander Legal Service. Ms Connors, you've stated in your statement and you've addressed it earlier before that while it's generally accepted that primary and early intervention is the best course of action, what is actually happening is that it's just offering a bandaid solution. Is that how - - -?---No.

No?---Clearly having ready access to support services for families that are in need is absolutely essential and agencies that are dealing with these families, such as health, absolutely welcome the opportunity to refer families into support services, however the families that we are really considering in the more tertiary end of the child protection system are often very resistant to referrals into support services. So the - actually, sorry, could you just ask me the question again? I've lost my train of thought. Sorry about that.

I was just recapping on a few things that have come out, but from your statement at page - - -?---Sorry, you just said is that a bandaid effect.

It's questionable about the effectiveness of the solution? ---Where I'm saying it's questionable around the support services is when there hasn't been a thorough - and I'm talking about the tertiary end of intervention, so where child safety are involved with families where there's been a notification. So we're looking at potential significant harm, et cetera. In those families, without a thorough assessment of what are the appropriate services and the capacity of the families to engage with those services and respond to those services, then simply doing a referral is a bandaid effect. So I'm not talking about primary, secondary interventions, I'm talking about tertiary interventions at a family that's already deemed or assessed to be a family where there's significant risk, and that in a number of those families we're looking at chronic problems, generational dysfunction, and by referring to a service that might go into three to six months and then be out, at times I think that looks like a bandaid, yes.

From your knowledge and from your experience, I suppose, with the SCAN team, would you accept that probably a number of these families that are presenting are of Aboriginal and Torres Strait Islander descent?---The ones that I see

through the SCAN team the minority are indigenous, Aboriginal and Torres Strait Islander.

The minority?---The minority are, yes.

You've made reference in your statement to RAI, referral for active intervention. Are you aware of the specific Aboriginal and Torres Strait Islander family support services?---Look, I don't know a lot about that, but my understanding is that that referral needs to come through child safety.

Yes?---Yes.

But you're aware that there is one that is specific to Aboriginal and Torres Strait Islander people?---Yes, but it's through – whereas RAI services, a number of them – so, you know, organisations such as health can do direct referrals to a number of those services.

Yes?---I'm not aware of the indigenous equivalent of that. The service you've mentioned, my understanding was that referral had to come through child safety.

Are you aware of the concept of the wraparound model?---No.

About wrapping services around the family to meet the needs, or investing in that early wraparound service model rather than - - -?---Yes. Not as – not termed that way.

Yes. I may have used - - -?---Supporting families, yes.

What would you say to the proposal that – and I speak specifically about Aboriginal and Torres Strait Islander children and young people, about their needs being better served by a family support service that would have the capacity to develop and deliver more specialist intervention services specifically in relation to those areas that we identify as being risk indicators like domestic violence and substance and alcohol abuse?---So, sorry, you're suggesting that the indigenous service have the capacity to provide those services?

To provide, yes - - -?---I mean, I think whatever service can provide services is great.

Yes?---As long as they're, you know, being provided in a way that's an accepted program that's being done by people with appropriate skills - - -

Yes – sorry, keep going?---Yes.

It leads me on to my next question. What do you think would be the minimal qualification that you would like to see for workers that are delivering these services?---I can't answer that, but again, I think often it's more

helpful to look at the skills that are required for some of these services. I know – well, I suspect that if we're looking at indigenous service providers that there may be some limitations of the level of qualification, perhaps, but I think it's a matter of defining what the skills are that are required and making sure that people have adequate skills and training. As to what actual qualifications, I can't really answer that.

I suppose just to clarify there, a lot of our families present with, you know, multi-generational dysfunction, and I think you've identified that in your statement, and present with alcohol and substance issues and domestic violence. I suppose to recap, you wouldn't like to see a minimum level of qualification for people that are trying to, you know, help these families overcome these identified child protection concerns, which other risk factors?---I can't identify what that qualification would be - - -

Qualification should be - - -?--- - - - but as I say, I think obviously if those services can be provided in a culturally appropriate way by people who indigenous families are likely to engage with, then that's a highly significant thing. So how you get that workforce, I'm not sure, but I think it is sometimes helpful to look at skills that are required to try to open up maybe who could provide those services.

If I could ask you to elaborate those skills, what would be the skills that you would identify?---Look, I can't answer that. I don't provide those services and I can't really expand on that.

You've also make a note in your statement - I think it's page 12, recommendation 3 - about adoption in select cases. Bearing in mind the impacts of the stolen generation for Aboriginal and Torres Strait Islander people, is there any special considerations that you think we need to turn our mind to if we were to apply that recommendation for Aboriginal and Torres Strait people?---Clearly maintaining connections with their culture is highly important and needs to be given significant consideration in any decisions that are made about removal or placement or intervention. I don't think there's much debate about how significant that is, to maintain that cultural connection. So, I mean, ideally the child's needs need to be met within an appropriate cultural setting, but the bottom line is the child's needs need to be met. I think across the broader child protection system I think there are some children where their families really aren't on the scene any more, haven't been since soon after birth; they're in guardianship of the department, it's very unlikely there's ever going to be reunification or really any significant contact with any family members, it seems unfortunate if adoption can't be considered for those children. So I think there are some cases where adoption is something that should be considered as opposed to long-term guardianship, but personally I don't know that there's huge numbers. I think the same would apply to indigenous children; if there was an appropriate - you know, it's got to be taken on its merits, but if you had a child where the biological parents have not been in contact with the child for some time and are very unlikely to and someone within the community wanted to adopt the child, I would think that would be something that should be considered.

I'd just like of you want something else. You've given evidence earlier about the first three years of a child's life and the importance of forming that primary attachment. Are you aware of the cultural aspect and primary attachment with Aboriginal and Torres Strait Islander children and how they form multiple attachments?---Yes.

Can you just elaborate then on how we grapple with that in the system here where we need to have a stable placement

for three years for a child - actually, sorry, can I just confer for a second. How do we apply that and consider that when we're determining placements, then?---Again, I think the issue is about a healthy attachment, a lot of that is around a child's needs being met so that somebody is attuned to the child so that when they're needing a response, somebody responds to them, so they feel secure that their needs are being met. I guess in our culture that's often one or two parents who are there for the child and the child feel secure in that environment. My understanding of attachment within indigenous families is that there's a much broader caregiving group, if you like, so if there's a healthy community, healthy extended family, the child is having its needs met but not by one person, by a number of people. So it is a different way of looking at it and so there would need to be care in being open to what the model of attachment is in that cultural setting. And certainly there is papers looking at the different attachment systems, if you like, of various cultures and they're all very, very different. But at the end of the day the child feels safe and secure and knows that somebody is there to look after it. And so it would be about assessing that. So yes, it would have to be done in a very culturally sensitive way. And often in that sense you're looking at a very functional community of people that the child can go to. And yes, I think that obviously needs to be considered.

If I can just talk to you a bit about section 21A of the Child Protection Act that's been the subject of a bit of discussion, especially in light of your recommendation about - actually, no, I'll just withdraw that, sorry. Keeping in mind that foetal alcohol syndrome or spectrum disorder is a significant problem for Aboriginal and Torres Strait Islander mums and kids, your recommendation in number 6, you suggest a TAO prior to birth. As a practitioner would you see any benefit to an unborn child protection order to allow for a future child to be protected? I'm just going to put the legal side of that to one side, about whether we can actually do that, I'd more like to focus on how we can best protect the child in that scenario?---I don't think you can enforce anything on a mother. I just can't imagine how on earth that can be done from an enforcement point of view. I think it is a public health issue. And while we can focus on alcohol, and obviously the detriment that occurs with foetal alcohol syndrome is something that we really want to avoid, often that can occur before the mother even knows she is pregnant, so how do we force it? I really don't know how you would do that. However, I think - like, at the moment the federal government are doing a public health campaign about smoking in pregnancy and that's where we've got to go. I think the message has to be a broad message through a public health campaign about the impact of alcohol, other illicit substances, smoking; but where do you draw the line? You enforce somebody in one area, you've got to do

the same for all areas that are detrimental, including smoking. So I think it's a matter of education.

Where would you start that as a response? At a community awareness level? Like, from a public health perspective? ---Yes, I think a community awareness level. I think it needs to be an opportunistic education, certainly through antenatal, but by then, by the time we see them in antenatal it is often a bit late with the alcohol issues. But through health clinics, like wherever you can get the message out, really.

Thanks?---And probably, actually primary care is - getting that message out in GP waiting rooms, et cetera, when GPs are seeing people.

Yes?---It's like any public health message, just taking the opportunity when you can.

In light of the discussion that we've been having about unborn and the removals, and with your knowledge of attachment, is there anything that you could suggest that should be implemented to ensure the least disruption to the child and the parent attachment in the context of an unborn child removal?---Sorry, could you say that again?

Sorry, when the child is removed at birth under an order, is there anything that you believe could be implemented that would be least disruptive to the attachment that should be allowed to develop between the parent and the child?---Well, I guess it goes back to what I was saying earlier. The predominant thing that needs to be maintained is primary attachment for the baby. Whether that be with the parent or that be with another significant carer, there needs to be sound attachment. If the baby has that, it will be able to reattach to another significant carer at some point. The other issue is about the bonding of the parent with the child and in the period of time where hopefully a fully informed, comprehensive assessment is being carried out to decide whether this baby is staying at home or whether this baby is being placed in somewhere secure for a reasonable period of time, there needs to be contact obviously but it needs to be very mindful of the emotional wellbeing of the child and so things such as allowing the carer to be part of the contact rather than removing a child from a carer, you know, and expecting the baby to simply have a visit with somebody that it really doesn't have a lot of contact with - all those things are important. I think often what happens is you've got a critical period of a child who's at significant risk soon after birth. It's not that uncommon, although I don't know the figures exactly, say, a baby may be removed under a TAO, but once the department have become involved, the baby may be returned at the end of the TAO when they've had time to actually assess that there are family members willing to be protective. They may feel that it's okay. The baby doesn't need to be away from the family. So I think there needs to be supports for mothers very much during that period of separation around maintaining breastfeeding, all those sorts of things. So I think planning around that, the possibility of providing child health support, visiting midwives to the mother - I think what often happens is the removal occurs and the mother is sort of a bit of an afterthought. So I think it's about really good communication and planning to support the baby and also support the mother at that time because it may well be the baby will be returned in three days or a month so you want to maintain those positive things.

The case-plan goal would be reunification so it would be working towards that. Would you propose that there needs to be a minimum amount of contact between - and I take in line your comments about the collaboration perhaps with the carers being there and things like that?---I guess one of my concerns is at the moment there is this constant undermining, if you like, of this drive for reunification and I guess what I'm talking about is making a decision one way or the other and giving stability and not the up and down sort of trying to maintain both, if you like, and so that when the decision is made, it's made and the child remains stable. Apart from that, once the actual sort of contact with the biological family, but there's no one

answer for everything. The family unit, the child,- whatever the issues are, all need to be addressed and assessed as to what plan there might be around contact. It may be very appropriate and very easy to have contact that's positive to both sides on a regular basis. There may be other situations where it's distressing for the child and it's achieving very little and I think there are times when the whole principle of reunification overrides what's actually commonsense and what's working for the child. So it may be appropriate. It may not. It's got to come down to appropriate assessments for that individual child and carer and family.

If I can just ask you to comment of something, it kind of draws on from that, but when families and children arrive normally to Child Safety for contact, they're allocated perhaps an hour. The child who has suffered already by being removed from the child because they're at risk of harm and they're perhaps traumatised from being in care, hasn't yet placed, comes along to contact in quite a heightened state and exhibits certain behaviour, normally stabilises and by that time it's the end of the contact visit. In those type of circumstances, is there any way that we can do that better to best meet children's needs and be mindful of their attachment and their development needs?---I'm sure there is but, as I say, I can't give you a one-blanket response that's going to be a formula for every child, but I think it's about being mindful of what people are observing and making sure adequate supports are put in place both for the child and for the biological parents around the contact rather than just an expectation that, you know, this will happen every so often, struggling together, hope for the best and off people go. I think the appropriateness of contact needs to be constantly reassessed and it may well be that there needs to be some observation, depending on the age of the child, by someone who can adequately assess what's going on and make some recommendations. So again I think it comes back to utilising expertise and really being thorough about the assessments across the whole - - -

Just on that, do you believe that the child safety officers are currently skilled to make that assessment?---I think that the skills are very variable and certainly, you know, I'm very aware a lot of things I've being saying are very - are raising questions about the functioning of Child Safety, but, you know, there are so many excellent people within the department who do an absolutely wonderful job. I think it's more about the systems really and I don't know absolutely but I think at times the contact visits may be monitored by a CSSO; you know, I'm not sure necessarily that the person who's supervising the contacts - you know, it may be one person one day and somebody else another day and all those things need to be taken into account, I think.

I suppose the issue that we see from that is that scenario that I put to you before, then there is an adverse inference drawn from the behaviour of the child where, you know, there could be another explanation?---So you're saying an adverse inference that it's to do with the biological parent and that's why the child - - -

The attachment between the child - you know, there's something there?---Mm.

In relation to the SCAN team - now, you're aware that the recognised entities are - - -?---Yes.

What benefits and information do you believe the recognised entity bring to the SCAN team?---I think it's very variable. I think in some SCAN teams we don't hear a lot from the recognised entity and there's other SCAN teams where the recognised entity is very - seems to be much more actively involved with the families and also along a continuum of the process of assessment and intervention and case planning, et cetera. So there does seem to be quite a lot of variability. To a certain extent I think you could say about all the core agencies there's variability so, yes, I've had various experiences.

I have nothing further, commissioner.

MR CAPPER: We have no questions, thank you.

COMMISSIONER: Thank you, Mr Capper. Yes?

MR HANGER: Sir, before Dr Connors is excused, can I just place something on record?

COMMISSIONER: Yes.

MR HANGER: That is that we have only had her documentation for a few days and it may well be that Mr Swan would want to respond to some of this material and I would just like to say he may well want to put something before you. I mean, technically I should have put that to Dr Connors but since it's an inquisitorial proceeding I hope you will forgive my not doing that.

COMMISSIONER: Yes, you can't if you don't really have the instructions.

MR HANGER: No.

COMMISSIONER: No, I will take that as read, Mr Hanger, and if there is anything that needs to be reput, we will work our way around doing that.

MR HANGER: Thank you, commissioner. While we're on that point, this inquiry has been conducted in a very amicable fashion and I'm sure that's the best way of doing it, but

it would help if we could be given statements as early as possible. I notice that Dr Connor's main statement is dated 28 September and we have only received it this week or last Friday, I think. It would enable myself and those backing me up to prepare better if we got them a bit earlier.

COMMISSIONER: Of course.

MR HANGER: I'm particularly concerned with the next stage of the inquiry that we're going into that we should be given those statements as early as possible, even if they're only drafts.

COMMISSIONER: Yes, I accept that.

MS McMILLAN: There was an issue and I'm afraid it was a communication issue because part of what Dr Connors put before us was not to be published. Unfortunately there perhaps was a transmission at our end that didn't get through.

COMMISSIONER: That nothing was.

MS McMILLAN: Yes. So I do apologise about Dr Connors and, of course, if Mr Hanger needs to adduce some further evidence, we wouldn't complain about that in the slightest.

COMMISSIONER: All right, yes. We will do the best we can to make sure that everybody receives the statements at the earliest time.

MR HANGER: Yes, I'm indebted to my learned friend, thank you.

COMMISSIONER: That helps the commission run more efficiently. All right. Do you have some re-examination?

MS McMILLAN: No. Might the doctor be excused?

COMMISSIONER: All right, yes.

Doctor, thanks very much. It is good to see you again and we appreciate the evidence that you have given and the time you have taken out of your work to give it.

WITNESS WITHDREW

COMMISSIONER: Tomorrow morning?

MS McMILLAN: 10 am.

COMMISSIONER: At 10.00.

THE COMMISSION ADJOURNED AT 3.34 PM
UNTIL THURSDAY, 8 NOVEMBER 2012

7/11/12