Submission by

Townsville Aboriginal and Islanders Health Services

Queensland Child Protection Commission of Inquiry

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Townsville Aboriginal and Islanders Health Services

We are a people of our ancestors; we are a people of our land; we are a people of our culture; we are a people of our dreamtime; we are a people of our people; we are a people of dignity; we are a people of our children……..

To tell our story we need to ask the Commissioner to journey with us through our history and past experiences, our present time and our future in which we hold so much hope, determination and longing.

When you enter on the journey and step into our world Commissioner we ask that you come with an open heart and a longing to know and understand and respect, for only from that place within you will you truly master the spirit of understanding our people.

When we speak of our children please be mindful that we are speaking of the ancestors of the children who will bear children and those children will honour today's children as their ancestors.

We need our children to walk a path that brings a sense of belonging to our people……..a path that is steeped in their culture and tradition.

The journey will take us to the many stories of grief and despair, of loss and great anxieties, of fear and trepidation, of chronic illnesses and premature death.

We walk bearing the many labels gathered as we pass through the different stages of our own development and survival such as family violence, drunks, drug abusers, homelessness, sexual abusers, child abusers, and juvenile criminals.

From these dark alley ways has emerged broken human beings seeking a sense of his or her dignity and worth, seeking a sense of belonging and inclusion, seeking to be loved and respected.

Today's journey is not too different from our past. The 21st Century will write its own words on our cultural history and sacrifices. The residue from our stolen generation lives on in the hearts of our elderly and is visible in our young. The evidence is profound in that we have the highest rate of children in protective care. Our journey and our story must not allow such atrocities to be deleted from the annals of Australian history or be repeated with the same "good intentions".

The stories written about today's Aboriginal and Torres Strait Islander people will carry the thoughts and aspirations of our people as written by our people. As you journey with us Commissioner we invite you to embrace the story of our world as we live it today. As we walk a

path of personal healing we ask you to acknowledge our grief and our losses and journey beside us with a shared determination to make our country and our land a safe dwelling place for all our people.

The simplicity of our love of family and kin is not a reflection of a weakness or discontent. The strengths that encompass this simplicity are magnified in the traditional extended families resolute to be there for one another. The presence of aunties, uncles, nanas, pops and cousins provide our children with traditional leadership and an understanding of their growth towards womanhood and manhood. This strength cannot be reproduced by any person in the public arena who has no knowledge or those who claim to have some knowledge and understanding of cultural appropriateness.

As we take you deeper into the experiences of our journey we will familiarise you with the undignified processes carried out by people who have very limited understanding or awareness of cultural appropriateness. We are bombarded with questions; case managed; assessed for this and assessed for that; judged as being compliant or non-compliant; taught strategies and/or techniques; put on programs and removed from programs; we are funded and non-funded; we are told what we need and when we need it but rarely told WHY we need it or, when we will cease to need it. People talk AT us and around us but rarely TO us.

While we recognise the intent as being one of service and an expression of care we are fearful of the ignorance that often accompanies and guides the good intentions of those wanting to journey with Aboriginal and Torres Strait Islander families and individuals. It is in this ignorance that we experience so much of our loss of culture and dignity.

Cultural consideration is our primary request of the Commission. We need that consideration to encompass every decision made by the Commission particularly with the attention given to addressing the over representation of Aboriginal and Torres Strait Islander children in care and the specific recommendations of the Crime and Misconduct Commission's (CMC) 2004 report *Protecting children: An Inquiry into Abuse of Children in Foster Care.*

Our journey to date has taken many turns and brought us face to face with adversities and hardship. Step gently on our land Commissioner and celebrate with us as we gather strength to rise above the insults and discrimination, the name calling, the degradation of our land and spirit, the shame felt by loss of dignity, the separation of our children from family and our cries in the

night awaiting their return. Our spirit is rekindled by our people who work for the Townsville Aboriginal and Islanders Health Services (TAIHS). With a background steeped in child protection TAIHS is a key non-government body of highly skilled professional personnel committed to the provision of Health Services for Aboriginal and Torres Strait Islander people. Since its inception in July 1975, TAIHS has grown in its commitment and service to children, young people and families and in 2012 is providing a wide range of primary and allied health, mental and social health, early intervention, stolen generation, homelessness, drug and alcohol and other programs.

The four TAIHS programs directly involved in delivering child protection services to the Townsville region and across a large area of North Queensland are funded by the now Department of Communities. The programs are the Recognised Entity (RE), Foster and Kinship Services (FKS), Family Intervention Service (FIS) and Family Support Services (FSS). TAIHS has been delivering the RE, FKS and FIS services since approximately 2001 and the FSS since late 2010. All four programs demonstrate TAIHS strong commitment and capacity to work together in partnership with our clients to achieve greater outcomes for Aboriginal and Torres Strait Islander Queenslanders.

The RE and FSS programs service an area that covers approximately 212,000 km^2 square kilometres or 12% of Queensland (including Palm Island). The Foster and Kinship Services cover an area of approximately 121,555 km^2 (7% of Queensland).[1] The FIS program delivery is confined to the city of Townsville.

Investment in the delivery of these programs has afforded TAIHS a unique and privileged insight and comprehensive understanding of the issues confronting the families in the region. These issues include alcohol and drug abuse, homelessness and over-crowding, trans-generational trauma, a transient population, high rates of single parent households, high numbers of families with young children, disengagement with the education system, chronic health problems, widespread poverty and unemployment, and family violence. The issues are widely recognised and acknowledged as contributing factors in the over representation of Aboriginal and Torres Strait Islander children in the Child Protection system in Queensland and all other States across Australia.

[1] *Queensland Regional Profiles*, Office of Economic and Statistical Research, Queensland Treasury and Trade (August 2012).

The Indigenous population of the region covered by the TAIHS services is 22,372 which represent 5.8% of the total population.[2] In comparison, Indigenous people represent 3.6% and 2.5% respectively of the total Queensland and Australian populations.[3]

As you see can see Commissioner, we have not been idle in our drive for self-determination and self respect which can only result from being masters of our own destiny. We are learning and in that learning we are truly discovering who we are as a people. We are rekindling our spirit and walking a path of belief in our ability to heal and transform our darkness into a light of wholeness and pride in being an Aboriginal or Torres Strait Islander person.

We further invite you Commissioner to journey with us in our efforts to strengthen our people, as indicated in our following case studies, and become familiar with the ways in which we believe many of the difficulties we encounter when working with our people are able to be resolved, as indicated in our recommendations.

Case Study 1:

Client is male, 41 years of age and of Aboriginal and Torres Strait Islander descent. Client has lived in the community all his life and is considered to be a respectable member of this community. He has been gainfully employed throughout his adult life and often takes on a second job part time. Client comes from a respectable family and has no criminal history recorded. Client and his partner reside in a remote aboriginal community where accessing particular services is often difficult or non-existent. Client lives in a de-factor relationship with his partner and their biological children, two boys aged 2 and 5years. Both children are currently in child protection.

Case Details:

16 months ago: - The mother made a notification to child safety that she had walked in and caught her partner indecently dealing with their oldest child who was around three years of age at the time.

With the support of Child Safety, the mother and two children left the remote community and were resettled in suitable, safe, affordable accommodation.

As there was insufficient evidence to convict the father (client) of any criminal offence, he was found to be not guilty of the allegations.

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[2] *ibid*

[3] Australian Bureau of Statistics (2012), http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickst/3?opendocument&navpos= accessed 28/08/2012

Child safety recorded this case as substantiated.

2 weeks later – The mother reported being afraid of her partner (client) and applied for a protection order for her and the 2 children. A hearing has been set to address the father's objection to this order. Two years on and this has still not happened.

The mother reported she was visiting the remote community for a week and than returning back to her new home with the children.

The mother states that she no longer wishes to continue with a protection order. Further, mother retracted statement regarding alleged abuse and in our review this has not been properly indicated.

2 months later – the child was noticed approaching his father (client) at the airport. It was reported that the father appeared agitated and sent the boy outside. Later it was found that the mother had returned to the remote community with the two children and is residing with the father (client) of the children. It is not known when this move occurred.

Notification is made and children are removed and placed on a two year protection order.

Kinship options are currently being explored by the department. Family has had no appropriate legal advise and do not understand what is happening. Lack of information does not facilitate worker's full knowledge and understanding which leads to misinformation

Concerns identified

The protracted delay in receiving support has been hard on the family. The Department's misinterpretation of the parent's feelings of helplessness and frustrations resulted in the family being labelled as having relationship issues and said to be displaying signs of mentally abusive behaviour. The effect of this judgement on the parents has created a sense of helplessness which has manifested in deep seated anger. The mother earlier expressed having thoughts of suicide due to these feelings of helplessness. The family have many concerns, one primary one being that the CSO has been observed making attempts to dodge the family when they attend the office to discuss concerns. Child safety moved forward actioning new case plans when previous case plans clearly demonstrated a lack of action or engagement, none of which was brought to the family's attention. Nor was the family asked why they made no attempt to participate in required activities. On many occasions the family made attempts to discuss the return of their children with the CSO. It appears that the CSO made the assumption that the family was well informed

regarding all the requirements. This raises two points. (1) Causation of the family not attending the case plan meeting in the beginning. (2) Why the issue of "no engagement" failed to raise concern particularly in the arena of improved communication between CSO and the family.

One of the main problems facing support workers is the limited information provided by CSO in the referral process. Too often support workers are given a snap shot of the concerns and the support worker then has to give considerable time to joining the pieces together which results in valuable time being wasted. If the support worker is left in the dark through lack of evidence, it raises concerns regarding evidence being withheld from the clients. If clients are also left in the dark because the CSO has not provided them with the evidence to support their claims how is the family meant to defend their name. The service expresses concern that children are able to be removed without vital information being put on the table for discussion by all parties.

Key Issues:

1) Lack of involvement by Child Safety officer during re unification process.
2) While the parents were present at the case plan development they were not advised of their rights nor had the processes explained to them.
3) Goals were never addressed or identified.
4) The review process did not raise concern or identify the need to communicate with the family regarding why they were not engaging with support services.
5) Visitation is not monitored by CSO raising concerns about how the parents are being assessed regarding their parenting skills and connectedness with their children.
6) A new case plan was devised without the family's knowledge. A copy was provided to the family during an arranged meeting with their newly appointed FSS support worker.
7) Visitation changed from fortnightly to weekly within a time frame of 18 months.

Practitioner's Recommendations:

There is a huge identified need for an improved style of communication when explaining to the parents what is required of them. This would enable greater understanding by the parents and assist in achieving necessary outcomes.

That Child Safety work in partnership with service providers

That Child Safety work as equal participants in assisting clients and refrain from working from a perceived position of superiority.

Case Study 2:

The family unit is Mum, Dad and six children. The family have been clients of our service for approximately two years with no major outcomes achieved due to the parents not fully engaging.

Case Details:

While working with the family there were many occasions when alcohol fuelled violence resulted in the police being called to the property. During these times the absence of a responsible adult capable of being in charge of the children was observed. The parents had a number of friends and relatives coming and going from the home on a regular basis. This seemed to add fuel to the tension and intensified the issues caused by the partying and drinking. The safety and security of the children was ignored by the adults. A Drug and Alcohol Safety Plan was developed with the family which proved ineffective with no cessation of partying or drinking.

The yard was often untidy with rubbish observed in every direction. Empty cans and bottles of alcohol were also observed around the yard and under the house raising concern for the safety of the children. On occasions, when housing or child safety visited the home, the yard would be clean and neat and tidy.

Regular visits to the family found the children in a very dirty condition and walking around in soiled nappies or, as often seen, completely unclothed. The family said they had not paid their gas bill resulting in their gas being cut off. Due of this they had only had cold water in the house for bathing the children. They explained how they boil the kettle for the children's bath sometimes. This situation would undoubtedly be contributing to the unclean state of the children.

The parents showed little concern regarding the necessary medical attention required for each child. The family failed to attend appointments and follow ups. The parents failed to seek medical attention for the burns, ring worms, cuts, etc. suffered by the children. The children's medical conditions are often dealt with by service providers. Often the service providers made medical appointment for the clients and just as often the clients fail to attend resulting in the children's health being put at further risk.

The family had also previously been clients of Relationships Australia (RA). This was terminated due to the mother's aggressive behaviour towards RA staff. Child Safety said they had no issues regarding working with the family.

Arrangements had been made for the father to attend a program; he presented on day one and chose not to return for the remainder of program. This action demonstrated his unwillingness to work on making necessary changes.

There is strong evidence to support the understanding that the children had no adult supervision. No concern was raised by Child Safety to address this matter. We were informed by Child Safety that a recent serious incident experienced by the family had not caused any immediate danger to the children.

Concerns identified:

The children's health appeared to be of little concern to the parents or to Child Safety. The parents failed repeatedly to keep medical appointments and with providing the children with prescription medication.

The children were present and exposed to the drinking and partying at the house and to viewing and hearing the violence that is a normal occurrence in the home. While the parents said they were willing and able to provide appropriate care for their children, there was no evidence in support of their statement. The service noted the children had not been bathed and were playing in the area where the drinking and partying was taking place. The service also believes that the environment was unsafe and unhealthy for the children and expressed confusion and concern that the plight of the children was not recognised by Child Safety.

The parents did not engage well with the service which meant they didn't achieve their identified goals. While they had identified their goals there was no application to achieving outcomes. The clients present as being totally reliant on help from others. There is no evidence to support the client's statement that they are "willing to do anything" to work with the service.

Systemic Issues Identified:

The lack of Child Safety involvement was identified. The service is confident that had Child Safety showed more concern and had more involvement, the motivation towards change by the parents would have been more apparent. The service also believes the parents may have been more involved in the health and well-being of their children had Child Safety been more involved.

The children have been exposed to incidents of violence occurring at the residence. It is noted that these children were not under protective orders.

The service found working with this family to be very frustrating. Had Child Safety identified that these children were at risk the potential for greater protection for the children would have been realised. The service understands there is reluctance on the part of Child Safety to have any further involvement with the family.

As the family have always had other people in the home, it was deemed by Child Safety that protective behaviours were in place, and therefore there was no failure to protect.

Key Issues:

1) The continuation of drinking and partying and the number of people making regular visits to the family's home.
2) Safety plans put in place to reduce the number of people visiting the home and to ensure greater safety and security of the children were ignored by the parents.
3) Failure by the family to attend medical appointments as arranged by the service providers.
4) Evidence provided by Child Safety regarding the children's safety being at risk failed to generate appropriate action from Child Safety.

Practitioner's Recommendations:

The child protection system needs to address parental responsibilities in much greater depth. It is important that both parents be held accountable with equal responsibility being shared between the mother and father.

The child protection system needs to seriously address the reliance on other family members in the home to provide care of the children. Where it is culturally appropriate, there is a need to highlight that parents are the primary care givers of the children. Every child has the right to protection from harm with parent/s having the primary responsibility for the upbringing and protection and development of their children. If a child does not have a parent able and willing to protect the child, the State has a responsibility to protect the child, but in protecting the child the State must not take action that is unwarranted in the circumstances. When making a significant decision about an Aboriginal or Torres Strait Islander child, the Chief Executive Officer or an authorised officer must give an opportunity to a recognised entity for the child to participate in the decision making.

Mainstream care agencies need to include TAIHS in the consultation process in relation to broader foster care issues or in relation to specific needs of Indigenous families.

Case Study 3:

Client is 41 year old female with 9 children ranging from 11years to 20 years. The four youngest reside with client and her current partner.

Case Details:

Client has been in the relationship with current partner for twenty one years'. Her ex- partner has perpetrated domestic violence against her consistently throughout the twenty one years and rationalises his behaviour as 'keeping them in check'. Client resided at an isolated farm for many years with her children where it is said her ex-partner abused her financially, sexually, emotionally and physically. The client disclosed that her three daughters were also sexually assaulted by their father (client's ex-partner). The case is under investigation.

Client is currently applying herself to rebuilding her life and the lives of her children and has expressed wanting to be reunified with her older children.

Client has had dealings with Child Safety for the past twelve years. It is reported Child Safety had been notified of no less than ten incidences over the twelve years regarding various allegations pertaining to individual children in the family. Though the allegations were substantiated with a conviction against the father, Child Safety found with each case that the child was not in need of protection.

Client is currently residing in a small, isolated town for the purpose of protecting the children from the father. Client said father is not taking the temporary protection order seriously. He has come to the town to see the children; he approached a police officer at the police station and asked him to help him see his children at the school. The police officer went with him to the school to see his children. Client was extremely distressed on hearing the school principle allowed her ex-partner to see the children.

Client spoke of the protracted domestic violence she has lived with for the past twenty one years perpetrated by her ex-partner and how it has affected her health. She said she has received very little support from Child Safety and other government departments over the years.

Client is Aboriginal and her ex-partner is non-Indigenous however, he was able to access ATSILS (Aboriginal Torres Strait Islander Legal Service) to defend a DVO that had been placed on him.

Client was refused support from ATSILS on the grounds it would be a conflict of interest. Client has sought legal assistance from four legal firms without success due to her case being too complicated. With the information provided to the service regarding the Indigenous client's experience with the legal service, we seriously question the Legal service's failure to support the Indigenous person.

Concerns Identified:

Client has issues of trust due to lack of support from Child Safety and other government departments including Queensland police and ATSILS.

Client lives in fear of her ex-partner ignoring the Temporary Protection Order and in an attempt to have contact with his children may resort to further harming them if he doesn't get his own way.

Key Issues:

Investigations into numerous reported incidences by Child Safety assessed the children as not being in need of protection.

Child Safety assessed 'substantiated incidences' as the child not in need of protection

Child Safety failed to identify patterns of cumulative harm perpetrated against the children over a twelve year period by their father.

Case Study 4:

The family unit is mum, dad and three children aged 9, 2 and 1 month.

The family was under an Invention Parental Agreement (IPA) with Child safety when they received the referral to TAIHS Family Support Services (FSS). Initial contact was made with the family by FSS on 24th January 2011.

Child concerns where identified for the one month old when Queensland Health staff noticed bruising on the child's arm.

The father had been caring for the children while the mother remained in the hospital due to complications following a caesarean delivery. The family had substantial family support and it is said the children were well cared for while the mother was in hospital.

While attending a child health appointment, client was informed that her one month old had three broken ribs. The attending medical practitioner ordered x-rays be taken of the child's shoulder, ribs and wrist. The mother became distressed by the way the medical team were holding the child's arm. She believed they were applying too much pressure. The x-rays revealed her child had three fractured ribs, a fracture on the child's wrist and another fracture on the child's shoulder. Clients were advised when they returned to see the paediatrician that the fractures had healed.

Client asked when the fractures would have occurred and was not given an answer. Doctor told client that the times of the injuries are unable to be determined.

Notifications were received and Child Safety visited the family home on 21st January 2011.

The parents said they were required to meet weekly child health checks until further notice from Queensland Health. Clients said that to date they have not received a response from Queensland Health. The allocated Child Safety Officer was not in receipt of paperwork from Queensland Health and therefore was not aware of requirements pertaining to these clients.

The service went with mother and child to attend a weekly health check where the child was reviewed by a relieving paediatrician. The doctor told the client that he had no knowledge of why the family was asked to bring the child in weekly. The relieving doctor changed the child's health checks to monthly.

The service was provided with very little information within the initial referral from the North Queensland Regional Intake Service. A paragraph was written about two small bruises noticed on the child's arm. A second referral was received on the 22nd January 2011 from the Department of Communities that had recorded notifications received from 2003.

Case Details

Client made a statement to the people present during a Family Group Meeting saying that she could feel the hospital staff pulling her child from her with extensive force during the caesarean section delivery.

The client's said that that they enjoy considerable involvement with their community including attending church and organising and facilitating community events. They also said that they provide opportunities for their children to engage in their cultural customs and practices, social events, community fates, recreational activities/clubs and church events.

Client is a mother of five children. Her two eldest children have been raised from a very early age by client's mother. Client say's she maintains regular contact with her two children. The service has observed that during these contacts the children appear to enjoy a healthy, parent/ child relationship.

My client's told me that they had taken their one month old child to Townsville Hospital for their child to have an MRI. My client's do not recall why the test was ordered. The parents of the child tell me of the distress they had when they saw their child in recovery with the side of the head shaved and a drip attached. When client asked hospital staff why their child's head had been shaved they were told their child was dehydrated. Staff explained they were unable to get a line in for the drip in hand and had to attach the drip to the side of the child's head.

After receiving the second referral it was documented that the child would be undergoing further tests to rule out a possible bone condition. Results confirmed that the child did not have any disorders that would explain the bruising. The referral received said the child had a fractured rib

and a fractured top left upper limb further on in the referral it reads the child had two pea shaped bruises on the left upper arm and three fractured ribs that had been confirmed by radiological examination the referral did not mention any injuries made to the child's wrist.

Developing a professional relationship with the family enabled the service to strengthen the parenting skills required to cope with their two year olds challenging behaviour. Client told the service that the techniques were being implemented however; the techniques were not working because the mum and dad were not working together with implementing the strategies and techniques. The service explained to clients that as parents they need to parent together and be consistent.

Key Issues:

During visits to the family home, the service observed the children displayed a secure attachment to their parents. The children played independently and received comfort, guidance and assistance from their parents when sought.

Unexplained fractures to shoulder, wrist and ribs were noted on client's one month old child. The parents are waiting to receive the results of the MRI. The Child Safety Officer told our service they had been in contact with Queensland Health regarding the child's MRI results. Child Safety Officer is waiting for Queensland Health to get back to them.

My clients reside in the family home with their three children. The 9 year child attends school; the younger children attend day care three days a week while the parents are at their workplace.

Client had our service that they are both gainfully employed. The mother said she is completing a TAFE course to further develop skills required of her job.

Systemic issues

Clients told the service they do not recall Queensland Health telling the family why the tests were carried out on their child; nor do they recall being given the results.

Other issues impacting severely and negatively on Indigenous families in relation to entering and/or moving through and/or exiting the child protection system.

It is important to note at this point that each of the TAIHS child protection services operates within a framework of its identified client as per the individual service's Service Agreement with the Department. The 'client' for each service is as below:

- Recognised Entity – the Department of Child Safety
- Foster and Kinship Care – the child/children in need of foster and/or kinship care

- Family Intervention Service – The Department of Child Safety
- Family Support Services – The family – with the best interests of the child/children being paramount.

Identification of the deemed 'client' for each service highlights a key factor in the different operational frameworks of the four services, and in addition, highlights the capacity of each service to act as an advocate (as and when appropriate) for Aboriginal and Torres Strait Islander families involved with the individual services and the Department.

1. Cultural considerations:

    1.1. At Departmental level, many Child Safety Officers (CSOs) are new graduates with little experience working with families and even less experience working with Indigenous families;

    1.2. Many CSOs do not have an adequate understanding of either Aboriginal or Torres Strait Islander cultures and while most are very keen to gain knowledge and understanding, the very nature of their work and the issues and time-frames they work within severely limits their capacity to gain such knowledge and understanding. Too often, it is left up to individual workers and hopefully if they have one, a good Manager and/or Team Leader to promote opportunities for workers to interact in a learning capacity with Indigenous organisations and/or workers so that the CSOs are able to learn;

    1.3. There is a significant issue regarding some CSOs still making value judgements when working with Indigenous clients. While TAIHS services attempt to deal with such instances on a case-by-case basis, it is very problematic that this is still occurring given that the majority of CSOs are trained across the various human service disciplines which specifically exclude the making of value judgements. It is also problematic given that the Department's own framework espouses that all contact with Indigenous people should be conducted in a manner that acknowledges and appreciates cultural differences.

2. Resources - Human:

    2.1. The number of cases allocated to individual CSOs is often very high and in too many instances, does not reflect the case mix i.e. the number of low, medium, high needs of the client families and does not provide adequate time for CSOs to properly engage with their client families;

    2.2. Whilst becoming less prevalent, there are still far too many instances where it appears that racism, bigotry and ignorance are still evident in the attitudes of some CSOs towards Indigenous families particularly parents. There is also an attitude in some instances, where the issues facing Indigenous families are so complex that CSOs do not know where to begin. If there is an Indigenous family support program operating in the

area, the family may be referred to that service. Unfortunately, in a few instances, this also means that the referring CSO then wipes their hands of the family and places all onus on the service to 'fix' the family.

2.3. New CSOs are at the mercy of 'time availability' to receive training in aspects of what is happening either in their local area and/or actual operational facets of their position. The onus is then placed on service providers, particularly Indigenous organisations to continually 'visit' Child Safety Service Centres (CSSCs) to 'update' new CSOs on their programs etc. Whilst TAIHS has been more than happy to do this when possible and believe such visits assist in creating positive rapport with the Department and CSSC staff, it is not the job of TAIHS program staff to be providing training to CSOs about what our programs do. This information has been provided to the Department and individual CSSCs on numerous occasions but it appears that it is rarely provided by the Department to new CSOs. The excuse that there is such a high turnover of CSOs and therefore TAIHS services 'should' be providing this information is merely an abrogation of Departmental responsibility to train and resource its staff appropriately.

2.4. CSOs, and indeed, all workers within the child safety system, work with highly disadvantaged families, many of whom are also highly dysfunctional. It is work that can and often is extremely stressful, too often – heartbreaking, and creates huge pressures on staff to try to always be doing the 'right' thing for everyone concerned. The majority of Child Safety staff are dedicated to assisting children and families and TAIHS acknowledges and appreciates their efforts to assist Aboriginal and Torres Strait Islander families who have entered the child protection system in any capacity. There needs to be a higher level of support for Child Safety Workers and either more staff to do the work required and/or improved methods of dealing with case load/case mix allocation – preferably both.

2.5. Workers in the community sector are also confronted with many of the issues facing CSOs. It is to the Department's credit that over the past ten years there has been a much greater recognition of how issues from the past and the lack of assisting clients to deal with and overcome past trauma has affected Indigenous people and significantly influenced the over representation of Indigenous children within the child protection system. In recognition of this, the Department has provided much clearer and more evidence based frameworks for programs aimed at working with families to reduce such over representation. However, this same positive feature has also created one of the key issues facing the Indigenous community sector working within the child protection system i.e. recruiting appropriately trained/qualified staff and particularly Indigenous staff with the required training/qualifications AND experience to deliver such programs. This generally means that there is a significant lead time in recruitment and often means that there is a high need for additional training for new staff to get them 'up to speed' before effective service delivery can be achieved. This in turn, places a higher impost on training requirements both in terms of time 'out of the field' and the financial cost of

such additional training. Unfortunately, neither of these imposts are generally recognised within key performance measures and/or reporting on Service Agreements by Department staff other than those who either still do or have significant experience working in the field with Indigenous families.

2.6. There is also an issue in relation to the delivery of training to foster and kinship carers where TAIHS staff are expected to pick up the slack of training not delivered by the Department or other community based providers e.g. mainstream services will not do outreach training for less than five people. However, TAIHS staff have to provide training to all of its client families regardless of numbers of attendees or the distances required to do so.

2.7. Several TAIHS staff (from both FKS and the FSS) have advised numerous instances where TAIHS has not been consulted on foster care issues that impact across the sector in both mainstream and Indigenous care and service providers. In one instance alone, a community service provider's meeting for the sector completely ignored everything stated by the TAIHS representative both at the meeting and later in the minutes of the meeting. Decisions were made as an outcome of that particular meeting that affected both the mainstream and Indigenous carer sector and that did not even remotely reflect the needs of Indigenous carers. Given the multiple competing time frames of all TAIHS workers, it is difficult to allocate time to attend what should be an inclusive meeting that respects all perspectives when it is known that it is "virtually pointless to attend because nobody is listening anyway".

2.8. A further issue impacting in the Indigenous foster and kinship care sector is the generally endemic failure of the mainstream and Government sector to acknowledge and therefore appreciate the differences between 'foster care' and 'kinship care'. These differences are largely cultural and what may be okay/not okay for an Indigenous family to do as 'foster carers' for Indigenous children not of their kinship group, may be the exact opposite if it involves children in 'kinship care'. This is particularly relevant when actions involve discipline.

3. Resources – Financial:

3.1. As alluded to at 2.2, 2.3, 2.5 and 2.7 above, there is a need for Government to recognise the absolute need for appropriate training for both departmental and community sector staff working in the child protection system and for the provision of appropriate levels of support for such workers. Funding allocation needs to reflect such recognition.

3.2. Government funding operates within a framework of an approximately 70/30% mix i.e. 70% of the total funding for a program is for salaries and related on-costs with the remaining 30% allocated to operational costs. Whilst it is acknowledged that there is

some flexibility within this model to alter the percentage mix, such flexibility is limited. A key issue with this percentage split model is that it does not address adequate funding for either the training needs identified above, nor the motor vehicle and travel, staff safety (e.g. Because of the lack of human and financial resources, TAIHS staff frequently have to travel long distances alone in comparison to Departmental officers where two people would always travel together) and related costs of delivering a service across an area of over 212,000 square kilometres. The Government and the Department need to address ways to efficiently and cost-effectively develop a funding ratio mix that is flexible enough to deliver a program in the manner that the Government and/or Department desire such programs to be delivered.

3.3. TAIHS acknowledges however, that Departmental officers have worked pro-actively with TAIHS to assist the four child protection services to use the limited resources in a way that facilitates meeting Service Agreements in the most cost-efficient manner and that has the highest potential to meet client needs in the majority of instances.

3.4. Financial support to carers in isolated and/or high cost areas (e.g. Palm Island, Hughenden) is the same as that provided to carers living in major centres (e.g. Brisbane) and does not take into account the higher costs of staple foods, transport and access to other needed services. It was reported by one staff member that when queried on this issue, a Departmental officer stated that "it was the client's choice to live in a remote area" with the implication therefore, that the clients should carry the higher costs of providing foster and/or kinship care. TAIHS staff have advised that in many instances, it is cheaper to buy the same staple items at Uluru than on Palm Island.

3.5. The following is an excerpt from an email from a TAIHS staff member in relation to costs and other issues involved in providing foster care, particularly in remote areas:

> The decision to remove the Sport and Recreation grant in my view, creates a situation where a negotiation for resources for all children in statutory care needs to happen on a case by case basis. This would be fair enough if there were some consistency in terms of what resources are to be factored into Case Plans and Placement Agreements from team to team, service centre to service centre and region to region, however, there is enough information to suggest that consistency between departmental workers is suffering from the individual views on making any commitments to resources which is based on their own beliefs on what is important enough to consider.
>
> Given that Placement Agreements are generally formed to assist carers to work towards catering for the child's strengths and needs as identified in their Case Plan, an emphasis on resources needs to be made in the various types of meetings used to formulate a Case Plan. The different types of meetings that I personally have been involved with that were tasked with identifying the child's strengths and needs are as follows:

- Stakeholder Meeting
- Family Group Meeting
- Case Plan Meeting
- Non-existent Meeting (Where the Child Safety Officer compiles a Case Plan similar to the previous Case Plan for the child and the Team Leader signs off on it anyway)

How does this relate to the Placement Agreement?

If there an expectation that a carer will facilitate transport to school, sport and recreational interests, family contact, cultural connections etc., and high costs that are impossible to meet through the carer payments are not factored into the Case Plan, it is highly likely that approval for the resources will need to come from the management of the service centre. In a lot of cases, this type of approval has taken the majority of the span of the Placement Agreement, if it is granted at all, which means that the child will generally miss out on having certain needs met due to the carer not being able to afford it.

So…how does this tie into maintaining placements?

If a child is removed from their family, (and as is quite often the case in our catchment area, their community), having their strengths and needs catered for is not a matter making life easier for the child. From the child's perspective it is an issue of survival. If there is constant disappointment to the child caused by being let down with facilitating their strengths and needs, in addition to the pain based trauma that occurs through harm, neglect or continual upheaval in their lives, the average foster carer and the majority of kinship carers do not have the necessary skills to prevent the reactions of the child to this adversity.

Whilst we as professionals and/ or community members cannot take back the trauma that most children in care have suffered, we can ensure that we do not cause anymore trauma to them by placing a priority on their strengths and needs over the budget. If we have to do without committing to certain projects that will appease voters who are oblivious to how hard life can be for others and pump resources into providing secure placements for children in statutory care, the dividends will be high enough to present it as a sound business decision.

4. Operational:

4.1. Child Safety assessments of the level of need and/or intervention required by/for individual families is based on the 'Family Risk Assessment' (FRA). The FRA was designed to eliminate many of the inconsistencies previously apparent as an outcome of Investigations and Assessments (I&As). However, the FRA is still completed by CSOs who 'tick' the boxes most appropriate to the concerns identified in individual families. This means that there is still scope for personal perspectives to determine the outcome of an I&A. There have been numerous cases where the findings of an I&A in terms of whether a child is in need of protection and the subsequent potential of placing an order

on the family does not reflect the situation found by TAIHS case workers across our service once they begin to engage with the families. There also appears to be little scope for flexibility to achieve a change in such outcomes. For example, in once instance where one of the TAIHS services made a notification in relation to their client family, the outcome of the I&A maintained the status quo as per the FRA (i.e. no order placed). This was despite the belief (alluded to by Department staff) that the case did require further intervention. It took considerable action on the part of the relevant TAIHS staff to advocate with the department to re-examine the circumstances of the case outside the FRA and for further action to be undertaken by the Department. The FRA is a useful tool, but it is not infallible and is just as subject to human perspective as any other electronic tool that requires a human being to 'tick a box'. There needs to be a more open and transparent way to address those instances where the FRA gets it wrong.

4.2. With the exception of RE, other TAIHS child protection services are generally not advised when further notifications occur relating to existing client families. Such advice usually only occurs where there is a close working relationship established between individual workers. This is despite the fact that various tools are available to Departmental staff to advise individual programs about updates etc. For instance, the Community Sector Information System (CSIS) used by the FSS Program can be used by CSOs to advise the FSS of any relevant information and/or update regarding an individual client family. This is rarely used and when CSOs are queried on the issue, FSS is usually advised by the CSO that they didn't know they could do it, or in some instances with newer CSOs, that they didn't even know CSIS existed. (Refer also to item 2.5 above and to Item 6 below.)

4.3. As noted previously in this submission, there are many CSOs who do not appropriately communicate with Indigenous families and who appear to have no real awareness and/or knowledge about the issues impacting upon their client families. TAIHS understands and acknowledges that the purpose of Child Safety is to protect children, however, in those instances where the best potential outcome is in working with the whole family, communication and mutual understanding is essential. Too many families receive no information from CSOs in relation to what is happening with their case, case plans are often unrealistic and simply unachievable by the family (e.g. attend various appointments in another town when the family has no vehicle and there is no public transport available), attend parenting or other courses that are simply not appropriate to the needs and/or issues occurring within a family and in some instances, not even relevant to the identified issues and/or concerns.

4.4. Participation by families in family support or other types of programs is generally not compulsory and many families merely pay lip-service to departmental and/or service requirements to assist them to meet goals (e.g. Case Study 2 of this submission). Had there been a higher level of intervention and participation by Child Safety and a more concerted effort made by Child Safety to listen to and work in with the specific service trying to work with the family, there may have been a better outcome. There needs to

be some method developed which places a stronger responsibility on parents in such instances to actually do more than pay lip-service to Child Safety requirements to engage with community service providers, particularly where alcohol, drugs and violence are key factors in the risks to children.

4.5. Current policies do not involve compulsory training for kinship carers. The TAIHS experience in this area over the last ten years is that training should be mandatory for all carers including kinship carers. In addition, all training for Indigenous carers whether foster or kinship, should be provided in a way that is culturally appropriate and relevant and should be provided in a way that easily understood by carers.

4.6. There is currently provision for transitioning children to exit the foster care child protection system. However, there is no provision within the system for transitioning children into care. Such a transition process should include facilitating the child/children's understanding of what is happening to them, a more effective partnering or 'matching' of children to suitable carers, and early provision of support and/or counselling if required to enable children to deal with both the trauma of the event that precipitated the need for removal and the additional trauma of the removal itself.

4.7. As noted at 1.3 above, there are instances where value judgements are being made 'against' Indigenous families. Whilst this is problematic in itself, it becomes more problematic if it results in families entering the child protection system simply because a CSO doesn't like someone's housekeeping standards or the way children may be dressed. We have received referrals where TAIHS staff visit the family and find no evidence of the 'so-called' poor housekeeping and/or poor hygiene of the children upon which the referral is based. In such instances, TAIHS often note different 'standards' may be present but that such standards are not unacceptable or that the children are at risk because of the difference.

4.8. There have been instances when carers (Indigenous and non-Indigenous) have been provided with too much information about the family situation and/or where such carers have attended Family Group Meetings and been present when topics have been discussed that should not have been discussed.

4.9. Mainstream foster carers are rarely provided with appropriate support when children are to be reunified with their own families. This is particularly problematic where the care period is extensive and attachments and bonds develop between the carer/s and the child/children and has lead to at least one known incident where TAIHS staff have believed the carer to be sabotaging the potential for reunification.

4.10. There are known instances where foster carers have not allowed either CSOs or RE staff into the home in order to assess the appropriateness of a current placement. While RE staff do not have right of entry, in some instances, CSOs are not enforcing their right of

entry and frequently agree to meet carers away from the home environment. Informal complaints regarding this issue by TAIHS staff to the department are often ignored.

4.11. There are numerous instances of CSO attending Indigenous families in their homes and conducting investigations without an RE worker being present. Where an RE worker does attend, it is not uncommon for the CSOs to fail to introduce the RE worker or to provide opportunity for the RE worker to advise the family of the RE role as a separate entity to the Department.

4.12. A further issue for the RE is the changes to the RE Service Agreement in late 2010. Previous to the change, the child was the 'client' but the amendment meant that the Department was now the 'client'. This effectively reduced the capacity of the RE to advocate on behalf of children and by extension, the families and various cultural considerations that applied to the child as part of the 'family'. In some instances this has hindered the best possible outcome for the child because the Department can now make a decision regardless of whether the RE agrees with that decision from a cultural perspective. In one instance, RE was told by a CSO that they "should remember who their boss is".

4.13. CSO's often assume the Recognised Entity has to agree with their decisions/stance. It is not the role of the RE to agree but to offer Cultural advice/practice information to child safety officers.

4.14. An Indigenous family is more likely to be placed on an I & A than a non-Indigenous family. All reports to the Department should be assessed on the issues to hand and not be influenced by other factors that have no relevance to the case.

4.15. There are many CSOs who are pushing for Indigenous parents to do the Triple P program regardless of whether the parents even need to do a parenting program or whether the Triple P program would be the most appropriate program for the family's needs or circumstances. Triple P has been an advantageous program for some families, but it is NOT the only parenting program available and for a CSO to penalise a family because they haven't done Triple P is simply unacceptable.

4.16. A serious issue impacting upon Indigenous families is the removal of babies immediately after birth. Whilst in a limited number of instances, this has in fact, been the best outcome for the child, there have been instances where little attempt has been made to address the issues prior to the child's birth and it would appear that the removal was the only option ever considered. In the instances where the Department/CSO has undertaken to address the potential issues and done an early referral to a support service, and where the support agency has been able to engage with the mother, the outcome is generally very different. Mother and child have remained together with the normal bonding between them occurring and accepted developmental stages being achieved.

4.17. An issue was also identified regarding the potential for children to be placed in foster care with families who hold very different values, attitudes, religion and/or cultural heritages without any form of consultation with the child/children's parents. Whilst it is accepted that there are times when it is in the child/children's best interests that they be removed from their family, parents should still have the right to have some input into the type of home, location etc. in which they will be placed.

4.18. A further issue in relation to the placement of children is that RE are not always informed of all aspects of the proposed placement and other children who may already be in the home. E.g. if a child with sexualised behaviours is being placed in a home with other young children this would not be an appropriate placement. There also needs to be more attention paid to the matching of age groups of children in a placement situation. RE cannot provide appropriate cultural advice pertaining to the placement of Indigenous children if it is not fully informed of all aspects involved.

4.19. There are instances where the Departmental time-frames for various actions by the Department are not met and this can be problematic for children and families, especially in instances where children are removed.

4.20. CSO's attending I&A's repetitively ask our families the same questions over and over again rather than moving on. The RE advisors say that this gets the families antagonised easily and especially when being asked repeatedly a question they have already answered in regards to their babies.

4.21. Child Safety are tending to want to end orders with older children particularly when they are displaying difficult behaviours. This is often at the expense of the younger children who are still in care. This leads to our families being in a catch twenty two position as the department will not look at the reunification of the younger children due to the older children being back in the home and not being able to be managed by the parents.

4.22. Cultural advice is not being sought from Recognised Entity (RE) regarding placement decisions prior to a placement being made. This is in breach of Child Safety Legislation.

4.23. Child Safety is not being transparent and honest with families. The information is not being addressed directly with the parents. RE advisors do not speak for parents.

4.24. RE advisors are not being invited to FGM's, Placement, Meetings etc. When they are invited they are predominately not given enough notice to attend. This is a legislative requirement. The same situation has applied to both the FSS and the FIS programs.

4.25. In those instances where either FSS, FIS or the RE has been invited, CSOs often assume that that service will advise all other relevant TAIHS services about the meeting. If the Department needs more than one TAIHS program to attend then Child Safety have to invite each individual service. TAIHS is not the manager of the case plan, Child Safety

are, and as such, it is their role to ensure all the stakeholders are invited not individual TAIHS services.

4.26. Often RE advisors are not receiving enough information regarding clients to make informed decisions in a timely manner.

4.27. RE advisors are not receiving AFFIDAVIT's documentation for courts in a timely manner, that allows adequate time for the RE advisors to read, respond and prepare for court. Sometimes they are not received at all until the court day.

4.28. Appropriate Cultural Awareness Training - (Localised) is needed for child safety officers. Their Cultural knowledge is very generic and often not relevant to our region. TAIHS RE have offered a number of times to provide this local knowledge to Child Safety but have not been taken up on the offer.

4.29. There are inconstancies in decision making by the different Child Safety service centre's.

4.30. Mainstream foster care support services often do not have Indigenous workers. This means non-Indigenous workers are working with Indigenous children in non-Indigenous placements. The subsequent inability to advise an Indigenous child on cultural issues if such agency does not seek support and culturally appropriate information from an Indigenous agencies can result in reducing the child's knowledge and awareness of their culture and subsequent dis-connection.

4.31. Children are often placed with families for respite without funding being made available to these families for the purchase of food and necessary supplies. Funding, when received, is not in a time frame that is financially supportive. Families are expected to 'provide' regardless of their financial circumstances. Under these conditions it becomes very difficult for Indigenous carers to take on the care of Indigenous children. The families have their own children and/or needs to cover leaving them poorly resourced to meet the extras. The department's view is that funding for essential food/supplies is not an income for the carers. This justification of payments being made two weeks post respite care is in breach of Standard (b) i.e. Department is not ensuring that children received appropriate physical care including adequate food.

4.32. RE was not consulted regarding the withdrawal of an application for a Child Protection Order. The understanding was that Child Safety was seeking a Two Year Child Protection Order. Following traditional Aboriginal culture the head of the family led family discussions with RE to source our views and opinions. This family meeting was not respected or considered by Child Safety leaving us to express grave concerns regarding significant decisions being made without consultation with the RE. Aboriginal people expect the requirements of the Child Protection Act be adhered to in relation to the RE being consulted. A disrespect for culture and tradition is evident in a failure to consult with RE.

4.33. The service expresses concern regarding Child safety's failure to comply with the following; Child protection Act 1999 Clause 6 subsection (1); When making a significant decision about an Aboriginal or Torres Strait Islander child, the chief executive or an authorised officer must give an opportunity to a recognise entity for the child to participate in the decision making process.

4.34. The service expresses concern regarding Child Safety's failure to comply with the following; when making a decision other than a significant decision about a Torres Strait Islander child, the chief executive or an authorised officer must consult with a recognised entity for the child before making a decision. However, if the compliance with subsection (1) or (2) is not practicable because a recognised entity for the child is not available or urgent action is required to protect the child, the chief executive or an authorised officer must consult with a recognised entity for the child as soon as possible.

4.35. Blue cards are often difficult for Indigenous people to obtain which significantly restricts the number of Indigenous families available to provide foster and/or kinship care placements.

4.36. There is a need to revisit the potential of residential homes for some children in need of care for those instances where either a suitable carer cannot be identified OR for those children with issues beyond the capacity of most carers e.g. significant disabilities and/or significant inappropriate behaviours.

4.37. Palm Island Safe house – only takes 6 kids

4.38. Kids set up to fail

4.39. Glasser's Theory – everyone needs to be loved & loved

4.40. Carers feel intimidated making complaints

4.41. MOC Process – In at least one instance, a carer deemed guilty even before the Investigation was undertaken. In addition, the process to be followed after the MOC was received was not made clear to the carer.

4.42. FKS should be able to attend with the Department when an MOC has been received so that they can provide support to the carer

4.43. Foster placements of Indigenous children are often made with convenience being the primary goal rather than being in line with the Child Placement Principle

4.44. The large staff turn-over in the Department excludes opportunities for building rapport with the staff and generates a subsequent lack of confidence in Departmental staff and processes.

4.45. Critical Importance of building relationships, understanding, mutual respect with departmental staff.

4.46. In relation to the Criminal Misconduct Commission's Recommendation 8.9 of the Protecting children: An Inquiry into Abuse of Children in foster Care Report (2004) – "That departmental policies and practices recognise the rights of children and biological parents and reflect this recognition in culturally appropriate ways that allow for all parties to be fully informed of, and involved in, case planning for children", it is the experience and view of FKS that this is not occurring.

4.47. There is a severe lack of adequate respite for carers resulting in significant burn-out and often, the creation of problems within the carers own families.

4.48. Whilst the Child Placement Principle is sometimes ignored, one of the issues impacting negatively on the application of the Principle is the severe shortage of Indigenous carers. A further issue impacting on the application of the Principle is the existing workloads of CSOs that mean they do not have the time or the resources to identify an appropriate carer and in some instances, the ignorance of some CSOs about what the provisions of the Principle or even of its existence.

5. Early intervention & Prevention

There is currently, and has been for at least the last ten to twelve years, a focus by the Queensland Government on Prevention and Early Intervention models of practice. The current Aboriginal and Torres Strait Islanders Family Support Services (ATSIFSS) is very good example of this focus with eleven services (of which the TAIHS FSS is one) across the State. Whilst there are some operational aspects that differ across each of the eleven services, a key element is that 75% of all referrals come under a loose definition of prevention and/or early intervention (non-statutory), with the remaining 25% being Statutory cases.

TAIHS began one of the first Indigenous family support programs in Queensland under the then Future Directions program in 2003. Known as the Intensive Family Support Action Research (IFSAR) Project, the program was designed to assist Indigenous families with children who were "identified as being at risk of harm through conflict, neglect and lack of parenting skills" (TAIHS (2003) *IFSAR Trial Report* – not published). The IFSAR Project went on to become the current FIS service still operated by TAIHS and funded by the Queensland Government, however the current FIS client base is 100% Statutory clients all referred to FIS by Child Safety with this client base in effect since approximately 2005.

In the 2003 IFSAR Trial Report[4], TAIHS sought to bring to the attention of the then Department of Families (Dof) that the concept of 'prevention and early intervention' that was being implemented by the Department did not, in fact, apply to the majority of cases being referred to IFSAR:

> The differing perspectives held by various personnel from the Department of Families regarding what constitutes prevention and early intervention caused a

[4] TAIHS (2003). Trial Report: Intensive Family Support Action Research Project

> great deal of concern to the IFSAR Project team and the CPACS Manager. Of the ten Department of Families referrals to the IFSAR project from 13th February to 18th March 2003, three were not progressed due to the complexity of the cases and needs of the clients which the IFSAR Project was not designed to address. The clients of these three cases, plus another two that were combined DoF/CPACS referrals as well as a further three DoF referrals all had significant histories of contact with DoF, in some cases for several years. Under no circumstances could these referrals have been defined as prevention or early intervention. Additionally, from information provided to IFSAR by the clients concerned, it was difficult to determine what, if anything, had been done to address the causes of the clients' problems in the first place. In other words 'child protection' was addressed but not necessarily the underlying causes of the 'child protection' issues arising (pg. 12).

Whilst the ATSIFSS program is designed to address much of what the IFSAR report was referring to in terms of understanding what constitutes prevention and/or early intervention and is a program that Queensland can be very proud of having initiated, the reality is that less than 10% of the 388 referrals received by the FSS to date could even remotely be deemed to be early intervention, much less prevention. Of even more concern is also the fact that the majority of the remaining 90% of families have significant histories with Child Safety extending from two to three years to up to ten years, and in some instances, up to twenty years. Numerous current adult clients – now parents - were children within the child protection and at least two families were children of families who were part of the initial IFSAR Project in 2003.

What is clear from the above, is that while we are now being able to assist our families in more appropriate ways and with somewhat better resources, there is still a major gap in addressing the underlying causes e.g.

- Housing – up to 90% of FSS clients do not have stable housing and regardless of the work to support these clients, FSS cannot build houses for them or assist them to find housing that simply does not exist;

- Alcohol and Drug Services – affecting up to 90% of FSS adult clients and regardless of the hows, whys and wherefores of clients' reliance on alcohol and/or drugs, there are long waiting lists to get clients into rehabilitation services and/or counselling to address the hows whys and wherefores of their addiction. Again, FSS cannot magically make services appear.

- Violence – domestic and/or other forms of violence – affecting up to 80% of client families and again, regardless of the reasons behind the violence, the majority of these families need to be able to access counselling and/or other types of programs to address the underlying causes. And yet again, FSS cannot assist clients to access services that simply either don't exist or have waiting lists that can be up to a year.

Family support programs can and do achieve significant outcomes for and with Indigenous families. However, they have no control over the availability of resources needed by the families. Many of the current programs/resources that are available e.g. violence prevention, parenting, budgeting, hygiene etc. etc. etc. are not delivered in ways that are appropriate to Aboriginal and Torres Strait Islander culture but more importantly, many of these programs don't even recognise the lived experience of Aboroginal and Torres Strait Islander people.

We can help our clients deal with the wait time, help clients enhance or improve their resilience and capacity to cope with limited resources, we can assist clients to gain other skills that enhance their parenting and communication skills etc. In some instances, and as and when appropriate, we can even provide clients with the opportunity to talk about the traumas that have affected their lives and we may even be lucky enough to find a counsellor or a rehab service, and sometimes even a house. But we cannot create these things nor assist clients to access what doesn't exist.

So in the end, whilst we go further than has previously been possible to address the underlying causes of the over representation of Indigenous children and families in the child protection system, many of the underlying causes are still the same as they were in 2003 and prevention and early intervention are still concepts as contentious in 2012 as they were in 2003.

6. Information systems and record keeping

6.1. Departmental expectations for data collection are often unrealistic and in some instances require significant resources to gather and collate. With the exception of the FSS, the three other child protection services have had to purchase their own data collection systems in order to address Department data requirements. For one of the services, it took multiple attempts by TAIHS to get permission to use existing funds to purchase a specifically designed data base as it was deemed to be 'not essential'. It was only after a Departmental Officer actually visited the office and saw the evidence of the work required and then advocated within the Department, that permission was granted.

The FSS program uses the Community Sector Information System (CSIS) provided by the Department. While the use of CSIS was initially highly problematic, it has since become an easier data base for FSS staff to use. The improvement has come about as the result of efforts by the Department to improve the system, and by the efforts of FSS staff to improve their use of the system.

Conclusion

The Case Studies and Further Issues contained in this document are weighed down with incompetence, poor communication, poorly informed decision making processes, poorly prepared

University graduates, limited cultural awareness, lack of human, physical and financial resources and government departments not being held accountable for breach of Legislation or for breach of their own policies and procedures.

Reducing the over representation of Aboriginal and Torres Strait Islander children in Queensland Child Protection system requires that we begin by diligently addressing all of the above. The current intervention style is proving to be inadequate. We need to stop using platitudes that give false hope and impressions of cooperation and proper functioning i.e. "requires a broad approach by both Government and non-government departments and agencies". The TAIHS experience suggests that such a statement is benign and attracts zero attention and has failed to bring about sustainable and wide-spread change in professional practices in government departments.

This is not to say that TAIHS does not acknowledge and appreciate and support the many changes that have occurred in the Department over the last ten years. We recognise the many Department and Child Safety workers who are dedicated to the work they do and to the children and families they work with and also acknowledge that we could not do our work effectively without the presence of these dedicated workers. In the end, these workers and ours, achieve positive outcomes for many Indigenous families in spite of the many challenges and barriers faced on a day-to-day basis in the workplace and from some of the families themselves. TAIHS highly commends these workers – our own and the Department's.

However, while we continue to tick the same boxes we ticked twelve years ago in the Forde Inquiry and retreat to a place of apathy we will continue to disadvantage our most vulnerable in society……..our children. The plight of children and young people today is a direct result of the non-action by those given the responsibility to implementing the identified support systems that had the potential to prevent so many of our young entering the Queensland Child Protection.

We see youth crime on the increase, suicide of our young on the increase, premature deaths of Indigenous babies at an unacceptable rate. The Indigenous truancy rate is also at an unacceptable rate, the outcome of which is a greater number of vulnerable children being exposed to an unimaginable life of deprivation caused by limited education.

All of these issues are interconnected. To deal with one issue means dealing with all of the issues. It also means that there has to be true collaboration between Government and the Community

and everyone has to stop paying lip-service to the words. If not, we continue the past and cannot reach the future. We will stay here:

The welfare and the policeman
Said you've got to understand
We'll give them what you can't give
Teach them how to really live.
Teach them how to live they said
Humiliated them instead
Taught them that and taught them this
And others taught them prejudice.
You took the children away
The children away
Breaking their mothers heart
Tearing us all apart
Took them away

(Took the children away – Archie Roach[5])

[5] Roach, A. (1999) Indigenous Song Writer

RECOMMENDATIONS

Cultural Considerations

1. That Departmental and Child Safety workers receive adequate and appropriate training and support to enable them to have a greater awareness and understanding of Aboriginal and Torres Strait Islander cultures and how these cultures exist as lived experience.
2. That Departmental and Child Safety workers receive adequate and appropriate training and support to enable them to have a greater awareness and understanding of how the history of the last two hundred and twenty-four years is still impacting upon Aboriginal and Torres Strait Islander people today.
3. That Child Safety workers are provided with opportunities to undertake training with local Recognised Entities and NGO partners to enable them to gain knowledge and understanding of local Indigenous issues and cultures (as per recommendation 1 above) but also to enable the building of effective relationships that will ultimately be of benefit to children and families.
4. That the Department initiate appropriate frameworks to hold its staff accountable to accord all Aboriginal and Torres Strait Islander people the respect and dignity due to any human being.

Human and Financial Resourcing

1. That appropriate levels of human and financial resources are provided to both government and community agencies working in the child protection sector.
2. That both government and the community sector recognise and openly communicate with each other about the real cost of service provision and work together to ensure that the many practices/services/programs that currently exist and that reflect best practice in the field are delivered in a way that achieves positive outcomes for children and families and in a way that makes the best use of the limited resources available.
3. That Senior Indigenous Resource Officers are employed by all Child Safety Service Centres and Regional Intake Services to ensure that appropriate considerations are given to all cases/situations involving Indigenous children and families.

Operational:

1. Any involvement by Child Safety with Indigenous clients **MUST** involve the local Recognised Entity. This is already legislated but does not always occur.
2. The Department must make Child Safety workers accountable to ensure that they adhere to the legislation at all times.
3. That the Department and Community agencies are held accountable to establish effective communication with each other and that all appropriate information is shared with clients and other relevant and agreed parties. The legislation to allow this already exists, but yet again, is not always complied with.
4. All Child Safety Officers be adequately trained in the use of CSIS **including** all new CSOs.

5. Options to apply some form of mandatory participation by parents to achieve family support and/or departmental requirements be explored.
6. That the 2010 changes to the Recognised Entity Service Agreement wherein the Department became the RE client instead of the child be rescinded.

Foster Carers:

1. Training and support of foster parents in how to cater for the specialised needs of children needs to be individualised to fit in with other competing demands on the foster parent (Burry 1999).

    - Foster parents would benefit from competency-based training and a system of accreditation that provides appropriate acknowledgment of the time and effort applied in acquiring the skills.

    - Trained caseworkers need to be made available to provide regular ongoing supervision with foster carers to ensure positive parenting practices are maintained and implemented correctly.
    - Foster carers be fully informed of the range of financial supports and terms of such support available to them at the time of application to become a foster carer.
2. We recommended that supervision initially be weekly as foster carers learn to implement strategies and adapt to having the child in their care, and gradually become less frequent as foster carers become more skilled. This is especially important during the first six months, as this is the time when placements are more likely to break down. Caseworkers need to also use a self regulatory approach to help foster carers learn to generalise the use of strategies to new challenging behaviours or problems as they arise, thereby increasing their competency and self-efficacy.

3. Professional support for foster parents needs to promote greater confidence and competencies. This can be accomplished by increasing foster parents' self sufficiency in becoming independent problem-solvers, self-efficacy so they have more optimistic expectations about the possibility of change, use of self management skills, and encouraging them to attribute changes or improvements in their situation to their own or their child's efforts rather than to chance, age, maturational factors or other uncontrollable events, and problem-solving skills.

4. A more vigorous recruitment campaign should be resourced and implemented to recruit more Indigenous carers. Such a campaign and subsequent approval process should take into account the difficulties for Indigenous people to access a Blue Card and the remoteness of many of the communities where Indigenous carers may be located;
5. Consideration needs to be given to re-examining the cost of providing foster care to carers and where necessary, more realistic funding provided to carers.