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ACKNOWLEDGEMENT

The Aboriginal and Torres Strait Islander Women's Legal Service NQ acknowledges the traditional owners of the region across whose land we conduct our business, the Bindal and Wulgurakaba people, to whom we pay our respects. We also pay our sincere respects to the Aboriginal and Torres Strait Islander Elders of today and to those who have passed on.

ABOUT ATSIWLSNQ INC

The Aboriginal and Torres Strait Islander Women's Legal Services NQ Inc. ("ATSIWLSNQ") has been incorporated since February 2006. ATSIWLSNQ delivers legal services, advocacy and community legal education including outreach work for Aboriginal and Torres Strait islander women in North Queensland.

The services provided by the ATSIWLSNQ include:

- legal advice, information and representation to Aboriginal and Torres Strait Islander women in NQ
- Community Legal Education
- Outreach work
- Advocacy and law reform submissions

Many of the clients accessing the services of ATSIWLSNQ are parents of children subject to intervention by the Queensland Department of Communities (Child Safety) ("the Department"). ATSIWLSNQ has a special interest in the support and legal representation of these parents and in the reunification of children with their families.

This submission is based on the knowledge and experiences of the ATSIWLSNQ and the women who have entrusted the ATSIWLSNQ with their experiences and legal issues.

SUBMISSIONS

SOME PRELIMINARY OBSERVATIONS ABOUT CHILD PROTECTION IN QUEENSLAND

The ATSIWLSNQ has maintained a strong involvement in assisting and representing Aboriginal and Torres Strait Islander women in North Queensland in relation to child protection issues. It is our observation that the system as it currently operates is fundamentally flawed, in particular in the following areas.

a) The Department of Communities (Child Safety) ("the department") has diametrically opposed and conflicting functions which inhibit its capacity to protect children. We refer to the department's roles as :

i. Prosecutor, in which it gathers evidence against parents to substantiate its legal cases for the removal of children believed to be at risk, often ignoring evidence which is inconsistent with its case;
ii. Case manager, in which it is required to manage children's contact with their families and the children's needs "in the best interests of the child"; and
iii. Facilitator of children's reunification with their families, including encouraging parents to do all things necessary to reduce "risks" and achieve reunification.

b) The increasingly dire outcomes for Aboriginal and Torres Strait Islander children are a reflection of a department in which:
   i. Cultural awareness is largely lacking (due to lack of training and the conflict with its own internal values); and
   ii. Structurally has little capacity to respond to specific needs in culturally appropriate ways; and
   iii. The only independent cultural oversight provided in the *Child Protection Act 1999* ("the Act"), namely the "Recognised Entity" (the "RE") lacks real independence from the department and lacks an effective system of evaluating its effectiveness in preventing the increasing removal of Aboriginal and Torres Strait Islander children and in overseeing the child placement principle.

c) Due to the weight of evidence gathering carried out by the department and repeatedly presented to the parents in various form (affidavits; case plans; comments; letters), parents often feel overwhelmed. This can be a serious setback to the children's reunification with their family.

d) The child protection system in Queensland, in its present form, is predominantly involved in gathering and recording and documenting evidence (primarily against parents), which may later be used at trial. This narrow focus renders it incapable of being proactive in its protection of children. It has the mechanisms to intervene in crises (much as a police force), but fails to protect children's needs before they become crises.

   We would therefore like to endorse the recommendations of the National Framework for Protecting Australia's Children 2009-2020 in so far as it recognizes that :

   > "Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children"
   >
   > And further its emphasis on a 'public health' model which aims to reduce child abuse and neglect and that:
   >
   > "..offers a different approach with a greater emphasis on assisting families early enough to prevent abuse and neglect occurring."

TERMS OF REFERENCE

This submission will address the following terms of reference:

1. Whether the current use of available resources across the child protection system is adequate and whether resources could be used more efficiently;
2. The current Queensland government response to children and families in the child protection system including the appropriateness of the level of, and support for, front line staffing; tertiary child protection interventions, case management, service standards, decision making frameworks and child protection court and tribunal processes; and
3. The transition of children through, and exiting the child protection system.

Recommendations contained in this submission will address the following:

a) reforms to Queensland's child protection system which the ATSIWLSNQ believes would achieve better outcomes to protect children and support families;

b) strategies to reduce the over-representation of Aboriginal and Torres Strait Islander children at all stages of the child protection system, particularly out-of-home care.

1. USE OF RESOURCES ACROSS THE CHILD PROTECTION SYSTEM

We consider the department's resources to be ineffectively utilized in the areas of prevention and early intervention and in the delivery of child protection services pursuant to the *Child Protection Act 1999* ("the Act"). Due to waste of resources and gaps in service delivery parents and families are left unsupported, resulting in delays to reunification after departmental intervention and ultimately harm to children and families in the long-term.

The damage to families and to children involves not only trauma to individuals but a real cost to the community *(National Child Protection Clearinghouse resource sheet, April 2011* sets out the estimated long term costs to the community). The following are some of the areas which, in our view, need to be addressed.

1.1 WASTED RESOURCES

1.1.1 Knowledge, skill and experience:

While we acknowledge the dedication, experience and skill of some departmental workers, it has been the unfortunate experience of many of our clients that there are departmental workers who lack the skill, experience, or cultural awareness to intervene in a way which effectively protects children from harm, maintains Aboriginal and Torres Strait Islander children's links with family and culture and reunites children in a timely way with their families.

Interventions lack a balanced approach, in terms of enabling children to maintain their family relationships. As a consequence of the misuse of resources, children are being kept out of home care for too long, being transitioned back to their families too slowly and ineffectively.

The damage to children and their relationships with their families is compounded by delays beyond what is necessary for the children to return to their families safely. It is not merely that children are kept from their families for a longer period of time, but at some critical points of a child's development, delay may mean the complete loss of the family relationship. We refer particularly to babies and very young children as well as to adolescents.

An additional problem which causes delay and prolongs children's involvement in the child protection system, is what the AASW submission has referred to as the "de-professionalisation of the child protection workforce since 2004"[i]. We note that the AASW has criticised the diversification of the qualification base of child protection workers as being inconsistent with best practice and resulting in a high turnover (73% in the first 3 years of practice, compared with an annual turnover of 11% in the UK). We are not aware of any economic assessment of the cost of such a turnover, but would submit that 73% is indicative of significant wastage. The high turnover further suggests that professionalism is not being adequately supported and encouraged.

Our main concern, however, is the outcomes for children and their families. The high turnover of staff is frustrating for parents trying to maintain contact with their children and to undertake programs which will promote children being reunified with their families. The usual experience for parents is that they begin to work well with a worker, only to find that within a few months the worker has moved on or left and the parent starts over with a new worker, re-establishing a working relationship, discussing strategies (sometimes different to those suggested by the previous worker), and arranging contact with their children.

We have been informed, but we are unable to verify, that it is departmental policy for Caseworkers in child protection matters to be changed every 3 months. If this information is correct, it is difficult to imagine how the human and economic cost of constant change can be justified against whatever other objectives the department is attempting to achieve. The strategy would appear to be enormously wasteful as another worker familiarises her or himself with the family and starts the process "from scratch".

The department may regard the caseworker as irrelevant, given that there are case plans, but this ignores the human relationship, the level of trust (if any) which parents rely on and the knowledge which individual workers hold.

Given the history of trauma caused by early colonisation and removal of children under past colonial policies (the "stolen generations"), many Aboriginal and Torres Strait Islander people have little trust in government departments. Failure to reunify in a timely and effective manner compounds the mistrust which many people feel towards the department.

1.1.2 Child Rescue / bad parent:

In addition to the burden on departmental resources of unskilled and inexperienced workers and frequent changes of workers, we have found an unhealthy culture of a "child rescue" [ii]mentality among some departmental officers, in which the main strategy is removal of children from their families under

the misguided belief that children are necessarily protected by removing them from their parents and/or family.

The corollary of the "child rescue" mentality is the belief in punishment of the "bad parent". Entrenched negative attitudes to parents and families is not helpful in terms of the "child's best interests" and often means that children are kept in out of home care longer than they would otherwise if the department were working effectively with parents.

We have had the experience, at the most extreme end of the "bad parent" ideology, of officers actually not disclosing significant evidence contrary to the departmental case and pursuing the long-term removal of children in the face of overwhelming evidence that such action was unjustified and that the children were being placed at risk by the department's actions.[iii] In that case, the children were returned to their home within 6 months of the department pursuing a long-term guardianship order for the children.

The cost of inexperience

Lack of experience may impact on departmental workers' judgment and the actions which they take. Holding a qualification without experience may impact on the effectiveness of professional judgements. Inexperienced workers may be more susceptible to "child rescue" and "bad parent" attitudes, which are counter-productive to supporting parents and reunifying children.

1.1.3 Failure to understand legal process

Many of the staff we have dealt with are inexperienced and/or recent graduates. Some do not understand that they are administering legislation (and therefore engaging in a legal process). As a result, departmental workers often provide what amounts to legal advice to parents (for example telling parents things about their legal position which may or (more often) may not be accurate).

Parents who do not have legal advice may not know that their actions can impact on their legal case, for example:

a) They do not seek legal advice because they do not realise that the department is bound by legislation and this enables and limits their actions;
b) Parents often do not know that they are entitled to legal advice;
c) The department records their interactions with parents, and this may be used against the parents for as long as they are involved in the child protection process;
d) The parents do not know that they may have other legal options than those which the departmental officers have informed them of.

We have included this in "wasted resources" since the department's initial failure to inform parents that it is a legal process often results in time-wasting, duplication of effort if and when solicitors do become involved, and inappropriate actions by parents due to their initial distress or long term despair and sense of disempowerment.

Recommendations :

1) *The department should better assess the qualifications, and aim to recruit for skill and experience.*
2) *There should be ongoing effective evaluation of workers, not based on the number of children that are removed but by the worker's demonstrated communication skills, ability to work with families, effective links with other supports in the community (including the parents' legal team if any), to link families with support services and to facilitate the reunification of children with their primary caregiver or family.*
3) *Professional development should be encouraged to improve workers' skills, including compulsory cultural competence training.*

1.1.4 Departmental role unclear to department and to parents

A fundamental flaw in the current system is the department's conflicting roles: prosecutorial and evidence gathering; managing children in its custody; and being responsible for facilitating the reunification of families. The conflict between different functions appears to cause confusion among departmental officers. Many departmental officers are proactive in gathering evidence *against* parents while at the same time they are responsible for linking parents and families with personal supports and deciding whether and how children should have contact with their families.

An outcome of combining these conflicting roles is inefficiency and delay within the system. The department expends a great deal of time and energy gathering evidence against parents. This inevitably means that parents' actions must be interpreted in the worst possible light as a possible "risk", where in any other context a particular situation may be viewed as not indicative of a "risk" to a child. For example, we have noticed the following types of situations:

a) Parents' initial comments to departmental officers may be used against them, although the parents may be under the extremely stressful situation of having their child or their baby removed by strangers. Every negative comment by the parents from this point on become evidence of the parents' "aggression" or "unwillingness to work with the department" or "unwillingness to engage". (In the alternative situation, we have known parents who did not react emotionally and were deemed to be "emotionally detached").
b) Parents' homes and family situations are scrutinised with an eye for evidence gathering. If the department does a home visit and the home is messy, or the shopping day is the next day, this may be interpreted in the worst possible light as evidence of the parents' negligence and chaotic lives (posing a "risk" to their children).
c) Observations of the parents' homes and lives are inevitably interpreted in terms of presenting evidence of "risks". For example, a worker visiting the home of a woman who formerly had a history of excessive drinking observed that a beer can was sitting on the kitchen table. The worker made no enquiries about this but used it in affidavit as evidence that the woman was untruthful and a "risk". The departmental worker who swore the affidavit failed to make any

enquiry about the evidence. She also failed to mention that the single beer can belonged to a guest who was sitting at the kitchen table at the time of the visit.

The prosecutorial role of the department, and its evidence-gathering function, inevitably undermines its capacity to support parents to achieve reunification, thus causing delays in achieving the goals envisaged by the Act. It is also a significant obstacle to parents trusting or working with departmental officers (which again causes inevitable delays).

Recommendation:

That the department clarify its role legislatively and structurally. Ideally the department should not be involved in evidence gathering against parents as this undermines their other roles.

1.1.5 Lack of unified child protection legislation or process for transferring child protection orders between States

Child protection orders made in other states often pose a problem for parents and children transferred to Queensland and result in delays and waste of resources. We cite the following example:

Children were transferred from interstate to kin in Townsville, where a child protection order was made in another State. The mother began to reside in Townsville where the children were. The department (Queensland) had no jurisdiction. The interstate child protection agency flew workers into Townsville each fortnight to supervise the mother's visit with the children.

Recommendation:

That the department develop more streamlined transfer procedures for children subject to Child Protection Orders interstate being transferred to Queensland.

1.2 GAPS

Notwithstanding the problem with Queensland's model of child protection, which we believe to be fundamentally flawed, some of the immediate gaps we have observed in the system are set out as follows.

1.2.1 Availability of preventive and early intervention resources in the community

We regard the early availability of resources to assist families, and to identify children in need of further supports and to provide supports to primary caregivers, as paramount to protecting children more effectively.

We have noticed the following gaps:

a) **Lack of support for families** (including after-hours support) for families in need, where there is a problem which has not reached a critical point (ie not a case which requires police or immediate departmental intervention). Families are left unsupported where a family member (or another person) has acted proactively to remove children from a potentially risky situation or parent.

Often the department's assessment is that the situation does not require any departmental support because a family member is protecting the children. This may leave family members unsupported financially and emotionally while also exposed to an unstable family member who is disgruntled about being told he or she cannot parent safely. We are aware of situations which have continued for 12 months or more, where the children are not deemed to be at risk because a family member, and not the department, has been proactive. The only solution for the family members may be to "stop helping" in order to force the department to become involved in assisting the parent with "at risk" behaviours.

b) We endorse the comments of the submission made by "Powering Families" in so far as there is a **lack of independent services for families and parents** (in the community) in which they can trust if they seek help or early intervention.[iv] Hence, parents are afraid to seek help for fear of being branded as 'unfit parents' and having their children removed. (The alternative would be for parents to feel that they could be acknowledged as acting responsibly where they recognise that they have a problem and seek help).

c) **Some key service providers require a referral from the Court or Child Protection services**. For example, the QIADP program (Queensland Indigenous Alcohol Diversion Program) offers a very significant level of support, including in-house accommodation, to people wanting to address drug or alcohol addiction, but it is only accessible by referral from the department or the court.

Recommendations:

1) *That the department improve the availability and responsiveness of its after-hours service for child protection services, and ensure it is available to people in regional and remote areas of the State (e.g. flexible shifts for evening, night, public holiday times and at times when crises are most likely to occur).*
2) *That family members who have taken responsibility for the children of family members with "at risk behaviours" be eligible for a proper assessment and support (e.g. economic, respite, and other support) to ensure that children's placements can be properly supported and protected.*
3) *That an assessment of existing family support services be undertaken as soon as possible and that early intervention services (not requiring involvement of the department) be funded in accordance with assessed need, and be accessible to families living in regional and remote areas.*
4) *That key services, particularly in the areas of drug and alcohol intervention, have their service delivery extended to parents who self-refer or who are referred by a legal service or a community support service.*

1.2.2 Failure to refer parents to legal advice

Very few departmental officers, if any, inform parents that they are engaging in a legal process. We disagree with the comments made by Ms Nicola Jeffers, acting Regional Executive Director of the Department of Communities (Child Safety) who at the Commission of Inquiry hearing in Townsville on 26 September 2012, who, while not admitting to the department's practices, implied that she was confident that departmental staff advise parents of their right to legal advice[v].

It has been our experience that departmental officers almost never tell parents that they are engaging in a legal process and that they do not as a rule inform parents that they have a right to seek independent legal advice. Fewer still take the further step of referring parents to a solicitor or a legal service. (We have had occasional referrals to our service with the assistance of more experienced departmental staff, but this is still quite rare in our experience.)

There is no process by which departmental officers can demonstrate that they have made parents aware of their right to seek legal advice or that the department is acting under a legal process or that the department may use any and all evidence (including verbal) against them, or that departmental staff have actually assisted parents to access a solicitor or a free legal service.

Recommendation:

1) *That departmental officers be required to inform parents of their right to legal advice before proceeding with an interview or taking any other action.*
2) *That departmental officers be required to provide parents with verbal and written information that departmental intervention is a legal process, that things that they say and observations that the department makes may be used against them in a court.*
3) *That departmental officers are required to assist parents to obtain initial legal advice from a community legal service, Legal Aid Queensland, the Aboriginal & Torres Strait Islander Legal Service or the Qld Indigenous Family Violence Service in their area.*
4) *That where a parent is an Aboriginal or Torres Strait Islander person that they be referred to a culturally appropriate service in the first instance. Where the parent is an Aboriginal or Torres Strait Islander woman that she be referred to an Aboriginal and Torres Strait Islander women's legal service.*
5) *That legal aid guidelines be changed to ensure that parents involved in child protection matters are entitled to legal representation at all stages of their legal matter.*
6) *That funding to Aboriginal and Torres Strait islander services be improved to ensure that every opportunity is afforded to families to stay together and that parents, and particularly women, have full access to justice and adequate assistance in relation to their child protection matters.*

1.2.3 Need for an independent Recognised Entity ("RE") with an appropriately skilled workforce

One problem that has left many Aboriginal and Torres Strait Islander families in the Townsville region unprotected and more exposed to a higher level of departmental intervention than may have been necessary, is the lack of independence of the RE and the low level of skill, training and support given to some of the front line workers. This is intended as a criticism of the system, not of individual workers.

Lack of independence

We understand that the RE is funded through the Department of Communities and that the department has access to the RE's files. This level of collaboration leads departmental staff to exercise authority over the RE in a way that suggests that they believe that the RE is beholden to the department. Clearly

this is a serious undermining of the RE's role as an independent consultative body in relation to Aboriginal and Torres Strait Islander children.

Workers employed by the RE appear to be given only information which supports the department's case. The RE appears to be under-resourced to make its own independent enquiries. It is not surprising that in the majority of cases, the RE supports the department's application. Cases in which the RE acts independently or actively questions the department's case in court are rare. In the most extreme case, we are aware of an RE worker being disciplined for changing her mind about supporting the department after viewing the evidence.

Recommendation:

1) *That the RE be funded independently of the department.*
2) *That the RE be sufficiently resourced for staff of the RE to be given adequate training to carry out their role independently of the department, including adequate resources to make their own enquiries into matters in which they are consulted.*
3) *That the role and functions of the RE be clarified in any future funding agreement, in particular to identify that the RE's function is to advise the department independently of the department's own views.*
4) *That the RE form part of an indigenous community consultative body to provide advice to the department and to the Minister on proposals to proactively protect Aboriginal and Torres Strait islander children, to support them to stay in their home, and to reduce the numbers of child protection interventions.*

Building a professional skill base

While the RE is intended as a consultative body, representative of the Aboriginal or Torres Strait Islander community, workers are also called upon to carry out complex and skilled professional roles, for example to interpret facts and evidence, to appear in court, and to be frontline workers on hand to respond to crises and negotiate with distressed families.

It appears that the roles that RE workers are required to carry out are highly complex, requiring a highly skilled and experienced workforce. In our experience, workers do not always receive the support and training that they need to carry out their multiple functions.

Recommendation:

1) *That the RE recruit experienced and trained workers wherever possible.*
2) *That the RE receive adequate funding for a training and professional development budget, and that meeting of training and professional development criteria form part of its accountability requirements, aimed at enhancing and supporting the professional development of staff.*

1.2.4 Cultural awareness and Cultural care plans

Cultural awareness training

The lack of cultural awareness training among non-indigenous departmental staff is apparent time and again in the planning process. There are numerous specific incidents of departmental staff continuing to misunderstand cultural issues such as how a child can be supported culturally. Some examples are:

a) Departmental workers identifying NAIDOC day as the "cultural event" which will meet a child's 'cultural identity' needs.
b) Departmental workers proposing that the non-indigenous foster carer take the child to NAIDOC Day when there are family members available to take the child.
c) Stating in a case plan that the child's cultural identity will be supported because one foster carer originates from an Aboriginal community which happens to be approximately 5,000kms away from the child's community.
d) Confusing the cultures of Aboriginal children and Torres Strait Islander children.
e) Departmental workers failing to understand the importance of the child's family in the development of the child's cultural identity.

The need for departmental workers to receive training that will strongly enhance their understanding of and sensitivity to cultural issues is absolutely essential in North Queensland, if workers are to avoid repeating the errors of the stolen generation authorities.

The need for Aboriginal and Torres Strait Islander children to be culturally supported is an imperative, due to the history of child removals (the 'stolen generations') and the impact that this continues to have on the cultural integrity of Aboriginal and Torres Strait Islander children in care. Case plans should be mandatory and we refer to and endorse the work and recommendations of the report of Terri Libesman, 2011 in relation to "Cultural Care for Aboriginal and Torres Strait Islander Children in Out of Home Care.[vi]

Recommendation:

1) *That as part of the department's training budget, it require staff to attend ongoing regular cultural training and evaluation from accredited cultural trainers.*
2) *That cultural awareness be regularly evaluated in the work that the department undertakes, including seeking cultural feedback by accredited trainers on work actually being undertaken by the department (clearly we are not suggesting that the department breach its privacy obligations in this consultation process).*
3) *That only staff who have attained an appropriate level of cultural training be permitted to work with Aboriginal and Torres Strait Islander families (including work on their case plans).*
4) *Every child in the custody and/or guardianship of the Department, must have a cultural care plan including a geno gram which is approved by the Recognised Entity and the child's Aboriginal or Torres Strait Islander parent or guardian.*

5) *That the Act be amended to make Cultural Care Plans a statutory requirement consistent with meeting the cultural needs of Aboriginal and Torres Strait Islander children in out of home care.*
6) *That community elders be contracted to hold regular activities for Aboriginal children and Torres Strait Islander children, which the children can attend while in out of home care (for example monthly activities co-ordinated through Aboriginal and Torres Strait Islander community organisations).*

1.2.5 Case planning

The department's confusion of conflicting functions creates a problem with maintaining the independence of the case planning process. We endorse the comments made in the AASW submission[vii], regarding the "failure to provide for non-adversarial and impartial decision-making forums".

Involvement of parents in case planning

The use of Family Group Meetings (FGM's) and the case planning process generally is an area in need of reform. The Act states as its purpose that family group meetings are :

(a) To provide family-based responses to children's protection and care needs; and
(b) To ensure an inclusive process for planning and making decisions relating to children's wellbeing and protection and care needs. (s.51G)

The reality, in our experience, is that parents are rarely if ever consulted with prior to the FGM or informed as to the purpose and content of an FGM, and case plans are frequently made with little more than token involvement by the parent/s.

Case plans are frequently made as part of an administrative process in which the parents are not seen as requiring involvement at all, hence no FGM is held in these cases, unless a parent or their advocate requests an FGM (and often, perseveres in this request against departmental opposition to an FGM). The development of case plans without parental involvement appears to breach s.51L and to be a misuse of s.51S.

Parents who are not legally represented or otherwise independently supported do not usually (in our experience) understand the purpose or significance of an FGM and case planning. They do not understand that it is an opportunity to progress and plan the reunification process and to exercise parental responsibilities in relation to their children in care. This leaves parents at a disadvantage and often frustrated by the slow pace (or complete stagnation) of the reunification process. It also leaves many parents feeling overwhelmed or excluded from their children's lives. Decisions about medical care may be made without the parents' involvement or input. Parents often do not receive their children's school reports or information from the school. Cultural decisions are often made without the parents' permission or input.

Case plans are frequently made well outside the statutory 6 month review time frame (s.51V(4)). Parents who have sought legal advice some time into the child protection process may not know if or

when the last FGM was, what its purpose was, what the current case plan for their children is. While caseworkers will often, in their own defence, state that they have provided the parent with a case plan, the parent does not necessarily have any understanding of what the case plan is, or its significance to their child. In our experience parents rarely read the Case Plan and hold the department to its commitments. Departmental claims to have "sent a copy" to the parents are often disingenuous.

Independence of mediator

We endorse the comments of the AASW[viii] noting that the department's FGM practices "appear to contravene mediation principles" adopted in other fields.

The "case planning convenor" is invariably an employee of the department who has been a caseworker and whose views inevitably impact on the meeting process and the parents' input. One particular example, which we have witnessed, occurred with a convenor recently transferred from casework. Each time a parent attempted to ask questions or provide input into the process, her responses were to shut down the parent with comments such as "we won't talk about that", "that's not open for discussion" and so forth. Fortunately her comments were challenged and the parents were able to contribute some valuable input into the process.

Recommendation :

That funding be made available for case meeting / FGM facilitators be independently sourced from a pool of accredited facilitators who are not employees of the department. A mechanism for achieving this may be for Legal Aid Queensland to be provided with funding to appoint facilitators for case planning meetings and FGM's.

Place for meetings

A further obstacle to independence is that case planning and FGM's are almost invariably held at the offices of the department. The alternative would be for use of an independent place, consultation on an appropriate venue, or choosing a culturally appropriate venue.

Recommendation:

That FGM convenors arrange for meetings be held in a mutually convenient and culturally appropriate venue in order to enhance and facilitate independence and the perception of independence.

Content of Case Plans

Case Plans frequently contain detailed and specific negative comments about parents. This is offensive to parents who have been working towards their children's return home. It is counter-productive to the reunification of families.

The first section of a case plan usually contains a heading "Summary of current child protection concerns". Until very recently it appeared to be standard departmental practice for this section to contain "cut and paste" excerpts from affidavits, of allegations against parents (usually untested and

unproven). Usually the form in which it was presented was neither a "summary" nor a "current child protection concern".

More recently some case plans are genuine summaries of the issues. We do not know if there has been a recent direction, guideline or change in practice, or whether some case planning convenors have changed their practices. In any event, case plans have usually been "cut and pasted" from affidavit material. They are often highly inflammatory and cause parents to feel as if they have received no recognition of the changes they have made.

Recommendation:

That case plans contain only the information necessary to identify any current child protection concerns in so far as these are risk issues being addressed by the parents in the case plans and that it not contain specific untested allegations.

2. THE CURRENT QUEENSLAND GOVERNMENT RESPONSE TO CHILDREN AND FAMILIES IN THE CHILD PROTECTION SYSTEM

As our comments in the previous section outline, we are of the view that the current response to child protection is wholly inadequate and that funding is wasted in targeting strategies that are ineffective, too late and often counter-productive. In this section we will outline some areas which we believe would offer more appropriate targeting of funds.

2.1 Proactive support for pregnant women

Ms Jeffers, Acting regional executive Director of the department, in her submissions before the Carmody Inquiry in Townsville on 26 September 2012, stated that removal of babies was an avenue of last resort and that the department made all reasonable efforts to assist pregnant women[ix]. With respect, we disagree with Ms Jeffers' comments, as her assertions do not reflect the experiences of our clients.

In our experience the department is secretive and unresponsive in relation to pregnant women. We have never had a parent inform us that the department has made more than a token effort to work with them in relation to perceived risks to an unborn baby. The usual practice, based on client accounts, is that the pregnant woman receives *a visit* from two departmental workers at their home (usually on one occasion). In most cases that we are aware of, the woman was vague about the purpose of the visit or what was proposed. In any event, no client has ever said that the department assisted them, and we are not aware of any cases where any genuine assistance has been given.

Our own experience of working with pregnant women whose children have been the subject of child protection intervention, is that we write to the department, referring to s.21A of the Act and ask the department to advise as to their intentions, whether they believe the child will be at risk and if so, what supports it is able to offer the mother in order to avoid the baby being removed after it is born. Our experience is that the department has required constant prompting to provide a response, which

suggests a strategy of delay. The response is usually vague and unhelpful, with no immediate plan to offer assistance to the mother. Sometimes the response has blamed another agency for not having capacity to assist the mother.

The outcomes have been poor for the woman and her baby once the baby is born. While we have successfully negotiated some babies staying with their mother, we have not been successful in all cases, even in those cases where we have sought specific information and assistance from the department.

Recommendations:

1) *The department be required under the Act to arrange for relevant community based services to provide assistance and support for a woman upon becoming aware of the pregnancy and having assessed the baby to be at risk.*
2) *That the department have a dedicated team to co-ordinate assistance for (at risk) pregnant women and settling of women and their babies in the community after birth.*
3) *That the department have a statutory duty to make all efforts (including mobilising community services) to assist (at risk) pregnant women (including proactively seeking assistance from family and other community agencies).*
4) *That (at risk) pregnant women be referred for legal advice as a matter of priority.*

2.2 Hospital based residential care units for mothers and babies

The department has submitted to the Inquiry that it does not necessarily become aware of an unborn baby at risk until late in the pregnancy. Our experience is that the department usually becomes aware by the time the mother is mid-way through her pregnancy.

Given, however, that there may be insufficient time for pregnant mothers to address risk issues or that planning may have been lacking on the part of the department, we recommend that the Queensland government fund a "mothers and babies residential unit" which is hospital-based and funded jointly by the Department of health and the Department of communities.

We recommend a semi-independent living unit where mothers can stay with their baby for an assessment period of at least 28 days (which may be extended up to 3 months if necessary). The unit would not be required to be large, given that it would be short-term.

Recommendations:

1) *That the Queensland government fund a number of small, semi-independent "mothers and babies units" at major hospitals covering the main regions of the State, where mothers and babies can be transferred to the unit for assessment and to develop an adequate support plan in the community for the mother.*
2) *That the department develop a specialist team to work with at risk pregnant women and "at risk" newborn babies.*
3) *That the departmental caseworker assigned to the mother during her pregnancy continue to work with the mother for the duration of her time in the mothers and babies unit, to develop*

a plan for the mother and baby to live safely in the community with adequate support services, accommodation, and family support and/or monitoring.

4) *That the Child Protection Act 1999 be amended to include a Court Assessment Order that a baby be assessed in a mothers and babies unit, with provision for the court to give directions to the department relevant to the purpose of the Court Assessment Order.*

2.3 Support for Young Parents at risk

We refer to the National Framework for Protecting Children[x] which envisages an approach that recognises that :

> *Recognising that the safety and wellbeing of children is the responsibility of all levels of government.*[xi]

We therefore recommend that funding be provided in areas where young parents can be supported in a community based setting. One example of such an approach is the "Young Mothers" group in Townsville, which provides ongoing support for young women with children. The group is not designed for "intervention" but for support of young women to become effective parents.

The support which young parents may receive from community based organisations may include:

- Parenting support (training and encouragement to learn parenting strategies);
- Transport assistance for mothers to seek medical or legal support;
- Information on medical, legal, child development and other areas which enhance parents' knowledge base relevant to their parenting;
- Recreation and networking opportunities;
- Strengths-based camps;
- Counselling;
- Planning for the child's future needs.

Recommendations:

That in funding community-based organisations, the Queensland government seek out and support funding which specifically targets groups which support young parents (mothers and/or fathers) having regard to the quality and level of support, targeting of young parents at risk, and the professionalism of the agency.

3. CHILDREN EXITING THE CHILD PROTECTION SYSTEM

The current child protection system, in our view, fails children exiting the system. There appears to be little planning. The planning, if it occurs, is too late, and there are few supports for children and young adults at this critical time in their lives.

In summary, *we recommend :*

1) *A specialist team within the department, which is dedicated to transitioning children out of care;*
2) *Planning and preparation of children in long-term care at an early stage of the child's adolescence;*
3) *Assistance to children to make the psychological adjustment to transition out of care;*
4) *A residential facility for adolescent children and young adults who either do not have a foster family to support them or who are transitioning out of care;*
5) *Government financial support for the child into early adulthood until the child achieves stability (stable employment; sufficient skills to continue to manage at a tertiary level of training or education). We would recommend that the Queensland government follow the NSW government model and continue funding for a period up to 25 years of age (depending on need).*

3.1 Specialist team

1) *We recommend that, as part of the department's funding it develop a specialist "youth team" in each of its regions, which is dedicated to transitioning children out of foster care. We would recommend that referral to the team begin in the children's early adolescence. While the actual workers may be a community based agency engaged by the department, we would still envisage the need for a youth and transition team within the department to work with children to assist in transition over a number of years.*
2) *We recommend that children at risk be identified and provided with an adequate level of ongoing and intensive support, with referral to relevant youth groups and other support services for teenagers.*

3.2 Residential care facility

Many children in foster care have bad experiences that leave them unsupported, or they have not been able to find families that they fit into. We strongly recommend that these children have a residential care option where they can live semi-independently and be supported and monitored by appropriately qualified and monitored house-parents. There are a number of examples of such residential facilities, similar for example to Women's Shelters and Safe Houses in Queensland, or the Catherine Villa model (Centacare) in NSW).

SUMMARY OF RECOMMENDATIONS

We endorse the recommendations of the National Framework for Protecting Australia's Children 2009-2020 in particular that :

> "Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children"
>
> And further its emphasis on a 'public health' model which aims to reduce child abuse and neglect and that:

"..offers a different approach with a greater emphasis on assisting families early enough to prevent abuse and neglect occurring."

1. **Recommendation** 1:
The department should better assess the qualifications, skill and experience of candidates for recruitment. There should be ongoing effective evaluation of workers, based on the worker's demonstrated communication skills, ability to work with families, effective links with other supports in the community (including the parents' legal team if any), to link families with support services and professionalism.

2. **Recommendation 2:**

That the department clarify its role legislatively and structurally. Ideally the department should not be involved in evidence gathering against parents as this undermines their other roles.

3. **Recommendation 3:**

That the department develop more streamlined transfer procedures for children subject to Child Protection Orders interstate being transferred to Queensland.

4. **Recommendation 4:**

That the department improve the availability and responsiveness of its after-hours service for child protection services (including more flexible after-hours and holiday shifts), and ensure it is available to people in regional and remote areas of the State.

5. **Recommendation 5:**
   a) That family members who have taken responsibility for children at risk, be eligible for assessment and support (e.g. economic, respite, and other support) to ensure that children's placements can be properly supported and protected.
   b) That an assessment of existing family support services be undertaken as soon as possible and that early intervention services (not requiring involvement of the department) be funded in accordance with assessed need, and be accessible to families living in regional and remote areas.

6. **Recommendation 6:**

That key services, particularly in the areas of drug and alcohol intervention, have their service delivery extended to parents who self-refer or who are referred by a legal service or a community support service.

7. **Recommendation 7:**

That there be legislative amendment requiring departmental officers to:

a) inform parents of their right to legal advice before proceeding with an interview or taking any other action;
b) provide parents with verbal and written information that departmental intervention is a legal process, that things that they say and observations that the department makes may be used against them in a court;
c) assist parents to obtain initial legal advice from a community legal service, Legal Aid Queensland, the Aboriginal & Torres Strait Islander Legal Service or the Qld Indigenous Family Violence Service in their area;
d) refer a parent who is an Aboriginal or Torres Strait Islander person to a culturally appropriate service;
e) refer Aboriginal or Torres Strait Islander women to an Aboriginal and Torres Strait Islander women's legal service.

8. **Recommendation 8:**

That in relation to parents having legal advice:

a) That Legal Aid guidelines be changed to ensure that parents involved in child protection matters are entitled to legal representation at all stages of their legal matter;
b) That funding to Aboriginal and Torres Strait islander services be improved to ensure that indigenous parents, and particularly women, have full access to justice and adequate assistance in relation to their child protection matters.

9. **Recommendation 9:**

In relation to the Recognised Entity:

a) That the RE be funded independently of the department.
b) That the RE recruit experienced and trained workers wherever possible.
c) That the RE be sufficiently resourced for staff of the RE to be given adequate training to carry out their role independently of the department, including adequate resources to make their own enquiries into matters in which they are consulted.
d) That the RE receive adequate funding for a training and professional development budget, and that meeting of training and professional development criteria form part of its accountability requirements, aimed at enhancing and supporting the professional development of staff.
e) That the role and functions of the RE be clarified in any future funding agreement, in particular to identify that the RE's function is to advise the department independently of the department's own views.
f) That the RE form part of an indigenous community consultative body to provide advice to the department and to the Minister on proposals to proactively protect Aboriginal and Torres Strait islander children, to support them to stay in their home, and to reduce the numbers of child protection interventions.

10. **Recommendation 10:**

That cultural outcomes for Aboriginal and Torres Strait Islander children in out of home care be enhanced through cultural awareness training of departmental staff and by providing children with cultural activities, including:

a) That as part of the department's training budget, it require staff to attend ongoing regular cultural training and evaluation from accredited cultural trainers;
b) That cultural awareness be regularly evaluated in the work that the department undertakes, including seeking cultural feedback by accredited trainers on work actually being undertaken by the department;
c) That only staff who have attained an appropriate level of cultural training be permitted to work with Aboriginal and Torres Strait Islander families (including work on their case plans);
d) Every child in the custody and/or guardianship of the Department, must have a cultural care plan including a geno gram which is approved by the Recognised Entity and the child's Aboriginal or Torres Strait Islander parent or guardian.
e) That the Act (s.83) be amended to make Cultural Care Plans a statutory requirement consistent with meeting the cultural needs of Aboriginal and Torres Strait Islander children in out of home care.
f) That community elders be contracted to hold regular activities for Aboriginal children and Torres Strait Islander children, which the children can attend while in out of home care (for example monthly activities co-ordinated through Aboriginal and Torres Strait Islander community organisations).

11. **Recommendation 11:**

That funding be made available for case meeting / FGM facilitators be independently sourced from a pool of accredited facilitators who are not employees of the department. (for example, Legal Aid Queensland to be provided with funding to appoint facilitators for case planning meetings and FGM's).

12. **Recommendation 12:**

That FGM convenors arrange for meetings be held in a mutually convenient and culturally appropriate venue in order to enhance and facilitate independence and the perception of independence.

13. **Recommendation 13:**

That case plans contain only the information necessary to identify any current child protection concerns in so far as these are risk issues being addressed by the parents in the case plans and that case plans exclude specific reference to untested allegations.

14. **Recommendation 14:**

That in relation to pregnant women whose baby is deemed "at risk":

a) The department have a statutory duty to arrange for relevant community based services to provide assistance and support for the woman upon becoming aware of the pregnancy and having assessed the baby to be at risk.
b) That the department have a dedicated team to co-ordinate assistance for (at risk) pregnant women and settling of women and their babies in the community after birth.
c) That (at risk) pregnant women be referred for legal advice as a matter of priority.

15. **Recommendation 15:**

That in relation to newborn babies deemed to be at risk:

a) the Queensland government fund a number of small, semi-independent "mothers and babies units" at major hospitals covering the main regions of the State, where mothers and babies can be transferred to the unit for assessment and to develop an adequate support plan in the community for the mother;
b) That the department develop a specialist team to work with at risk pregnant women and "at risk" newborn babies;
c) That the departmental caseworker assigned to the mother during her pregnancy continue to work with the mother for the duration of her time in the mothers and babies unit, to develop a plan for the mother and baby to live safely in the community with adequate support services, accommodation, and family support and/or monitoring.
d) That the Child Protection Act 1999 be amended to include a Court Assessment Order that a baby be assessed in a mothers and babies unit, with provision for the court to give directions to the department relevant to the purpose of the Court Assessment Order.

16. **Recommendation 16:**

That in relation to supporting youth:

a) The Queensland government support funding to community organisations which specifically support young parents (mothers and/or fathers) having regard to the quality and level of support, targeting of young parents at risk, and the professionalism of the agency.
b) The department develop a specialist "youth team" in each of its regions, which is dedicated to transitioning children out of foster care.
c) That children at risk be identified and provided with an adequate level of ongoing and intensive support, with referral to relevant youth groups and other support services for teenagers.

17. **Recommendation 17:**

That in relation to planning for children transitioning out of foster care:

a) The department develop a specialist team dedicated to transitioning children out of care;
b) Planning and preparation of children in long-term care begin at an early stage of the child's adolescence;
c) Children be provided with assistance to make the psychological adjustment to transition out of care;
d) The Queensland government fund a residential facility for adolescent children and young adults who either do not have a foster family to support them or who are transitioning out of care;
e) The government provide financial support for the child into early adulthood until the child achieves stability (stable employment; sufficient skills to continue to manage at a tertiary level of training or education). We would recommend that the Queensland government follow the NSW government model and continue funding for a period up to 25 years of age (depending on need).

18. **Recommendation 18:**

Children who have not been able to find families that they fit into, have a residential care option where they can live semi-independently and be supported and monitored by appropriately qualified and monitored house-parents. (for example based on the model of residential facilities, similar for example to Women's Shelters and Safe Houses in Queensland, or the Catherine Villa model (Centacare) in NSW).

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[i] Submission by the Australian Association of Social Workers Queensland Branch, August 2012, p.3
[ii] We use the term "child rescue" in the same sense in which it has been described in the submission of Dr Phillip Gillingham, Snr Lecturer in Social Work, University of Qld.
[iii] In one particular case, the evidence being hidden was only disclosed in subpoenaed material which indicated that the course being taken by the department was not only unjustified but actually placed the children at a specific risk of harm.
[iv] "Powering Families Submission" *Powering Families, Paula-Ann Hallinan*
[v] Transcript of XN NL Jeffers, 26/9/12 at pages 19-17 – 19-19
[vi] "Cultural Care for Aboriginal and Torres Strait Islander Children in Out of Home Care, Libesman, T, 2011, *SNAICC Secretariat of National Aboriginal and Islander Child Care.*
[vii] Submission by the Australian Association of Social Workers Queensland Branch, August 2012, pp.6-7
[viii] Ibid
[ix] Transcript of XN NL Jeffers, 26/9/12 at pages 19-29 – 19-36
[x] *Protecting Children is everyone's Business: National Framework for Protecting Australia's Children 2009-2020.*
[xi] Ibid p.9