TRANSCRIPT OF PROCEEDINGS

THE HON RONALD SACKVILLE AO QC, Chair
THE HON ROSLYN ATKINSON AO, Commissioner
MR ALASTAIR JAMES MCEWIN AM, Commissioner
MS ANDREA JANE MASON OAM, Commissioner

THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

9.30 AM, TUESDAY, 24 NOVEMBER 2020

DAY 2

Lincoln Crowley QC, Senior Counsel Assisting
Dr Kerri Mellifont QC , Senior Counsel Assisting
Ben Power and Elizabeth Bennett, Counsel Assisting

CHAIR: Good morning. May I invite Commissioner Mason to perform the Acknowledgment of Country.

COMMISSIONER MASON: We acknowledge the First Nations people as the original inhabitants of the lands on which this hearing is sitting. [Ngaanyatjarra language spoken] We recognise Brisbane [Ngaanyatjarra language spoken]. We recognise the country north and south of the Brisbane River as the home of both the Turrbul and Jagera nations. [Ngaanyatjarra language spoken] and we pay respect to the Gadigal people of the Eora nation. Their land is where the city of Sydney is now located. We pay deep respects to all Elders past, present and future and especially Elders, parents and young people with disability.

Thank you, Chair.

CHAIR: Thank you, Commissioner Mason. Are there any appearances to be announced beyond those that were announced yesterday?

MS ROBB: Good morning, Chair, my name is Sally Robb (inaudible) ---

CHAIR: If not, then -

COMMISSIONER ATKINSON: I'm sorry.

CHAIR: I'm sorry.

MS ROBB: I beg your pardon, Chair. My name is Sally Robb. I'm instructed by Robertson Solicitors and I appear on behalf of Leigh-Anne Pokino.

CHAIR: Thank you very much.

Yes, Mr Crowley.

MR CROWLEY: Commissioners, this morning, the first witness to give evidence will be Dr Tracy Westerman. Dr Westerman has had some pre-recorded evidence given and we'll be hearing that this morning. There is a transcript that accompanies the pre-recording and that's to be found in the Tender Bundle part F at tab 51. I'll tender that transcript into evidence and ask that it be admitted as Exhibit 8.4.

CHAIR: Yes, that can be done.

EXHIBIT #8.4 - PRE-RECORDED STATEMENT OF DR TRACY WESTERMAN

MR CROWLEY: And if we might have then the recorded evidence of Dr Westerman played to the Commission.

[VIDEO RECORDING PLAYED]

MR CROWLEY: We have here today to talk to the Commission Dr Tracy Westerman. Dr Westerman, are you able to hear and see me okay?

DR WESTERMAN: Yes, I can.

MR CROWLEY: Before you give your evidence, will you take an affirmation.

DR WESTERMAN: Yes, I will.

DR TRACY WESTERMAN, AFFIRMED

EXAMINATION-IN-CHIEF BY MR CROWLEY

MR CROWLEY: Dr Westerman, you are an Aboriginal woman and a practising psychologist. Can you tell us about where your people are from

DR WESTERMAN: So my traditional people are from the remote Pilbara area, from between Port Hedland and Marble Bar. Their traditional tribal affiliation is the Nyamal people that sit around (inaudible) origins in Yandeyarra starting in the Pilbara.

MR CROWLEY: You are a practising psychologist. Can you tell us about your qualifications.

DR WESTERMAN: Yes. So I undertook a Bachelor of Psychology at the University of Western Australia which I concluded in 1996. I then went to work with the Department for Community Development back then in the Western Desert, took a period of seven years away from study. Went back to Curtin University and undertook a Masters degree, including psychology, which ended up being a combined Masters and PhD focusing on the psychological assessment of Aboriginal people, which I concluded in 2002, and that made me the first Indigenous person to complete a combined Masters and PhD in clinical psychology in Australia.

MR CROWLEY: You mentioned about working for the Department of Community Development. What was the position that you had back then?

DR WESTERMAN: The position back then was as a Graduate Welfare Officer which essentially was providing welfare-based services.

Back then we actually were combined with Justice as well, juvenile Justice, so we were actually involved with child welfare-based services, as well as justice services, but essentially as a child protection worker.

MR CROWLEY: Throughout the time that you were completing your studies, did you become a psychologist with the Department?

DR WESTERMAN: Yeah. I was the beneficiary of their 80 per cent scholarship scheme, which was an incredible scheme that the Department used to have, which they have now ceased sadly. But what it actually meant was they would annually allowAboriginal people who were employed within the Department to apply for a scholarship, which was 80 per cent of your wage while you were studying. And then when you finished your study, you owed them the years back that they had supported you for, which was 80 per cent of your wage. That meant that I was able to complete my Masters degree and PhD, which I did in three and a half years, both Masters and PhD.

MR CROWLEY: In terms of your current practice, what is your role now?

DR WESTERMAN: So in 1998, I started Indigenous Psychological Services which is a company that basically provides psychological services to Aboriginal people. That exists with an absence of government funding.
The idea, I guess, behind Indigenous Psychological Services is that we are able to provide mostly assessment, intervention, prevention and training programmes that have now since 1999 become nationally driven. So we have a national base in Perth, but we actually provide services across Australia, across a whole raft of different services, mostly psychologically based. I'm the Managing Director, I should say.

MR CROWLEY: Now, in your statement, you referred to the Jilya Institute. Just tell us about that.

DR WESTERMAN: So the Westerman Jilya Institute for Indigenous Mental Health is really a non-profit. So it is charity based. The idea, I guess, is that 20 years' worth of evidence-based work can actually then be driven by a non-profit which enables us to access research and other funding to a greater degree to ensure that the evidence-based programmes that have been developed by IPS are able to be driven at a national level, across, I guess, suicide prevention, mental health, cultural competency, justice and educational outcomes.

MR CROWLEY: I want to take you back now and ask you about your PhD focus.

Can you tell us, what it was, in particular, that you were examining as part of that study.

DR WESTERMAN: Yeah. Predominantly it was around the escalating rates of child suicide, the origins of it being in Western Australia. Sadly, we've had now decades of the highest rates of child suicide in the world.

What I actually found was that we were very poor at answering the 'why', which was really assessing the causal pathways to Indigenous suicide, and I was finding that what was happening was it was all starting off with assessment being culturally biased towards Aboriginal people.

What I actually did was went out and explored whether there were different risk factors for Indigenous suicide. And so we started from the ground up and built assessment tools that enabled us to determine whether the nature of indigenous suicide was different. We actually know that to be causal pathways, so, of course, the causal pathways answer the 'why'. So why was it that we're having such high rates of Indigenous suicide. What I was finding, not just in Australia but also internationally, was that we were just making assumptions that the causes for Indigenous suicide were the same. So no one had actually bothered to explore that at a whole population level. So I did that and developed the first unique clinically and culturally unique psychometric tool called Westerman Aboriginal Symptom Checklist for Youth. That basically told us that not only were the causal pathways to Indigenous suicide different, but the risk factors around depression were different, trauma looked different. Also what we were able to do was then inform programmes around preventing the escalation of those different risk factors. That's, I guess, what we started to do was look at that idea of difference but at a level that was population informed-, rather than just assuming that the risk factors for suicide and mental health were the same.

MR CROWLEY: Now, one of the things you mentioned earlier as well was about cultural competence and assessment of cultural competence. Was that something that was part of your PhD focus as well?

DR WESTERMAN: Yeah, it was a big focus on it because, of course, what you need to do is you need to get the assessment right in terms of making sure that it is then culturally valid or informed.

The next bit, obviously, is we've got practitioners that essentially Universities aren't ensuring that they have training around various standards of cultural competency. So, again, in terms of answering the 'why', we went out and asked Aboriginal people the sorts of things that theywere able to tell us that predicted cultural competence. And, interestingly enough, that had never been done, not just in Australia but also globally, that we'e able to determine the predictors of cultural competency from a level of population-informed information.

So, what we then did was determine those predictors, which range in different levels, and we designed the first cultural competency tests, for want of a better phrase. That became known as --- now is known as the Cultural Competency Profile for Mental Health.

Now, what that enables us to do is it enables us to not only measure cultural competency but, importantly, what that's enabled us to do is also improve cultural

competency by doing targeted training intervention at a practictioner level. So, it is quite exciting stuff. And, I guess, since then now, we've adopted the General Cultural Competency Profile, as well as recently the Cultural Competency Profile for Child Protection, using that same idea of science informing what predicts cultural competency.

MR CROWLEY: Yes, I will come back to those and ask you some more questions about those a bit later, but I just want to follow through at the moment with the psychometric assessment tools.

After you completed your PhD and your studies, you then went on to develop a range of psychometric assessment tools that were of your own volition and own making. Tell us about those.

DR WESTERMAN: Yeah. I guess the first time was the youth tool, which obviously enabled us to screenearly intervention, early stage for risk. Then, of course, the natural progression was to develop an adult scale so that's for ages 18 and above.. We were able to then screen for early intervention, early stage of risk across suicide and mental health and, increasingly, we were looking at that around crimogenics and the justice system.

The next thing, the next test that was developed, was called the Acculturation Scale for Indigenous Australians which has an extraordinary range of benefits. I guess what it enables us to do, at a basic level, is it enables us to inform the contribution of cultural identity as, I guess, the buffer for risk.

Now, the reason why that's very important is because not all risk factors can be reduced. So, what we know, for example, is that racism is a significant moderator of suicide risk and a significant contributor to mental health risk. You can't eliminate racism from the equation. So, there's some risk factors that are unalterable. So what you can do instead is you can figure out things that actually buffer risk. So, we've got the only body of research that actually determines the things that actually buffer or moderate suicide risk, and what we know is that acculturation enables us, if you have a strong sense of cultural connection, cultural identity, that it actually buffers risk factors, such as racism, and those sorts of factors that we can't necessarily alter. So, what we were able to do is we're able to, obviously, do some testing, if you like, of Aboriginals with focus around cultural identity and then that informs treatment and intervention.

Obviously, the next thing we need to do then is design programmes that are capable of treating the sorts of things that we know buffer risk and also, you know, address risk factors, which we've also done.

The next test that we've developed is called the Acculturative Stress Scale for Aboriginal Australians and that's actually really exciting, in the sense that it has enabled us, again, to gauge and measure and treat the impacts of racism and marginalisation for Aboriginal people. And what we have actually been able to

determine, which is, again, pretty innovative in terms of the sorts of things that are going on internationally, is that we've been able to figure out the impacts of racism for Aboriginal people.

Now, I guess what we know is that there is this --- again, it just enables us to figure out at a treatment-based level, or risk-based level, how racism and marginalisation impacts. And then, obviously, what we can do is we can figure out the sorts of things that enable those vulnerabilities to be addressed from a practitioner perspective.

So we don't just talk globally around things. We actually talk around individual risk, the sorts of things that can actually reduce risk, and the sorts of things that can actually measure the impacts of what we're doing.

MR CROWLEY: The psychometric assessment tools that we are talking about, these are developed specifically for Australian Aboriginal people ---

DR WESTERMAN: Yeah.

MR CROWLEY: --- to be assessed for a whole range of things.

DR WESTERMAN: Mmm.

MR CROWLEY: Risk factors for suicide was where it started.

DR WESTERMAN: Mmm.

MR CROWLEY: But also mental health conditions, mental illness.

DR WESTERMAN: Yeah.

MR CROWLEY: And, from that, that would include psychosocial disability leading from those mental health conditions.

Now, could you just tell us about, in the psychological assessment, what distinction do we make from the use of tools and the testing and the assessment in itself.

DR WESTERMAN: Okay. That's a good question. Again, testing would be the actual tests, themselves. So tests that have been developed that, we think, are good indicators or good measures of, say, intelligence in children; it's good measures of, say, disability; good measures of, say, depression. Those tools need to actually go through a process of psychometric determination, so that's the first thing, and that's actually quite a complex thing to do.

There is a clinical side of things. So, the more that you actually sample populations of people, that then gives you sufficient data so you can actually figure out whether the test is actually a good measure of something. So, for example, if something is a good measure of depression, then what should happen is, statistically, all of those

items that actually depression should actually clump together statistically. And they'll refer to it as accounting for a certain amount of the variance, which actually means that those items don't vary too much statistically from each other because they are really strong impressions --- this is me trying to explain psychometrics to non-psychologists. So that's the first thing, that you need to determine the science around the measure is actually a good measure.

The next thing, I guess, that's s a real failing in most of these tools is that they are not actually culturally informed. So they haven't actually included Aboriginal people in the design, in the construction of the test.

The next bit that actually talks to assessment is that you then need to assess the person. So, you can get them to do a test. That's just testing. Assessment is actually then, I'll have a conversation with you or do a clinical assessment or interview with you, to see whether those indicators are actually the case in your day-to-day. So for example, if I've have done an assessment that tells me "I know that you are of average intelligence," then I need to have some measure, some gauge that actually tells me day-to-day that the test is actually valid and indicates that you are not that bright.

Now, that is the difference between testing and assessment.

So, often, what then happens is people will just choose a test and use the test alone to determine whether someone is functional or not. Assessment in terms of whether someone is functional on their day-to-day, you know, ability to interact and to function, and all those sorts of things. So, that's the difference between testing and assessment.

MR CROWLEY: And in that process, where does the clinical assessment by the practitioner come into it?

DR WESTERMAN: It comes into it, I guess --- I mean, the testing is part of it, I guess. What people should be doing when they administer tests is that they should be watching and interpreting how people go about undertaking a test.

The trouble is that if people are coming from a different cultural background, they don't understand how to interpret a test qualitatively. An example would be: Aboriginal people have very different learning styles. So what I would do when I'm administering a mainstream test of intelligence is that I'm actually looking at how an Aboriginal person goes about undertaking that task. And so that actually informs me about the sorts of cultural strengths that Aboriginal person has. Now, you can't do that unless you're actually looking at it from a cultural understanding of difference. And so often what happens is with a non Indigenous practitioner, they're unwittingly not able to interpret tests in a qualitative way, just purely because they don't understand the cultural differences of learning style and cultural differences of, you know, how people go about solving problems.

MR CROWLEY: I want to ask you some more about the role that the testing might play, the psychometric testing you have been talking about, in the assessment of disability.

DR WESTERMAN: Yeah.

MR CROWLEY: So, in terms of how those type of psychometric tests might be used, they might be used for determining cognitive or intellectual functioning disability.

DR WESTERMAN: Yeah.

MR CROWLEY: Or an intelligence level which might indicate impairment, you have already spoken about.

DR WESTERMAN: Yeah. So essentially there is a significant body of research now going back to the 1960s and in Australia in 1981 with Judith Kearins' work that tells us that the mainstream tests of intelligence just to start with, are actually inherently biased or they're flawed. So what was happening was when intelligence tests first came out, Aboriginal people consistently were doing badly on mainstream tests on intelligence.

Now, how that was appraised was that the tests were inaccurate, that Aboriginal people lack intelligence, and so that was known as the deficit debate. Now, when Judith Kearins came along, she was quite incredible in terms of single-handedly changing the whole flow of that argument around the fact that the reason why Aboriginal people do poorly on mainstream tests of intelligence is because you are tapping into a cultural difference in intelligence. And so she actually found that what we're seeing, for example, is that Aboriginal people predominantly 80% of Aboriginals are visual spatial learners.

Now, as you can appreciate, because the tests haven't been constructed from Aboriginal world of intelligence, what then happens is Aboriginal people consistently will be set up to fail. So we're starting from a playing field that's basically down here, that's not equal.

Then, of course, what you have is the reality of the lack of face validity of those tests and that means just the pure face of it, people can't kind of understand the words, the language. The sorts of things and the way the tests are actually written, straight away Aboriginal people sort of don't have a structured training in English as part of our normal language development, a set language development. Of course, what's going to happen is people are going to do worse at those tests purely because of a cultural difference; not dense. So what happens, obviously, is that if you are assessed as being of lower intelligence, then, of course, that label will follow you for the rest of your life in any school-based systems and there is already an assumption that people are less capable than what they are.

What we then know is that there is significant research around the self-fulfilling prophecy, which essentially means, based on Pedersen and Walker's research is that teachers' consider Aboriginal kids to be less capable than non-Aboriginal counterparts. So the knock-on effects of all these sorts of inherent errors and bias within mainstream tests are actually quite significant, and that is just talking of the cognitive part of the assessment, the mental health and suicidal risk part of the assessment is actually even more higher if that's possible.

MR CROWLEY: Yes. Those things that you have been talking about, are they the sort of bias that might fall under the construction ---

DR WESTERMAN: Yeah.

MR CROWLEY: --- label, construction bias in the development and design of the test?

DR WESTERMAN: Yes. There's 3 main areas just in terms of, you know --- in terms of validity. Now you've got reliability. So reliability remains an obsession with the same results every time. So what we tend to find is that Aboriginal people will be assessed by someone who lacks cultural competence, and they will get a certain IQ or a certain score, and then they're assessed by someone who has cultural competence, and the score is significantly higher.

Now, intelligence should not go up and down like the stock market. It should be fairly stable. So if you get that degree of difference, based on even the same test, then there's concerns with the reliability of the test.

What we have been really bad at informing at a national level around is explaining the 'why'. So the fact that we're able to measure cultural competency based on the cultural competency test, provides us with a very unique opportunity here to not only explain the 'why', in terms of why intelligence tests are so culturally flawed with Aboriginal people, but it also enables us to address it. If it can improve the cultural competency of psychologists, then do we have --- does it actually predict better utilisation and application of mainstream assessment tools?

As an example. In terms of validity, there's three main areas. Just to make it really, really quick and simple, the first one is construct validity. So tests need to be constructed from an Aboriginal view of intelligence, an Aboriginal view of depression, an Aboriginal view of whatever. So, it's about the tests being constructed from the ground up. No tests have actually done that except for mine.

The second issue is then called 'face validity. And face validity sounds exactly how it seems, means exactly what it sounds like, and that is, on the face of it, I can't understand this test, because of the language that's not actually Indigenous-specific, because of the words that I can't relate to, because of just difference in language.

The final validity that most of the tests that are used in Australia really lack is

this thing called 'predictability', which I've talked about a little bit already. Essentially what that means is that if I assess you and I consider you to be at low levels of intelligence, then that test better predict that you lack intelligence in terms of your day-to-day functional capacity. And what we have found consistently in all of our work across Australia is that when Aboriginal people have been assessed by mainstream tests of intelligence, they consistently lack all those validities in terms of predicting that someone is actually not as capable as what, you know, the test says they are. They just lack that functional and practical validity.

MR CROWLEY: With those deficits in the validity of the tests, what is the impact on the outcomes then for Aboriginal people who undergo those type of tests?

DR WESTERMAN: Well, I guess the first thing is that they are labelled inappropriately and that is just the cognitive side of things. So people labelled as not being terribly bright, which is with a high likelihood for Aboriginal people, that is then going to follow you through life in terms of educational outcomes.

We see it in employment outcomes, for example. So we're seeing --- we do a lot of work with mining companies. I used to do lots of work with mining companies, who would short-list people on the basis, on the use of a mainstream test of intelligence. And, of course Aboriginal people would not pass mainstream intelligence tests, which basically means that people don't get an opportunity for employment.

Then what happens, of course, is that instead of putting promising role expectations to get created by the environment, assuming that people lack intelligence, I guess what we're seeing in the mainstream is that people, Aboriginal people, experience misdiagnosis, overdiagnosis and underdiagnosis, arguably more than any population in the world. So you are more likely than anything to get it wrong, and that's not a circumstance we should be facing. We are seeing the rates of suicides, the rates of child removal, the rates of incarceration and poor educational outcomes and we should be doing a better job of it than we are currently doing.

MR CROWLEY: I want to just ask you about that. In the child protection area, a First Nations parent with a disability, a cognitive or intellectual type of disability, which has been assessed by the use of these type of mainstream assessment tools, how do you consider that those type of use of mainstream tools might be biased or flawed in the way the assessments are carried out?

DR WESTERMAN: I guess it's the same principle, that because the tests --- tests are really interesting. They often tell you what people can't do; they don't tell you what people can do. I guess if you have an understanding of cultural difference, then your job is to explain what people can do.

So an example would be when I assess Aboriginal people --- I'll use mainstream tests, but what I'm actually really doing is I'm really good at departing from mainstream administration processes in the way that loads on to cultural differences, and then I see whether that makes a difference in terms of outcome. Then what that

means is I can actually inform others and say, "Look, if you actually alter your teaching practice, if you alter how you go about, you know, delivering your counselling or therapy in this particular way, an Aboriginal person is going to be more likely to understand it they're going to be more likely to process it" and that's what people want to know. People want to know that.

What often happens is because people have a lack of cultural understanding in parenting differences, and cultural living style differences, they're unable to inform people about the 'why' and what they need to do that's different, that taps into learning style differences.

MR CROWLEY: We talked about the mainstream assessment tools. What about if a mainstream assessment tool is adapted to use in a situation of making an assessment on a First Nations person, is that suitable?

DR WESTERMAN: Not really. I will give you 2 really sobering examples, I guess.

One is the Minnesota Multiphasic Personality Inventory and the other one is the Death Depression Inventory, and I can give you lots and lots of examples. So let's just start with those 2, just for time brevity.

So the death depression inventory is a good example of a tool that has been used globally. Now, what actually happens with tests is they're constructed from a mainstream view of something. We've got pretty good evidence that actually tells us that depression looks different; that suicide and trauma looks different. So, really, what you're doing is you're failing to recognise difference from the very start.

So then what you're doing is you are accentuating, adapting, and often that means just rewording or requesting the person doing the test, but what you haven't done is you haven't addressed the construct and predictably of those tests.

A good example with that depression inventory is that the words --- the wording is quite negative, so it is characteristically negative. Now, you may have actually heard of this thing called the "Yes Syndrome". It is quite well-known. It is about language difference and it is related to Aboriginal people to a certain extent. Diana Eades refers to this as "gratuitous concurrence". Essentially what this means is that if you negatively phrase a question, an Aboriginal person will agree to that negatively phrased question; will endorse it. So that is called the yes syndrome and it is fairly consistent for research into that.

The reason why this is relevant is because depression inventories are quite differently phrased, and so what they have shown is that, and interestingly enough Chinese populations have this as well, is that when you use a mainstream depression inventory, because they are quite legally phrased and they concern sort of the differences in symptomatology of depression, then what will happen is Aboriginal people will score high culturally, because of cultural difference, not because of deficit.

Another example is the Minnesota Multiphasic Personality Inventory (MMPI), that's also the (inaudible) as well. The problem with that is that it has items in there that actually tap into cultural difference.

An example will be Aboriginal people who believe, who have a prevailing belief system, that that spirit of deceased might come and visit us. We actually have it as prevailing belief system. Now, Aboriginal people can endorse that, it is a cultural difference. When that happens, when they lose the MMPI, they label it as psychopathic deviance, because they peak on the psychopathic deviant scale. So there's extraordinary examples of mainstream tests and the desire to adapt them, but what actually happens is you inherit these flaws, both scientifically and culturally, and then ending up clinically of those flaws into the adaptation process, so it actually doesn't achieve a lot.

MR CROWLEY: When we are talking about a mainstream test, what do we mean by "mainstream"?

DR WESTERMAN: I guess what we mean is --- interestingly enough, most of the tools have been developed based on American college students, which probably says a lot about American college students. They often --- you know, they're available to do big issue research and so what would happen is they get paid to --- in issuing, you know, inform the development of psychometric tests and then they mould them mostly on American college students. What will then happen is that they bring these tests into, you know, Australia or Japan, or wherever they be, and then ultimately what would happen is they at least get good norms but it's predominantly Eurocentric, it's predominantly, you know --- like, the term I use is obviously "mainstream" but it's predominantly generated from, you know, a Eurocentric view of intelligence, mental health, disability, whatever you want to call it. Most of them come from either North America or the US.

MR CROWLEY: I want to ask you then --- you mentioned earlier about the Aboriginal people being underdiagnosed, overdiagnosed, misdiagnosed. What are the consequences for those testing results for a First Nations person with a cognitive or intellectual disability, or a mental illness, with those type of assessment results?

DR WESTERMAN: I think if I'm going to say something uniform across underdiagnosis, misdiagnosis and overdiagnosis, it's basically that if you get assessment wrong, you get treatment wrong. It's as simple as that. So all those levels of assessment, if you get the assessment wrong, you get treatment wrong. You fail to, you know, target the sorts of things that are going to make an actual difference to the lives of indigenous people. And I guess what happens is people don't get access to the services they need, don't get access to the programmes they need. But, most importantly, if you get assessment wrong, you can't actually measure the impacts of what you are doing properly and, in fact, there is a lot of evidence that suggests, that shows, that if you get assessment wrong, you get

treatment wrong, and you can actually make things worse.

So obviously if you assess someone as being, you know, not eligible for services, then that is obviously going to impact them greatly. If you assess someone as being accessible to services, but you've actually got assessment wrong, ie, they are not terribly bright when they really are quite bright, then that actually creates a self-fulfilling prophecy in terms of the assumption that they lack intelligence when they actually have a cultural difference in intelligence.

So it has lots and lots and lots of impacts. Whether it is misdiagnosis, overdiagnosis or underdiagnosis, essentially what is happening is you are not actually making a measurable difference to the lives of Aboriginal people, ultimately.

MR CROWLEY: Let me just ask you, then, about a more specific setting that we're concerned with at the moment, in a child protection system setting.

DR WESTERMAN: Yeah.

MR CROWLEY: That type of psychological assessment using tools of that nature, if there is a misdiagnosis, or overdiagnosis, how do you see that that might then have a bearing then upon the type of actions or outcomes in the child protection system?

DR WESTERMAN: Oh, look, children get removed. Simple as that. So we currently don't assess, for example --- a great example is we will go into a community and we'll do an assessment on parenting capacity, and what we will do is we'll start off using generally, which is a nuclear family model in terms of who a child is more attached to, who constitutes the attachments of the actual child, themselves, and so obviously with Aboriginal people, we attach at a whole community level, so there's a whole-of-community kinship attachment map. And certainly the work we did in Western Australia, we're hearing really distressing stories on the fact that children were being removed on the basis that child protection workers have failure to understand how to do cultural mapping. That a kid who looks like they are being neglected when in fact they were being cared for by an "Aunty" or an "Uncle", consistent with indigenous kinship systems. So if you don't understand things like skin groups, if you don't understand things like the dynamic nature of attachment for Aboriginal kids, then, clearly, what you can do is you can get that wrong very quickly and to show you that children aren't neglected on the basis of cultural difference, and then kids end up in care when they shouldn't end up in care. The knock-on effects of those --- well, I guess what we're seeing in Australia is that we are very risk focused rather than prevention focused from the very start.

Then, of course, when you don't understand attachment based differences, you can see difference as attachment disorders, and I see this playing itself out pretty much every single day that Aboriginal peoples will parent their kids very differently. We have very different parenting styles.

So a great example is --- we actually encourage kids to be more concerned about the

group rather than the self, and often what happens is parents won't be involved in problem-solving at an individual child level, and they encourage kids with poor environments, without families and without restrictions, but be more concerned with siblings, cousins and mates as a mechanism of developing boundaries than actually living with siblings and cousins and mates. Now, that looks like parental neglect, or the term "neglect", so that's just one example.

There are things, for example, like avoidance relationship as (inaudible) dictate. Some communities will have skin groups. That's another great example. That looks like avoid and attachment disorders, that people cannot be close to other people because of avoidance-type relationships. So, there is this myriad of cultural factors that actually mean that Aboriginal people are consistently being assessed as having poor parenting capacity. They'll be assessed on attachment-based disorders and, essentially, it's about the fact that the tests aren't always interested in what they're talking about and we have to construct the tests from the ground up to ensure that we're actually getting assessment right and then treatment becomes better informed, access to services become better informed, and we're actually really clear, I guess most importantly, about the sorts of things that are informing the programme outcome in a robust way.

MR CROWLEY: The question I was asking there started with talking about the assessment tools, but I think in your answer you have talked about both the use of the tools and the actual assessment or by observation and looking at the family dynamics as well beyond the assessment tool. But what you say is the same type of perceptions and absence of the cultural understanding impacts upon the outcome.

DR WESTERMAN: Yeah, absolutely. Absolutely. Because parenting differences have been seen as deficits and there are differences and often what happens again --- and some of it is without intent, in some regions, literally, people do not understand that Aboriginal people parent their kids differently. So the problem is, through the lack of cultural competence in child protection, that child protection workers have a fear of getting things wrong, and particularly a child is at risk because they don't understand cultural difference life. So even cultural mapping, understanding kinship, and cultural mapping makes an extraordinary difference to the outcome.

MR CROWLEY: How would a practitioner, whether they're in the child protection system or not, but how would a practitioner go about then identifying whether a culturally appropriate assessment tool and assessment framework is required or not?

DR WESTERMAN: I guess --- the first thing is people generally --- we just say people need to identify as indigenous Australian, so then obviously that then dictates it should dictate difference.

The work that we do across Australia, essentially --- and certainly the work in Western Australia is around looking at cultural policies and procedures, and so what

that provides organisations with is a step-by-step. So an Aboriginal person will identify it. The next phase that you do cultural mapping. The next phase is that these are the sorts of treatment implications that those sorts of things then have. These are the assessment tools that are more culturally fair that you can actually use. So essentially that's what you need a "step-by-step" that can guide organisations around those sorts of things, without just making assumptions that people ask you how to do it, because clearly they don't. So it's really around organisationally people being able to be tracked around, you know, difference and then being informed around the sort of things that need to be done differently, more procedural.

MR CROWLEY: Just following on from that, how would a practitioner making an assessment about, for example, parenting capacity assessment, how would they be able to determine whether the result of the assessment is cultural difference rather than an actual deficit?

DR WESTERMAN: I guess the first thing is cultural mapping which is acculturation scale that I've talked about. So we will initially do an acculturation scale which then informs the attachment map, and the next thing we actually do is at an individual child level is that we would actually figure out what capacity there is from within the community context to respond to the whole range of --- attachment is actually assessed based on the environment's ability to respond to a whole range of positive and negative emotions that a child needs, so that's essentially what attachment is seen as.
The difference is with Aboriginal people is that there are many more people that respond to the whole range of, indeed, the emotional needs of a child.

The trouble is when you go in and you try and assess from a mainstream perspective, you're often missing the attachment map that the Aboriginal child has which is based on the nuclear family: Mum and dad.

So the first thing I would do as a practitioner is I would see a high-risk kid and I would observe, and observe and observe and observe, at community level, every single emotion that child emits, whether it is anger, distress, happiness or whatever, and which person in the community responds to those different emotions, and whichever emotion they fail to respond to, I then teach them how best to respond to those different emotional needs.

So how you develop secure attachment is in the environment's capacity to respond to a whole range of positive and negative emotions in a child.

The trouble is, is that people are coming in, looking at it from a mainstream mum and dad perspective, and they're assuming that attachment needs are not being addressed and responded to in a child, when they actually are, and so it's something that is really fundamental in relation to getting assessment of attachment parenting really quite wrong.

MR CROWLEY: I want to ask you more about, then, for an individual worker or

assessor, in a child protection system setting, how important is it for that person to have cultural competence in carrying out their roles?

DR WESTERMAN: Yeah, absolutely critical. Because I mean, I think what we're seeing is we have failed to measure --- except for the work that we've done. So if we've sampled 500 child protection workers and we've actually failed nationally to actually measure the contribution of cultural competency or lack of cultural competency on outcomes for Aboriginal families. So I guess the ability to teach cultural competency provides us with --- the first thing it does is it tells us the nature of the workforce. It tells us where people are at in terms of just having different standards of cultural competency.

What that then enables us to do is it enables us to figure out whether areas where there's high Aboriginal child removal, high rates of child removal have lower rates of cultural competency, compared to regions that have, you know, lower rates of child removal, high Aboriginal population.

So, we've been able to essentially demonstrate that in our work that we've done with testing cultural competency of child protection workers.

What that enables us to do then, it enables us to inform what to do in order to get us our best opportunity of reducing rates of child removal because, essentially, what it means is we've been able to determine from an evidence-based perspective a contribution of cultural competency to the high rates of child removal. Improve cultural competency, hopefully reduce rates of child removal. But cultural competency is a really ill-defined thing. And what we've actually been able to do is define it based on 18 different dimensions.. So that then informs really targeted intervention.

So what we've again done with our cultural competency work is we tested based on cultural competency. I then design a targeted training intervention, and then we post-test them to see what improvements we've had.

Now, we're the only ones that have actually managed to do that. So, can you measure cultural competency? Yes, you can. Can you improve cultural competency? Yes, you can. So that's really exciting stuff. And so what it enables us to do, is again, explain the 'why', but also 'why' then informs what to do about it, which is what sort of training people need, how you can actually ensure people get the training they require, but most importantly we can then develop robust data around, hopefully, the rates of child removal decreasing relative to improvements of cultural competency. But that's something that needs to be driven nationally. And that's something that needs to be, I guess, longitudinally and, you know, driven over time so that we can really be clear about what is having an impact on reducing child removal rates.

MR CROWLEY: You have been talking about the cultural competency. Is it enough for someone to undergo cultural awareness training? Is that the same thing?

DR WESTERMAN: No. Cultural awareness, what we have found is there's 18 different dimensions of cultural competencies so there's 5 major areas.

One of those is cultural knowledge which is your basic cultural awareness. So, give people knowledge and that's sufficient. Obviously we know that's not the case.

Within cultural knowledge, there's actually 4 different dimensions. So we test things, for example, like local cultural knowledge, application of knowledge, child protection-specific knowledge, so they're things such as I know about assimilation policies. I know that attachment mapping --- I know about attachment mapping, I know about lack of identify formation. I know about all these sorts of things that I need to understand in order to ensure that I'm addressing the needs of Aboriginal families better. And then we have just general cultural knowledge.

Then we have skills and abilities which actually looks at your ability to adjust your counselling, adjust your therapeutic interventions, that tap into cultural differences in, you know, cultural strengths.

The next thing we look at – its actually pretty full-on - is beliefs and attitudes and cultural empathy and awareness. Now, those questions really tap into unconscious bias. Now, this is something that is really challenging as a trainer because what I actually do is I do targeted intervention around addressing unconscious bias or racism in people, in a way that makes unconscious bias conscious; that gives people the strategies to shift them at a level of prevailing belief system.

So the cultural competency tool really, it actually assesses whether people have inherent racism. And then my job is to put them into training workshops that address unconscious bias in a way that shifts their prevailing attitudes around baseline racism and those sorts of things. So it's not easy to do but, I mean --- you know, it's quite challenging but this is the stuff we spend time doing.

The last couple of resources and linkages…

(DOG BARKS)

…having access to culturally appropriate…

(DOG BARKS)

Sorry. That's my dog…culturally appropriate assessment tools and links and so forth…

(BARKING CONTINUES)

…organisations. And the final one is just organisational cultural competency. Can I just go and stop her?

(BARKING CONTINUES)

Sorry. Jilya. Stop it. It's alright. She's doing her guard dog thing. Sorry about that. The last one is organisational cultural competency. So essentially what we do, is people get to gauge the cultural competency of their organisations and of course we do that by Aboriginal versus non-Aboriginal staff which by itself is actually really interesting in terms of the differences that we see.

MR CROWLEY: Now, in terms of the assessments of cultural competency, you have talked about the tool that you have developed that can measure cultural competency. Apart from the tool that you have developed, that can measure cultural competency. Apart from the tool that you've developed, are there other ways that that can be measured?

DR WESTERMAN: No, not to the extent of science that we've actually applied. What we have done again is we have gone out and asked Aboriginal people if you had to go in to a counsellor, if you had to go in to a service, what are the things that tell you, that give you confidence that they are culturally competent? And so we defined that with Aboriginal people, so it's really robust scientifically.

Once we figured out the predictors, now what we've done, we've normed those tests Australia-wide, so we've normative data on all of these 3 tests. So, 500 in the child protection cultural competency, over 3,000 on the mental health one, and over 3,000 on the general cultural competency profile.

What it actually does is it taps into all dimensions of cultural competency. There are some cultural competency-based tools internationally, but they focus mostly on the beliefs and attitudes bit. We focus on many more dimensions than that, with the idea being that we want to actually evoke behavioural change, and that's the difference with the work that we do and also, you know, having something that has now been demonstrated to be capable of improvement. You know, we targeted intervention, training intervention.

MR CROWLEY: You mentioned earlier on about --- you used the phrase "causal pathways". How important is the cultural competency of people undertaking assessments in the child protection field for First Nations people, particularly parents with disability? How important is it to have that competency in terms of those causal pathways?

DR WESTERMAN: It's critical. It's absolutely critical. Because essentially --- the first thing is getting the tests right which is the causal pathway stuff around suicide and mental health. So it's actually the causal pathways around suicide and depression, you know, just for example, like they differ.

The next bit, though, is about how the practitioner interacts with an Aboriginal person and/or is able to apply assessment in a culturally appropriate way. You know,

are you able to assess, you know, your Aboriginal family and your Aboriginal clients in a way that we know is culturally appropriate; are we able to apply culturally appropriate interventions?

If we actually don't assess the levels of cultural competency, then we can't actually figure out what impact a lack of cultural competency is having overall on those, you know, terrible statistics we keep talking about, you know, the overrepresentation, of child protective services, suicide rates and those sorts of things.

No university has actually required anyone in the health profession has minimum standards of cultural competency. Essentially what that then means is that all the training is inherently mainstream. So this is why getting cultural competency right is so critical because it informs the 'what', which is the sorts of training that people need, the sorts of capacities that people need in order to be able to go out and do appropriate work at a community level. So if we're not actually getting that right in terms of understanding the nature of the workforce, then we're not actually giving them what they need to be able to ensure that they are culturally competent when they're working with Aboriginal communities, and I see this every day.

We have, say, psychologists graduate and they'll be sent out to remote Kimberley and they'll absolutely fall apart at the seams because they are feeling culturally unsafe every single day, with the fact that their training is so mainstream and so inherently --- it hasn't been tested with Aboriginal people, that they really struggle to know literally from engagement, all the way through to therapeutic testing, whether any of their training actually is culturally appropriate. So it is really quite critical to this whole area.

MR CROWLEY: In your statement, Dr Westerman, you have made a number of suggestions and recommendations for things that the Commission may consider for change in this area and in the scope of what the Commission's inquiry is concerned with. Are there any particular aspects of those recommendations that you would like to speak to?

DR WESTERMAN: I think probably --- the big one --- I mean, we keep coming back to assessment again and I guess probably the main thing is getting the tests right. So develop unique clinically culturally valid tests.

The next thing is actually ensuring we have cultural competency as standard across all these areas so that people are actually capable of administering assessments, ensuring that they can then have treatment programmes that have been determined as, you know, as having effectiveness with Aboriginal people and be able to, I guess, have a national body that actually drives all those sorts of things for people who are just really struggling day-today-, to know, you know, what sorts of things they can do to make an impact to the lives of Aboriginal people.

I guess I've spent, you know, 22 years training well over 30,000 practitioners across this country, so I have a pretty good yardstick of how much people are struggling,

and we really are letting them down in terms of informing them around treatments and best practice, giving them culturally appropriate; you know, assessment tools to be able to do that and, most importantly, just not gathering any evidence of what is actually working at a national level which, you know, you just --- it's almost like we're continuing to throw good money after bad money, really aren't we?

MR CROWLEY: Yes, thank you, Dr Westerman. That's all the questions I have.

DR WESTERMAN: Okay.

[VIDEO RECORDING ENDED]

CHAIR: Yes, Mr Crowley.

MR CROWLEY: The witness that we have is Leigh-Anne Pokino. But before we commence her evidence, could we perhaps have a short break for a few moments just to get ourselves organised?

CHAIR: Shall we resume at 10.35am Brisbane time, 11.35am Sydney time?

MR CROWLEY: Yes, thank you, Chair.

CHAIR: Thank you.

ADJOURNED **[10.26 AM]**

RESUMED **[10.43 AM]**

CHAIR: Yes, Mr Crowley.

MR CROWLEY: Thank you, Chair. The next witness we have is Leigh-Anne Pokino who is present in the room to give her evidence. There's a statement of Ms Pokino in the Tender Bundle part B at volume 2, tab 15. I tender that statement but ask that at this stage a non-publication order be made over the statement until further order.

CHAIR: Yes, all right.

There will be a direction then that the statement and no part of the statement of Ms Pokino is to be published until further order by the Commission.

EXHIBIT #8.5 - STATEMENT OF MS LEIGH-ANNE POKINO

Can we proceed to Ms Pokino's evidence.

MR CROWLEY: Yes, we can proceed, thank you.

CHAIR: Thank you.

MS LEIGH-ANNE POKINO, AFFIRMED

CHAIR: Thank you, Ms Pokino, for coming to give evidence to the Royal Commission. Mr Crowley will now ask you some questions. Thank you.

EXAMINATION-IN-CHIEF BY MR CROWLEY

MR CROWLEY: Ms Pokino, can you just tell us, first of all, where you currently work and what your role is, please?

MS POKINO: Yes, I currently work at Inala Indigenous Health as a caseworker there. I provide intense case management to Aboriginal families and I'm also a racial equity specialist under the Institute of South Pacific for courageous conversations about race. So I have two hats.

MR CROWLEY: Just dealing with your role at the Inala Indigenous Health Service, how long have you been in that position?

MS POKINO: I've been in that position for 4 years but I've actually been working at Inala Indigenous Health for 16 years.

MR CROWLEY: Do you have qualifications in this area?

MS POKINO: Yes. So I completed a bachelor of Indigenous primary healthcare at UQ. And I also have done a diploma of youth work and have also done that further training for creative conversations about race.

MR CROWLEY: Just tell us a bit more about that. What is that qualification?

MS POKINO: It's a two-day training workshop that talks about race and racism within systems and it looks at your own personalised experienced as a racialised being. It took me a year to become an accredited facilitator for that, and it teaches tools, because we're socially constructed not to talk about race or racism, so it's a two-day workshop where we teach participants tools to talk about race and racism,

and you get that multiple perspective as well, so it's a real personalised journey for people. And it is life-changing for them, as we've had a lot of feedback about that. So I'm one of the four facilitators.

MR CROWLEY: When you say it's a two-day workshop, it's a two-day workshop that you teach as a facilitator?

MS POKINO: Yes, so I'm accredited for that through the South Pacific, there's only about 8 of us in Australia that can actually deliver that workshop. It's a specialised area that I work in and yes, it is a two-day program that I deliver as part of that.

CHAIR: Ms Pokino, I wonder if you wouldn't mind speaking just a little more slowly because we do need to translate your evidence, and it needs to be followed on a realtime transcript. So you're not the first witness that's been asked to speak a little more slowly, if you wouldn't mind just bearing that in mind. Thank you.

MS POKINO: Thank you.

MR CROWLEY: Ms Pokino, can you tell us a bit more then about your role at the Inala Indigenous Health Service, what you do there?

MS POKINO: So my current role as the caseworker is providing that intensive support to Aboriginal and Torres Strait Islander families and in particular the women, and it's always led by the women and, yeah, I'm pretty much client led, client focused and I try to empower them to make decisions. So it's an intensive case management model.

MR CROWLEY: Now, the health service itself, what sort of services does it provide?

MS POKINO: So, it was originated by Dr Noel Hayman and Aunty Nola White 25 years ago. They were the founders of Indigenous Health, and it's a primary healthcare setting. It's a one-stop shop for Aboriginal and Torres Strait Islander people. It has doctors, nurses in a clinical setting. It has a community health team, who is what I fall under, it has a psychologist, social worker, health workers, client support officers and then it also has a research component. So we're known as a centre of excellence, so --- we're like a one-stop shop for Aboriginal and Torres Strait Islanders.

MR CROWLEY: I want to ask you about one of the programs that you've been involved in in particular, the Empowering Strong Families program 4077. Can you just tell us about that?

MS POKINO: So that was originated from - we realised that there was high smoking rates among pregnant Aboriginal women and we wanted to do something about it. So we got some funding under the Tackle Indigenous Smoking grant, and it was around the new initiatives. So we thought if we could provide a service to these

women and an intensive case management model of care, we could really start to address smoking, because at the moment, smoking within a mainstream setting is really focused on smoking itself. When you work in an Indigenous health context, it has to be a holistic approach. That's where the program started from and we've changed it over the years to suit the community because it's always community-led, not service provider led. We listen to community.

MR CROWLEY: When you say it's changed over the years, why has it changed?

MS POKINO: When we first started, our main goal was to try to help these women to either reduce or quit smoking. We soon realised that that was not a priority for these women. We had to start to address some of the issues that these women were facing. So it became that once we can address the stresses and the barriers that these women and families are facing, then we can look at smoking. So we started to change the model of care. So it suited the participants.

MR CROWLEY: What were some of the issues that you were seeing, the bigger issues?

MS POKINO: Intergenerational trauma, drugs and alcohol, abuse, quite traumatic, and things with Centrelink and housing. Housing is a major issue. So there was a lot of issues that --- if you don't have a stable house, food on the table, you're not going to address smoking. Once we addressed those basic needs that everyone in Australia is entitled to, then you can start to address smoking in that context.

MR CROWLEY: The way in which the program changed, did it then become more an emphasis on the big issues first, and then we get to smoking?

MS POKINO: Yeah, and you will see with our research that has now been published that's what we talk about. We talk about if we can address these issues with the women, the ones that they tell us are the issues, then you can start to get smoking on the agenda, and we did have women quit, we definitely had people reduce smoking, which was a celebration because with all the stresses in their life it can be a hard one to address smoking as well as a priority.

MR CROWLEY: Give us an outline then of how, with that change in focus of the program, how the service and the program went to tackle those bigger issues?

MS POKINO: I guess to tackle those big issues you really have to ensure that you have the trust of the women and the community. You have to ensure that it's led by the women and that you're actually empowering them. You are walking alongside them. I never work with clients and walk in front of them, I am always going on the journey with them, I think that's the real key when working with women, Aboriginal women in particular, not just sit at your desk and wait for them to come to you. You've actually got to get out in community, and once they know you, they're familiar with you, then you're able to address some of those hard issues because they trust you.

MR CROWLEY: I should ask you this, Ms Pokino. You work in this area and with Aboriginal and Torres Strait Islander families and women in particular. But you're not a First Nations person yourself?

MS POKINO: No. I'm actually a white woman from New Zealand, and I think that's why I'm here today, is to speak up because I've supported these women for 16 years and I think it's important that the truth needs to be heard.

MR CROWLEY: I will just ask you to confirm this is the position, coming here today to give your evidence, even though you are employed by the Inala Health Service and Queensland Health, you've come today to give your evidence, they're your views, you're not expressing views or opinions held by the Department?

MS POKINO: Definitely not. This is my 16 years of experience and training is what I'm speaking on behalf of today, is what I've seen and witnessed and when I walk alongside these women, it's their stories as well.

MR CROWLEY: Can I ask you about the women that you work with in the service, can you tell us how many of them have poor mental health conditions?

MS POKINO: I'd say, in my opinion, 100% of the women I work with either suffer from depression, anxiety, or post-traumatic stress. 100% of the women, they have suicidal ideation. I'd say 100% of women I work with, suffer from mental health.

MR CROWLEY: And in the program, are they considered as being clients who have psychosocial disability?

MS POKINO: Yes.

MR CROWLEY: Just tell us about how they are then treated for those disabilities.

MS POKINO: So, the women I work with, I guess, when you work in an Aboriginal community, there's a lot of shame and stigma attached to mental health. So through my role as a caseworker, I provide that intensive case management and support and advocate for them to access Mental Health Services because there's always a lot of stigma. So getting them into a GP for a mental health care plan, with the possibility of referring on to a psychologist or medication if the doctor sees fit.

MR CROWLEY: And in your particular role, is it an advocacy role, a facilitating role, can you just describe what it does?

MS POKINO: Yeah, so for me I strongly advocate for these clients because often we live in a world where we're not all born equal. So I see part of my role as a white woman is to really advocate strongly for Aboriginal people and speak up in situations where power - where they don't feel they have the power to talk up. So I'm a real strong advocate for these women and families.

MR CROWLEY: You've told us earlier about building a relationship of trust with the clients. How important is that?

MS POKINO: That's fundamental. If you don't have trust then you won't get anywhere. I mean trust is key to working within an Aboriginal community because they suss you out, they figure out who you are and they will soon find out just by looking at you if you're legit or not. I mean, I've been there for 16 years so I've built that reputation, I guess, over the years that has led me to be where I am today.

MR CROWLEY: In the types of things that you do in your role, does that involve being in contact with other government agencies or departments?

MS POKINO: Yes. So I have a lot of contact with Housing, Centrelink and Child Safety.

MR CROWLEY: In that contact are you acting in that advocate and conduit kind of role for the clients?

MS POKINO: Yes, that's correct.

MR CROWLEY: What sorts of things do you do when you're in contact with those departments?

MS POKINO: In my role as an advocate, I ensure that the women's voices are heard. Often I've found and the women tell me that they feel disempowered when they are talking to government organisations. So as part of my role is to ensure that their voices are heard and ensure that they're treated with dignity. I find that when I have been to meetings with departments, there's a disempowerment to Aboriginal women, and they're unable to speak their truth and there's stigma associated, too, for these women. So I see my role as a white woman to really speak up and speak into that space and challenge, and support the woman through that process --- because it's a hard system to manoeuvre, especially when you're an Aboriginal woman in a system that's not built for Aboriginal people.

MR CROWLEY: I want to ask you specifically about the role that you perform as an advocate assisting these women with the child protection system, so the Department of Child Safety. You have interactions with them in your role?

MS POKINO: That's correct, I've - yeah.

MR CROWLEY: Just tell us the sort of range of things that you do.

MS POKINO: So I do a lot around child safety. I attend the home visits, I attend the family group planning meetings, I attend any meetings -

MR CROWLEY: Just a little bit slower, thanks, Ms Pokino.

MS POKINO: So I pretty much attend all the meetings and walk with the women through the journey as they process and manoeuvre child safety systems. And the investigations on the part of --- and the IPP agreements and all that. So anything I can do to support and advocate for the women.

MR CROWLEY: I should ask you this. The health service where you perform this role, what sort of service area do you deliver to?

MS POKINO: So we service - we get people coming from Cherbourg, so there's no kind of set boundaries as to - I mean, we work within Metro South but, you know, we know that people come from Cherbourg and are able to access our service which is, yeah, fine. But I, yeah, we work within Metro South. So Logan down to Beaudesert, out to Redlands.

MR CROWLEY: And in those contacts with Child Safety, are you in regular contact with the local Child Safety service centre?

MS POKINO: Yeah, so there's different services throughout Brisbane that I've had a lot of interactions with. Some of our mums may live out at, you know, on the north side, or at Ipswich way, so yeah, I do have - I have had contact with many different branches of Child Safety across Brisbane.

MR CROWLEY: When we talk about contact, is that on the phone, by email?

MS POKINO: No, on the phone, a lot of face to face. So when an investigation happens, I'm at the forefront with the women advocating and supporting. So there's a lot of phone calls and obviously meeting with the Child Safety officers. So it's quite an intense kind of process as well as looking after the women through that process.

MR CROWLEY: In that role that you perform with the women advocating for them in the child safety area, just tell us how you assist women who have those type of disabilities, psychosocial disabilities, how you assist them to interact with the Department.

MS POKINO: Well, I guess I provide that intensive support, counselling, yarning, just strongly advocating for them because all the women that I've dealt with that have gone through the system, it actually heightens their mental health. So from many occasions I've had women wanting to just give up, you know, wanting to just commit suicide and go, "Stuff it, they can have my kids." They're already defeated before they've even started the fight. So I find part of my role is empowering these women to fight the system that may not be built for them, but encouraging and supporting and counselling and checking in on them, whether it's daily, weekly, because it definitely impacts their mental health and heightens it severely.

MR CROWLEY: Now, I want to ask you about the types of supports for women in these positions. So where the Department has taken some action in relation to a child

of one of your clients, are you able to tell us about the type of supports that you're able to facilitate with the Department?

MS POKINO: So what tends to happen is a plan is put in place where the women may have to, you know, if they have drug and alcohol issues, if they have a domestic violence relationship, if they have mental health, and there's things that the Department require them to do in order to potentially get their children back in their care.

So part of my role is to support them through that process. So helping them to access domestic violence services, counsellors, rehab, if that's what they need to do, and looking at the domestic violence and, yeah, stuff like that. But often I find that the pressure put on Aboriginal women to do this, especially address their mental health, can be re-traumatising for them. I don't think it has - when these plans are put in place, I don't know how much culture has impacted on these decisions. I think that's a massive component that the system forgets about, and I know from my 16 years' experience how important culture, country and connection and spirituality is to Aboriginal people.

So when they do these plans and they make these women have to address this trauma, it's actually not acknowledging their resilience, nor is it acknowledging their cultural connection. So you're almost setting the parent up for failure, in my opinion, from what I've witnessed in my 16 years of experience.

MR CROWLEY: Just on the way in which culture is taken into account, are you able to tell us, from your experience and observation, how is it factored in?

MS POKINO: In my opinion it's not factored in, as in, you know, say for example, part of the plan is for the women to access a Mental Health Service. There are not many mental health services that are culturally appropriate for Aboriginal and Torres Strait Islander in my opinion in Brisbane. So as a result this woman is - has no option but to see a non-Indigenous psychologist which can be re-traumatising if you look at history. Can be re-traumatising for that woman.

So I think the systems that we have in place don't acknowledge culture and the spirituality and the connection that Aboriginal and Torres Strait Islander people have. I mean, it's very Westernised kind of plan that's put in place, and when it's put in place, the women I work with don't have the power to challenge it. So they have to agree to do what Child Safety wants them to do if they are to get their children back. And I've found in times that even when they do do what Child Safety wants, they do not get their children back. I'm actually going through a case at the moment like that. So it's quite, yeah.

MR CROWLEY: You mentioned a couple of a different programs or things that women might need to do as part of that process. Rehabilitation programs is one you've mentioned. In relation to those and your clients, from your experience, is cultural consideration culture a factor which is part of what those recommended

programs encases?

MS POKINO: No, I don't find that culture is acknowledged through any of the systems, and it's not - on the ground level it doesn't happen. It might happen - might be a legislation up top that says, you know, you need to ensure it's culturally appropriate, but on the ground level it's a very different story. Yeah, it's a very Westernised model of care.

MR CROWLEY: What about with parenting programs?

MS POKINO: There are very limited parenting programs for Aboriginal families, and we've also got to acknowledge, too, the lack of resources available for Aboriginal and Torres Strait Islander communities. They're underfunded in that area, and often when you try to refer to an Aboriginal organisation, there's quite a waitlist, like, it's not just going to happen overnight. So there's a lot of pressure on the already existing Aboriginal and Torres Strait Islander programs that are within Brisbane, but they are very limited and over my 16 years, I've actually seen a lot of funding being pulled out of community organisations, which is sad because it impacts the community especially out at Inala.

MR CROWLEY: Going back to your clients who have disability as an issue as well, are there, from your experience, disability supports or services and programs through the Department when Child Safety is involved often to the parents?

MS POKINO: So from my opinion and what I've witnessed, it can be very tokenistic. It can be "Here, we'll refer you to, you know, a program, we've ticked that box, it's done". They don't actually follow through or follow up. The referral might be put in place but it's just a tick of a box which is - it's not genuine and it's not authentic. I find that there's very limited support for Aboriginal and Torres Strait Islander families going through the system. And often they will look at me to almost do their dirty work for them, which, yeah, I don't do.

MR CROWLEY: Just on that issue of the disability programs, are there any programs that are culturally appropriate and safe for First Nations parents?

MS POKINO: There are organisations at Inala that's available but, once again, it's like resources - not enough workers, not enough money put into it. So there are services out at Inala but not often a worker is always available to take on caseloads.

MR CROWLEY: And the clients that you advocate for when these type of services or programs are part of what they have to undertake, do they have a choice to which service provider to go to?

MS POKINO: Sometimes they have a choice if they speak up, but quite often, in meetings that I've been to, they're disempowered. So they will just say yes, yes, yes, because they're too fearful to speak up in that place. So they will often say something to me afterwards and then I will advocate for the parent, which is often

what happens.

MR CROWLEY: Now I want to ask you then about, going back to the child safety cases that you've been involved with, what your observations have been and your experience has been about having Aboriginal and Torres Strait Islander people from the Department as part of that process to assist with identifying what's needed for a parent and their family?

MS POKINO: Yeah, well I can count on one hand the amount of times when there's been an Aboriginal and Torres Strait Islander representative within that meeting or any interactions with Aboriginal and Torres Strait Islander families. I've had a lot of interactions over the last 4 years, and like I said I can count on one hand when there has been an Aboriginal and Torres Strait Islander person.

MR CROWLEY: Can I just ask you, when we're talking about a representative, an Aboriginal and Torres Strait Islander representative, who is that person?

MS POKINO: There's generally --- from my understanding, there's generally a person within each office that is Aboriginal or Torres Strait Islander, and my understanding is they're meant to be involved with any Aboriginal and Torres Strait Islander family that comes to attention of DOCS.

MR CROWLEY: That's the cases you're talking about?

MS POKINO: Yes, but very rarely is there an Aboriginal or Torres Strait Islander person from Child Safety within the meetings, definitely not at any of the home visits. And I think, if I can say, that sometimes those positions are just tokenistic. It's a tick of a box. I'm not sure whether those people's voices are heard within the system, but there's definitely many times when there's no cultural safety provided for the family that's going through the system, which is a failure by the system.

MR CROWLEY: I should ask you this, Ms Pokino, you're talking about from your experience particularly in your role within the program, in the Inala Health Service. How many cases would you estimate you've been involved in which have been in this advocating role for mothers, parents with disability in contact with child protection?

MS POKINO: So over the 4 years, I've had about 10 families come into contact with Child Safety. Having said that, it could have been numerous times, so I've had many families where there's been a notification put in, an investigation has happened and it's been closed down. Three months later, another investigation, so it's a continual cycle, a continual re-traumatising for the parents and the families. So it's 10 families but it could have been - I know a family that we've had about 5 investigations. So it can be ongoing. Some families are, yeah, within 6 months at least they can be in the investigation.

MR CROWLEY: In terms of the things that you would recommend could be

changed about the current system as you see it, are you able to tell us the type of things that you think should be a priority?

MS POKINO: I think for me, I firmly believe, in order to change a system, we need to look at where the power lies. I think it's important that we have Aboriginal and Torres Strait Islander people in power. That's from the top all the way down, and I think when I speak to that, you can't just have one Aboriginal person at the top and expect them to talk on behalf of Aboriginal and Torres Strait Islander people. It needs to be authentic and genuine, and it needs to be down throughout the system. To make a real change in the system we need - power needs to lie with Aboriginal and Torres Strait Islander people.

MR CROWLEY: And what about in terms of the individual case officers at that level?

MS POKINO: So the individual case officers, I think, it's fundamental that there's anti-racism training, there's cultural competency training as well as understanding the history of Aboriginal and Torres Strait Islander people. We need to know the true history in order to effectively culturally and sensitively work with Aboriginal and Torres Strait Islander people. So at a ground level, from my experience in what I've witnessed, is many of the workers are not culturally appropriate. So there needs to be further training done for child safety officers.

MR CROWLEY: What about the supports, the availability of supports for your clients, and particularly those with disability?

MS POKINO: I think definitely there needs to be more resources put in for Aboriginal and Torres Strait Islander communities. There needs to be more people on the ground level, getting out in community, supporting these families and walking alongside them while they go on this journey. So I think there needs to be more workers on the ground. There's a lack of resources out there at the moment, and money keeps getting stripped away. And we're not going to be able to address racial disparities if we're not putting the money where it needs to go and that's on the ground level.

MR CROWLEY: Thank you, Ms Pokino, that's all the questions I have.

MS POKINO: Thank you.

CHAIR: Yes, thank you.

Commissioner Mason, do you have any questions you would like to put to Ms Pokino?

COMMISSIONER MASON: No thank you, Chair.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner McEwin?

QUESTIONS BY THE COMMISSION

COMMISSIONER McEWIN: Yes, I have one question, thank you, for Ms Pokino. Ms Pokino, thank you. Look, you've described a lot of, in terms of your evidence, your many interactions with the families. Have there been any times at all when there have been some successful stories or is there anything that you can point to that might work well in your experience? Thank you.

MS POKINO: I mean, I think it's always a good outcome when an investigation is closed on a family. I think that's probably a success story when we're able to support the mother through the system to ensure that the investigation is closed, that another child isn't brought into care again.

COMMISSIONER McEWIN: So in other words, when there's less intervention, perhaps, from the system and where the family might be supported to be a family?

MS POKINO: Yeah, I think - yeah, I think there needs to be, instead of removing the child and putting another Aboriginal child in care, we need to provide appropriate support to the families as they go - yeah, which doesn't often happen.

COMMISSIONER McEWIN: Thank you.

CHAIR: Ms Pokino, thank you very much for coming to the Commission and giving evidence. We appreciate both your statement and the oral evidence you've given today. Thank you very much.

MS POKINO: Thank you.

THE WITNESS WITHDREW

CHAIR: Mr Crowley, yes, what is next, please?

MR CROWLEY: Chair, we next have scheduled a short break, mid-morning break, and then after that we'll be continuing with the next two witnesses between then and lunch.

CHAIR: So shall we say another 10-minute break?

MR CROWLEY: Yes, thank you.

CHAIR: Thank you. We'll adjourn then for 10 minutes.

ADJOURNED [11.16 AM]

RESUMED [11.29 AM]

CHAIR: Yes, Mr Crowley.

MR CROWLEY: Thank you, Chair. The next witness we have is Thelma Schwartz and I can indicate that Mr Power will take this witness and also the next witness, Professor Higgins.

CHAIR: Thank you.

Yes, Mr Power.

MR POWER: Chair, I call Thelma Caroline Schwartz who is present in the Brisbane hearing room.

CHAIR: I'm just waiting for Ms Schwartz to appear on our screen.

Yes, thank you, Ms Schwartz. Thank you very much for coming to the Royal Commission to give evidence. I will ask you, please, to follow the instructions of Commissioner Atkinson's associate to take either the oath or the affirmation as the case may be. Thank you.

MS THELMA CAROLINE SCHWARTZ, SWORN

CHAIR: Thank you, Ms Schwartz. Mr Power will now ask you some questions. Thank you.

EXAMINATION-IN-CHIEF BY MR POWER

MR POWER: Ms Schwartz, could you tell the Commission your full name?

MS SCHWARTZ: My name is Thelma Caroline Schwartz.

MR POWER: Have you prepared a 20-page statement dated 20 November 2020 for

this Commission?

MS SCHWARTZ: Yes, I have.

MR POWER: Are the contents of that statement true and correct to the best of your knowledge and belief?

MS SCHWARTZ: Yes, they are.

MR POWER: Commissioners, I seek to tender Ms Schwartz's statement which is STAT.0232.0001.0001.

CHAIR: Yes, and you want to give that an exhibit number?

MS SCHWARTZ: Yes, and the next exhibit number is -

CHAIR: I'll take a guess and say 8.5.

MR POWER: Thank you. Chair, I think it's 8.6. I apologise.

CHAIR: Very good. All right, we'll mark the exhibit as Exhibit 8.6.

EXHIBIT #8.6 - STATEMENT OF MS THELMA CAROLINE SCHWARTZ

MR POWER: Ms Schwartz, do you identify as a First Nations person?

MS SCHWARTZ: Yes, Torres Strait Islander through my mother's line.

MR POWER: And since 2005, have you been the Principal Legal Officer of Queensland Indigenous Family Violence Legal Service?

MS SCHWARTZ: Yes, that's correct.

MR POWER: And is that known by the acronym QIFVLS, also pronounced "K-W-I-F-F-L-E-S"?

MS SCHWARTZ: That's right.

MR POWER: I'll refer to it in evidence as QIFVLS.

Prior to becoming the Principal Legal Officer of QIFVLS, did you practice in a number of areas of law?

MS SCHWARTZ: That's correct.

MR POWER: What were those areas?

MS SCHWARTZ: I practised for a number of years at the Aboriginal and Torres Strait Islander Legal Service, ATSILS, in Cairns. I practised for 9 and a half years in that capacity representing Aboriginal and Torres Strait Islander men, women and children across the Magistrates Court, the Children's Court of Queensland, the District Court, Supreme Court and the Queensland Court of Appeal. I've also had the benefit of practising in commercial litigation for 7 and a half years in both Northern Territory and Queensland with a practice that was personal injuries, bankruptcy, negligence, whether that's professional negligence, medical negligence, motor accidents, so a very broad, general litigation commercial practice.

MR POWER: And that commenced when you were admitted in 1999 in the Northern Territory?

MS SCHWARTZ: That's correct.

MR POWER: And you were admitted to practice in Queensland in 2003?

MS SCHWARTZ: That's correct.

MR POWER: Is it correct that QIFVLS is one of two community-controlled family violence prevention legal services for Aboriginal and Torres Strait Islander people in Queensland?

MS SCHWARTZ: That's correct. Our other sister organisation is based in Roma, the Aboriginal Family Legal Service.

MR POWER: Now, your statement, which has been tendered as an exhibit, goes through the very wide range of work that QIFVLS does, but I want to turn to the child protection practice and in particular First Nations parents with disabilities.

At paragraph 26 of your statement, your statement goes through the new cases that occurred during the last financial year, that is July 2019 to June 2020, and it records that new child protection cases constituted 31.3% of your new cases which was the highest percentage of the categories of any new legal cases. Now, could you just expand on that and whether that is a new phenomenon with regard to that being the highest percentage, that is child protection of your work or is that something that's occurred over time?

MS SCHWARTZ: In relation to paragraph 26 of my statement, I started with QIFVLS in 2015. The predominant nature of our work has been in relation to domestic and family violence legal case work representation or family law case work representation.

For that particular reporting period, for child protection matters to outrank both domestic and family violence matters and family law matters is a new phenomenon.

It was the first time that I had seen it in my time at QIFVLS.

MR POWER: Now, does QIFVLS keep data about clients that have a disability?

MS SCHWARTZ: Unfortunately no. It's not a specific funding requirement under our service level agreement with the National Indigenous Australians Agency. We generally collect it, but it's not reported on to the funder.

MR POWER: And so that's in the form of your internal file notes would record it but not in terms of data collection for reporting purposes?

MS SCHWARTZ: That's correct.

MR POWER: Based on your experience, can you say how many of your First Nations clients have diagnosed or non-diagnosed disabilities?

MS SCHWARTZ: It's been my experience that a high proportion of our clients will present to us with the sequelae of trauma. Trauma being either physical trauma from fleeing a physically violent relationship, or the trauma that's associated, that would probably be called post-traumatic stress disorder which is undiagnosed. So these are the types of clients that we deal with on a day-to-day basis in my practice.

MR POWER: And what about the - your clients who are parents who are having contact with the child protection system? From your experience, what proportion of those parents were themselves children who had once grown up in the child protection system?

MS SCHWARTZ: It's a sad reality of my practice, but a high proportion of those people would have been children themselves of the system, and that seems to be a reflection that I've seen across my practice experience in criminal law practice where I have seen and represented grandparents, adults, and children who have all had connection with the child protection system, unfortunately.

MR POWER: And we'll come to it later, but that experience over the course of your legal career and with QIFVLS led you to the view that there needs to be early intervention before problems emerge?

MS SCHWARTZ: I absolutely agree the focus needs to shift to early intervention, to see a shift away from tertiary responses. That has been further amplified in the family matters report of 2020. Our system is not working. It's completely inadequate to deal with. The over-representation that is continuing to rise in relation to Aboriginal and Torres Strait Islander people's connection and intersection with the justice system, whether that's the criminal law justice system, the juvenile detention or juvenile youth justice system, and the child protection system.

MR POWER: Now, at paragraph 30 of your statement, you use the term "birth suite removals". Can you explain to the Commission what that means?

MS SCHWARTZ: A birth suite removal relates to a pregnant woman who is about to give birth and who has to go into hospital or into an area where they're waiting to go to hospital to physically give birth to their child. It's an unfortunate area that I see quite commonly across all of my offices in Queensland where we seem to have repeated contact with the Department in relation to this practice.

MR POWER: Now, from your experience with QIFVLS, is this a rare phenomenon or is it something that occurs more commonly?

MS SCHWARTZ: Unfortunately, it is quite a common occurrence. Only last week I had an incident in my Cairns office where we were notified of a young mother who had travelled down from the Cape York who had recently given birth with a very new baby, staying in a halfway house to return back home, and the Department had made their intentions known that they were going to remove that child. However, they wouldn't tell us at what time they wished to remove that child, so we had to play a game of cat and mouse to work out when we could actually get to Mookai Rosie, the Aboriginal-controlled community hostel where she was staying, to actually short-circuit and circumvent that removal.

It occurs. It's probably one of the more, I would call it a heinous practice, and it's unfortunate that it's still continuing, it's been continuing since my time in 2015, and I don't see a decrease in its application by the Department.

MR POWER: Now, you at QIFVLS have adopted a case management model that addresses legal and non-legal problems with families and particularly women who are victims of domestic violence. In terms of the development of that holistic system, was that in any way connected with your observations of birth suite removals?

MS SCHWARTZ: Our development of the model which is spoken to in the body of my statement, was as a direct consequence of birth suite removals that we saw occurring in the Rockhampton catchment area. I started in QIFVLS in 2015. We started working on that model in 2016 and that model, we have grown in the context of the funding bucket we currently receive from the funder. We don't get anything additional for it. We've developed it, it has been independently assessed by the Charles Darwin University when Minister - then Minister Nigel Scullion was the Minister responsible for family violence prevention legal services. Charles Darwin University spoke to the need for this model to be used across all of our sites. Unfortunately, we haven't been able to get that funding across the line across all of our sites, and it operates only in Rockhampton and Mt Isa at this point in time.

MR POWER: And you've spoken about an evaluation report from Charles Darwin University. Was that a report commissioned by your agency or by the Commonwealth itself?

MS SCHWARTZ: The report was commissioned by the then Department of Prime

Minister and Cabinet. We were funded under the Indigenous Australian stream at that particular point when we were headed by then Minister Nigel Scullion. It was commissioned into the overall effectiveness of family violence prevention legal services across Australia of which there are 14, and QIFVLS is one here in Queensland.

MR POWER: Now, without going into detail, what did that report say about the effectiveness of QIFVLS model of early intervention through a case management model?

MS SCHWARTZ: Effectively we were onto something.

MR POWER: And we - the Commission can make inquiries but from your perspective, is that a report that you think would help the Commission in an appreciation of the work that your organisation is doing?

MS SCHWARTZ: I certainly do believe it will assist the Commission to see the value of the work that we do, that we have come up with as an Aboriginal community controlled organisation, finding solutions for our people with our people and driving the change that we want to see on the ground.

MR POWER: Now, you've mentioned birth suite removals. Have you seen birth suite removals occurring with First Nations mothers with a disability?

MS SCHWARTZ: Yes, I have.

MR POWER: And what are your observations about how that affected those women and whether they were given any assistance after the removal of their children?

MS SCHWARTZ: I think the impact is further compounded for a person with disability. There are access issues immediately that a person with disability faces. It's further amplified as a First Nations person. I see a complete lack of hope, a complete lack of despair, just wanting to give up and not engage with the system. We haven't even got to trying to get this child back to negotiate terms, to have engagement, but it is a system that is stacked against that individual from the outset. I'm sorry but it's a bleak system, it's a system where there is no hope for an individual, and it traps people into this cycle that they can't get out of, or break free of.

MR POWER: Again, is that something that your case management model of legal and non-legal interventions tries to assist those people with?

MS SCHWARTZ: The beauty of our case management model is that it builds on the self-efficacy and the self-determination of that individual to take back control, to take back some power, and understanding to address the drivers that have bought them into contact with the system in the first place, to really get them back and connect them, let's say it's an issue of not having adequate housing. It's an issue of drugs and

alcohol. It's an issue of family violence. How do we address this to support you to take back control and make you safe, thereby your children safe? So it's a self-empowerment model, yes.

MR POWER: And why QIFVLS? Why not some aspect of the broader government agencies? Why QIFVLS to perform that role?

MS SCHWARTZ: If you're talking about Aboriginal and Torres Strait Islander people, with respect, Aboriginal and Torres Strait Islander people, Aboriginal community-controlled organisations should be taking the lead in this discussion. I believe that we have signed off a national partnership agreement on closing the gap, which is about building the capacity and strengths of our Aboriginal community-controlled organisations.

As I've said before, we have the solutions to our problems. Fund us. It is quite clear, through the numerous reports that we have been through in this State, and across the country, the failings of the child protection system let alone the justice system as a whole, in relation to the over-representation of Aboriginal and Torres Strait Islander people as a whole. So we've come up with a way to deal with this, and take back an aspect of control as opposed to the paternalistic way the system has dealt with and treated Aboriginal and Torres Strait Islander people.

MR POWER: Moving to a slightly different topic. At paragraph 31 of your statement, your statement contrasts the way that First Nations mothers who have been the victim of violence are treated, when firstly they were in the domestic violence - domestic and family violence setting, as opposed to when the same women are in the child protection system. Could you explain to the Commission what the differences in treatment are in those two systems?

MS SCHWARTZ: Ultimately the child protection system is adversarial and inquisitorial. A woman, and it is gendered, who enters the domestic and family violence system, given that the outcomes and supports that have been implemented from the Not Now, Not Ever report, is fully supported. There are support mechanisms. You have high-risk teams. You've got a whole wraparound approach to supporting her flee. That violent relationship and to move on and feel safe with her children.

Now, a notification would have been made that there was domestic violence that she was fleeing. That notification is then sent to the child protection system, particularly where there are children involved. The Department will then get in, in that child protection continuum and will say, "Well, hang on a minute, we're actually going to now start the process to remove your children, because you've failed to protect this child. This is a child in need of protection. You have exposed that child to domestic and family violence."

So you can see that by coming forward and making the disclosure that you've been a victim, which is all of this advertising and the whole genesis of the Not Now, Not

Ever report, this is now used as a catch-22 for this mother and used against her to remove her kids.

MR POWER: And coming then to First Nations parents with a disability, from your experience, how do they tend to come into contact with the child protection system?

MS SCHWARTZ: I believe I've spoken to that in my statement and that would be through contact with police, domestic violence incident reports and medical presentations and clinics at the hospital.

MR POWER: So what you've just said about First Nations women generally, being treated very differently in domestic and family violence setting as opposed to the child protection setting, is that the same or different with First Nation's women with disabilities in those two systems?

MS SCHWARTZ: It's probably further amplified for a First Nation's woman with a disability, given that she's already on the back foot because of her disability, and that is - there's already that limitation on access to justice. So you then reach out to access supports, protective supports through the domestic violence systems, at which you then get in the form of an order being made. But it's formed the basis for the grounds for the removal of child and child protection intervention on the other hand.

MR POWER: And so you've said form the basis of that child protection intervention. From when you became the Principal Legal Officer with QIFVLS in 2015 through to now, in terms of the reports that were prepared, what is the expression of domestic violence being used as a measure at risk to children? Is it the same in 2015 to now, or is it in any way different?

MS SCHWARTZ: When I first started in 2015 it was quite common to be put into the 600-page affidavit material that the basis for the removal of a child was because the mother had failed to protect the child given she had exposed them to domestic and family violence. That would be the sole reason we would see across all of my offices for children being removed.

Another one of the key bases that would have been tied in with the removal was the fact that the mother had been herself a child within the child protection system. Those were the two key grounds for removal. And that was 2015, and obviously, I've said to this Commission, that led to us creating a case management model to deal with what we were seeing happening with the Department.

Now, I'm seeing, with a shift since the amendments came in in 2017 to our legislation here, the choice of words used for removals has become a bit more sophisticated. We're not explicitly saying "Well, we're removing your children because of your exposing the child to domestic and family violence", and I think that's because of the involvement of the Official Solicitor, the Director of Child Protection Litigation, but when you dig down and analyse the evidence within the affidavits, it still comes down to exposure to domestic and family violence, you're a

child yourself who has been through the child protection system.

MR POWER: Now, QIFVLS has, in some of its offices, this case management system, what is your experience about whether the child protection agencies welcome a First Nations mother having support from QIFVLS at an early time?

MS SCHWARTZ: It was only about two weeks ago I had a discussion probably on the ground managers of a child safety office in one of our catchment areas, I won't say where, who basically said to me that my case management model was a duplication of existing on-the-ground services, what was the reason or why was the reason they should be involved with QIFVLS? And I kind of sat there and thought, "Hang on a minute, we've got these wonderful Aboriginal and Torres Strait Islander child placement principles within the act. I thought participation would have been key to this!" And it was quite an adversarial conversation, which is not what I wanted, because our idea is to actually engage proactively with the Department because there is a crisis on our hand. Their whole attitude, and that discussion with me, was on the basis that "There is nothing wrong with the Department. There are no failings within this Department". And I remember saying, that's funny, given the recent report into the death of Mason Jet Lee and the amendment that was pushed through in relation to permanency and the Queensland Government's commitment to implementing the further recommendations.

So it was quite a hostile discussion from that particular Department, unfortunately, in that region. And I'm absolutely gobsmacked because some of the other regions where we do work, we've managed - my teams on the ground have managed to establish fruitful and productive relationships with individuals within the offices and we're getting those referrals at the investigation and assessment phase, or prior to the investigation and notification stage that "We have a family, we've actually referred them to you, so you can have a discussion about what it is that we want to do", and I have received one phone call myself directly because I've been pushing in this space to be earlier involved where I've had a woman contact me directly saying, "They've told me to call you. "Great, I'll put you in contact with the right office."

MR POWER: So what you've just said there is in certain areas, in certain regions, there is, I suppose, a person-to-person relationship with people within child protection or child safety who have seen the value of what you're doing and made those personal connections. What do you think should be done across the board in terms of Aboriginal controlled community organisations and child safety and the timing of involvement?

MS SCHWARTZ: I think this probably ties to my recommendations that I would like to see occur. One of the key things that I'm calling for is, and it's consistent with our submissions and our national forum's submissions, is a child protection notification scheme where we are notified very similar to the custody notification scheme. As soon as an Aboriginal and Torres Strait Islander person comes into contact with the Department, we're notified, or the person is given the choice of a legal service provider that can assist them if they're not comfortable with an

Aboriginal community-controlled one.

MR POWER: And that reference to custody was, from your experience with ATSILS, where an Aboriginal or Torres Strait Islander person is in police custody, there's an obligation to notify ATSILS that there is an Aboriginal person in custody?

MS SCHWARTZ: That's correct. I think I've been very vocal in my submissions that I've referenced in my witness statement. This is not something that is new. This is something that we have been saying and I have been saying, as well as my CEO, for many years about where we build in these systems. It should be statutorily built in, as well as a statutory onus placed on the Department to take active efforts to actually assist families succeed with programs. Instead of having this sole focus on intervention and removal and has been a practical reality in my practice.

MR POWER: So paragraph 48 of your statement deals with what QIFVLS and organisations like it can do if there's involvement at an early stage. Could you just speak to that so that we can understand what are the key things that early intervention can achieve in a family protection - child and family protection scenario?

MS SCHWARTZ: One of the key things that we see, still, in this space is parents not understanding what it means to be engaged with the Department. When the Department says "You need to do a program", well, what does it mean if I don't do that program? What does it mean if I only do it halfway and then something comes up and I don't engage?

Now the Department aren't going to disclose to that family, well, it's going to then lead to an intervention occurring. At no point in time do they then think that this person needs to go off and get some independent advice. I know that we've got the independent person in theory, in practice here in Queensland. It's not being utilised. And it's been underutilised which is consistent with our submissions in a number of forums to the Department and the minister responsible.

This is about people understanding --- it's like a contract. What am I getting involved with and what are the consequences if I breach? Because it's not understanding --- another aspect that we see still occurring, unfortunately, is gratuitous concurrence. Yeah, I just did it because they're the authority figure. I said I would do it but I knew I couldn't do it. No one explained to me what that meant.

MR POWER: And in terms of that explanation to a First Nations person, and assistance with negotiating with the child protection system, why is an Aboriginal-controlled community organisation important to do that?

MS SCHWARTZ: We're culturally safe. We know our people. We should be leading the way in these discussions with respect. For too long we have sat at the back, and I think, especially with the shift in focus, with our national partnership agreement on closing the gap, we actually should be preferenced. We've been working on the base level, on ground level for so long within our communities, we

know our communities, we should actually be given a chance to develop systems and work through our outcomes with our people.

I'm tired of seeing a one-size-fits-all approach. It doesn't work. How many times you say that, but still they insist on a one-size-fits-all because it fits quite nicely with an economic or a budgetary framework to deliver.

MR POWER: By that, do you mean it's so expensive to have children in out-of-home care that things being done early is in fact economically better?

MS SCHWARTZ: I think if you have a look at the Family Matters Report 2020, and I'm obviously referencing it quite a lot because it was released, I believe, last week, you will see the amount of expenditure that is spent on tertiary responses. It's exponential. If we were to divest some of that money at that tertiary response end into primary intervention and prevention, we could actually circumvent what we're seeing at the back end, which is an over-representation.

I believe the Family Matters Report has stated quite openly, if there isn't a change in trajectory, there's going to be an increase, a further increase, a doubling of numbers by 2029 in terms of Aboriginal and Torres Strait Islander children in out-of-home care.

MR POWER: Thank you. Now paragraphs 45 to 47 of your statement go to problems that arise when QIFVLS or organisations like it are brought into the picture at a very late stage. That's dealt with in your report, so I wanted to deal with just one last issue, and that is with regard to kinship placements, which you've touched on.

At paragraph 58 of your statement, you discuss the problem of kinship placement and the Blue Card requirements for such placements. Now, can you expand on that for the Commission as to what the issues are about Blue Card requirements for First Nations people?

MS SCHWARTZ: So normally, to hold a Blue Card there are a number of disqualifying offences under the Act. They are related to violence, and what we will see in our communities is, unfortunately, a number of Aboriginal and Torres Strait Islander people would have come before the criminal justice system and have criminal histories that have recordings for violent offences, not just breaches of contraventions of domestic and family violence orders or sexual offending.

So if you've just got a history where you might have been a young lad, you got into a bit of trouble and you've accrued a history of violent offending, that, in theory, will then be used as a disqualifying offence for you to hold or have a positive notice for a Blue Card, which means that you can't be considered as a kinship carer for a child within community.

MR POWER: You can apply to QCAT, though, and have that requirement removed - sorry, the Blue Card overridden. Why can't that occur?

MS SCHWARTZ: That's correct, you certainly can. We do assist families in that context. Why it becomes problematic is the time that QCAT will take to make a determination, and then you've got the child protection proceedings running, steamrolling down the other end. So it will eliminate a potential class of kinship carer. And what we then see, particularly in my Gulf communities, children being removed from home base, taken to a community they have no connection to, and placed with carers who are normally non-Indigenous. So I'm at a bit of a loss, given our *Human Rights Act*, placing the importance of connection to culture, land, values. I've got a complete quandary here, and the expectation will be that I run that through the Human Rights Commission for some form of determination. But...

MR POWER: And so obviously enough - Blue Card is an important safety feature; is there a way around it, in your view, to try and not involve in litigation, whether case litigation or test case litigation --- is there a way around that to try to solve that catch-22 situation?

MS SCHWARTZ: I believe that would be consistent with our calls as a member of the National Family Violence Prevention Legal Forum and as an Aboriginal community-controlled organisation. The establishment of Aboriginal Child Commissioners, with a right and overview of Blue Cards. I don't have any faith in the Department having any ability to have a look at this. I don't believe they're independent enough, not under its current structure. I would prefer to see that sitting completely separate and independently from the Department.

MR POWER: Now, your statement closes with recommendations made from your experience and they're at paragraph 63 to 68. I won't go through those, but was there any closing message in your oral evidence that you wanted to communicate to the Commission?

MS SCHWARTZ: I think people generally have a sense of inquiry and report fatigue in relation to Aboriginal and Torres Strait Islander issues, particularly. And, you know, I really hope that some systemic reform comes out of this, and particularly in the State of Queensland in relation to the state of our child protection system.

It is a system in crisis. I can't accept that it is a system that is not broken, that does not require to be fixed. I look at the deaths of Mason Lee, I look at the deaths of young Willow that's still being investigated, the two young boys recently here in Brisbane who were found living in the conditions that they were. It is time to change what we're doing. I cannot accept that we, in a modern society, cannot change trajectories, particularly the appalling trajectory in relation to out-of-home care and over-representation of Aboriginal and Torres Strait Islander people.

MR POWER: Thank you.

Chair, that's the evidence in chief, subject to questions from the Commissioners.

CHAIR: Thank you, Mr Power.

QUESTIONS BY THE COMMISSION

CHAIR: Ms Schwartz, can you tell me, or tell the Commission, about the Queensland First Children and Families Board? What does that do?

MS SCHWARTZ: That's a good question. It's not one I have had a lot of contact with.

CHAIR: If you don't know, that's fine. There will be some evidence of that [audio distorted] Elders across Queensland and was designed, perhaps, to address some of the issues you've identified. I just wondered if you were familiar with it.

MS SCHWARTZ: No, Chair. It's not an organisation that we've had a lot of dealings to deal with, unfortunately, if it is here to proactively assist, and I think that probably, with respect, shows some of the very evident gaps in Queensland.

CHAIR: And what about the First Nations Council, do you know about that?

MS SCHWARTZ: I believe I have. I believe I've seen reference material but no direct engagement.

CHAIR: Okay. I think we're going to be told that there were 121 recommendations made by the Queensland Child Protection Commission of Inquiry in 2012, all of which were accepted, 115 completely and six in principle, I think. And that since 2015 there have been further reviews with a total of 200 further recommendations. It does sound as though there have been some fairly concentrated attempts in Queensland to improve the system and address some of the issues you've identified. I'm just wondering what your perspective is on why apparently these recommendations, many of which are said to have been implemented, haven't changed the system sufficiently in your view.

MS SCHWARTZ: Thank you, Chair. I think this really comes back, with respect, to a complete requirement for an overhaul of the Department itself. We have had very positive engagements with the then-minister Minister Farmer, and senior executive directors of her then department in relation to how to better work with the department and engage. Unfortunately, what we see quite consistently across all of my offices is a complete difference in practice on the ground. It's not being effected or implemented, and we see that quite regularly in relation to the Aboriginal and Torres Strait Islander child placement principles which aren't implemented or affected uniformly across Queensland.

CHAIR: You've referred to your case management approach. Has there been an

assessment or evaluation of the case management approach in terms of its effect on children - First Nations children being taken into the child protection system?

MS SCHWARTZ: It was independently evaluated by the Charles Darwin University. I haven't reviewed it recently to see that particular aspect of it.

One of the key recommendations that came out of it was we were recommended as an organisation to become specialist - a specialist child protection organisation as well as a speciality in domestic and family violence.

CHAIR: But as you know, there has not been an assessment to determine whether your approach has led to a reduction in the number of children who have been placed into the child protection system?

MS SCHWARTZ: No. We certainly didn't do that given we started in 2016.

CHAIR: Thank you very much. I'll ask Commissioner Mason if she has any questions.

COMMISSIONER MASON: Yes, I do.

Thank you, Ms Schwartz, for your evidence today. So the organisation that you're the Principal Legal Officer of, the Queensland Indigenous Family Violence Legal Service, is a member of a national peak body. So therefore, at a jurisdictional level it's connected to national conversations and also potential solutions across the board, and you talked about seeing the intersection of women with child protection, domestic and family violence, they being Aboriginal and Torres Strait Islander women and families, and also the intersection of disability in the work that you do, talked about this case management approach.

I've written in my notes a primary care case management approach and at the primary level, as you were saying, not so much at the tertiary level, where that concentration should be. And you also mentioned the National Agreement recently, finalised with the peak Aboriginal organisations, the national partnership, and all Australian Governments. So I've said all that to come to this question.

In your view, with that level of capability of understanding the issues, and you've mentioned that these are not new solutions, what would you say to this Royal Commission around escalating and elevating this solution because this primary care to women and families needing cultural support as well as legal support during those primary stages of contact with the child protection system particularly, and families, women with disability. If we don't do the changes now, you've talked about where we could be in 10 years' time in terms of the numbers.

So I acknowledge there's been so much effort and advocacy, but we don't seem to have the transformation of being heard and the structural changes being made.

Do you see hope in the new - the National Agreement or the work of your peak organisation? Does the work need to happen at a jurisdictional level? What's your feeling? What's your sense of what's possible in the next few years?

MS SCHWARTZ: I think we're at a very exciting position for change. QIFVLS is a Queensland State peak feeding into the Closing the Gap bodies who have fed into the overarching agreement. So as a State peak here in Queensland, we are coming together with the other nominated State peaks here to work out what the implementation plan should look like, particularly in relation to the target to reduce the amount of children coming into contact with the child protection system by, I think it was 2045 from memory, or - I don't know, it's by 45%, sorry.

It is an exciting time. I think there needs to be a consistent adoption of policy frameworks not only in Queensland and other States, but actually led by the Commonwealth, with an overarching framework. We need to see how this will tie in, particularly to embed and implement the national partnership agreement on closing the gap. We're talking about changing wellbeing outcomes. Justice and child protection is a bit of that. But this is a life outcome for an Aboriginal and Torres Strait Islander person, and improving life expectancy and what that looks like.

I am buoyed by a sense of hope given what's happened at a national level. I am losing hope, given what I see on a day-to-day basis here in the State of Queensland, in relation to child protection. It's a continuous fight with the same messaging, and I come back to that definition of insanity. How can you expect change if you keep doing the same thing over and over again? That's all we do here. And seriously, something needs to change. I don't know how many more reports you need to show you deficiencies and gaps. We need to do things differently, we need to do things better, and let us lead the way as an Aboriginal community-controlled org.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: Yes.

Ms Schwartz, thanks for your evidence. Before, you were talking about birth suite removals, you mentioned generations of people subject to child protection and child removal, grandparents, parents and then their children. And I think you mentioned in passing in the juvenile justice and adult criminal justice system. Do you see, in your experience, a link between children in the child protection or child removal system and then graduating to juvenile justice and adult imprisonment?

MS SCHWARTZ: Thank you for that, Commissioner. Yes, there is a clear link. I've seen that throughout my practice, unfortunately. And you can see that highlighted quite recently in the Queensland Productivity Commission report on recidivism and imprisonment, where there's a very detailed timeline, unfortunately.

It is a sad reality, I have represented children in the Children's Court who have been very little, who have been in contact, children of the system. Those children have

then gone on to keep offending, and then when they turn 17, 18, I represented them as adults and, you know, saw them go through the plethora of orders until those children went to adult jail.

COMMISSIONER ATKINSON: So is part of the solution for closing the gap on imprisonment rates, changing the rate of child removal?

MS SCHWARTZ: Yes, they're all connected, in my respectful submission. Everything here is connected. You can't, with respect, view this in a silo because it flows like a river. They are little jigsaw pieces that link and this has been one of the frustrations with how departments operate. They operate with the blinkers on, with siloed vision.

COMMISSIONER ATKINSON: Thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: Ms Schwartz, thank you very much for your evidence today, for your detailed statement and for your insights, we're most grateful to you. Thank you.

MS SCHWARTZ: Thank you, Chair.

THE WITNESS WITHDREW

CHAIR: Mr Power.

MR POWER: Thank you, Chair. The next witness is Professor Daryl Higgins who will be appearing via videolink, and he should be brought into the system shortly.

CHAIR: We'll just wait a moment and see if Professor Higgins appears on our screen. Someone is holding up 10 fingers, I don't know if that means 10 seconds, 10 minutes or 10 hours.

We now have Professor Higgins, you can hear us?

PROF HIGGINS: Yes, I can, thank you.

CHAIR: Thank you very much for coming to give evidence, albeit remotely. If you would good enough to follow the instructions of Commissioner Atkinson's associate, she will ask you to take over the oath or the affirmation, as the case may be. Thank you.

PROFESSOR DARYL HIGGINS, SWORN

CHAIR: Thank you, Professor Higgins. Now Mr Power will ask you some questions from our Brisbane hearing room.

MR POWER: Chair, if I can deal firstly with the statements of Professor Higgins.

Commissioners, you will find a copy of the statement in Tender Bundle F at tab 1. I seek to tender this statement into evidence to be marked as 8.7. The material that is annexed to this statement is at Tender Bundle part F tabs 2 to 27. Can I ask that be tendered into evidence to be marked 8.7.1 to 8.7.26.

CHAIR: That can be done, thank you, yes.

EXHIBIT #8.7 - STATEMENT OF PROFESSOR DARYL JOHN HIGGINS

EXHIBITS #8.7.1 TO #8.7.26 - ANNEXURES TO STATEMENT OF DARYL JOHN HIGGINS

MR POWER: And that statement is dated 12 November. Professor Higgins has also provided an addendum statement dated 22 November 2020. That is part F of the Tender Bundle at Tab 28, and it has annexures which are at Tabs 29 to 33. I ask that the addendum statement and its annexures be tendered as Exhibits 8.7.27 to 8.7.32.

EXHIBITS #8.7.27 TO #8.7.32- ADDENDUM STATEMENT OF DARYL JOHN HIGGINS AND ANNEXURES THERETO

CHAIR: Yes, that can be done as well, thank you.

EXAMINATION-IN-CHIEF BY MR POWER

MR POWER: Thank you.

Professor Higgins, could you tell the Commission your full name?

PROF HIGGINS: Daryl John Higgins.

MR POWER: The statements that I've just referred to, a 24-page statement and a 16-page addendum statement, are those statements true and correct to the best of your knowledge and belief?

PROF HIGGINS: Yes, they are.

MR POWER: Now, you are presently a professor and director of the Institute of Child Protection Studies at the Australian Catholic University, having been appointed to that position in 2017?

PROF HIGGINS: That's correct.

MR POWER: And prior to that time from 2011 until 2017 were you the Deputy Director (Research) at the Australian Institute of Family Studies?

PROF HIGGINS: Yes.

MR POWER: Could you just describe to the Commission what is the present model across all State and Territory jurisdictions of child protection in Australia?

PROF HIGGINS: In Australia, there is a lot of commonality between the models that we have in each State and Territory in terms of what governments fund and operate to protect children, and it's what I would call, and many researchers and analysts in this space would call a reactive model, that's based on risks, so assessment of risks and responding to those risks. It would fall within what we call a tertiary response, once harm has already happened or when there are very high-risks that meet the threshold for intervening from a State perspective, so meets the guidelines or sorry, meets the State or Territory legislative threshold for intervening that those systems come into play.

MR POWER: I was going to say, you've done a chart that demonstrates those things. If I can ask that 0052.0003.001 be placed on the screen?

I was going to say this is a chart that you've prepared showing primary prevention, secondary prevention and tertiary prevention?

PROF HIGGINS: That's correct. And really, the State Government and Territory Government statutory systems fall into the tertiary prevention, both the management of risks and obviously protecting children once harm has already occurred, but also the very intensive kind of services and supports that are offered to address the needs of children when they have been harmed but also to address those families where there are high-risks.

So, for example, SafeCare, you will see on the bottom there, is an example of those programs where families have already come in contact with, have been notified to a

statutory child protection department, that's an evidence-based program for trying to address those parenting deficiencies or the needs of parents who have already come in contact with a statutory system.

MR POWER: We're going to hear from you develop this, but where should the focus of money and time be in terms of a successful child protection system?

PROF HIGGINS: I very strongly believe that a successful child protection system, or systems, can only be put in place when we actually have interconnections based on a public health model of prevention. So, putting the majority of the funding and the effort and investment into primary prevention activities, and you can see from this chart the kind of characteristics of those primary prevention activities need to be ones that are directed towards, you know, the whole of the population, ones that are not necessarily based on high levels of risk, and they are lower in effort and cost, but they're also more highly accessible to families because they're not stigmatising, and the way in which they are best delivered is through universal service delivery platforms. So, to be blunt, not through a statutory child protection agency, which is often quite a stigmatising engagement for many children and families who are experiencing need.

MR POWER: You've mentioned stigma of engagement with the statutory child protection models, from the work you've done, how does the present system affect First Nations parents in particular?

PROF HIGGINS: I think it's particularly problematic for First Nations parents because not only is there that stigma of "I am being seen as being deficient in some way, in terms of my parenting skills and capability", in order to be - to come to the attention of a statutory child protection service, or even to be referred to some of those intensive family support programs that many statutory services run, and refer families that don't yet meet the threshold for child removal, but they recognise that the family is in need and there's a support that's required.

But I think the additional challenge that First Nations parents have is, of course, the legacy of past removal practices, so the Stolen Generations, and the inherent racism that many First Nations parents encounter with government agencies in seeking services that all of that comes to mind for many parents.

MR POWER: Now in your statement you've mentioned some European systems are better focused on primary prevention. Can you give an example of such a system?

PROF HIGGINS: Yes, one of the examples that I give in my witness statement is of Scotland where they have a program in place called Getting It Right For Every Child. So that acronym is GIRFEC, Getting It Right For Every Child. The idea behind that is supports for families are delivered not through the statutory system, per se, but through those community agencies that are already engaging with families and with their children. Most importantly, within that model, there is a lead professional, a named individual, who has responsibility for that family and particularly

coordinating where there might be a greater level of need and therefore services to interconnect with that child and that family.

So, for example, a family that might have a child with disability, it might be the local paediatrician who ends up being the named individual to coordinate responses.

Where it's a child of a parent with disability, it could be a disability support agency that might be the one who has that contact point and as the child develops, and moves through the kind of systems, so, for example, might be engaging with early childhood education or with school systems, that named person might shift to someone within that mainstream system. The point being that there's coordination and that there's non-stigmatising contact, and most importantly, that it's in place for all children, not just for a named subgroup who are seen as being high risk and therefore requiring a different kind of response, but tailoring can occur within the service responses that that named person coordinates in order to meet the level of need of all families.

MR POWER: You've dealt with that at paragraphs 46 to 51 of your addendum statement. Has that Scottish system been in place long enough for there to be research done on its effectiveness of avoiding children going into out-of-home care in Scotland?

PROF HIGGINS: I don't believe that it has. I believe there are some limited findings, because it's only been in place since 2014 when the legislation was enacted. Of course, you know that there's a significant lag time between legislation being implemented, policies being delivered on the ground and then, of course, being able to see those changes following through, and, of course, the time that's needed to be taken for research.

So to the best of my knowledge there isn't a current comprehensive outcomes evaluation for that program, but I am aware from research that is available, looking at international comparisons of child protection systems, does point to this feature being one of the lead examples in the UK of what a public (audio distorted) support for children's wellbeing.

CHAIR: Can I ask if you have - have you studied the Scottish system in Scotland itself or you're basing this upon what you have read about the system?

PROF HIGGINS: Yes, thank you. No, I haven't been to Scotland to study the system. I'm basing it from the available research, but also from some work that I did in support of the scoping of the Their Futures Matter (TFM) access redesign system, and so I've worked closely with the team at TFM, and they did a lot of background checking, including having some personal communication with the key contacts in Scotland.

So I didn't do that personally but I directed that work from the TFM team as part of their analysis of what could be important design features moving forward for New

South Wales under their proposed TFM model.

CHAIR: Is the Scottish system compulsory in the sense that everyone, every family gives birth to a child is required to have a person such as a paediatrician or social worker allocated to them for this purpose?

PROF HIGGINS: My understanding is that it's not so much it's compulsory from the family's point of view because no one would compel them to engage with those services in that particular way, but more that it is compulsory from the other side that services have to take all reasonable efforts to allocate that particular person. So whether the services are taken up and (inaudible) with is a separate matter.

CHAIR: Presumably the family has to be told that someone has been allocated to be there?

PROF HIGGINS: Yes, I presume so.

CHAIR: All right, thank you.

COMMISSIONER ATKINSON: Sorry, it's Commissioner Atkinson here.

Are you aware that in Scotland, for a long time they've regarded juvenile justice as a problem of the welfare of the child rather than criminal offending?

PROF HIGGINS: Yes, and I think that that's why Scotland is kind of put forward as one of the leading examples within the United Kingdom, because they take a very child rights focus to this work and they see the interconnection, as we should be doing in Australia, between the youth justice and the statutory out-of-home care system where there's a very high level of overlap in terms of children and if you want to apply a prevention lens, many of the same kinds of activities that you would want to put in place in order to reduce the likelihood of children being removed from their birth families, are the same kinds of supports and interventions that you would want to put in place in order to reduce the likelihood of children and young people coming in contact with youth justice systems. So similar investment for very common overlapping outcomes.

MR POWER: Chair, I have approximately 15 minutes more questions for Professor Higgins, and then Ms Furness SC has a request to ask some questions which we estimate, subject to leave, will take about 10 minutes, so 25 minutes in total. Would you prefer to break for lunch now or continue for that approximately 25 minutes?

CHAIR: I think that unless we have evidence that everybody has consumed enough to keep them comfortable, we should probably break for lunch as to preserve wellbeing among all of those participating, and so let us then adjourn for lunch.

That means, I'm afraid, Professor Higgins, you will need to come back. I'm sorry for the break in giving evidence, but we were planning, I think, according to a timetable

that I've seen, of having lunch for one hour. Is that satisfactory or do you want that time reduced?

MR POWER: Chair, could we resume at 1.30 Brisbane time?

CHAIR: Yes, we can resume at 1.30 Brisbane time and that is 2.30 Sydney time. We will adjourn until then and resume with Professor Higgins' evidence. Thank you.

MR POWER: Thank you, Chair.

ADJOURNED **[12.37 PM]**

RESUMED **[1.31 PM]**

CHAIR: Yes, Mr Power.

MR POWER: Chair, could we resume with Professor Daryl Higgins, giving evidence by videolink?

CHAIR: Yes, we can. Thank you. This time five fingers have gone up, now Professor Higgins appears on the screen, within the five seconds.

MR POWER: Professor Higgins, we concluded with a discussion of the Scottish system of a focus on primary prevention. Are there examples of primary prevention programs operating in the Australian system?

PROF HIGGINS: I think there are, but there's a lot more investment in secondary services. So ones that have a targeted, if you like, population group that they're trying to service, rather than providing supports to all, and so that's where a lot more of our focus in terms of investment from a government perspective, in particular, is. If we're thinking about primary prevention activities, that's really the ones that are located in, you know, schools, early childhood centres, health clinics, maternal and child health services, and should really actually be business as usual for those organisations. But, unfortunately, we don't have, in my view, a joined-up system that child abuse and neglect prevention and other primary prevention activities are really based in those situations.

But I can give some examples, if you would like, of some of those more intensive, secondary services that we have operating that I think are somewhat akin to the kind of supports that are a key feature of the Scottish Getting it Right For Every Child Model.

MR POWER: Yes, if you can do that.

PROF HIGGINS: One example I was involved with conducting an interim evaluation two years in for is the Victorian system called Cradle to Kinder. So it is an intensive (inaudible) model on referral from child protection, so that's the caveat. I think that it's a very strong limitation of it, and certainly doesn't meet the requirements for being a primary prevention activity. But, for what it is trying to do, which is dealing with higher risk families that have already come to the attention, i.e. been referred to the statutory child protection service, it's a really great model.

What the key feature from our research, it was having a lead worker who really developed a positive relationship with the family, through things like home visits, spending time actually with the family --- often it's the mother --- and would, you know, play with the child, and therefore have opportunities to kind of model what good parenting might be. And of course, if we had an integrated theory of change about how to prevent child abuse and neglect in Australia, one of the things that should identify, of course, is the key role of parenting skills and capability. Some of the target groups for getting into the Cradle to Kinder program are young people, young parents who have themselves been in care, who are Aboriginal or Torres Strait Islander, who have disability, or who have other high levels of need as determined by the criteria set by DHHS.

But it's that really long-term engagement, the positive trust that's built up between the individual worker and the family and particularly the practical support that is provided through brokerage funds. So if the thing that's stopping that mum from being able to, for example, go and undertake some training, so they might already have got a priority place at child care, but, you know, is having difficulty getting to training and maybe it's an issue to do with, you know, not having a pram to be able to get out of the house easily or not having funds to purchase a particular thing.

So having that discretionary money in order to be able to meet the very practical needs of families experiencing high levels of vulnerability was just some of the examples of key features of that program that were positive.

MR POWER: And that fits with the holistic view of how a family deals with a number of government agencies and having somebody who can assist them through that maze?

PROF HIGGINS: Yes, but even more than just assisting them from getting services from others, they actually are kind of doing therapeutic work themselves with the family. Like I said, being able to kind of model those positive parenting behaviours and provide using a strengths-based model, so in other words, not criticising for the negative things but actually being able to observe and praise the parent for, you know, for the positive work that they are doing, which is something that's often missing when we just simply have a case management approach where there's not that kind of therapeutic, positive relationship and trust building that goes on between a worker and the client.

MR POWER: At paragraphs 41 to 45 of your addendum statement, you describe a

less intensive primary prevention program called Sing and Grow. Now, very briefly, could you explain how that less intensive program would work in an ideal system of primary prevention and connection to services?

PROF HIGGINS: I think it's a good example of primary prevention because it doesn't - unlike, you know, Cradle to Kinder, and all of those important and necessary intensive secondary services, it doesn't have the kind of selection criteria and it doesn't have to be accessed because you have already come in touch with the child protection system. Of course, the program and the skill set can be deployed there but, in fact, it's a program that can be available to all parents. And I understand from colleagues in the Sing and Grow program that it is able to be and in fact has been used and adapted with First Nations communities, and adapting the kind of repertoire that they use with their songs to including Indigenous languages and in consultation, of course, with local Elders to get appropriate permissions for doing so.

But the important thing is that it is a direct engagement with parents to teach parenting skills relating to child development. How to interact appropriately with your child depending on their age and teaching really practical skills.

MR POWER: And part of your statement deals with them assisting with reunification through programs related to Sing and Grow?

PROF HIGGINS: That's right. It's not necessarily the standard way Sing and Grow is deployed but it has been funded by government in order to play that role of supporting contact between parents and their children where children have been removed through the child protection system. So rather than just expecting parents to spend an hour a week or an hour a fortnight with no support, this is a structured way that the parents spend time with children who have been removed from their care, in order to build that positive relationship that they might otherwise not have opportunities to do, and obviously to address some of the other things that were seen as inadequate and the reasons for their removal in the first place, that they weren't providing appropriate care and didn't necessarily have the appropriate parenting skills. So it's being deployed to address those very practical needs and to develop skills.

MR POWER: How would primary prevention of child maltreatment work in a First Nations context?

PROF HIGGINS: I think the first and most important thing to say is that for it to work for First Nations parents, it really does need to be delivered within a cultural context and, of course, the go-to there is, of course, for Aboriginal community-controlled organisations to really have responsibility and to be empowered to deliver those kind of supports and services. They are the ones who know their own community, they have the kind of cultural authority to be able to speak on behalf of their community and can identify what are the things that are needed and there's lots of examples. I was one of the people responsible for writing the Closing the Gap Clearinghouse that looked at all of the evidence in relation to

what is needed in order to promote safety in communities, including prevention of child abuse and neglect, and that was really the key recommendation that we made through all of that work is that it has to be community development approaches based on empowerment of local Aboriginal and Torres Strait Islander community to lead that.

CHAIR: Professor Higgins, in paragraph 13 of your addendum statement, you say that an example of community development approach is an intended pilot program of delegated statutory child protection functions to First Nations community controlled child protection bodies in Queensland. What is that a reference to?

PROF HIGGINS: That's a reference to the legislative reforms that have gone on in Queensland in order to address the problems, if you like, of over-representation of children and young people in the out-of-home care system, so this is not about primary prevention or even secondary interventions, this is about tertiary interventions, once children have already been notified to the Department that rather than the Government directly itself responding, and being responsible for, you know, risk assessment and decisions around placement or removal, or, in fact, intensive supports and work with those families in order for children to remain safely at home, or engaging processes such as family group decision-making, et cetera, to understand what are the challenges and what are the supports that are needed, that that process can, under Queensland legislation, be delegated to an Aboriginal community-controlled organisation. So that's what that delegated authority is referring to.

CHAIR: Do you happen to know which provision that is in the Act?

PROF HIGGINS: Sorry, I will need to take that on notice. I have been working with the peak body in Queensland, the Queensland Aboriginal and Torres Strait Islander child protection peak in supporting their members exercising those delegated authorities.

CHAIR: Thank you, that's all right. We can find that out ourselves. Thank you.

PROF HIGGINS: It's probably important to say there are a range of different delegations, not just one delegation, and different agencies exercising different delegations depending on their capacity and their level of maturity as an organisation in exercising those kind of functions.

MR POWER: Turning then to First Nations parents with disabilities. Within a primary prevention and community development of responses, what adjustments and changes in approaches would be needed to assist First Nations parents with disabilities?

PROF HIGGINS: I think it really depends on the nature of the disability and therefore the level of need and support that different parents might have, and that's why I am a very strong advocate of the kind of public health approach to primary

prevention, because the agencies and support services that families where parents have disability might already be engaging with, it could be a local GP or, in a First Nations context, probably more likely to be an Aboriginal community-controlled health organisation. They are the ones that are going to be able to understand what the nature of the disability and the challenge that that family has and what supports might need to be wrapped around or adjusted.

The unfortunate thing is when you get to the statutory system trying to respond, you end up with, you know, the agencies and who are working with them are still coming under the obligation to have mandatory reporting, and I think what's much more important in this context is actually mandatory service responses and how we make reasonable adjustments in the kind of supports that are available to First Nations parents with disability to assist them in their task of parenting, whether it's practical things like helping them get to a childcare centre or to school, or whether it might be adaptation of learning materials to support them in their parenting role.

For example, I'm familiar with a widely available parenting program called Triple P that has worked with Indigenous communities to develop an Indigenous-specific version of group Triple P that meets the kind of cultural needs. So it's those kind of adaptations, both from a disability lens and from a cultural lens that I think are critical in terms of coming together to support First Nations parents with disability.

MR POWER: Professor Higgins, the last topic I wanted to come to was data. Is there sufficient data about people with disabilities within the child protection system?

PROF HIGGINS: Well, unfortunately, there's no one answer to that because we have, you know, 8 different systems in Australia, every State and Territory is different and every data collection system is different, so there's no common platform across all of those and that's why it's an incredibly difficult and complex process in Australia to even have an aggregated view, and that data is then (audio distorted) through the Australian Institute of Health and Welfare who produce the Child Protection Australia Report annually. That is an incredibly large amount of work to find rules for data consistency out of those separate systems.

But the short answer is, I don't believe we have good and we certainly don't have consistent data collection across the State and Territory systems around the number of parents with disability who have come to their attention, or even more importantly, the ones who have been referred for intensive supports through the kind of secondary service system or even of the type of disability and more importantly, again, the types of supports that are being provided to them, you know, the nature of those reasonable adjustments, if you like, from a disability rights perspective that we would hope and expect to have in place.

MR POWER: You touched on this earlier, if there is a collection of data about First Nations data and disabilities, what is necessary to avoid the possibility of misuse of that data and discrimination against parents by collection of that data?

PROF HIGGINS: Yeah, it's a complex one and I'm aware that there is already concerns, particularly amongst First Nations organisations that identification of Aboriginal and Torres Strait Islander status brings the risk of racism and of biased views about the nature of risk that child protection workers and other people, a whole range of different, you know, service provider systems will encounter.

So that fear, I think, is amplified in this instance, that will disability status, if it's routinely collected, lead in a way to that heightened perception of risk and bias towards seeing these parents as being less capable or automatically assuming a lack of capability, rather than the opposite, which is what I'm advocating for, that it be used to describe in more detail what is the level of need and how can those needs best be addressed in order to avoid any potential risk escalating.

MR POWER: So a system that, if the data's collected, the primary obligation is for the collector of the data to be setting out what they're doing to address the needs that that data identifies?

PROF HIGGINS: That's right.

MR POWER: Professor Higgins, at paragraph 88 of your 12 November statement, you go through in considerable detail about recommendations to reform the child protection system, and those are recorded in your statement.

Chair, that's the evidence-in-chief of Professor Higgins, and I understand that Ms Furness SC for the State of New South Wales seeks leave to ask some questions.

CHAIR: Yes. Before we do that, I will just ask whether any of the Commissioners have any questions they wish to ask at this stage that may be relevant to anything that Ms Furness wishing to address.

Commissioner Mason, is there anything you wish to ask Professor Higgins?

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: Yes, Ms Furness, I think you do want to ask Professor Higgins some questions?

MS FURNESS: I do.

CHAIR: Professor Higgins, Ms Furness represents the State of New South Wales and is currently in Sydney and will ask you some questions from that location.

Go ahead, Ms Furness.

CROSS-EXAMINATION BY MS FURNESS

MS FURNESS: Thank you.

Professor Higgins, have you had the opportunity of reading the Secretary of the Department of Community and Justice's statement, Mr Coutts-Trotter?

PROF HIGGINS: No, I haven't read it in detail. I was aware that he has made a statement, but I haven't read it in full.

MS FURNESS: Have you had access to the statements?

PROF HIGGINS: I believe they were part of the witness list.

MS FURNESS: There are 2 areas I wanted to ask you and they're related. First appears in your main statement in relation to the child protection workforce, and that's paragraph 44 of your statement and there, in summary, you say that the trainings, your knowledge of the child protection workforce needs to be broader and tailored to meet cultural needs of diverse groups such as First Nations.

PROF HIGGINS: Yes.

MS FURNESS: And the second related matter appears in your supplementary statement. It starts at paragraph 12 and it's the community development approach to the welfare of children where you argue that that approach requires a community-led ground-up approach. That's right?

PROF HIGGINS: Yes.

MS FURNESS: You accepted they're related in that you would want the training of staff to also have the benefit of that ground-up approach, I take it?

PROF HIGGINS: Yes, you're right, although I probably would point out that my comments in relation to training were really in relation to training of the tertiary workforce whereas most of those who are involved in community development approaches, it's not driven by the tertiary workforce. Of course, there needs to be interconnection between all of the levels of public health approach to child abuse and neglect prevention, but they're at opposite ends of the extreme. Community development approaches would be the primary prevention activities, largely, and the statutory workforce, whose training my comments relate to, is dealing with often the

most high-risk and at the opposite end of the continuum.

MS FURNESS: But you would nevertheless want those at that end of the continuum to have an understanding of the cultural needs of particularly First Nations family and children who they're working with?

PROF HIGGINS: Absolutely. And of course the middle ground is often the kind of services that are developed through a community development approach can be extended to that kind of secondary system where, through referral from a statutory child protection workforce, you know, they can work collaboratively in order to try and address high risk, but that shouldn't be, in my view, the primary entrance point, if you like, into those services, if you're going to address issues of stigma and so forth.

MS FURNESS: Now, Professor, I want to ask you questions about aspects of the current New South Wales system. I'm going to do so by reference to Mr Coutts-Potter's statement. Do you have that in front of you?

PROF HIGGINS: No, I would need to go and find it.

MS FURNESS: That's all right. I can take you to the relevant sections. Now, you're aware that the NSW system has a Caseworker Development Program, aren't you?

PROF HIGGINS: Yes.

MS FURNESS: That's a 7-week mandatory program for all new workers, do you understand that?

PROF HIGGINS: Pretty much every jurisdiction has a similar kind of process for supporting caseworkers within the statutory service, yes.

PROF HIGGINS: Were you aware that the Caseworker Development Program in New South Wales was recently developed, or redeveloped in close partnership with AbSec? Have you heard of that?

PROF HIGGINS: No, no, but that's pleasing to hear.

MS FURNESS: It's certainly a good thing in terms of providing those involved on the ground with First Nations issues to be redeveloping a caseworker program, isn't it?

PROF HIGGINS: That's right, that's is dealing with that third part of the public health continuum, yes.

MS FURNESS: Now, it's also the case that there's been a Connecting with Aboriginal Communities mandatory training program in New South Wales, were you aware of that?

PROF HIGGINS: No, as I said, I'm not familiar with the detail of the training programs in any of the States and Territories in a specific sense, but it's consistent with my understanding of what happens in most jurisdictions.

MS FURNESS: And in relation to this training, the Grandmothers Against Removals, GMAR and Stolen Generation members and local community Elders have been involved in the development of that training. That also is a very positive move in relation to training of caseworkers, is it not?

PROF HIGGINS: Yes.

MS FURNESS: Now, it's also the case that the Caseworker Development Program covers a deal of material in relation to parents with disability. Are you aware of that?

PROF HIGGINS: As I said, I don't have specific knowledge of that.

MS FURNESS: Again, for that to occur would be very positive, in your view?

PROF HIGGINS: Yes, but not sufficient.

MS FURNESS: I'm not suggesting that it alone will make significant changes, but it is a component that is a positive one, is it not?

PROF HIGGINS: That's right.

MS FURNESS: You referred in your statement at paragraph 65 to the Parenting Research Centre providing training to those working with parents with intellectual disability, to support tailoring their practice. You're familiar with that in your statement?

PROF HIGGINS: Yes.

MS FURNESS: And it would, again, I would suggest, be positive if what was done by the Parenting Research Centre is replicated in what is done through the Caseworker Development Program?

PROF HIGGINS: Yes, yes. I'm familiar with the Parenting Research Centre's kind of philosophical approach to supporting parents with disability, and so if that's replicated in training for those who are working outside of the statutory child protection system as well as those working within it, that is a good thing.

MS FURNESS: Now, are you aware of the Aboriginal Case Management Policy that was introduced in New South Wales in 2018?

PROF HIGGINS: No, I'm not familiar with a number of the individual policies of the States and Territories.

MS FURNESS: I'm at paragraph 113 for those who want to follow in Mr Coutts-Trotter's statement. The New South Wales Government released the Aboriginal Case Management Policy in 2018, as I say, and it was developed by AbSec, which is the New South Wales Child, Family and Community Peak Aboriginal Corporation

PROF HIGGINS: Sorry, I missed your question?

MS FURNESS: You were not aware that that Case Management Policy was developed by AbSec?

PROF HIGGINS: No, I fully accept that there are a number of policies in each of the States and Territories that are developed in collaboration with peak bodies in their respective State. Here in Victoria where I'm based, we have a similar kind of engagement with the Victorian Aboriginal Child Care Agency and I know that in Queensland, (inaudible) who I mentioned just before, play a similar role in collaborating with States around their policies and practices, and as you've pointed out, training as well --- all of which is positive, but it's dealing with a very small part of what the need is from my perspective. My evidence relates largely not to the statutory system, but to the gaps in relation to the absence or the difficulty of getting appropriate prevention services based in universal service delivery platforms. So not the child protection system itself.

MS FURNESS: But you accept that in child protection systems, at least to the extent of you know of it in New South Wales, that there's a deal of collaboration between First Nations peoples and peak bodies and the statutory system in order for those First Nations people to be involved in developing and running services?

PROF HIGGINS: Yes.

MS FURNESS: Now, are you familiar with the Productivity Commission report in January 2020?

PROF HIGGINS: Yes.

MS FURNESS: There is data there, and it's referred to at paragraph 184 of Mr Coutts-Trotter's statement, where it's recorded that from 2015-16, 2019-20 there has been a 33% reduction in Aboriginal children entering out-of-home care in New South Wales. Now, I take it that you would see that as a positive measure of change?

PROF HIGGINS: Absolutely.

MS FURNESS: Now, the other recent report was the Family Matters Report 2020, are you familiar with that?

PROF HIGGINS: Yes.

MS FURNESS: And in that report at page 16 it records that New South Wales leads the nation in the proportion of expenditure on ACCO, that's the Aboriginal and Torres Strait Islander community-controlled organisations. So New South Wales leads the nation in proportion of expenditure on ACCOs overall. That's positive aspect of the work in New South Wales again?

PROF HIGGINS: Yes. Although I would note that it doesn't necessarily break down, to my understanding, what the expenditure is in relation to supporting those Aboriginal community-controlled organisations to undertake primary prevention activities in their communities as opposed to targeted, intensive family support programs, and so that's one of the things that I believe my evidence is pointing to strongly, is shifting not just the investment from the statutory tertiary system into the secondary system, but shifting it even further down into the primary prevention activities and taking a community development approach to that.

So I agree that what you're pointing to is positive, but if you're asking from my evidence would I say that that's sufficient, I would say no, and that like other States and Territories, that there is still more that could be done to prevent the kind of risks from escalating, and more intensive (inaudible).

MS FURNESS: Thank you. So we don't know the break-up from that figure. All we do know is that it does lead the nation overall on that expenditure.

PROF HIGGINS: Yes.

MS FURNESS: Thank you, I have nothing further.

QUESTIONS BY THE COMMISSION

CHAIR: Thank you. Just to refer to the legislation that you referred to, Professor Higgins, the relevant provisions are contained in part 2A of the *Child Protection Act 1999* which is headed "Prescribed delegates for Aboriginal and Torres Strait Islander Children."

PROF HIGGINS: Thank you, Chair.

CHAIR: Thank you very much for giving evidence and for both of your statements, detailed statements. And we appreciate your contributions to the work of the Royal Commission. Thank you.

PROF HIGGINS: My pleasure.

THE WITNESS WITHDREW

CHAIR: Yes, where do we go from here?

MR POWER: Chair, the next two witnesses are Meegan Crawford and Carina Muller who will be giving evidence as a panel. They are witnesses from the Queensland Government. Ms Elizabeth Bennett will take these witnesses from Melbourne. The 2 witnesses will be present here in the hearing room in Queensland.

CHAIR: Right, thank you very much.

MR POWER: Chair, we'll probably just take a minute or so to set up but we'll proceed to do that now.

CHAIR: Yes, we won't adjourn, we'll just wait until the setting up takes place, but I can see Ms Bennett on the screen so we're part of the way there.

I think we now have Ms Crawford and Ms Muller in the Brisbane hearing room with at least one cup of coffee, which is good.

I will ask Ms Crawford - Ms Crawford and Ms Muller, please, to take the oath of affirmation as the case may be, so if you will be good enough to follow the directions from Commissioner Atkinson's associate, she will administer the oath or affirmation.

MS MEEGAN CRAWFORD, SWORN

MS CARINA MULLER, SWORN

CHAIR: Thank you for coming to give evidence. Ms Bennett will ask you some questions. She is in Melbourne. You're in the Brisbane hearing room. Commissioner McEwin and I are in the Sydney office of the Royal Commission and we hope that there (inaudible).

Yes, Ms Bennett.

COMMISSIONER ATKINSON: Chair, somewhere there is quite a bit of background noise.

CHAIR: Ms Bennett, I deeply regret to say that it is said that it's coming from your end.

MS BENNETT: I see, yes, I can see the problem. I have a junior sitting very close to the microphone, I might just ask her to move away from the microphones, thank you, I'm grateful.

CHAIR: Okay.

COMMISSIONER ATKINSON: And tell her to stop breathing!

MS BENNETT: Yes, it seems a difficult instruction but I will try!

CHAIR: The first task is to get rid of the junior. Once you've done that ....

EXAMINATION-IN-CHIEF BY MS BENNETT

MS BENNETT: Thank you, Chair.

Ms Crawford, you've made a statement of 31 pages dated 23 October 2020, is that right?

MS CRAWFORD: Yes, that's right, yes.

MS BENNETT: With a number of annexures?

MS CRAWFORD: Yes.

MS BENNETT: And are the statements of that - are the contents of that statement true and correct, Ms Crawford?

MS CRAWFORD: Yes, they are.

MS BENNETT: So Chair, the statement of Ms Crawford can be found at Tender Bundle part D, tab 1. I ask that it be marked Exhibit 8.8. It has 6 annexures and I ask that they be marked exhibits 8.8.1 to 8.8.6, if it please the Chair.

CHAIR: Yes, that can be done. Thank you.

EXHIBIT #8.8 - STATEMENT OF MS MEEGAN CRAWFORD

EXHIBITS #8.8.1 TO #8.8.6 - ANNEXURES TO STATEMENT OF MEEGAN CRAWFORD

MS BENNETT: Ms Muller, you have made a statement of 17 pages dated 28 October 2020, is that right?

MS MULLER: That's correct.

MS BENNETT: Are the contents of that statement true and correct?

MS MULLER: Correct.

MS BENNETT: Thank you.

Chair, I ask that --- the statement can be found at Tender Bundle D tab 8. I ask that it be marked Exhibit 8.9 and the exhibits be marked 8.9.1 to 8.9.5, if it please the Commission.

CHAIR: Yes, that can be done, thank you.

EXHIBIT #8.9 - STATEMENT OF MS CARINA MULLER

EXHIBITS #8.9.1 TO #8.9.5- ANNEXURES TO STATEMENT OF CARINA MULLER

MS BENNETT: Now, Ms Crawford, you are the Chief Practitioner in the Department of Child Safety, Youth and Women, is that right?

MS CRAWFORD: We've actually had a change in name for our Department. So we had a State election not long ago and there have been some machinery of Government changes. Yes. So we're actually now the Department of Children, Youth Justice and Multicultural Affairs.

MS BENNETT: All right, from hereon I might refer to that organisation as the Department, if that's convenient.

MS CRAWFORD: Yes, please.

MS BENNETT: Thank you. Now, you report directly to the Director-General of that Department, is that right?

MS CRAWFORD: Yes, that's right.

MS BENNETT: Okay. And Ms Muller, you ---

CHAIR: Might I ask what happened to women?

MS MULLER: That's the Justice and Attorney-General, yes.

MS BENNETT: --- (overspeaking) --- Chair.

MS CRAWFORD: So women and domestic and family violence went across in the machinery of Government changes.

CHAIR: Thank you.

MS BENNETT: So just so I understand, is domestic violence now the focus of a different Department, not your Department?

MS CRAWFORD: Yes, that's right.

MS BENNETT: And it previously was the concern primarily of your Department, is that right?

MS CRAWFORD: Yes. So it was -

MS BENNETT: Okay, we might come back -

MS CRAWFORD: Yes, it was one area of our Department. So we had child safety, youth, and women.

MS BENNETT: And, as part of women, domestic violence?

MS CRAWFORD: Yes.

MS BENNETT: I see. And Ms Muller, you're the Executive Director in the Department, is that right?

MS MULLER: Correct. Yes.

MS BENNETT: Who do you report to?

MS MULLER: The Deputy Director-General of Strategy.

MS BENNETT: Okay. Now, just so that we understand, Ms Muller, you say that the role of the Department is to support children, young people. That remains the case after the machinery of Government changes, is that right?

MS MULLER: Correct.

MS BENNETT: And just so that we can place this in a machinery position, that's the part of the Department that is involved in the identification of interventions that might be required for child safety, is that right? Ms Crawford?

MS CRAWFORD: Yes.

MS BENNETT: And that can include removal at an extreme, is that right?

MS CRAWFORD: Yes, that's right.

MS BENNETT: Now, Ms Crawford, you say in your statement at paragraph 12, you tell the Commission that First Nations children are over-represented in child protection, is that right?

MS CRAWFORD: Yes, that's right.

MS BENNETT: And they comprise about 43% of children receiving ongoing intervention. Is that right?

MS CRAWFORD: Yes, that's right.

MS BENNETT: You refer to that in your statement - yes?

MS CRAWFORD: Yes. I was just going to clarify that ongoing intervention can include intervention with a parental agreement arrangement or a child protection order.

MS BENNETT: Understand. Thank you. Now, you refer to that as racial inequality in your statement. Can you explain why you describe it that way in your statement?

MS CRAWFORD: We do not want the over-representation of Aboriginal and Torres Strait Islander children. We want the responses for Aboriginal and Torres Strait Islander children to be similar to those that non-Indigenous children experience. So we try to work so that we don't have over-representation in our system?

MS BENNETT: And is it fair to say that you work hard to try to identify the causes of that over-representation?

MS CRAWFORD: Yes, I think that's a reasonable statement. Yes.

MS BENNETT: There's been a lot of evidence over the last day or so about the notion of unconscious bias. Are you familiar with that concept?

MS CRAWFORD: Yes. Yes, it is something that people will raise particularly in relation to child protection workers. So what are the biases that they bring to their assessment and decision-making processes, yes.

MS BENNETT: And so can I ask you to explain to the Commission what you understand unconscious bias to mean?

MS CRAWFORD: Well, you might unconsciously have a particular view of a particular cohort of people, for example. So you might have a negative view of a particular cohort of people.

MS BENNETT: And it's unconscious because?

MS CRAWFORD: You don't necessarily verbalise that, but it may well influence your decision-making.

MS BENNETT: And it's inherent in the concept in the very title, the person themselves may not be even conscious of that bias, is that fair?

MS CRAWFORD: That's right, yes. So we do raise this issue with our child protection workforce and it is part of supervision practices with more experienced senior team leaders that when they are reflecting and analysing the cases that are before them, that there is an opportunity to check in and to unpack any potential biases.

MS BENNETT: Because as it relates to First Nations people, is it your Department's view that unconscious bias can operate to the detriment of First Nations people in that space?

MS CRAWFORD: I think it can operate and it speaks to a number of strategies that we have put in place to put a focus on culture and to increase cultural capability in our organisation. So, for example, we have cultural practice advisers and Aboriginal and Torres Strait Islander practice leaders to assist our staff in their decision-making, and we have --- (overspeaking) ---

MS BENNETT: Can I pause you there for a moment. I'm sorry, I have a question about those positions. Where do they rank in terms of the officers carrying out child protection work in your Department?

MS CRAWFORD: So the Aboriginal and Torres Strait Islander practice leaders are a PO6 level, which is equivalent to a Child Safety Service Centre Manager position, and the Cultural Practice Advisers are in the administrative stream at an AO4 which is, I understand it, sits somewhere between a PO2 and a PO3, which is our Child Safety Officer level. So we do, for example, have some difficulty attracting our Cultural Practice Advisers to our baseline Child Safety Officer positions because the AO4 position is higher than the PO2 position, if that makes sense.

MS BENNETT: Yes. Is it possible for the people in that position to override decisions that they consider to be culturally inappropriate?

MS CRAWFORD: Not necessarily to override, but certainly to influence heavily, and they are consulted as the cultural specialists that they are. They will bring the cultural lens, they will bring an understanding of cultural authority, cultural obligation, community expectations. So I would say they are influential in the decision-making.

MS BENNETT: And if it turns out that a Case Officer, or an Authorised Officer disagrees with someone in that position, is that recorded anywhere? Is there any record kept of a disagreement between those Cultural Officers and others?

MS CRAWFORD: There may well be. So what we try to encourage in our practice is what we call a practice panel approach. So when there are significant decisions being made in relation to all children, but particularly Aboriginal and Torres Strait Islander children, we may well bring a panel of the workers and any critical friends together. Those panel meetings are minuted and if the Cultural Practice Adviser, or, indeed, the critical friend who might be from an Aboriginal or Torres Strait Islander non-government organisation, if they have a view that is different to other members of that panel, that would be minuted.

MS BENNETT: Is that centrally recorded somewhere where it's possible to audit the extent to which - or the number of times or proportion of times? So does the Department have no insight into the number of times the advice of those practice leaders is disregarded?

MS CRAWFORD: I don't think their advice would ever be disregarded. It would form part of the discussion and the consideration and, no, we don't have data. As I say, that would be reflected in practice panel minutes.

MS BENNETT: So you don't know if there is often disagreement or rarely disagreement?

MS CRAWFORD: I don't have data to suggest either. No.

MS BENNETT: So you can't assist the Royal Commission to understand if their views are disregarded or not?

MS CRAWFORD: What I can tell you is that our Cultural Practice Advisers are highly valued members of our staff. They come into those practice panel discussions as highly valued staff. They bring a cultural lens that we see as very important.

MS BENNETT: It was suggested by one of the witnesses, I think Ms Pokino, that positions of this kind are tokenistic and they don't carry significant influence. I take it from your evidence that you would disagree with that?

MS CRAWFORD: I do disagree with that, and in fact, I was very disappointed to hear that. Very disappointed. We do not see them as tick-a-box or tokenistic. They are highly valued members and often sit on our leadership teams within Child Safety Service Centres. And I can say that the positioning on leadership teams, and their high worth has probably come about because of our continuous quality improvement processes. So we have service and practice delivery standards that our Child Safety Service Centres are held to. The very first standard is culture. So we want a culturally responsive, culturally humble approach to the work that we undertake with our children, young people, parents and families.

MS BENNETT: Now, we've talked a bit about the rate of interventions for First Nations children. Are you able to assist the Royal Commission in the rate of

interventions for children with a disability?

MS CRAWFORD: We do have some data around interventions with children with a disability. So perhaps what I can offer the Royal Commission is that in the transition to the NDIS, our Disability Centre of Excellence did some modelling on what we should expect to see in terms of NDIS plan eligibility. So there was modelling that suggested between 16 and 20% of children in our system would have a disability that would make them eligible for an NDIS plan.

We've been working very hard to ensure that children with a disability do have supports from NDIS. I actually think we're the jurisdiction with the most success in this respect, so - and we have seen in some locations that percentage increase up to 25%.

So we have referred almost 2,500 children for NDIS plan eligibility, and just under 2,000 children are currently supported with an NDIS plan.

MS BENNETT: And what about parents and carers? Does your system maintain accurate records about parents or carers who have a disability?

MS CRAWFORD: No, no, we don't. It is something -

MS BENNETT: And your statement says - your statement at paragraph 27 notes that it's difficult for you to extract data about disability status and need. Is that still the case?

MS CRAWFORD: Yes, it is still the case. What I can advise, though, is that we are changing our client information system, so it's a very significant investment and change in the system, and we are helping inform the data fields in that system so that we can capture disability-related data far more accurately.

I am pleased to say that the specialist services team, which is a team that I oversee, which focuses on children with a disability, are key to that reform and are influencing that system design.

MS BENNETT: All right. Now, has the proportion of First Nations children, the subject of interventions from your Department, been increasing in recent years or decreasing?

MS CRAWFORD: In terms of out-of-home care or Aboriginal and Torres Strait Islander entering care, our rates have remained relatively stable for about nine quarters now, and I'm looking to Carina because she is the expert in this sort of data.

MS MULLER: So for about the last two and a half years, a proportion of children who are in care who are Indigenous has stayed relatively stable at about 42, 43% of total children in care. That doesn't mean, though, that in number terms that we haven't seen an increase in the total number of Indigenous children in care, we have,

both as number and as a rate per 1,000. So that figure that Meegan was referring to, is basically showing that the growth rate of Indigenous children in care for the last couple of years has basically been the same as the growth rate for non-Indigenous.

So I guess the overall comment is that we have seen increasing growth of Aboriginal and Torres Strait Islander children in our system. There's a couple of areas where we haven't. One of them is in terms of the number of children that have been substantiated, so those children that we find following an investigation that they have been harmed or at risk of significant harm.

That, both in number terms and as a rate per 1,000, has stayed relatively steady since 2012-13. In fact, we had a little bit of a decrease there for a while but with COVID hitting this year, we have seen that surge up in demand again at the moment.

CHAIR: Ms Muller, what are the actual numbers, if you can take us from, say, three years ago, how many children are in care altogether, how many First Nations children are in care? What are the numbers over the last three years?

MS MULLER: Yes. Would you like me to start from kind of the beginning of the system, or just for out-of-home care?

CHAIR: Just start with out-of-home care and then we can work on something else.

MS MULLER: Okay, so we have about 10,200 children in care in Queensland in total, and about 4,400 of those are First Nations. So that's where we get 43% of children in care currently are First Nation.

That figure has increased; back in 2016, so a few years ago, it was about 42% of total children in care were First Nation. If we look back to the year before our reforms -

CHAIR: Not the percentage, sorry, I want us to know, say in 2016, 42% of what? What was the total number of children in care in 2016 compared with the 10,200 in care?

MS MULLER: I can look that up for you.

2016, we had 3,609 First Nation children in care out of a total of 8,654. If we look back at, say -

CHAIR: There's been roughly a 16% increase in First Nations children in care over the last four years?

MS MULLER: Correct, and for us in Queensland, we typically look at the year prior to our Commission of Inquiry reforms, which is 2012-13 as our base year. So if we look back then, we have had an increase of about 1,200 more First Nations children in care since then, and back in the year before our reforms, 39% of children in care were First Nations. So we have continued to see increasing numbers, increasing as a

rate per 1,000 and increasing as an overall proportion.

Now, in the last couple of years, that has started to slow. So in 2016 when we did the forecasting in terms of where we were going to be getting to with this, we had calculated that by this year, over half of all of our children in care would be First Nation. Now since that time we've only put on that extra 1 percentage point, and that was really one of the key things that sparked the development of the Our Way strategy, which is that 20-year strategy which is basically saying this is not good enough. We do need a fundamental rethink and we need to eliminate this disproportionate representation of First Nation children and families that are in contact with our system.

CHAIR: Thank you. I'll leave Ms Bennett to explore the fundamental rethinking of this. Please.

MS BENNETT: Yes, thank you, Chair. So there's been increases over time and is that a matter of concern to the Department, that the increases are continuing?

MS MULLER: Yes. Publicly we require -

MS BENNETT: Sorry, go on.

MS MULLER: Sorry, I was going to say that publicly we will say that it's the most significant issue that we face as a system.

MS BENNETT: Okay. So - but we're not aware of what proportion of those young people or their families have a disability? So we don't know if that's trending up or down as well. You think you might know, in terms of children, if there are more with a disability into care or not?

MS MULLER: We have historically not had fantastic data recording in our system in terms of children with disability. So as Meegan said earlier, there has been significant work under way with the NDIS to making sure we get those records in our system. So what we really have at the moment is probably around 20% of children in care with disability. We don't really know how that compares to the past.

MS BENNETT: And can you tell me, though, what definition of disability the Department is using to come up with that statistic?

MS CRAWFORD: Yes. So you will see in my statement that there are a number of fields that we include in our client information system. So it's quite a broad definition of disability, and what we did was we added these fields --- the fields have been there since, I think, 2007, but we added extra fields with the transition to the NDIS so that we could keep records of any NDIS plans.

MS BENNETT: This is paragraph 29 of your statement, is that right?

MS CRAWFORD: Yes, that's right.

MS BENNETT: That's where you say the disability types are not explicitly defined.

MS CRAWFORD: That's right. But there's a dropdown box.

MS BENNETT: The last line.

MS CRAWFORD: Yes, it's a dropdown box from which workers can choose.

MS BENNETT: But that is not - there's other, so you can have anything of A to T of the dropdown menu, and then there is U, which is "Other".

MS CRAWFORD: Indeed, yes.

MS BENNETT: And so in terms of - and indeed there's also not specified. What do you understand would be included in the not-specified category?

MS CRAWFORD: That is a question.

MS BENNETT: Thank you.

MS CRAWFORD: It might be something that's not yet diagnosed, that's not specific to those other categories.

MS BENNETT: Well, do the other categories need a diagnosis?

MS CRAWFORD: Not always, no, but we will, where required, seek a specialist or expert diagnosis.

MS BENNETT: Can it just be the case officer or the authorised officer's perception of that person?

MS CRAWFORD: We would encourage more rigorous information gathering than just their perception. So it might be information that's being provided by family members or the GP or teachers, education personnel. Those are the sorts of sources that would inform the collection of that data --- it's broad.

MS BENNETT: It's not just that it's broad, it's undefined ---

COMMISSIONER McEWIN: Ms Bennett, sorry, may I just clarify that.

So are you saying, Ms Crawford, it's Commissioner McEwin here, are you saying the caseworker relies on second-hand information at times sometimes to, if say, a teacher might say the child has X disability, is that what you're saying in terms of this collection of information?

MS CRAWFORD: Our preferred source of information would be the parent or the child themselves, but the other sources of information that may be available to us may be those other professionals in contact with the child and the family.

COMMISSIONER McEWIN: Thank you.

MS BENNETT: It's fair to say that there's no specific definition of disability that is applied by your Department in this capture of data?

MS CRAWFORD: That's a fair statement, yes.

MS BENNETT: So do you - are you aware of the definition under the *Disability Discrimination Act*, is that a definition that is talked about in the Department?

MS CRAWFORD: It is something that we include in our training, and in our disability practice kit, which Child Safety Officers and other staff can access through our Child Safety Practice Manual.

MS BENNETT: But that's not the definition adopted for these purposes?

MS CRAWFORD: Well these are different categories of disability whereas the definition that we include in our training and other resources is that disability is any restriction or lack resulting from impairment of ability to perform an activity in the manner or within the range considered normal.

MS BENNETT: All right, we might come back to that a little later on when we get to some of the structured decision-making models.

MS CRAWFORD: Sure.

MS BENNETT: I wanted to move on to make sure we all - well, sorry, while we're talking about disability, I wanted to raise with you that Commissioner Lewis, in her statement, which you may not have read, she says that First Nations parents with a disability or parents of a child with a disability are more likely to experience service inequity. Would you agree with that proposition?

MS CRAWFORD: I think it's likely that a parent with a disability may experience service inequity and we, as service providers, need to work hard to ensure that there is equity in the services available.

MS BENNETT: I'd like to then just turn to briefly identify the structure of the Department. We've done this a little bit. I just want to be clear, as I understand it, authorised officers are effectively the frontline workers who interact with families and children, is that right?

MS CRAWFORD: Yes, they work directly with children and families.

MS BENNETT: And they're authorised by the Chief Executive under the Child Protection Act?

MS CRAWFORD: That's right.

MS BENNETT: They're authorised with a - have appropriate expertise. What is that expertise?

MS CRAWFORD: So we - Child Safety Officers and senior team leaders are required to have a bachelor level qualification. Our preferred pathways are social work, human services, and psychology. So they come with those basic bachelor degrees, and then we offer them mandatory and non-mandatory training on their entry to our workforce.

MS BENNETT: Okay, and ---

MS CRAWFORD: I should say, whilst social work, human services and psychology are our preferred degrees, we do accept other degrees at times when people have completed core subjects that relate to the work and engagement with children and families.

MS BENNETT: All right. And these authorised officers who have a range of powers that they exercise often upon reasonable belief, is that right? So they make application - yes?

MS CRAWFORD: On the basis of their assessment and we endeavour that Child Safety Officers do not make decisions in isolation. So they are often supported by either another peer or a more experienced Child Safety Officer and their senior team leader.

MS BENNETT: Okay. Can you explain to the Commission the role of the Director of Child Protection Litigation in this structure?

MS CRAWFORD: So the Director of Child Protection Litigation does not sit in our structure. It was a key recommendation from the Child Protection Commission of Inquiry that our litigation model changed quite significantly. So the DCPL, as we call it, if I may, I will refer to it as that, the DCPL, actually is an independent body and reports through to the Attorney-General of the Department of Justice and Attorney-General. So they are now the applicants in child protection matters, not child safety staff. So a DCPL ---

MS BENNETT: Have you observed a shift in the litigation conduct since the Director's Office has been - or the DCPL's Office has been in place?

MS CRAWFORD: Yes, I had seen some shifts. I can speak to what the Commission of Inquiry was trying to achieve. So they were keen that we were - that parents had more transparency of information, that there was greater procedural

fairness afforded to them, that there was some oversight of child safety decisions, that we were model litigants, and that there was a specialist knowledge applied to Child Protection Order applications.

MS BENNETT: Chair, I'm asked to seek indication to you as to when a good time for a break would be. I'm also told there is some ongoing noise problems with the microphone that we can't determine the source of, so I wonder if that means that we should have a brief break while we work that out. It's a little bit earlier than I had anticipated, but I'm -

CHAIR: Let us have a break. It is now Queensland time 2.40. So if we return at 2.55 it would be 3.55 in Sydney. Thank you.

MS BENNETT: Thank you, Chair.

CHAIR: Thank you, Ms Crawford, thank you, Ms Muller. We will resume in 15 minutes.

ADJOURNED **[2.40 PM]**

RESUMED **[2.54 PM]**

CHAIR: Yes, Ms Bennett.

MS BENNETT: Thank you, Chair.

Ms Crawford, I think before that break we were talking about recording --- keeping records of disability status for parents and carers. Is that something that the Department will be looking into in the future?

MS CRAWFORD: Yes, it will. Yes. So with our new information system, we're hoping that those fields will be - well, they will be built in and that we will have more accurate data capture potential.

MS BENNETT: And will that data capture be of specific definitions of disability?

MS CRAWFORD: Yes, I would suggest it will be.

MS BENNETT: Thank you, Ms Crawford. Now I would like to ask you about some of the structured decision-making tools that you refer to in your statement.

MS CRAWFORD: Yes.

MS BENNETT: So at around paragraph 46, you talk about, I'll call them SDMs,

structured decision-making assessments, as I understand it. Now as I understand your evidence, these were introduced to try to increase consistency of decision-making, is that right?

MS CRAWFORD: Yes, it was as a result of the 2004 Crime and Misconduct, CMC Inquiry into abuse in foster care. So the guidelines that were issued said we needed a more standardised way of assessing and safety planning and then case planning.

I should just make the point that they're not all risk assessments. So there are eight tools in the structured decision-making toolkit, and really, they support decisions rather than assess risk necessarily.

MS BENNETT: Yes, some do, and some guide the decision-making, is that right?

MS CRAWFORD: So they all guide decision-making. They're all tools that guide decision-making, yes.

MS BENNETT: But some do that by seeking to identify and ascribe a risk level based on a number that relates to certain factors?

MS CRAWFORD: So one of the tools is - one of the tools is an actuarial tool. It's the family risk evaluation tool.

MS BENNETT: All right, perhaps we might go to that tool.

Operator, that is at QLD.0003.0028.0248.

That's the first page, and I think that the tool that you are speaking about is at page 003.0028.0305 and perhaps I could test that with you. Is that the tool that you're talking about there?

MS CRAWFORD: I'm sorry. I don't have the exhibits marked as you do, but yes, it does come up on the screen. Thank you. Yes, that is the family risk evaluation tool. If I can offer ---

MS BENNETT: Sorry, can I just - I'll just ask you a few questions first, if that's all right?

MS CRAWFORD: Okay, sure.

MS BENNETT: So on the left-hand side we have measures of neglect --

MS CRAWFORD: Yes.

MS BENNETT: --- and if one scores 0 to 2, that will be considered a low-risk score on the neglect scale. Is that right?

MS CRAWFORD: Yes.

MS BENNETT: And if you score 3 to 5, that would be a moderate risk of neglect?

MS CRAWFORD: Yes. It's all contained there at the bottom. I don't have - I can't see the full screen, I'm sorry. I'm just trying to go to it in the manual so I can be - speak with more authority.

MS BENNETT: It's Exhibit E and page 55 and 56, and perhaps the operator could put document 0306, the page annexed to it up as well. Thank you, operator.

And so you will see that this is the tool as a whole, and so the authorised officer will be completing this tool and they will be identifying - they will be ascribing a score to neglect and a score to abuse and then they will be able to identify a risk level at low, moderate or high. Is that a fair summary?

MS CRAWFORD: Yes, it is.

MS BENNETT: I'd like to just understand the way that this tool works in practice because it's intended to operate objectively, and I'm interested in understanding if it might inadvertently operate in a way that identifies higher risk for First Nations people or people with a disability, okay? Is that a concern with this tool that you're aware of?

MS CRAWFORD: Yes, it is a concern that has been raised and it is a concern that we have spoken with the developers of the tool about.

MS BENNETT: Just to pause there, the developers of the tool, have they validated this tool for First Nations people?

MS CRAWFORD: Yes, they say they have factored equity for Aboriginal and Torres Strait Islander families.

MS BENNETT: When you say "factored", is that the same as validated?

MS CRAWFORD: Yes.

MS BENNETT: Okay. And is that nationally or in Queensland or where's the - where's that research been done?

MS CRAWFORD: As I understand it, it's using a Queensland data set.

MS BENNETT: Okay. Now - and when did that validation complete because I wasn't able to see reference to that validation in your statement?

MS CRAWFORD: I would have to find the date. I think it was 2015 but I can come back to you with the actual date.

MS BENNETT: All right. We might ask you to take that on notice. The (audio distorted) has been updated a number of times since 2015, hasn't it?

MS CRAWFORD: It has, yes.

MS BENNETT: Including by reference to various First Nations specific issues?

MS CRAWFORD: That's right. And we -

MS BENNETT: So has it been validated since those updates?

MS CRAWFORD: No.

MS BENNETT: Okay. So let me just ask you about at N1. So if I understand correctly, an authorised officer will ascribe a 0 or 1, depending on the answer to the question, of whether the notification includes neglect or not, is that right?

MS CRAWFORD: That's right. So that's the current notification, yes.

MS BENNETT: Is that a substantiated notification or is that a notification as yet unverified?

MS CRAWFORD: Usually this is done after, so at the completion of the INA process. So typically, yeah.

MS BENNETT: Okay. And then at N2, we see prior child safety notifications. There's a score of 0 for none, 1 for one notification, and two or more is 2. Now I understand that this refers to all prior notifications regardless of if they were investigated, assessed, substantiated or unsubstantiated, is that your understanding?

MS CRAWFORD: Yes, that's my understanding.

MS BENNETT: So is there a risk of over-report for First Nations families in that category?

MS CRAWFORD: Yes, I think there is a risk of over-report, yes.

MS BENNETT: And you could score 2 because of that over-reporting risk in that category, couldn't you?

MS CRAWFORD: You could, yes.

MS BENNETT: Yes. Then at N4, this is a prior out-of-home placement category, so you'll gain a point if the child has had an out-of-home placement in the past, is that right?

MS CRAWFORD: That's right.

MS BENNETT: And more First Nations children we know have been placed in out-of-home care, is that right?

MS CRAWFORD: There's a higher proportion of children in out-of-home care who are First Nations, yes.

CHAIR: Sorry to interrupt. Is that a reference to a prior out-of-home placement for the particular child ---

MS CRAWFORD: Yes.

CHAIR: --- or that the parent has been - had had a child that has been subject to an out-of-home placement previously?

MS CRAWFORD: Should be for the child, Commissioner.

CHAIR: Thank you.

MS BENNETT: The next is N5, the number of children living in the notified household. So a family will score 0 if they have three or fewer children, and they will score 1 if they have four or more children. Is that more a measure - is that something that you would consider to be a proxy for poverty? The number of children in the one house?

MS CRAWFORD: No, no, I would not see it as a proxy for poverty, no.

MS BENNETT: So you wouldn't see a risk of over-representation of First Nations children in that category?

MS CRAWFORD: I do think that Aboriginal and Torres Strait Islander parents often have more than three children. I think there are large family groupings, yes, but I don't think it's a proxy for poverty. I think it's more about a proxy of possible parental stress and capability to meet all those children's needs.

MS BENNETT: All right. Could I take you down to N10.

Now, this is a measure, as I understand it, where the primary parent has a history as a child of abuse or neglect. There will be a score of 1 again. Now, is abuse or neglect something that might be more common in First Nations families with a history of dispossession?

MS CRAWFORD: Yes, we know that from research, yes.

MS BENNETT: And so this is part of - is there a risk of over-representation for First Nations people in this category as well?

MS CRAWFORD: Yes. Could I just offer how this tool is used?

MS BENNETT: Yes, I'd like to come to that because I think that there's steps, so I just want to understand how these factors - I understand what these factors are first, if that's all right.

MS CRAWFORD: Sure, certainly.

MS BENNETT: Yes. So N11 then look to the primary parent mental health. Now, what is the definition of "mental health" being applied here?

MS CRAWFORD: Yes, good question, I think it is a broad definition of mental health.

MS BENNETT: Isn't a definition of mental health, as I understand it, a past or current mental health problem. So what is a mental health problem?

MS CRAWFORD: Well, usually it's an emotional psychological impact on a child, so if a parent is having a struggle with their mental health, it might be anxiety, depression, psychosis, schizophrenia, and if that's having an impact on the child.

MS BENNETT: Why does that impact have to derive from a mental health problem to create a score on this scale?

MS CRAWFORD: I'm sorry, why does it need to derive?

MS BENNETT: Why does there have to be a mental health problem? Why are you not just looking at the effect on the child, why does it have to be tied to a mental health problem?

MS CRAWFORD: It is our job to assess whether there is an impact of the mental health issue for the child. But I see what you're saying. I see what you're saying.

MS BENNETT: So any person who has had a mental health problem in their life could qualify for this if in the view of the authorised officer, the child is - what would be the qualifier? Most of the population has had a mental health problem at some time in their life. What will score a 1 on this?

MS McMILLAN: I object to the question. That's not a fair question. Where does that derive from, that most adults -

CHAIR: I'm not sure, Ms Bennett, that in the absence of evidence --- you can say that most adults have had a mental health problem without at least defining "mental health problem", so perhaps ---

MS BENNETT: Well, is depression a mental health problem?

MS CRAWFORD: Yes.

MS BENNETT: And so that's a widespread issue in the community, isn't it?

MS CRAWFORD: Yes, it is.

MS BENNETT: Are all the mental health problems captured by this factor diagnosed by a professional?

MS CRAWFORD: Not necessarily. It might be a parent's self-report.

MS BENNETT: Could it be about the authorised officer's assumption?

MS CRAWFORD: Not an assumption. As I said before, we rely on information-gathering to inform our assessments.

MS BENNETT: There's no definition that an authorised officer can apply to identify a mental health problem, is there?

MS CRAWFORD: No.

MS BENNETT: So, it will be left entirely to individual discretion as to what constitutes a mental health problem, is that fair?

MS CRAWFORD: Individual professional judgment, yes.

MS BENNETT: That's right, and your authorised officers are not necessarily medically trained, are they?

MS CRAWFORD: No, they're not necessarily medically trained. As I said before, they typically come from social work, human services and psychology backgrounds, which would cover subjects related to health and mental health.

MS BENNETT: But you're not suggesting that they're diagnosing mental health problems?

MS CRAWFORD: No, I'm not suggesting they're diagnosing. I suggest that we partner with health partners to do that.

CHAIR: Ms Crawford, what would happen if a parent disclosed that she, if it was the mother, had been prescribed antidepressants over a period of time? Would that demonstrate a mental health problem?

MS CRAWFORD: Potentially it could, Commissioner. What I am keen to offer the Royal Commission is how this tool is used, though.

CHAIR: Please do tell us.

MS CRAWFORD: Yes. So, there has been suggestion in some of the criticism and the research that it's this tool that's used to make a removal decision. That's not the case. So removal decisions are based on the safety assessment which is a different tool in the SDM suite. So we remove a child when they are assessed as unsafe. What the FRE, this tool that is before us, helps us determine, is the level of ongoing intervention that should occur. So, for example, if you score a high risk level, then there are certain contact arrangements that are prescribed. So what the tool helps us determine is that if it's a high-risk, then we should be seeing that family once a week as well as support contact.

The low or moderate determines the level of frequency of the ongoing contact. I think what worries researchers is that we are basing our removal decisions on the use of this tool, and that's not the case.

I have -

MS BENNETT: I might come to that.

MS CRAWFORD: I have huge respect for the researchers who have examined this tool, and please know that we are assisting them with further research regarding this tool.

So I know that there have been some statements made about it, and that it possibly is inequitable to Aboriginal and Torres Strait Islander children. We are supporting further research by independent researches regarding this, and we will be providing more recent data sets for them to reference.

CHAIR: Ms Crawford, you've said that this is, in effect, a trigger to determine whether some kind of contact should be made with the family presumably in order to both provide support and to determine whether there is a possible case for intervention. Is that a fair way of putting it?

MS CRAWFORD: It's certainly assisting in determining the ongoing support that a family might need and the level and intensity of that support, yes.

CHAIR: But that wasn't the totality of my question.

MS CRAWFORD: Sorry, Commissioner.

CHAIR: Does it also provide an entree for assessing or possibly assessing whether there should be a decision in due course made about whether a child should be removed or not?

MS CRAWFORD: As I said, a removal decision is based on safety assessment.

CHAIR: I understand, but isn't this a necessary prerequisite to get to the point where you make a determination based on safety considerations?

MS CRAWFORD: The safety assessment actually comes before this tool, Commissioner.

CHAIR: Could you explain how that is?

MS CRAWFORD: So when we have contact with a family, we need to determine if there are any immediate harm indicators for a child. So there are 12 immediate harm indicators that we list in a safety assessment and what we are determining at that point is whether a child is safe, safe with a plan, or unsafe. So we complete the FRE at the end of our investigation and assessment process to help determine whether there should be a case opening decision or whether there should be other supports, and then what the frequency of that support should be.

I'm sorry if that's confusing.

CHAIR: It is very confusing, I'm afraid, at least to me. You say that there is initially an assessment of safety or lack thereof, based upon 12 criteria.

MS CRAWFORD: That's right.

CHAIR: And if there is assessed to be a risk to safety, what's the point of this evaluation?

MS CRAWFORD: So this is where the terms "risk" and "danger" are very important to understand. So when we're doing an initial safety assessment, we're determining if there's danger, immediate danger for the child. The family risk evaluation helps us to determine whether this child is more or less likely to experience a further incident of abuse or neglect in the next 12 to 24 months and what level of support should be offered.

So this applies to both in-home interventions and out-of-home interventions. So what I can offer the Royal Commission is that many of our interventions are intervention with a parental agreement. So we have about 2,500 of those matters. Where we actually offer in-home support to families, and what this FRE will help us determine is how often we should be seeing those children and that family in their homes.

CHAIR: Yes, all right. I'll leave Ms Bennett to explore that as appropriate.

MS BENNETT: Thank you, Chair. So I think where we were is accepting - would you accept the general proposition that there are a number of these measures that appear to respond readily to First Nations people?

MS CRAWFORD: Yes, and it is something we've raised with the Children's

Research Centre, yes.

MS BENNETT: And would you accept that at least in the instance of N11 and the question about primary parent mental health, that there is a potentially disproportionate impact on people with mental health issues?

MS CRAWFORD: Potentially there is impact for parents with mental health, yes.

MS BENNETT: Are you concerned it could be stigmatising for people to seek help for their mental health issues if it might be recorded against them?

MS CRAWFORD: We encourage parents to seek the help that they need. I should also just make clear that these tools are not publicly available. They're not published, so what you are being provided is not actually a public document. It's a locked document.

MS BENNETT: So, individuals may not know why they're scoring high or why their depression might have led to a higher score or greater intervention, is that fair?

MS CRAWFORD: No, I'm not saying that. We, of course, immediately outline the concerns that we have with families, and about why we are concerned, and about why we are taking the approach that we are. We need to -

MS BENNETT: And so family -

MS CRAWFORD: We need to chase that up with families.

MS BENNETT: So a family that scores a 1 on N11, for example, will be told "Your past mental health problem was a reason that we had a concern --- was part of the reason that we had a concern." Is that the case?

MS CRAWFORD: It should be, yes.

MS BENNETT: Do you know if it is?

MS CRAWFORD: I would say it is, yes.

MS BENNETT: And are you concerned that that might be stigmatising for people who would otherwise seek help for their mental health difficulties?

MS CRAWFORD: As I say, we try to assist people to address the issues that are impacting on their children. It might be that there is no current impact of a mental health issue for a parent. So we do like to be seen as a helping organisation where we actually help parents get the assistance they need to increase safety for their children.

MS BENNETT: Would you accept that not all families view the Department in that

way?

MS CRAWFORD: Yes, I would accept that. I would also accept others -

MS BENNETT: Sorry, I interrupted you.

MS CRAWFORD: No, no, that's okay.

I would accept that not everyone sees us as helping. And that is why we have, over the last number of years, worked very hard, particularly in the context of the child protection - the Commission of Inquiry, to bring particular tools that enhance our engagement and our transparency with families so that they fully understand the reasons why we're involved with them and what we are concerned about for the future.

MS BENNETT: Okay. You've heard some evidence that some people, for example, were unaware that notifications were made adverse to them in the past. Now it appears on this measure that previous notifications, irrespective of whether they were verified, will count towards a risk score. Is that your understanding?

MS CRAWFORD: Yes, that's right.

MS BENNETT: And this might be the first time that someone is told that those notifications have been made.

MS CRAWFORD: Notifications are followed up with an investigation and assessment process, so they should know that. So they will have been consulted on that.

MS BENNETT: But you agree with me that this measure counts notifications irrespective of whether they have been verified or substantiated or even investigated?

MS CRAWFORD: Not even investigated but - so child protection notification is followed up with an investigation and assessment.

MS BENNETT: I might challenge you on that.

Could you go to page 57 of that document at 0307, operator.

Now, at N2.

MS CRAWFORD: Sorry, if you wouldn't mind. Oh, here, sorry. Yes.

MS BENNETT: At the first dot point:

> *Count all prior child safety notifications regardless of whether they were investigated and assessed, substantiated or unsubstantiated or recorded with*

no possible outcome.

MS CRAWFORD: Yes, you're right.

MS BENNETT: Okay. So it might be the first time that someone hears about it when they are scored as being at higher risk because of previous notifications?

MS CRAWFORD: Potentially, yes.

MS BENNETT: That's not overwhelmingly transparent, is it?

MS CRAWFORD: As I say, we're really encouraging our staff to be as transparent as possible in their work with families. Families need to know why we are concerned, why we are involved with their children.

MS BENNETT: I accept that, but you agree with me that that's not what this measure says?

MS CRAWFORD: I agree it does not say that and there are times -

MS BENNETT: And where do we find -

CHAIR: Can we just make sure, please, that one is speaking at a time, because it's a little difficult.

MS BENNETT: Yes. I wanted to ask you about N13 on that measure before we move on, because that concerns primary parent criminal history.

So if the operator could return to the previous page. My understanding is the risk score --- and the page before that, thank you, operator, at N13. Now my understanding of this category is that this will capture a criminal history excluding traffic offences other than drink driving, but all other offences will be captured by N13, is that your understanding?

MS CRAWFORD: That is my understanding. That is what the definitions say.

MS BENNETT: And so your understanding is that any previous criminal conviction except for driving offences, other than drink driving, is an indicator of risk?

MS CRAWFORD: It would add to the risk score, yes.

MS BENNETT: Including those offences that had been identified as disproportionately affecting First Nations people?

MS CRAWFORD: Yes.

MS BENNETT: So this is another category that could disproportionately affect First Natio

ns people?

MS CRAWFORD: Yes.

MS BENNETT: I count about six in the neglect category, and I won't go through this process again, but on my count, we are almost at high, at high risk for members of the First Nations community, simply because they come from that community. Is that fair?

MS CRAWFORD: In the way that you describe it, yes, it is a concern, which is, as I say, why we are open to more research regarding this tool.

MS BENNETT: I understand that. I would like to move onto what happens next. So there's an override section. So if the operator could show 0306, the page on the right-hand side is the final risk level, bottom third of the page, and that shows low, moderate or high. And then an ongoing intervention decision.

Now, as I understand it, an authorised officer can decide to go against, can decide to override the decision that's mandated, if you like, or directed by the tool in certain circumstances. Is that right?

MS CRAWFORD: Yes, and that would be approved by a senior team leader. So they would not make that decision in isolation.

MS BENNETT: And do you keep any records about how often an override is sought to be exercised?

MS CRAWFORD: We used to have a data management report provided to us. That hasn't happened in the last couple of years. We were getting that report from the Children's Research Centre who would compile it after being provided with our data. We had hoped that we would be able to provide that report ourselves internally, and unfortunately that hasn't happened to date.

MS BENNETT: So the Department has no insight into how often authorised officers are departing from the recommendation of this tool, is that right?

MS CRAWFORD: We have had that historically, we have had that information historically, and those rates of overrides had remained relatively stable over a period of time. Right now, we don't have access to that data, and it is something that we would like.

MS BENNETT: How long has it been since you have had access to that data?

MS CRAWFORD: It's about two years.

MS BENNETT: Okay. And this SDN, in its current form, was last amended, I think in your statement, on 2018?

MS CRAWFORD: With the cultural consideration updates and also -

MS BENNETT: Yes.

MS CRAWFORD: Yes, and also references to domestic and family violence that we - so we are maturing in our understanding of domestic and family violence, and so amended some of the wording in the tools to reflect that maturity.

MS BENNETT: And you haven't had any data about overrides since those amendments?

MS CRAWFORD: No, that's right.

MS BENNETT: Have you ever sought data about the override being applied in circumstances where First Nations children are involved?

MS CRAWFORD: Yes. Yes. As I recall, the overrides - so that the management report did include a separation of decisions made for both Aboriginal and Torres Strait Islander and non-Indigenous children.

MS BENNETT: And that's something you're seeking to re-invigorate in the future, is that right?

MS CRAWFORD: Yes, absolutely.

MS BENNETT: And what about for people with a disability; is there any data on how often there is an override in that context?

MS CRAWFORD: No, no, there's not.

MS BENNETT: Okay. Now, I think - so the effect of this can be that a family is effectively monitored more closely by the Department if they are identified as being at a higher risk, is that fair?

MS CRAWFORD: Yes, that's fair. They're offered more support, yes.

MS BENNETT: Okay, right, so let me go back. Are supports offered to parents with a disability who might need that support for their family?

MS CRAWFORD: Yes. And what we aim to do now is to ensure that they have access to the NDIS and the support that is available through NDIS planning.

MS BENNETT: Okay, so that's - they have access to NDIS support. Your Department, does that provide separate support for those parents?

MS CRAWFORD: Yes, it does.

MS BENNETT: Can you tell me about how you go about assessing the kind of supports that those parents might need?

MS CRAWFORD: So it would depend on the harms that the child has experienced. What we are concerned about for the future, so what the impacts are for the child. So it will depend on what the parental functioning means for the child.

MS BENNETT: Okay, to give an example, if a parent is struggling with mental health, will they receive mental health support from your Department?

MS CRAWFORD: Not from our Department, but we would partner, we would partner to ensure that they do have the support that they need.

MS BENNETT: So whose responsibility -

MS CRAWFORD: Particularly if there was an impact for the child.

MS BENNETT: Okay, so if there's impact for the child, will your support go to the question of risk or to the total support needed for the parent? Do you stop at risk or do you go further than that?

MS CRAWFORD: We want children to be cared for safely by their parents, so we will try to ensure that the parent has the support they need to care safely for their child. So if the issues are that they need assistance with parenting skills or meeting nutritional needs, or understanding the educational needs of a child, then we will address the impacts for the child.

MS BENNETT: And is that something that is dealt with in part through a parenting capacity assessment?

MS CRAWFORD: Where required, we may seek external specialists for a parenting capacity assessment, but often we will be talking - often we talk and gain information from parents, from children, from those people who are close to the family, to the parents who are offering them both formal and informal supports.

MS BENNETT: And at what stage does the *Human Rights Act* come into play for your decision-making?

MS CRAWFORD: So, as you - as this Commission knows, the *Human Rights Act* came into being in Queensland in January. It's fundamental to our practice. If our Child Safety Officers are operating in accordance with the *Child Protection Act*, it's compatible with human rights.

MS BENNETT: If any action taken, if it's not unlawful because of the *Child Protection Act*, it won't otherwise be unlawful because of the *Human Rights Act*?

MS CRAWFORD: What we ask is that staff consider human rights, and that there is proportionate consideration to human rights and to child safety.

MS BENNETT: All right. Well, my question really is, at what stage of decision-making --- so if you were deciding to remove a child from their family, is the *Human Rights Act* a step in that decision-making? The rights protected by the *Human Rights Act*.

MS CRAWFORD: It's all part of our policy and the way that we operate. So we ask Child Safety Officers to consider the 23 human rights in all of their activities and actions, yes.

MS BENNETT: Yes, so at each stage they will ask themselves, before removing this child, I'm going to consider the right to culture, the rights to First Nations culture, the right to privacy and family, I will consider all of those things before taking that step? Is that right? Is that your expectation?

MS CRAWFORD: Well, as part of that decision-making and children's safety, and children's safety is our paramount concern, yes.

MS BENNETT: Yes, and you heard, I think the criticism earlier, that one of the witnesses suggested that they had not seen substantial evidence of human rights dialogue, is that consistent with your experience?

MS CRAWFORD: I think it's probably fair to say that our Child Safety Officers aren't always referencing the *Human Rights Act*. If they are operating in accordance with the *Child Protection Act* then that is compatible with human rights, and we have said that the *Human Rights Act* and the - all 23 of the human rights are fundamental to our practice and our approach. All of our policies have been updated to reflect that. This is --- the Aboriginal and Torres Strait Islander Child Placement Principles are fundamental to our approach as well. So we are saying that - and there were legislative amendments in October of 2018 to say that we needed to consider the five elements of the Child Placement Principle in all of our processes and decision-making.

MS BENNETT: And how do you measure if that's being done?

MS CRAWFORD: How do we measure it? That's a good question, too.

So it's through our processes that we pay attention to those five elements of the Child Placement Principle. So things like, you know, have we worked to keep children in their families? Have we partnered with Aboriginal and Torres Strait Islander families and then Aboriginal and Torres Strait Islander support agencies? Do we maintain connection to culture for children who might be in our system? We do reference the five elements of the Child Placement Principle.

CHAIR: Ms Crawford, can I ask you, please, what the expression "ongoing

intervention decision" means, which is on page 56 of the document? What is an ongoing intervention decision?

MS CRAWFORD: So that, as I referenced before, Commissioner, that might be an intervention with a parental agreement, so it's ongoing case work with a family, or it could be through a Child Protection Order. So it covers both, "ongoing intervention" covers both: intervention with a parental agreement, or a Child Protection Order.

CHAIR: That's what I rather thought I was asking you earlier, that this was a gateway to a possible order affecting the child.

MS CRAWFORD: An intervention with parental agreement is not an order, Commissioner. It's an agreement with parents.

CHAIR: It's something that the - that there might be some pressure put upon the parent to agree, mightn't there?

MS CRAWFORD: Pressure on them? I think what we would articulate is the harm that the child has experienced, why we think they're a child in need of protection, and why we think that they need ongoing support and intervention to increase safety.

CHAIR: I understand why you express it that way, but in fact, the parent, if the parent is to agree, then the parent would be presented with information that would indicate why, in the case of the mother, she should agree, wouldn't it? Wouldn't that be the case?

MS CRAWFORD: Yes. Yes. So, again, we would relate that back to the harm the child has experienced and what we think needs to happen to increase safety for that child, or those children.

CHAIR: What we've got here with the document that you've been taken to by Ms Bennett at some length, the outcome of that is an ongoing intervention decision and this document is called the Policy and Procedures Manual, Structured Decision-Making in Child Protective Services. An ongoing intervention decision does seem to be a decision that affects the rights of people directly, both the child and the parent. That's a fair assessment, isn't it?

MS CRAWFORD: It's a fair statement and as I said before, it's focused on what this child needs to be safe or to increase safety.

CHAIR: Yes, thank you.

MS BENNETT: Have you heard the phrase "gratuitous concurrence"?

MS CRAWFORD: Gratuitous concurrence? I'm not familiar.

MS BENNETT: Have you heard the phrase before?

MS CRAWFORD: No.

MS BENNETT: The Commission has heard some evidence that some First Nations people will defer to authority figures when asked to comply with certain requests in a statutory context. Are you familiar with that concept?

MS CRAWFORD: I am familiar with that concept and it's why, in the October 2018 legislative amendments, we said that Aboriginal and Torres Strait Islander peoples do need support in --- or may choose to have support, in the interactions that they have with us, and that they do have the choice to have an independent person to assist them to participate in decision-making. So, yes, I'm conscious.

MS BENNETT: Are your officers required to refer them to a support person?

MS CRAWFORD: They are required to offer them an independent person, yes.

MS BENNETT: Are they required to - well, they're not required to refer them, are they?

MS CRAWFORD: No. So a family may, for example, nominate a member of their own community to be their independent person, but we have funded family participation programs who can also offer a family, a staff member, as an independent person.

MS BENNETT: And you don't require your officers to notify any First Nations organisation that a family might be at risk of having a child removed?

MS CRAWFORD: So what we do is, we use the family participation program as the point of investigation and assessment so that they assist parents participate in the decision-making. So with the family participation program and the guidelines that we have written, we've said that there are three key areas in which they should be involved.

So during the investigation and assessment process, through a case plan review, through a short-term order, and before the expiry of a short-term Child Protection Order. And so that is our attempt to make sure that Aboriginal and Torres Strait Islander parents and families are supported in decision-making and in discussions with us.

MS BENNETT: My question is: are your officers required to refer them to a lawyer?

MS CRAWFORD: No, no. I'm sorry, I misunderstood that.

MS BENNETT: Are your officers required to refer them to a peak First Nations organisation?

MS CRAWFORD: They are required to offer them an independent person who might be a member of the community or might be provided through an FPP.

CHAIR: Ms Crawford, what do you mean required to offer them an independent person? Do you mean that the case officer is required to say, "Here is a particular person I can refer you to if you wish", or does the case officer say, "You have a choice, if you wish, to get hold of someone to help you"?

MS CRAWFORD: The latter, yes.

CHAIR: The latter?

MS CRAWFORD: Yes.

CHAIR: How many First Nations parents have entered into agreements with you at this time, as of today, roughly?

MS CRAWFORD: I don't have that data, Commissioner.

CHAIR: Would you have the data that demonstrated what proportion of those had actually received independent advice before entering into the agreement?

MS CRAWFORD: No, I don't. It is something that we are working toward in the new information system. And it is assistance, Commissioner, to participate in decision making, so it's not legal advice as such.

CHAIR: No, I'm not limiting - sorry, I'm not limiting my question to legal advice. I'm asking what proportion of those who have entered into agreements with the Department have received independent advice of some sort or assistance.

MS CRAWFORD: Thank you.

MS BENNETT: I wanted to ask a little bit about the previous reports that have been actioned by the Department.

Now, I think, Ms Muller, this relates primarily to your statement. If I understand it correctly, there have been, if you like, generations of reports about - that touch upon child protection issues, and I think the first you refer to in your statement goes back to 2012. Is that right? Is that fair?

MS MULLER: The 2013 Child Protection Commission of Inquiry, yes?

MS BENNETT: Yes. And as I understand your statement, there were 115 recommendations that were accepted in full and six recommended in principle, is that right?

MS MULLER: That's correct.

MS BENNETT: And so far, not all of those recommendations have been implemented, is that right?

MS MULLER: 115 have been as at June 2020.

MS BENNETT: Yes, so --- and are there some leftover, of the recommendations of 2013?

MS MULLER: There are six that are currently under way that are scheduled to be finished by the end of next year, correct. Yes.

MS BENNETT: And which, of any of those, relate to First Nations people?

MS MULLER: Most of those outstanding recommendations are mostly about legislative reforms so applying to all people, so looking at rights and then also the regulation of care.

MS BENNETT: Yes. Was there further review of 2015 that have had a further 200 recommendations the paragraph 16 of your statement followed by the Royal Commission into Institutional Responses to Child Abuse which you say had a large number of recommendations concerning child protection.

MS MULLER: Correct.

MS BENNETT: Is there a central repository for the recommendations concerning child protection that have been made by these inquiries?

MS MULLER: Yes, there is. So, within our Department there's a program office that keeps a register of all of those different recommendations, and then also there's a program office in the Department of the Premier and Cabinet that also has a central register, say, of the Commission of Inquiry recommendations and so on.

MS BENNETT: And is there any way to identify which of those recommendations specifically relate to persons with a disability?

MS MULLER: I am not aware in terms of how they've set up that whole kind of data system. I daresay it would be apparent if it was within, say, the total of the recommendation or the wording of the recommendation.

MS BENNETT: I see. And would the same be true for recommendations concerning First Nations people?

MS MULLER: Yes, particularly given that so much of the child protection system, given that we do have such a high level of representation, all recommendations will be for Aboriginal and Torres Strait Islander people, and then there may be in addition to that some specific recommendations.

MS BENNETT: Now, as I understand your statement, the latest strategy document for improvement and change in this area takes us between 2019 to 2023, I think it's paragraph 18 of your statement.

MS MULLER: Correct.

MS BENNETT: Is that right?

MS MULLER: Correct.

MS BENNETT: So does that work, as part of that strategy, incorporate the previous recommendations?

MS MULLER: Correct. So this strategy is really for the next five years of our reform program, so up to the period 2023. It's bringing all the different recommendations together and looking at what it is that Government wants to achieve over the forward period. So everything has been brought under the banner of what we've called Supporting Families Changing Futures.

MS BENNETT: There are still some areas that are under review, though, according to your statement, over the coming years, including over representation of First Nations families. I think you say that at paragraph 42 of your statement. So is the program of work that's coming, both the implementation of previous reports and consideration of future change?

MS MULLER: Sorry, could you repeat that question?

MS BENNETT: What I'm really asking, Ms Muller, is have you identified what you think you need to do to fix the over-representation of First Nations people and just have to do it, or are you still trying to work that out?

MS MULLER: I think we have a lot of the building blocks or the foundations for change in place, and I think we have been working with our Indigenous peak and with our community-controlled organisations and through the establishment of our Queensland First Children and Families Board, that we know that there are certain things that are working, and that we want to continue to enhance. So, for example, we know our family support services for First Nations families that are run by community-controlled organisations are working and are helping to prevent those families from coming in contact with the child protection system.

We know that in terms of having decisions made by First Nations people rather than doing-to, so Government changing more towards, you know, "We trust that you know what to do to safely raise your child", that we are getting a lot of positive support for that, and that we are seeing, you know, that is something that we want to continue to progress, the increased investment in community-controlled organisations, the further delegation of authority.

MS BENNETT: I'm sorry to interrupt. I guess what I'm trying to work out is, are you only in implementation phase now or are you still developing solutions?

MS MULLER: We are in a constant cycle of adjustment and adaptation and so, you know, the Commission of Inquiry was very clear themselves that we should never really just fix things in place, we've got to be constantly monitoring what's working and that we should be adjusting and adapting. And, of course, we have had additional reviews and recommendations that we also need to bring into the scope of our reform program. We also have a system that's not static, we're not in a controlled environment, there are lots of external factors and lots of changes in our external environment. So we are constantly looking at how we can improve our system, constantly listening to our stakeholders and what it is that we need to do to move forward.

CHAIR: I wonder if you wouldn't mind paying attention closely to the question. I think the question was what is actually underway to address the over-representation of Aboriginal and Torres Strait Islander children and families in the child protection system, which was identified in the 2019 UFCC report or evaluation as something that needed more attention. So the question is, what is actually being done to overcome that difficulty of over-representation?

MS MULLER: Okay, so in 2017 there was a release of the Our Way Strategy and the first Changing Tracks action plan. So that is the 20-year strategy to - which looks to eliminate the disproportionate representation of First Nations families in contact with our system.

Associated with that, Queensland established its Queensland's First Children and Families Board which provides advice to the Department and to the Minister, provides leadership for that strategy and also provides advice to the Department in terms of where it should be increasing its investment.

The other thing that then occurred was a series of - the rollout of our 33 Family Wellbeing Services across Queensland over 2016 to 2018, so those are the community-controlled organisations. We get about 4,500 families going to those services every year. We are seeing some good success from them. We've also had legislative amendments, so, for example, I believe - my understanding is we're the only State or Territory to include all elements of the Child Placement Principle within the Act. We also had changes in 2018 to enable delegated authority where the powers of the Chief Executive can be delegated to the CEO of a community-controlled organisation.

CHAIR: If I can interrupt to ask, something I did want to ask, how many delegations have been made?

MS MULLER: So at the moment we have two early adopter sites that are working on seeing families within their area that will be willing to participate in delegated

authority. My understanding -

CHAIR: Just to cut this short a little, is the answer to my question "none"?

MS MULLER: My understanding is that within the next few weeks we will have our first families.

CHAIR: Yes, I will take that as "none".

MS MULLER: So the answer currently --- yes, would be --- - yes.

MS BENNETT: Thank you, Chair.

CHAIR: We do get there in the end.

MS BENNETT: Yes. Chair, I'm conscious of the time and I wanted to ask finally about something from your statement which was the trial you refer to at paragraph 60, the Aboriginal and Torres Strait Islander family-led decision making trial which you say was quite successful. Can you tell us what's happened following that trial?

MS MULLER: So my understanding is that family-led decision-making has now been rolled out State-wide, it's an integral part of our family participation program.

MS CRAWFORD: It's what our family participation programs use and we understand the elements of family-led decision-making. For example, family-only time, and assisting families through that process to make plans and come to decisions themselves.

MS BENNETT: So was the pilot, as it was evaluated in 2017, was that rolled out across the State, was it?

MS CRAWFORD: Through family participation programs, yes.

MS BENNETT: And were there significant changes between the pilot and the ultimate rollout?

MS CRAWFORD: Not as I understand it, no.

MS BENNETT: Chair, those - I note the time. One could go on for quite a while on these topics. I was told to be wary of the time. It's five to 5.00 Melbourne time. Is that the - and I wanted to make sure there was time for the Commissioners to ask any questions.

QUESTIONS BY THE COMMISSION

CHAIR: Yes, I think we will ask the Commissioners if there are any questions, if that's convenient and perhaps even if it's not.

Yes, Commissioner Mason?

COMMISSIONER MASON: Thank you, Chair. I had an interest in understanding the numbers of Aboriginal and Torres Strait Islander people working in child protection, so, understanding the 43% of Aboriginal and Torres Strait Islander kids in out-of-home care, what's the workforce numbers look like for Aboriginal and Torres Strait Islander people working in the child protection system?

MS MULLER: So for the Department as a whole, and we are referring to our former Department of Child Safety, Youth and Women here, in June we had 205 Indigenous staff within our Department, which represents just under 6% of all staff in our Department.

In terms of Child Safety Officers, so the direct frontline, we have, again, in June, 31 Indigenous Child Safety Officers and that includes our senior Child Safety Officers, which is just over 2.5% of all Child Safety Officers.

COMMISSIONER MASON: Thank you.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: Can I follow up by asking what strategies are you using to do something about that gross under-representation? If I could describe it as that. I think I can fairly describe it as that.

MS MULLER: So there was a recommendation from the Commission of Inquiry about Indigenous scholarships and cadetships. So those have been operational now for a few years. So the scholarship program is aimed at Indigenous staff within our Department and getting them to get, say, a bachelor degree, and the cadetship program is about Aboriginal and Torres Strait Islander people currently at university where we provide financial support and then have that as a pathway through into employment.

I do have the numbers somewhere in terms of how many that we've actually had to date. Certainly for the scholarship program, because it's done part-time and, you know, it's a three-year degree, so it ends up taking people, say, six years to do it, my understanding is that we've had, I think, two people graduate with another four to occur this year, I'm not too sure on that. And my recollection, but I can get back to you with whether this is correct is that I think it was 14 people in terms of the cadetship program to date.

COMMISSIONER ATKINSON: So that's not going to be sufficient, is it? You're going to have to have other strategies?

MS CRAWFORD: It's part of our work force strategy to attract Aboriginal and Torres Strait Islander peoples to our staff. So through cultural practice advisers and other strategies. So you will see our recruitment material does say that we encourage Aboriginal and Torres Strait Islander peoples to apply for positions, and we have a number of identified positions as well.

COMMISSIONER ATKINSON: So I have -

COMMISSIONER MASON: I was interested, if there's been any thought towards providing an avenue for First Nations people who have had engagement, interaction with child protection to - and come through it having an avenue to make a contribution for future families as advocates in the system?

MS CRAWFORD: So, yes, Commissioner, there has been consideration to that. We help fund the Family Inclusion Network which is an advocacy body for parents and families. So Aboriginal and Torres Strait Islander parents can be part of that network.

COMMISSIONER MASON: That's within the Department?

MS CRAWFORD: No, it's external to the Department but we provide funding.

COMMISSIONER ATKINSON: So my next question is on a completely different topic. We've heard evidence earlier about people who suffer from mental health problems, a psychosocial disability, having the child removed from them and then having to fight to get the child back compared with, say, a person who has a broken leg going to hospital and needing some short-term care for the child.

My question is about if someone suffers from any kind of disability or illness that requires them to have short-term care for the child, has any thought been given to that child being kept with the parent safely while they undergo treatment, and, if so, are there any programs that the Department has for that kind of care because, let me explain, it's well known that people suffer from post-partum problems, sometimes even to the extent of post-partum psychosis. Are there programs in the Department for the child of such a person to be kept safely with their parent so that the bonding can continue and they're not necessarily separated?

MS CRAWFORD: Commissioner, those sorts of programs don't necessarily sit in our system. So I'm conscious that there is a program, I think it's through the Belmont Hospital that --- I'd have to go and look for that, but through Queensland Health. So for women who do experience post-natal depression, or psychosis, that there are programs that keep the baby with the mother while she obtains assistance, so --- because the bond, the attachment is viewed as so important.

COMMISSIONER ATKINSON: And is particular attention given to the link between the mother, if the mother is a First Nations mother, and the child, or is this all just done in Health and really your Department has nothing to do with it?

MS CRAWFORD: Well, our hope would be that they would receive the help they need through Health so that they don't come to our attention, so that they are being --
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COMMISSIONER ATKINSON: And if they don't?

MS CRAWFORD: If they don't get the help they need, they are notified to us if there are concerns about the child safety. So if that child has suffered significant harm or is at risk of suffering significant harm.

COMMISSIONER ATKINSON: Do you need the partnership with the Health Department to try and work through these issues?

MS CRAWFORD: We work in strong partnership with Health to resolve child protection matters, and we have what's called a scan system here, where we can liaise directly with our health partners about what it is that our parents and families need.

CHAIR: Commissioner McEwin had a question?

COMMISSIONER McEWIN: Thank you, Chair. Yes, my question is primarily for Ms Crawford.

If I can take you back, Ms Crawford, to the discussion around parent capacity assessment and where the First Nations parent with a disability may be about to enter into an agreement with the Department, I want to try to understand precisely or better what support is available to, say, a First Nations parent with an intellectual disability to understand what is actually going on, to understand, for example, the nature of the agreement that they are about to potentially enter into?

MS CRAWFORD: So we do provide guidance to our staff about how to communicate with a parent with an intellectual disability. Where we are really concerned about capacity, we may well link with the Office of the Public Guardian so that they can advocate on behalf of the parent and support them in those processes.

COMMISSIONER McEWIN: All right, one quick follow-up question then is: what training and what information is given to your staff to ensure that they really do understand that if somebody is not able to understand, you know, the proceedings or the conversation, how does that work?

MS CRAWFORD: So we have a number of different training modules that focus on working with parents with a disability. We also have a specialist services clinician team. So what we often encourage Child Safety Officers to do is to consult with that specialist services team so they have disability expertise and will assist Child Safety Officers access the support that parents need.

COMMISSIONER McEWIN: Thank you, Chair.

CHAIR: Thank you.

Just a couple more questions from me. Do I understand that in order to be appointed as a frontline caseworker, it is essential to have a bachelor's degree or better?

MS CRAWFORD: For a Child Safety Officer, yes.

CHAIR: Why?

MS CRAWFORD: Why?

CHAIR: Yes, why wouldn't you appoint some First Nations people, for example, with special expertise of the kind that we've been discussing even though they may not have tertiary qualifications?

MS CRAWFORD: So the Cultural Practice Adviser positions are available to First Nations people who don't have a qualification.

CHAIR: But what's the answer to my question?

MS CRAWFORD: Yes, we would consider it. We would. In fact our chief human resource officer has been talking about that very thing.

CHAIR: Yes. All right, and the other question is, in the light of all of the changes that we've heard about and the recommendations that have been implemented, why, in your opinion, has the number of First Nations children been into care increased over the last years?

MS CRAWFORD: I think there are multiple disadvantages for Aboriginal and Torres Strait Islander peoples and that there are a number of macro issues and systemic issues that impact on them and that those are the things that need to be addressed.

CHAIR: And do you think you're addressing them?

MS CRAWFORD: I think through the Our Way strategy and the through the advice of our Queensland's First Children and Families Board, we are going some way towards that, yes.

CHAIR: Alright, thank you very much. Thank you both to you, Ms Crawford, and to Ms Muller for giving evidence. Ms Bennett, there's nothing else that arises as far as you're concerned?

MS BENNETT: There is. I'm sorry, Chair. I'm told that Ms McMillan for Queensland has two questions, or seeks leave to ask two questions.

CHAIR: Yes, Ms McMillan. Very nice to hear from you, please go ahead.

MS McMILLAN: Yes, same to you, Chair. Ms Crawford, you were asked some questions about the structured decision making and the manual you were taken to and you said there's ongoing interventional work in relation to that. You said we're accessing further research in relation to that. Who's providing the further research in relation to this?

MS CRAWFORD: So we're supporting a research application made by Professor Clare Tilbury who is seeking to run analysis of a more recent data set. So the data set that has been referred to in Professor Tilbury's previous publications relate to a 2010-11 data set and we have said we support that research with a more recent data set, particularly post the Commission of Inquiry recommendations.

MS McMILLAN: Commission of Inquiry, which one? The '13 or '15?

MS CRAWFORD: '13.

MS McMILLAN: The '13 one, right.

MS CRAWFORD: Thank you.

MS McMILLAN: The data set, what are you talking about the data set? What does that mean?

MS CRAWFORD: It's the use of the SDM tools and things like notifications, re-notifications, substantiations, re-substantiations, that kind of data.

MS McMILLAN: How they're or if they're taken into account, is that what you mean?

MS CRAWFORD: You'd have to ask Professor Tilbury about her methodology but we're supporting the application.

MS McMILLAN: Alright, this is a sneaky third but it only arises out of Commissioner Atkinson's question. Do you have any knowledge or oversight about the perinatal at the Mater Mothers Perinatal Unit there for mothers and babies?

MS CRAWFORD: No, I'm not close to that.

MS McMILLAN QC: Alright, thank you. The other one was Ms Pokino gave evidence this morning, you've already responded about in relation to some of her evidence, but at a local level in Inala what is available, to your knowledge, to First Nations people who are in contact with your Department?

MS CRAWFORD: So we have both the Family Wellbeing Service and the Family

Participation Program that covers Inala. I've made inquiries with the Inala Child Safety Service Centre to see what other supports are available. They say they're very well connected to the local communities, the traditional --- local community, the traditional owners and Elders and they've got very active Cultural Practice Advisers as well.

MS McMILLAN(?): Is there a program called Kummara?

MS CRAWFORD: Yes, there is.

MS McMILLAN: What's that?

MS CRAWFORD: It's a family wellbeing service.

MS McMILLAN: And what is ATSICHS?

MS CRAWFORD: ATSICHS, so that's a family wellbeing service run through the Aboriginal and Torres Strait Islander Health Service. So with the family wellbeing services, we're very keen that there be the support that families require and those Aboriginal health services are often very well equipped to provide holistic support to families.

MS McMILLAN: Is there any availability of independent entities that feature First Nations people?

MS CRAWFORD: Not typically through the family wellbeing services, that's more typically through the family participation programs but, as I said to Ms Bennett, we do encourage families to nominate members of their own community for that assistance.

MS McMILLAN: Do you know of the program yourself or have made inquiries about the program Ms Pokino's involved with?

MS CRAWFORD: I understand it's a Health Department and it's an anti-smoking program. It's not a program that my local colleagues know very much about.

MS McMILLAN: Thank you. Thank you, Chair.

CHAIR: Thank you, Ms McMillan. I can see why you became a lawyer and not a statistician. Thank you very much, Ms Crawford and Ms Muller, for coming and giving your evidence and for your detailed statement. We appreciate your attendance. Thank you.

THE WITNESS WITHDREW

CHAIR: Ms Bennett, I assume we now adjourn until 9.30 am Brisbane time, 10.30 am Sydney time tomorrow?

MS BENNETT: Yes, thank you, Chair.

CHAIR: Thank you very much. We'll now adjourn.

ADJOURNED AT 4.11 PM UNTIL WEDNESDAY, 25 NOVEMBER 2020 AT 9.30 AM AEST

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