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# TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

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

IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

MT ISA

..DATE 17/10/2012

Continued from 16/10/2012

..DAY 25

THE COMMISSION COMMENCED AT 9.44 AM

COMMISSIONER: Good morning, Ms McMillan?

MS McMILLAN: Yes, good morning, Mr Commissioner? I'm sorry there has been a delay but, on speaking with Dr Parry, it became apparent that Ms Ferguson who's sitting beside him who is the clinical nurse consultant and is the child protection liaison officer was able to give also very cogent evidence and, given that I understand Dr Parry would revert to Ms Ferguson in relation to a number of questions asked of him, we thought it advisable - and there's no objection to this procedure - that they give evidence simultaneously, if that meets with your approval.

COMMISSIONER: It seems expedient to me.

MS McMILLAN: Yes, all right, thank you.

**PARRY, RHYS** sworn:

ASSOCIATE: For recording purposes, please state your full name, your occupation and your business address.

DR PARRY: My name is Rhys David Parry. I'm a director of paediatrics at North West Hospital Health Service and I'm working at the Mount Isa Hospital.

ASSOCIATE: Please be seated.

DR PARRY: Thank you.

COMMISSIONER: Welcome, doctor.

**FERGUSON, CHRISTINE PATRICIA** sworn:

ASSOCIATE: For recording purposes, please state your full name, your occupation and your business address.

MS FERGUSON: My name is Christine Patricia Ferguson. I'm a clinical nurse consultant for the Mount Isa Hospital.

ASSOCIATE: Please be seated.

COMMISSIONER: Ms Ferguson, welcome. Welcome, doctor.

MS McMILLAN: Thank you.

Dr Parry, have you prepared a statement in relation to this inquiry which was declared on 5 October this year?

DR PARRY: Yes, I have.

MS McMILLAN: Would you have a look at this document being

handed to you? Is that a copy of your statement?

DR PARRY: Yes, it is.

MS McMILLAN: Are the contents true and correct?

DR PARRY: Yes.

MS McMILLAN: All right, thank you. I tender that.

COMMISSIONER: Dr Parry's statement will be exhibit 86 and it will be published in its current form.

ADMITTED AND MARKED: "EXHIBIT 86"

MS McMILLAN: Yes, thank you.

Dr Parry and Ms Ferguson, have you jointly prepared a document which you have given to me this morning entitled "Information for Consideration of Inclusion in the Queensland Health Portfolio to the Queensland Child Protection Commission of Inquiry"?

MS FERGUSON: Yes, we have.

DR PARRY: Yes.

MS McMILLAN: All right. Can I show you this document? Is that a signed copy signed by both of you of that statement?

MS FERGUSON: Yes, it is.

DR PARRY: Yes.

MS McMILLAN: All right, thank you. I tender that as well.

There's no reason that can't be published, is there?

MS FERGUSON: No.

DR PARRY: I'm not sure if that was the final version. There may be a slightly edited version which we could tender.

MS McMILLAN: You have got no objection to - - -

MR SELFRIDGE: There's no objection to the tender of that document.

DR PARRY: The content is basically the same.

MS McMILLAN: Yes, okay, thank you.

COMMISSIONER: All right. The joint statement dated 16 October 2012 will be exhibit 87 and it will be published.

ADMITTED AND MARKED: "EXHIBIT 87"

MS McMILLAN: Can I just start by having you both indicate your experience and qualifications? Dr Parry, you have indicated you're the director of paediatrics North West Hospital and Health Service. You were appointed to this position in 2011.

DR PARRY: Yes.

MS McMILLAN: And prior to this appointment you worked as a locum paediatrician at the Royal Children's Hospital in 2010 - - -

DR PARRY: Yes.

MS McMILLAN: - - in general paediatrics and child protection rehabilitation medicine. Your training in paediatrics took place between 1993 to 2010 in Victoria, Tasmania, Northern Territory, Western Australia and Queensland.

DR PARRY: That's correct.

MS McMILLAN: Pretty much covered the whole country by the sound of it.

DR PARRY: Almost.

MS McMILLAN: Almost. Your qualifications include an MBBS 1992 and an FRACP 2010 and that's the College of Paediatricians, isn't it?

DR PARRY: I think Royal Australasian College of Physicians.

MS McMILLAN: Physicians, right, thank you. Now, Ms Ferguson, can I ask you to, please, provide your qualifications and relevant work experience together with how long you've been in your current position?

MS FERGUSON: I'm a registered nurse. I gained my general nursing certificate in 1990. I've had various nursing roles in Mount Isa Hospital and for many years I worked in occupational health. I have been the child protection liaison officer for the Mount Isa Hospital and Health Services Board since August 2005.

MS McMILLAN: Okay, thank you. Just in terms of for each of you - Dr Parry, you are the child protection adviser,

you've indicated, and, as I understand your statement at paragraph 7, you work closely with and rely heavily on the assistance of the child protection liaison officer who is Ms Ferguson. Is that correct?

DR PARRY: That's correct.

MS McMILLAN: All right; and is it the case that - prior to your taking up the position, did Ms Ferguson have much in the way of assistance in her role as the liaison officer?

DR PARRY: I might let her answer that.

MS FERGUSON: I did when I initially started the role for several years. We had a director of paediatrics and then on his resignation there was a period of time, possibly a year and a half, two years, where there was no director, yes, so I had little assistance.

MS McMILLAN: All right, thank you. Now, can I take you to your joint statement? You say from a child health viewpoint major child protection issues you commonly face include excessive parental alcohol consumption resulting in high rates of FASD, foetal alcohol syndrome, domestic violence and neglect. Now, can I ask you, firstly - and perhaps you both may want to comment on that - how prevalent is it in your experience in this area, the occurrence of children being born with indicia of that foetal alcohol syndrome?

DR PARRY: I think it's a huge problem in the district, more than I've experienced in other districts.

MS McMILLAN: Yes.

COMMISSIONER: Can we just for the record explain what it is?

MS McMILLAN: I was about to ask.

COMMISSIONER: Right.

MS McMILLAN: What are the indicia, would you say, of foetal alcohol syndrome? I'm right in understanding they're both physical often and also indicate or manifest themselves in both intellectual and emotional developmental issues. Is that correct?

DR PARRY: Yes, that's exactly right.

MS McMILLAN: All right. Can you perhaps go from there into more specifics?

DR PARRY: We talk about foetal alcohol spectrum disorder,

recognising that there's a huge range of presentations. Foetal alcohol syndrome really refers to children who have the recognisable facial and physical manifestations, but there are more subtle cases where the physical features are much more subtle, if present at all, but these children are still at risk of developmental and learning problems of a significant nature.

COMMISSIONER: What are the physical features?

DR PARRY: The physical features - there are facial features such as a thin upper lip or a featureless and thin upper lip. Sometimes they have a microcephaly or a small head circumference. Sometimes their ears are a little bit abnormal, but it's a difficult appearance to be certain of clinically. I think clinicians often argue in particular cases whether or not it's present and in different people groups or ethnic groups it can be more difficult in some than in others. So I don't think any more we can be - I mean, there is no diagnostic test for it. It's difficult on history to obtain accurate information about maternal alcohol consumption during pregnancy so often it's a presumed diagnosis.

COMMISSIONER: What are the subtle symptoms that you use to make the presumptive diagnosis?

DR PARRY: Sometimes they're not subtle. I think if a child doesn't come to our attention, they may carry their subtle features through life and it doesn't necessary cause a problem with their health. And it may not cause a significant enough problem with development or learning to actually come to anyone's attention. But I think it's probably safe to say that the greater the degree of alcohol exposure during the pregnancy, the greater the likelihood of that child presenting later in childhood with developmental issues and then evidence of learning problems. And so this is specific learning problems with literacy and numeracy, IQ, things like that, but also associated with other features such as poor attention and increased activity levels; the - if you like - the ADHD or attention deficit hyperactivity-type symptoms. They're common in this disorder.

COMMISSIONER: So in a child protection setting specifically what's the relevance of the disorder for parents and children in the system?

DR PARRY: I think in children whose mothers have had a significant alcohol intake during pregnancy it's usually safe to say that the alcohol consumption is not confined to the mother. Probably often alcohol consumption is present to a problematic degree in the extended family. I think alcohol consumption doesn't exist on its own; it often, as we all know, exists in conjunction with other social problems. And so these children who are born with these problems are born into families that have problems.

COMMISSIONER: So the incidence of the disorder is what, a barometer of the health of the family generally - the functioning health?

DR PARRY: I think that's fair to say. I mean, these are the children who because of their developmental problems are more likely to require a consistent nurturing environment, and this is often - as we all know, the presence of excessive alcohol consumption in a family often is associated with domestic violence, crime, things like that. So these are children who are unlikely to be raised in the kind of nurturing environment which is so important for kids with developmental and learning problems.

COMMISSIONER: What about the meeting of their needs? What extra needs do they have because they've got this disorder, over their lifetime?

DR PARRY: Well, I think children with developmental learning, attention or behaviour problems need more expert management in terms of upbringing, boundary-setting, all of those things. And I think there's plenty of evidence that children that don't get an adequate level of input in their early years in terms of the provision of all the basics of life - physical, emotional needs met - are more likely to struggle at each developmental level in life. I think those problems compound as the child goes through life.

COMMISSIONER: Okay. So if we have a child with the disorder; if we're likely to have a family that's dysfunctional, that's unlikely to meet even their basic needs; and on top of that we have a child who has higher than normal needs and the only way you would meet them is with intensive therapy, which is unlikely to be provided by the family of birth. Is that a fair summary of what you said?

DR PARRY: Yes, I think that's right. And I think in our district it's also important to recognise that once we identify that these children and families need this increased level of support in a remote location such as

ours, expertise to assist these families is scarce and known to be scarce, with a high turnover of professional staff available, which leads to lack of continuity and poor communication across different agencies that are trying to help. So I think the odds are stacked against these children in many ways.

COMMISSIONER: So when they come into the child care system it's going to - as substitute parent the system has to somehow meet these needs that have not been met by their family of origin, which will - what, over time do they increase, the needs; or can - are they going to have needs for their life, or are there remedies for them to be functioning? I mean, the object of the system is to take a child in care from the moment of their need of protection and ensure that when they exit the system they're functioning, socialised adults.

DR PARRY: Mm.

COMMISSIONER: Can you do that as a substitute parent with somebody who suffers this disorder?

DR PARRY: I think it's difficult because I think if you are born with foetal alcohol spectrum disorder I think it's fair to say that that individual will have some limitation of potential in their life in terms of intellect, learning potential, social skills, all of those things. So once you have a child that is born with limited potential and then suffers the compounding effects of suboptimal environment and upbringing, things are likely to get worse with time rather than better. I think it's difficult to - because even with the best input during childhood, because the child has reduced potential in those sort of basic areas, it's unrealistic to expect that through - even with the optimal therapy and input you're going to normalise this child and produce a normally-functioning adult with intellect and social and vocational abilities in the normal range. So I think you're dealing with someone that has a reduced potential across the board, and due to the then compounding effects of suboptimal environment and upbringing as this child goes through life missing out on the basics that are required to be achieved at each step, as the child gets older the problems are going to become greater. So I think initially you'll have a child or a baby - a toddler who has developmental delay in terms of motor skills, fine motor skills, social skills, language skills; then that child will get to school age not having acquired those basics, it will be very hard for the teachers to build on those basics because the child is already behind, so the child will need extra level of input, not just for the learning, for the language, for the literacy and numeracy, but for the managing behaviour, the reduced attention span, the propensity for not just hyperactivity but aggressive behaviour; all of those

things. And then compounding that in our population is a whole range of health problems that most children have that we commonly see; chronic middle ear infection, which affects their hearing and therefore their speech and language development, and a whole range of other health problems that contribute to making growing up - for the kids in our district there's just a whole host of obstacles that they need to overcome.

You can imagine these kids that get to school and they're already behind and then they struggle through school and have all these - not just academic, but behaviour problems. They have a high school failure rate, a drop-out rate, and we find that once they drop out of school and the families, for whatever reason, are not capable of getting them back on track, often the kids in our district are just sort of roaming around using substances, such as volatile substances, and it's just really apparent these kids, they've fallen off the tracks and they're not doing well in life in any aspect of life; then they're at risk of early sexual activity, early pregnancy, sexually transmitted infections. All these things unfortunately seem to happen together to a large number of very young people.

COMMISSIONER: What I'm hearing out of that is while they are likely to be in need of protection certainly at some point - probably during pregnancy was when their need of protection was at its highest, but after birth they're not likely to be in a family that can meet their overall needs, but their need of protection is probably not their highest need. It's something else that they need as well as being protected. They need something more than both their family and any system can give them to bring them to adulthood as highly functional, or functional enough, and socialised. How do we as a society meet the needs of these children who are born with this disorder? If their parents can't do it - won't do it or don't do it - how does society provide what it can? Over their lifetime, I mean, because the child protection system works until they're 18. It's an arbitrary cover. Now, on their eve of their 18th birthday, their orders will end, but obviously their needs don't, so they'll go into some other system unless they can go home or they'll go into no system. The child protection system is only going to ever be part of the solution, isn't it?

DR PARRY: It's a complicated question. I wish I had the answers. I think that the importance of the child protection system for these children centres around minimising risk and stepping in hopefully before a child suffers harm. When we're talking about exposure to toxins like alcohol, how do you prevent that? I mean, I think in health - well, in life we talk about prevention is better than cure and I think in recent times we've put in place all kinds of health promotion strategies which have been effective in some areas of society, but for whatever reason it doesn't seem to be as effective in our district, in our remote communities. I think we all know there are all kinds of cultural issues that make it difficult for our Aboriginal people to trust and take on board the package of health care that we provide in this country. It's difficult for the child protection system to really be involved in health promotion and preventative medicine, because I think the child protection system needs to be there to respond once harm or risk of harm is identified;

so I think the child protection system is to respond once these risks and harms have been identified.

COMMISSIONER: But at the moment it has to wait until birth to intervene. That is, that system.

DR PARRY: At the moment, yes.

COMMISSIONER: Do you see any benefit it altering that so that the child protection system can act preventatively before birth? That is, between conception and birth.

DR PARRY: I'm wondering how that could be done.

COMMISSIONER: So am I, but obviously that's where the highest protected need is at that point.

DR PARRY: That's where it all begins, isn't it?

COMMISSIONER: Yes.

DR PARRY: During pregnancy. I guess when you have young mothers who are growing up and living in communities where there is a high degree of social dysfunction and domestic violence, a lot of these pregnancies are unwanted, and the proportion of mothers who are probably sub-optimally motivated in terms of making sure everything is just right in their pregnancy, unfortunately that's not what we see.

COMMISSIONER: And would be challenged to rear even a healthy child.

DR PARRY: I think that's correct. How do you motivate these mums to stay off alcohol and cigarettes, and so forth? It's a huge question.

MS McMILLAN: In the foetal alcohol figure on page 1, you say for the year 1 July 2011 to 20 June 2012, there were 27 reports of reasonable suspicion lodged with Child Safety Services for women drinking when pregnant. Now, can I just ask you, would those reports usually emanate from within your health service?

MS FERGUSON: Yes. They do, yes.

MS McMILLAN: All right. You note that it's not mandatory, so I take it would one infer from that that was under-reporting, if you like?

MS FERGUSON: Absolutely.

MS McMILLAN: I'm not being critical by asking that. I just mean that the figure is maybe higher than that because it's not mandatory.

MS FERGUSON: Absolutely, yes.

MS McMILLAN: All right. And would you, Ms Ferguson, have a greater awareness, shall I say, of the impact of drinking when pregnant than perhaps some other health workers? For instance, I take it you would probably be more ready to refer that on Child Safety if you were concerned about that than perhaps maybe other health workers.

MS FERGUSON: Yes. It's pretty standard that when a women presents to (indistinct) she's under the influence and it's deemed that she's pregnant, it's standard for a referral to go into ADOTS, which is our alcohol, tobacco and other drugs - - -

MS McMILLAN: Well, I was going to ask what do you do about referrals to other agencies that might be able to assist?

MS FERGUSON: Our basis referral is to ADOTS and they're available in the communities, as well. I think most places have a worker. Normanton, Wellington, Doomadgee.

MS McMILLAN: And how effective do you think that is?

MS FERGUSON: Well, we can't force a woman to go to the sessions.

MS McMILLAN: No, of course.

MS FERGUSON: It's up to her whether or not she uptakes.

MS McMILLAN: And I suppose that for many women, the idea that drinking while pregnant would affect the health of your baby, if it's an unwanted pregnancy perhaps that's not much of an inducement not to drink. What do you think?

DR PARRY: I think this is a huge question. I think in medicine we're all aware that it's very difficult to change people's lifestyles. We can think of anyone - we can think of cigarette smoking, we can think of weight problems. These things are related to lifestyle choices that people are at liberty to make. Within medicine, we're always talking about ways we can approach these problems to form a therapeutic alliance with patients and families to discuss these things. What I think we're starting to realise is that the traditional paternalistic approach is that this is bad for you and you really shouldn't do this. This isn't good for your baby. Those kinds of messages just aren't that effective.

So we now talk about more modern concepts like motivational interviewing where you help a patient understand or to take ownership, I guess, of their own problem and to problem solve for themselves ways that they can improve their lifestyle and make better choices and it's about staying on board with that person while they're on that journey. Now, I think when we're talking about health services which are largely run by non-Aboriginal people in a situation like this trying to support a young Aboriginal mother to make better choices for herself and her baby, it's apparent that there's a whole host of difficulties in that interaction, cultural considerations, and it's really difficult to do well. It's really difficult to be effective in that and I think that the people who are best at it and are most highly trained are the people that probably end up in these services like ATODS, but it's difficult and it would be interesting to hear from the ATODS people on this question.

COMMISSIONER: Presumably they have siblings who have got the same disorder. If I am a child with the disorder in a family of the mother, unless she changes her - makes different choices, my brothers and sisters are going to have the same disorder. Is that a trend?

DR PARRY: I think you'd assume that.

MS McMILLAN: Common.

DR PARRY: Yes, it would be hard to imagine that one child would be affected and one not, although I think we do know that there are factors such as post-natal depression or social, you know, situations at the time - domestic violence might be happening in one pregnancy but not the next. So it is possible, I guess, but I think the rule would be that most siblings - you'd expect most siblings in a family to be affected in a similar way.

COMMISSIONER: These are always difficult. Difficult problems always pose different questions and sometimes the answers will be controversial and even then they may not achieve their objective, but what's your position on the type of intervention, assuming that the best time for intervention, protective intervention, is before birth and given that we live in a liberal democracy that allows people to make choices for themselves, but the state does intervene on occasion even to protect themselves from making choices that are harmful to themselves and certainly when their choices not only impact on them but on others and in particular vulnerable children? Is there an argument for a more coercive intervention pre-birth for protective purposes than simply leaving it up to a mother who's, as you say, suboptimal in the choices she makes for herself and clearly for her child?

DR PARRY: I guess I have difficulty with the word

"coercion". I think we recognise that when we identify that there's risk for a baby or a child in the care of its biological parents, by intervening and placing that child in another care - an alternative care arrangement doesn't necessarily guarantee a good outcome for that child. We know that removing a baby from biological parents and placing them in foster care creates a whole new set of problems.

COMMISSIONER: No, I wasn't talking about that. It's too late then anyway. The harm is already done. The child has got the disorder.

DR PARRY: Right, okay. So are you talking about - - -

COMMISSIONER: Removing the mother from the environment that creates the risk for the child.

DR PARRY: Yes, or removing the other risk factors such as supply of alcohol and prohibition - - -

COMMISSIONER: It's probably easier to remove a person than alter an entrenched environment.

DR PARRY: Yes.

COMMISSIONER: There would be a lot of human rights issues around that, but the most basic human right we have, I suppose, is safety and security and if we're in utero and we can't enforce those rights, there's not much point having it. So is there anything anywhere in the world or in the literature that grapples with this problem from the point of view of removing the environment or the mother from the environment that's toxic to the unborn child?

DR PARRY: Well, no, I'm not aware of any studies, but I wonder whether we're talking about - I mean, what we do in the district is we bring mums from the remote communities to Mount Isa. Is it about 36 weeks of gestation?

MS FERGUSON: 36.

DR PARRY: So they will deliver in Mount Isa and not out in the communities. That's the rule. Occasionally babies break those rules and get born before 36 weeks in the middle of nowhere, but we find that that's difficult for our mums from the remote communities. They don't like being away from home for several weeks. Often they do have some support, extended family, in Mount Isa but often it's - they're still unhappy and homesick, very keen to get back home, so I don't know - you know, just following on from your idea about maybe bringing a mum to - well, away from her community presumably to Mount Isa earlier in the pregnancy - I don't see that that's a solution necessarily because Mount Isa itself - there's a lot of alcohol

available.

COMMISSIONER: Yes.

DR PARRY: It would be very, very hard to achieve this. I think it would need to be an intervention that involved extended family and community elders and have all of those supports in place, but I think you're right. I think in order to break this cycle - we've got kids that are exposed to alcohol before birth which limits their potential in life. They're much more likely to then be getting pregnant early, then having kids of their own with - so foetal alcohol syndrome breeds further foetal alcohol syndrome and until that cycle is broken it's hard to be optimistic about the future for our people.

COMMISSIONER: On one view the harm is already done before birth. Before the system can intervene the harm is already done. All the system can do then is palliative care, but this is the child protection system which is based on a need of protection, not high-end other needs. So we're using a protection system to meet other needs that it's not built for meeting.

DR PARRY: Yes, I agree. I think there is a gap for our unborn babies at the moment. There are some measures in the system at present. It isn't mandatory to report concerns about an unborn baby. I wonder if that needs to be looked at because you're right. That's when the problem starts and that's when we need to identify and put - - -

COMMISSIONER: Let me run this past you: I'm hearing a lot from communities that they have been sort of cut out of the picture a bit and that primary responsibility of the parents, if it's lacking, is then very rapidly assumed by the state and the community's responsibility for the family and the children is being underutilised. Now, that seems to me to be a fair enough argument provided you have got capacity within the community to actually fulfil whatever responsibility it has. So once you identify the responsibility, you have to look for capacity to fulfil, but assuming that and assuming that the community does have the capacity, is a willing and able substitute parent itself, if you like, there is an argument - and mandatory reporting has got a bad name often because of what's reported and by whom it's reported and what's done with it because there's a tendency to over-report for under-reporting. However, if you bring it down to making mandatory reporting fit for purpose, you might argue that it is the community's responsibility; the elders, the aunties and the grandmothers in the community who have got an obligation to report what they see.

It's a question of who they have an obligation to report to and whether they can do anything about it at a local level, which is the ideal place to be doing something about it. So who would be the mandatory reporter of suspected abuse or neglect of an unborn child?

DR PARRY: I guess in a remote community you would hope that pregnant mothers have some link with their local health service, so I guess it's the local health providers. In some of our remote communities, in the smaller communities there is no full-time doctor; there's often one full-time nurse.

COMMISSIONER: Midwives? Are they midwives in the communities?

MS FERGUSON: A visiting midwife.

DR PARRY: From Mount Isa, yes.

COMMISSIONER: Okay, but at the moment the health professionals don't have the report suspected foetal alcohol disorders?

MS FERGUSON: They're not mandated to report in utero problems.

COMMISSIONER: You aren't?

MS FERGUSON: No. But what is the baby becomes a legal entity in its own right, then there mandated.

COMMISSIONER: Yes. And that's just because of the concept of person, presumably.

MS FERGUSON: Presumably.

COMMISSIONER: All right. How long have you got after conception to prevent the disorder developing? Does it take six months, or if you stop drinking after three months is it - - -

DR PARRY: No, I would think it is the first trimester that most of the damage is done, so early part of pregnancy. I would have thought that is usually the case.

COMMISSIONER: So if you had a therapeutic confinement model for the first trimester, would that be beneficial to the child? Call it voluntary at the moment.

DR PARRY: Put the mum into some kind of voluntary custody? Is that - - -

COMMISSIONER: I'm not sure how you do it. Even thinking out loud about those things is problematic. But if the

mother would voluntarily self-refer and place herself out of alcohol's way for the first trimester, would that help?

DR PARRY: Maybe. Some of our communities have a - what the centres called?

MS FERGUSON: (indistinct)

DR PARRY: No, for the kids.

MS FERGUSON: Safe house.

DR PARRY: Safe house. There's a safe house in Doomadgee and there's one in Mornington Island. Maybe there could be a safe house for pregnant mums. I mean, the problem is that sometimes the pregnancy is concealed or I think in these probably high risk cases we don't know that - sometimes the mum doesn't know she is pregnant until - - -

COMMISSIONER: And I'm assuming in a lot of cases it is a child giving birth to a child.

DR PARRY: Yes, that's absolutely right.

COMMISSIONER: So we therapeutically confine our mentally ill, but we don't seem to take that extra step.

DR PARRY: Yes. I think confinement is - - -

COMMISSIONER: One of those words that - - -

DR PARRY: It's a difficult work, isn't it? And I just wonder whether what we need to be doing is swinging in with effective and meaningful supports for pregnant mums, and that's in terms of swinging in with extended family and community Elders as well is a health system working together to protect these mums and provide that safe environment, I guess.

COMMISSIONER: How would you do that in, say, Aurukun or Doomadgee or any one of the 20 communities that we've got?

DR PARRY: I'd need to enlist local support on a massive scale. It would need to be something that really changes the way the community functions; get the grandparents and the Elders back on board, give them a role in all of this. I think that's part of the problem, is that in many of the communities that I've seen the grandparents, the older ones who - I mean, we've got some fantastic grandparents into our communities and it's wonderful to meet them sometimes. They're actually very good at engaging with non-Aboriginal people, with health professionals, et cetera. But unfortunately there are some grandparents who you can see they have an alcohol problem themselves, and I think the reasons for the are very complex but part of that is that I

think - I'm not an anthropologist and I don't want to be out of line, but our Aboriginal communities seem to have lost a lot of hope and their traditional ways of functioning of the extended family and respect for Elders. I think that's what's happening or what has happened in recent decades across the country.

COMMISSIONER: So the community has lost the moral authority to intervene with its own population - - -

DR PARRY: Yes.

COMMISSIONER: - - - to enforce their own normative standards.

DR PARRY: Yes.

COMMISSIONER: Which to them, culturally, are acceptable. Do you know of a community that would be capable? What I'm curious about is this: that the community could have already done it. A community could have already assumed responsibility for this if it was capable of it. So because the community hasn't addressed this problem in any structured way, does that mean there is no community out there capable of doing it will or willing to do it?

DR PARRY: I can't think of a good example in our district. What's been happening in Fitzroy Crossing, in the Kimberley in Western Australia is the best example I can think of where a community has reinvented itself through the crucial involvement of local Elders who have, in the face of opposition, successfully limited availability of alcohol - or at least full strength alcohol - in the town, and it actually has - according to what we're hearing - successfully turned the community around. Not only is alcohol less available, there's much less violence, there's much less crime. The emergency department is a whole lot less busy. I don't know of - I mean, this is what I'm told and that was successful due to an effective collaboration between health professionals that came in with the right attitudes and the right approach, working together with key Aboriginal Elders, and that's been successful. I have thought about is that something we can achieve in Mount Isa and in our district. I think it's difficult; Mount Isa is a melting pot of so many different people and, you know, with the mining community, who have an expectation that alcohol will be freely available. Unfortunately, that means that alcohol freely available to our Aboriginal people and it's not doing them any good. But even in our remote communities such as Mornington Island, which is supposed to be a dry community, there is availability of alcohol there; that's what I'm told, anyway. I'm not an expert, but I'm told that they make their own out there, and that causes all of the problems associated with alcohol consumption that we

see in other communities. So just by having a dry community is not enough, you need a real effective change in the attitude of the entire community.

COMMISSIONER: Do you see a role for the Family Responsibilities Commissioner? You know, the welfare reforms. You see, they play a role in the communities where they keep an eye on school attendance and they have meetings and it's aimed at empowering the community.

DR PARRY: Yes.

COMMISSIONER: Could model like that be adapted or modified to play a role in the health as well as the education of the children?

DR PARRY: Maybe I'm not too familiar with that. Do they have Aboriginal members as - - -

COMMISSIONER: Yes, they do.

DR PARRY: They do. I think that's the key - I think.

COMMISSIONER: Often they're council members as well as commissioners.

MS McMILLAN: One of the issues also difficult with elders is a lot of them are doing primary parenting themselves, aren't they, of very young children in these communities; so if they're motivated and willing in terms of prevention strategies, a lot of their time arguably is taken up with parenting another generation of very young children often, because the mother's aren't willing or able, for instance, to parent them primarily themselves. Is that your experience?

DR PARRY: Yes, I think - it's hard to give a simple answer. I think even in the problematic communities in our district there are families that do well. You know, there are families that stand out as actually doing well and if there is a mum who's not doing well, who's in a domestically violent relationship, there's alcohol or other substances being used, sometimes there is a grandmother figure or aunties that can step in and assume responsibility for the children and at the same time they can continue to be involved with - - -

MS McMILLAN: Parenting issues.

DR PARRY: - - - bigger issues in the community and function as elders in a wider scale, other than just looking after babies.

MS McMILLAN: Yes.

DR PARRY: We do see that. We do see some examples, but, you know, we just need to be more part of the culture, I think. When a young mum isn't doing well, we don't want to sort of see that all the alternatives for swinging in and supporting that mother are actually not doing well themselves. It would be nice if this was the exception rather than the rule, but it seems to be more common.

MS McMILLAN: Can I just ask you - you've made a lot of reference to the spectrum disorder in Indigenous communities. Is it more prevalent in Indigenous communities than in non-Indigenous populations, I should say, within your health area?

DR PARRY: Without a doubt.

MS McMILLAN: How many mothers anecdotally are you able to say engage with health in terms of strategies to assist with understanding and also preventing them abusing alcohol? Tina, you may - - -

MS FERGUSON: I would say not many.

MS McMILLAN: And have you got some insights as to why?

MS FERGUSON: Sometimes I think there are difficulties, particularly if they're still living in the communities. There are all those difficulties about they may not keep appointments - they don't keep a calendar like we do. When clinicians go to the clinics, they engage the services of health workers to try and locate the people that they're looking for, and that's not always successful either, so therefore they're not engaging on that trip and they might not be back for another month. Things like that, or it might be that they have - you know, it's clearly documented that they have been informed of the risk to the unborn, but they're happy to accept that risk. That's documented frequently, as well.

MS McMILLAN: All right. Dr Parry, in your statement you talk about services that visit schools. Are you aware of any health programs being provided to schools to educate teenagers about issues such as foetal alcohol spectrum?

DR PARRY: I'm not.

MS McMILLAN: Okay.

DR PARRY: But they could exist, yes. I haven't heard of any.

MS McMILLAN: If they do, you're not aware of them?

DR PARRY: I mean, I'm sure the schools have as part of their curriculum - - -

MS McMILLAN: All right.

DR PARRY: - - - education regarding life skills, but - it's an interesting question.

MS McMILLAN: All right. Now, in terms of the volatile substance misuse, again you'd say that's one of the other major child protection issues, both of you, in your document. Now, in terms of that would you give us a definition of what is termed volatile substance misuse? What substances are involved and what are the effects?

DR PARRY: Okay. Yes, okay. So I think the main substances we're talking about are petrol, paint, glue. I

guess they're the ones that we usually see. Aerosols are really popular actually; aerosol cans. I guess the definition is any use of these volatile substances in order to address an underlying difficulty. I think there's more than one reason that young people misuse volatile substances. Sometimes it's just peer pressure and it's maybe to try and achieve a bit of a high. Sometimes it's a form of escapism. Apparently I've heard that it reduces hunger, so if you're not getting the basics in terms of food, nurturing, you might turn to these sort of substances to escape your plight.

MS McMILLAN: What are effects of volatile substance misuse? What are the short-term effects?

DR PARRY: Well, it's toxic to the lungs, so these kids often come into emergency with cough, wheeze, breathing difficulty. There is obviously an intoxicating effect. Sometimes they're very drowsy. It's hard to actually wake them up and have a conversation. Sometimes there are behavioural effects, as well, so it may result in aggressive behaviour, risk-taking behaviour. Sometimes mood difficulties and I've seen kids become suicidal while affected by these substances.

MS McMILLAN: In long-term, can it also include cardiac issues?

DR PARRY: Yes. I would have thought, yes, that would be one of the short-term effects actually.

MS McMILLAN: The liver?

DR PARRY: Liver. Yes, I'm sure there's liver toxicity, but brain toxicity is the main one, I think.

MS McMILLAN: What about loss of hearing?

DR PARRY: It's possible. I'm not aware of that.

MS McMILLAN: All right. Now, in terms then of, you say - impacts in terms of behavioural matters, you say it can result in aggression, suicidal ideation. Does it also result in obviously them becoming involved with criminal activities; risk-taking sort of behaviours?

DR PARRY: Definitely, yes.

MS McMILLAN: Yes, all right. Now, Ms Ferguson, you may be able to answer this. We heard evidence from Senior Sergeant Harvey yesterday, who said that - she was here previously for some years and then just returned in the last couple of years - she noticed a pattern of older children who are involved in perhaps illegal activities but also, as I understood, substance misuse and that pattern

being played out in a younger generation. What do you say about that?

MS FERGUSON: I totally agree. I've nursed here since 1992 and the children I nursed as babies back then are now parents of several children, and I see history repeating itself with these children. In my personal opinion, I think the problem in our society has got a lot worse over the 20 years. You see a lot more issues with behavioural difficulties, teenagers disconnected without willing and able carers.

MS McMILLAN: Is this Indigenous and non-Indigenous young people?

MS FERGUSON: I would say predominantly Indigenous, but, yes, increasingly also with non-Indigenous.

COMMISSIONER: And what is driving that, do you think?

MS FERGUSON: I think that - you know, I'm a firm believer in early interventions and I am very upset with the amount of drinking mothers; the foetal alcohol problems. I think that it's all very well when we have these little babies that are manageable and cute, and they might get taken into care if the parent is not willing or able or that there's risk, and then as they get older there are behavioural problems and they're hard to manage and hard to place, and then all of a sudden they're not attached to a parent any more, foster carers can't keep them, they break down placements and then these children are just left to fend for themselves. Although child safety try very hard to put in services to support them to get them back to - whatever resources we have to try and get these children back on track, it's really uptaken and we have a lot of failure with trying to help these children.

COMMISSIONER: Fighting a losing battle.

MS FERGUSON: Fighting a losing battle.

MS McMILLAN: In terms of the sexually transmitted infections, would I be right in asking you both that this seems to be a very prevalent feature of what you see in the health sector here?

DR PARRY: Yes, very much.

MS McMILLAN: Yes, and you've in fact prepared some statistics, I note, on page 2 in terms of the notification. I should ask you - chlamydia, gonorrhoea and congenital syphilis are all notifiable conditions under the Health Act, aren't they, so you have to notify if that's the case. Now, just looking at those figures, at first blush it's apparent that they're much higher in the females that you've indicated here. These are ones that are less than 18 years old. In fact they're almost three times the number of males, aren't they?

DR PARRY: Yes.

MS McMILLAN: Can I ask you why it is you think that it's so much higher with females than males?

DR PARRY: I think the females are more likely to come to our attention. I think that's the issue.

MS McMILLAN: Would they also because they might also be having children themselves?

DR PARRY: Absolutely, yes, so this may be part of antenatal care, but, yes, I think we know that males across all sectors of society are less likely to seek medical care and I think this goes for young people, especially as I think there are lots of males out there that are undiagnosed.

MS McMILLAN: All right. In terms of mapping, are any of these - again can I ask you, what are the rates like in terms of indigenous, non-indigenous? Is it more prevalent in one group of young people than the other?

DR PARRY: I'd like, you know, to check with public health to see if they have those statistics, but I suspect again the rates are higher in the Aboriginal population and that's what the literature suggests, I think, and probably across the country, but we know that there's been a syphilis outbreak in Doomadgee in the last few months. So this has been recognised as a major public health problem so there's been a lot of effort put into raising awareness and trying to deal with that problem.

MS McMILLAN: In terms of impacts on - a number of these conditions, is it correct, are transmitted, if not through the placenta, also at the time of birth, is that correct, to children of people who have sexually transmitted diseases?

DR PARRY: Yes, we do see it. We do see what we call vertical transmission of - syphilis in particular is a particular problem, but, yes, it goes for chlamydia and gonorrhoea as well.

MS McMILLAN: All right; and in terms then for care of those babies I take it they need specific care, do they?

DR PARRY: Yes. So a baby with congenital syphilis, so with a mother with syphilis that was inadequately treated - yes, the baby then requires 10 days of intravenous penicillin treatment as well as some other unpleasant investigations like - - -

MS McMILLAN: Lumbar punctures.

DR PARRY: A lumbar puncture is often required.

MS McMILLAN: Which is no doubt very painful for the baby.

DR PARRY: It is.

MS McMILLAN: Is it correct that for the person who actually has the sexually transmitted disease there is often a course of injections that's required of antibiotics to treat that?

DR PARRY: Yes.

MS McMILLAN: I understand that they are reasonably painful, are they?

DR PARRY: Yes, all injections are.

MS McMILLAN: Have you got any data on how much people follow through with that course of injections?

DR PARRY: Yes, we do hear of cases through sexual health from time to time when people decline the treatment; yes. This is adults or adolescents, yes.

MS McMILLAN: Now, in terms of impacts on babies longer term if they vertically have it transmitted to them, what are their longer-term impacts on them?

DR PARRY: Well, I mean, congenital syphilis historically was a terrible illness and caused all kinds of complications affecting multiple organ systems but particularly the brain. We don't see those severe cases any more because we're better at - I think we're better at diagnosing it and treating than we were back in the dark ages.

MS McMILLAN: What about preventative strategies? Given you've obviously provided figures of under 18-year-olds, are you aware, perhaps both of you, in terms of what secondary services are offered to young people in terms of sex education and also generally services that can address this issue?

DR PARRY: There's a fairly widespread program, health promotion, which I think for the syphilis outbreak is centred around condoms or condom use.

MS McMILLAN: What about reaching out into communities?

DR PARRY: Yes, there are lots of posters up in the communities. These are for people that actually - - -

MS FERGUSON: Sexual health - I think sexual health do routine visits out to the community but are based in Mount Isa.

DR PARRY: Yes.

MS McMILLAN: Okay. Now, I want to ask you just about some availability of secondary services generally. Now, we know, for instance, that there is no program like Evolve available, is there, in this district and one of the things that's become apparent in this area is that 80 per cent of substantiations of notifications are as a result of emotional harm or risk of emotional harm? Now, clearly one would think something like an Evolve service would be very beneficial for children and young people who have particularly emotional harm perpetrated upon them. Correct?

DR PARRY: Yes.

MS McMILLAN: Do you have anything of the like, firstly, available in Mount Isa and then particularly out in the communities?

DR PARRY: Yes, we often wish we had an Evolve service. Does everyone know what Evolve is?

MS McMILLAN: Perhaps give us your understanding.

DR PARRY: Yes, so it's a mental health assessment and therapy program that's offered to children in care referred - I think they need to be referred by Child Safety and I think specifically to work with children in care who clearly have been harmed or there's been substantiation of harm. They're in need of protection and most of these kids will have suffered harm, often multiple kinds of harm. Emotional harm I think is - it's an interesting area because I think it's - on its own it's difficult to measure but it tends to co-exist with other forms of harm so physical harm, sexual harm, neglect. There's almost always an association with emotional harm and that combination causes difficulties for children in all kinds of areas, as we were discussing earlier. So a program like Evolve is - it recognises the fact that these children who have not only been harmed and traumatised in a significant way and have really significant attachment difficulties due to the

absence of a willing and able carer in those crucial early years. Evolve is a really important - that kind of therapy is really important for these children. So for children in our district - and we know that there's a lot of them that are placed in care here and have suffered trauma, have attachment difficulties. Because they're placed here in Mount Isa and often with - especially with the Aboriginal children there's a requirement to try and place these children on their land so basically to remain in their community or at least in the district rather than ship them off to a care arrangement on the coast, and you can see the argument working both ways that we do want to keep children, you know, where their homeland is, especially if there's a possibility of reunification in the future but, on the other hand, they miss out on the specialist and expert services like Evolve that they would potentially really benefit from. So our services here are less specialised and there's a higher turnover of staff and the services here tend to become overwhelmed because of the magnitude of the need out there.

MS McMILLAN: So in terms of secondary services that exist in the communities, in terms of the Royal Flying Doctor Service attends how often at communities like Doomadgee, for instance?

DR PARRY: Well, there's an RFDS child health nurse that would be there each week, probably for several days each week, I think.

MS McMILLAN: Would that be more targeting physical ailments, if I can put it that way?

DR PARRY: Yes.

MS McMILLAN: What in terms of - there's a Queensland Health nurse who resides, for instance, in Doomadgee. Is that correct?

DR PARRY: At the moment is hospital in Doomadgee.

MS McMILLAN: As well, right.

DR PARRY: So there's one full-time doctor and the functioning hospital out there.

MS McMILLAN: Right.

DR PARRY: So there's nursing staff, pharmacists and the like.

MS FERGUSON: And there's an adult mental health clinician based at Doomadgee and at Mornington Island.

MS McMILLAN: Is there a child mental health practitioner?

DR PARRY: Not specifically, no. There is no child mental health - the child and youth mental health service is based here in Mount Isa and they do provide a visiting service to Cloncurry but I don't think at this point in time they're able to visit the smaller communities.

MS McMILLAN: You gave me an example before the young person in one of these communities who you're of the view for his own safety, and I gather those around him, should perhaps be removed and provided with the medication. Could you just outlined to the Commissioner how that worked or perhaps didn't work in terms of accessing assistance for him?

DR PARRY: This was a boy - if it is the case I'm thinking about - - -

MS FERGUSON: Very recently we've had case whereby a youth was displaying behaviour that was possibly unsafe around him. He had a weapon. He assaulted a police officer and

he was required to go to the local hospital, and whilst there the best way to manage him was to handcuff him. Unfortunately the mental health clinician at the time, even though not a child mental health clinician, they were on leave so there was essentially no one in that community for that child at that time, and we had to wait until RFDS had an available flight and sedate him to the point that he wouldn't be a threat on the plane - - -

MS McMILLAN: And then what happened longer term in getting him assistance?

DR PARRY: I think there are so many cases where there's difficulty - these kids will present with difficult behaviour, sometimes very violent behaviour, very difficult for their carers to manage. I'm not sure which case you're referring to, but - - -

MS McMILLAN: There's one you were of the view that he needed some medication and you wanted him, I understand, assessed - - -

DR PARRY: Yes.

MS McMILLAN: - - - to provide some psychotropic medications.

DR PARRY: Yes, I don't - I think the problem there was this is a boy in care with really significant behavioural problems. He's school-age; really not going very well at school; his behaviours in school were so difficult, his aggression and he's just level of distress about being there was so great that he could only attend for an hour or two each day. The carer described some difficulty managing him, especially around just managing him in the home along with several other children who were in care as well. And as time went by this child got bigger and more determined and became more and more of a management problem. I got involved because of this behaviour difficulty and as a general paediatrician I'm happy to assess any case that comes my way, I guess, and if it involves attention deficit and hyperactivity and stimulant medication, I'm comfortable with that, but when we get to the point of needing more significant - you know, to be considering more potent medication - psychotropics, for example - to manage aggressive behaviour which is presenting a risk that child or to others around him or her, I really need to be able to liaise with and have support from a child psychiatrist or a child psychiatry service. So in a place like Doomadgee where I only visit every month or two and the clinics out there, as you can proper imagine, are fairly chaotic, I don't get a lot of time to spend in the family, as these particular complex ones are very, very difficult to tease out and require not only history-taking and examination, which is often very difficult to do; review of the notes

out there, which are often not filed in an orderly fashion, and to be gathering information from all relevant sources. So it's hard enough for me to make my assessment. Child psychiatry, they rely on my assessment in order to give advice because they actually don't visit. So it became apparent to me that this child was not doing well in Doomadgee. His care arrangement to me seemed inadequate. I think this particular carer was quite overloaded. The school wasn't able to manage him and his particular needs. They don't have a special education unit here in Doomadgee and school were very clearly saying that they could not manage this boy. From a health point of view I find it very difficult to manage these kids because I only get to see them once every month or two and it is a sub optimal environment, and we have no child psychiatry service, which I think was really important for this boy. So when I presented this - got the help that I could and presented to child safety, "I think this boy needs to move. I don't think his needs can be met in Doomadgee." And I recommended he be transferred to a larger centre, preferably larger the Mount Isa, somewhere where he could access the Evolve program, things like that, and an appropriate educational environment and a carer environment, a carer who could be trained to manage his needs in an expert way and be able to focus on his needs and not the needs of several children. Some of the carers here in Mount Isa, they seem to get not one difficult child, but several difficult children, and it's very difficult. So for this particular boy I recommended that he be relocated. The department were not able to act on that immediately and the next thing I knew I was getting a call from a psychologist who had been contracted by child safety to provide an independent opinion, and her opinion was the same as mine, which was nice. But she rang me and suggested maybe we need medication for this boy. I'm sorry this is such a long story, but in the end our child psychiatry service recommended that this boy be admitted to the in-patient facility in Brisbane to allow a two-week assessment. So moving this boy, who doesn't like unfamiliar environments; how do we move him? Well, do you know, $50,000 later and got him down to this admission and the outcome of that admission really wasn't that helpful for me. They said, "No, he doesn't need medication." And I was none the wiser, really, on how we manage this boy. This was weeks and months of liaison with so many different agencies; with child safety, with mental health, with the retrieval service from Queensland to try and facilitate the logistics of this, and this is one case; there are so many cases that need this level of involvement. So that's an example of how stretched the services are here and how difficult it is to really achieve anything, even when a whole team of people are working really hard. Sometimes the outcomes are just unsatisfactory and is the typical scenario.

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MS McMILLAN: Is it correct, the understanding that children up to 5, there's very little in the way - particularly in remote communities - of secondary services? So any sort of therapeutic assistance; so things like speech therapy, or it might be to do with behaviour, some sort of specialist in relation to that; that those sort of secondary services are largely not available, or if they are, there are a very long waiting lists?

DR PARRY: Well, there are available, and it's not just the waiting lists, it's the fact that the clinicians are not all working for Queensland Health. Queensland Health does provide an outreach service, but we work together with and we rely on the assistance of other agencies, such as RFDS and primary health services such as the Medicare locals, which in our district used to be called - North-West Primary Healthcare is now called Central and North-West Medicare Local.

So that's the primary health facility that provides allied health services, so speech therapy, occupational therapy, psychology, et cetera, to - - -

MS McMILLAN: Are they easy for you to access?

DR PARRY: Yes, you know, it's my second year here and I think in my second year in the district I'm now getting - yes, I've met some of these clinicians and been able to successfully work with them, but it's - the age-old problem with remote locations is that the clinicians come and go. There's a high turnover of staff. So once I've identified - I need to have been here for a while to establish these links with all of these different agencies and clinicians and once I've made these links, then before I know it they're gone. They've moved on to another job or another district and we've got to start from scratch. So this is what these children and families just have to accept, that it's - part of living in a remote location is that there's going to be some suboptimal aspects to the service provided. There's no enough people and the people come and go too much and that's - the key thing is developing these therapeutic relationships with other clinicians and with the families and we need that continuity but it's the one thing we often don't have.

MS McMILLAN: Can I ask - from five up there's perhaps - is there a greater availability because they're of school age that they can perhaps get some of that assistance through the education process?

DR PARRY: Yes; yes, Education Queensland has - - -

MS McMILLAN: That's presuming they attend school, of course.

DR PARRY: Yes, that's important.

MS McMILLAN: Yes.

DR PARRY: Yes, Education Queensland do have sometimes visiting allied health clinicians. Sometimes there have been cases where the primary health - the Medicare local allied health clinician is also the Education Queensland allied health. It's the same person, but I think the education system has the same problem filling those positions and - - -

MS McMILLAN: I - sorry.

DR PARRY: It is. It's just, yes, we often recommend or refer to these services but sometimes it's a long time before it actually happens because of the availability.

MS McMILLAN: What's a long time? What would you term a long time?

DR PARRY: Months.

MS McMILLAN: Months. Are there incentives for health workers in remote communities or to attend remote communities?

DR PARRY: Financial?

MS McMILLAN: Yes.

DR PARRY: I think so. I think most organisations - yes, I think most organisations will.

MS McMILLAN: Okay. So if I can pull that together, what do you both say you could see as perhaps some achievable suggestions for an improvement for delivery of service particularly, as you've outlined, to remote communities, particularly in view of the significant challenges that you've identified in your evidence of the foetal alcohol, the substance misuse and the sexually transmitted diseases apart from these other general health issues that you have identified? Would having a child psychiatrist here assist a great deal, in your view?

DR PARRY: Well, I think it would. I mean, we have access to a child psychiatrist through video-conferencing and occasionally that person visits the district either to see cases or to be involved in educational activities so that's good, but, you know, I think it's always good. The more specialists you have locally, the better it is for patients.

MS McMILLAN: And an Evolve-type service?

DR PARRY: I thought the plan for Evolve was that it would eventually roll out into all districts but it just hasn't.

MS McMILLAN: Yes, all right. Now, I just want to move briefly onto this SCAN model. You have both indicated in your document that it functions well in effective collaborations, but can I ask you: is it your understanding that for a matter to go to SCAN it needs to be at a notification level, that is, the notification as the Child Safety Department terms it?

DR PARRY: Yes, I mean, that's the rules at the moment.

MS McMILLAN: Was it your understanding, each of you, that prior to 2010 the latest SCAN iteration has been that if you had - as a stakeholder, which clearly Health is, you could put a matter to SCAN that might be termed a child concern report. Is that correct?

DR PARRY: Yes.

MS FERGUSON: Yes, we could.

DR PARRY: Yes, we can.

MS McMILLAN: All right. What do you say, each of you, about the fact that it now has to reach that notification level before it can go to SCAN?

DR PARRY: I know Tina would like to talk about this. I mean, it's often the case that - yes, do you want to answer this one?

MS FERGUSON: I just think in my opinion if it's reached notification stage, I'm confident that Child Safety is already investigating and that services are being put in place to determine the risk of that child. However, when it's a child concern report and it doesn't meet Child Safety's threshold for intervention, then nobody is actually following up on that family and I think if we could bring it to the table with multiagency discussion, Queensland Police might have more to offer to Child Safety, Queensland Health, Education and even the recognised entity. We might be able to present a bigger picture of concern for that individual child, but as it stands on a child concern report we can't do that.

MS McMILLAN: Would it also help perhaps with earlier intervention if you could do that as a report level rather than waiting for a notification so that, for instance, if it's identified problems - and we've had some other evidence about Young People Ahead and other agencies that exist in Mount Isa that perhaps you could divert them maybe out of heading towards a notification if you could get to it early enough?

MS FERGUSON: I think that at Queensland Health we definitely try to do that and part of our education strategy to clinicians is that we are a health service and let's support the family as best we can so that they don't reach, you know, the level of intervention.

MS McMILLAN: But, say, police come in with a different piece of information that reveals that the concern is perhaps slightly different from what you'd understood it or was more widespread. Do you think that would assist in getting an earlier intervention in the case?

MS FERGUSON: Absolutely, yes, and I think that has actually happened at SCAN previously where Child Safety may have decided not to have intervention and yet when it's tabled all the different concerns, they said, "This changes things and we will definitely be intervening."

MS McMILLAN: All right. I have nothing further, thank you, Mr Commissioner.

COMMISSIONER: Thanks, Ms McMillan. Mr Selfridge?

MR SELFRIDGE: Yes, thank you.

I would just like to clarify a couple of points there to be placed before the commissioner for me. First of all, the document that you brought along today, the joint document which is exhibit 87. In the course of that document, as Ms McMillan asked you some questions in relation to it, you identify a whole series of statistics, numbers, in relation to foetal alcohol syndrome or spectrum disorder, volatile substance misuse and sexually transmitted diseases. That, as I understood your evidence - we heard from certain parts of your evidence those statistics cover all members of the community, both indigenous and non-indigenous. Is that correct?

DR PARRY: Yes.

MS FERGUSON: Yes.

MR SELFRIDGE: Yes. I suppose a question for you, Ms Ferguson: are you able to access a breakdown of those statistics in relation to how many refer to indigenous and how many refer to non-indigenous members of the community?

MS FERGUSON: I can certainly look into the foetal alcohol statistics. I could probably provide a breakdown of that.

MR SELFRIDGE: Yes.

MS FERGUSON: As for the STI figures, I would have to consult with public health to see if they would be able to do that for us and also for the volatile substance misuse I should be able to.

MR SELFRIDGE: Yes. So there would be - sorry, the first would be readily available to you now that you can consult with public health in relation to that. Is that what you're saying?

MS FERGUSON: Yes.

MR SELFRIDGE: Yes, okay; and would you be able to pass the breakdown of those figures through to the commission?

MS FERGUSON: Yes, absolutely.

MR SELFRIDGE: The next thing is: as far as these questions on foetal alcohol syndrome or spectrum disorder earlier, are you, Dr Parry, aware of any studies here in Australia into foetal alcohol syndrome? Are you able to

access any studies that you know could be readily available to yourself at some point that you would be able to supply to the commission?

DR PARRY: Yes, there is a lot of work being done.

MR SELFRIDGE: Sure.

DR PARRY: Yes.

MR SELFRIDGE: I think you mentioned before - outside the restroom you mentioned there was a study being done in Alice Springs in relation to it. Is that correct?

DR PARRY: That was more - is to do with the volatile substance misuse.

MR SELFRIDGE: My apologies.

DR PARRY: Yes, but I think the foetal alcohol work has probably been done right across northern Australia so Northern Territory, Queensland and Western Australia. I think there's a lot of work been done.

MR SELFRIDGE: Okay. In terms of that, would you be able to access any information and supply that through (indistinct) back to the commission?

DR PARRY: Happy to.

MR SELFRIDGE: Thank you very much. There are no further questions.

DR PARRY: Yes, okay.

COMMISSIONER: Thank you. Ms Bates?

MS BATES: Just for your purposes, my name is Jay Bates. I'm from the Aboriginal and Torres Strait Islander Legal Service. I have a few questions relating to particularly the statement of Dr Parry. The first question relates to paragraph 9. Given that over-representation is predicted to reach 60 per cent in the coming years of Aboriginal and Torres Strait Islander children in the child protection system, the Aboriginal and Torres Strait Islander Legal Services position or comments has raised the need to have culturally competent or, in accordance with your statement, cultural sensitive responses to better engage families and children. For the benefit of the inquiry and building on that knowledge, in paragraph 9 you talk about your improvement of your understanding of family relationships. Can you elaborate on your understanding of relationships in cultural issues in Aboriginal and Torres Strait Islander families in Mount Isa and, following from this, how this knowledge is then applied in your practice?

DR PARRY: Is this in dot point 2, paragraph 9?

MS BATES: It's actually the last dot point where you talk about:

> *Improved understanding of family relationships in cultural issues, has enabled us to more effectively support local families through collaboration with relevant community organisations.*

Could you expand on your understanding of relationships in cultural issues in Aboriginal and Torres Strait Islander families in Mount Isa and, secondly, how this knowledge is applied in your practice.

DR PARRY: Yes. Well, for me personally, I'm originally from down south, so it wasn't until I moved to Darwin in about 2005 that I started to have a lot of contact with Aboriginal children and families, so that was a steep learning curve for me. I guess as a trainee in paediatrics working in Darwin, it was emphasised to me but it was always very apparent to me, that there was an extra dimension for someone like me working with Aboriginal

families. There were obviously some barriers to effective communication and so I think for me and for all non-Aboriginal health professionals who work with Aboriginal people, there is an educational process in terms of cultural competence and cultural sensitivity, in terms of how we effectively provide care to Aboriginal children and families. So it requires a different kind of approach to communication to what we're traditionally taught. I think teaching in modern medical schools is much better than it was in general, but a lot of this is obviously learned on the job and for me that's where I really started to learn the importance of approach to history-taking and interacting with Aboriginal families. So the emphasis is really on development of listening skills, of aspects of non-verbal communication to make sure that I'm communicating in a way that is appropriate and not offensive to families. For example, you know, avoiding excessive eye contact, avoidance of talking too much and just allowing enough time for people to think and to answer questions in a way that they've comfortable with, and to not step over any cultural boundaries and to allow time for develop of trust, and obviously making use of Aboriginal liaison officers in a clinical consultation is just so important. So when I moved to the Mount Isa district obviously I was aware that Aboriginal health was going to be a major part of my practice here, so as the director of the paediatric service in the district, I've made it a priority with my team to pay attention to these aspects of communication to ensure that there is a respectful attitude in my unit. I won't tolerate any disrespectful talk amongst my staff and we always involve the Aboriginal liaison officers - - -

MS BATES: For the purposes of the inquiry, could you just discuss what the role of the Aboriginal liaison person is? Is that person stationed in Mount Isa?

DR PARRY: Yes.

MS BATES: Does that person travel to the remote communities?

DR PARRY: I think in Mount Isa we have three Aboriginal liaison officers who are in the hospital. I don't know if they're full-time, or they're close to full-time. Their attached to our allied health department and we are encouraged to refer - involve them whenever we have an Aboriginal family admitted. We actually have made it clear to the Aboriginal liaison officers that they don't need to wait for referrals, that they're welcome on our ward any time to come and talk to us about our patients and our families. We always make sure of their assistance. In the other communities - I think a high proportion of the staff in all the other communities are Aboriginal. I'm not even sure if there are specific Aboriginal liaison officers,

because I think the staff there are largely Aboriginal in terms of the admin staff at least, and the - yes, Aboriginal health workers there.

MS BATES: Just breaking the question down a little bit further, you've talked about knowledge and application of various aspects of cultural issues. Could I just get you to focus on your understanding of Aboriginal and Torres Strait Islanders family relationships or clarify that a little bit further?

DR PARRY: Obviously, yes, the extended family is of vital importance with Aboriginal people and I think in our western world we can learn a lot from Aboriginal people and the emphasis they put on involvement of extended family. I think in our society too many families are isolated and living in situations where they don't have extended family support. In terms of parental relationships, I understand that in many Aboriginal cultures there is an emphasis on the importance of extended family in that a mother's sisters are often considered to be mother figures, as well as the father's brothers are also considered father figures. The importance of family support is obvious. When we're dealing with an Aboriginal family, they will often requested an opportunity to talk with extended family before they make a decision about something. I think they'd be the main aspects.

MS BATES: Thank you. Has this resulted in more culturally appropriate engagement and quality outcomes relating to Aboriginal and Torres Strait Islander families in particular?

DR PARRY: Yes, I think it has. I mean, I think we're continually trying to improve the way we do this. Can I use an example? There's a community here in Mount Isa called Yalambie. It's an urban Aboriginal community consisting of about probably 10 or 12 houses or cottages and in my first year here in Mount Isa it became apparent that there were some significant social difficulties at Yalambie, that kids often had significant health presentations and there was difficulty connecting with the families at Yalambie, and there even seemed to be - there really seemed to be a lack of trust, that the people there really didn't enjoy attending the hospital and were suspicious of what went on there, and some of that may have been fear around the child protection system and past experiences that they'd had. There was an Aboriginal health worker here at the time who was working at Yalambie and there was also - I was told by the hospital administration that there was a clinic - that they were looking for a junior doctor to attend a clinic down at Yalambie and they were having difficulty deciding which doctor should go down. I decided that perhaps the paediatric service needed to take some responsibility and try and provide that service, and it was an opportunity for us to get out there and get to know people in the community and provide a high level of medical care for those children and families. So I worked - I established a really close and effective working relationship with the Aboriginal health worker at Yalambie and she managed to set up the logistics of a clinic that I could visit down there on a fortnightly basis and she would identify children and families that would come down to the community centre at Yalambie for consultations. They didn't need a referral. And I guess I - in that clinic I tried to put into practice the principals that I'd learned in my training in Darwin and in the Kimberly as well as in this district. Yes, we began a clinic at Yalambie which I think was quite effective in establishing - or just beginning to establish that trust relationship with some of the families down there. Unfortunately the health worker involved then moved to a different job at Mornington Island and that clinic has really ground to a halt because of the absence of a key Aboriginal health worker who could make that work. It just wasn't appropriate for me to front up at Yalambie and say, "Right, okay, it's time for the clinic. Who's going to come?" And so that's a real concern for me, that we haven't been able to identify someone to succeed Karen in that role. But we continue to work closely with Karen in her role at Mornington Island and that's been really helpful. So the Yalambie story is just one example, but in all of the remote districts that we visit - and I've had

several visits now personally, me and sometimes other members of my team - to Doomadgee, Mornington Island, Djarra and Normanton, as well as some of the other districts. And I guess I try and use those approaches in all of those places; that we just make sure that we're trying to deliver those services in a culturally competent way. But there's always room for improvement. This is only my second year in the district, so I do feel that I'm in my second year here I'm beginning to make some really good links with Aboriginal families. They're starting to recognise me around the district now. Sometimes at the airport they'll acknowledge me and want to chat, which is really nice. I think to me, just being here two years has been long enough to start establishing some of those links. I hope that it can continue to improve over time. Another aspect to this is there's been some - encouragement, incentives - for us to establish a tele-health service to the remote Aboriginal communities. That's come from outside of the Mount Isa district, from Queensland Health. We've actually - this year we were able to - for the first time for several years - employ a paediatric trainee or registrar. We managed to get funding from the college for this registrar position. That's been called the - he's termed the outreach tele-health registrar. And so Matt accepted that position as a new paediatric trainee this year and he's been heavily involved in the outreach program and also trying to set up and develop regular tele-health services with Doomadgee and Mornington Island. I was very sceptical of this program when we started because I felt that there was a high risk that Aboriginal families would struggle to accept health services provided by tele-health, basically by face on a TV screen asking questions from a distant location and not being able to be in the room, having direct contact and communication, with no opportunity for physical examination. But we have found that it has been really effective if we have a key person present at the other end. Sometimes that's an Aboriginal health worker, sometimes it's an RFDS nurse. We found that in terms of - usually in the setting of following up families who we've met during outreach clinics, we've met them face-to-face and they know us, that they actually accept quite well the concept of a follow-up appointment via tele-health. That actually helps us, just through the additional contact, get to know the families better. It helps us make use of the local clinicians to become involved in that process. And I think it just helps with continuity in general. So I think if we're smart about how we use it, it's actually been actually really helpful and a step forward in the way we provide health services to these communities.

MS BATES: Could you see that as being beneficial in the child protection realm in terms of an outreach tele-health facility? A tele-linkup facility, not specific to health, but specific to child protection follow-ups?

DR PARRY: I think it depends on the case. I think we have to be cautious in that situation. I think it's sometimes hard to predict cases that may or may not have a child protection aspect. I think from our point of view it's so beneficial to have a relationship and a therapeutic alliance with a family and I think that the better we know families and understand the way a community works, I think the advantage of that is that it gives us more opportunity, perhaps, to prevent problems and to put in supports where necessary to prevent situations escalating to the child protection level. I don't think that tele-health clinics on their own are the answer, it's all about working effectively and collaboratively with the community on all levels, and we're just part of that. But the better the service we provide, you know, I think it actually supports - we need to support the health staff on the ground in these communities and help them support these families.

Yes, so I don't think we do Telehealth or Outreach to these communities specifically with any child protection goals in mind, but in terms of - what we're trying to do is provide a comprehensive and hopefully holistic and culturally competent health delivery to people regardless of where they live in the district.

MS BATES: Yes, but would you agree that with some of the difficulties you've outlined in terms of accessing specialist supports that may be a method that could be contributing to those holistic goals in having children and families access services in the remote areas?

DR PARRY: Are you talking about, say, getting some of the specialist services into the remote communities by Telehealth; not just our general paediatric service but maybe linking in with other more specialist services?

MS BATES: Yes, that's what I was trying to get to?

DR PARRY: Yes, well, I don't think we've really done that. We've done that in more acute health settings; like, there was a very sick child in Mornington Island this year who didn't survive, but that situation - in that situation the local - when that child presented, the local health staff contacted Mount Isa and also the retrieval services and a specialist intensive care doctor from Brisbane linked in through the Telehealth system and was there providing support and advice to the team on the ground. One of my locum paediatricians actually flew out to the community in the middle of the night with the RFDS team to assist the doctor out there. So it was a pretty - I think it was a very good response and the fact that we had a paediatric intensive care specialist tuning in from Brisbane providing the team with support at that acute stage was really wonderful and even though in this particular case there was a tragic outcome several weeks later, it did show that we do have the ability to provide this specialist-level service if we use the Telehealth facilities effectively. So I think that can continue to be developed in acute settings and certainly in Mount Isa here we are continually trying to develop Telehealth services with subspecialists on the coast in Cairns, Townsville and in Brisbane, but I think it's the next step to try and provide those expert - access to, you know, expert subspecialists directly to the remote communities and it's something that we should consider, but it is actually hard for us. Sometimes it's very hard for us to actually get a specialist on Telehealth. For example, we've got a few kids with kidney problems that we are trying to set up a Telehealth clinic with a kidney specialist, the paediatric kidney specialist, in Brisbane and we set this up at least a month ago but it's not till November. So sometimes even with the technology available and with our local desire to access this service - sometimes we can't guarantee or promise that

it'll happen but I think it's something that we're continuing to make efforts to develop as time goes by.

MS BATES: Can I just take you back to foetal alcohol spectrum disorder? What are the types of treatment plans and supports that Queensland Health delivers to children with this suspected diagnosis?

DR PARRY: Well, in our district these kids - we become aware of them at different points in time. Sometimes we're aware of the risk during the pregnancy or in infancy and I guess at that time care centres around supporting mother or parents, extended family, to ensure that the home environment for this baby is optimised and in other cases these kids might be referred to us due to developmental or behavioural difficulties in the preschool years, but often it's at the time of school enrolment that the problems become evident to schools, to teachers, and they will - that will prompt a paediatric referral. So whenever we become aware of a child - and sometimes it's foetal alcohol spectrum disorder. Sometimes there's another - sometimes there are multiple contributing factors to the developmental or behavioural issues - you know, as the director of the paediatric service, you know, I try to ensure that we do the best assessment we can, involve other health professionals and agencies and schools in the assessment process and talk to families about the results of our assessment and the diagnoses we're considering and then the treatment. Ideally treatment will - you know, sometimes medication has a role in kids that might have problems with attention and impulsivity, but, you know, I believe that medication should always be combined with a behavioural approach so making use of whatever services are available in Mount Isa or in the surrounding communities which may involve referral to Centacare or a mental health service or psychology services through - or allied health clinicians through the primary health care organisations and RFDS. So I think we do this in a case-by-case basis and we try and identify what the needs are and put a plan together, you know, from a health and education point of view of how we can most effectively care for this child and family.

MS BATES: The next question relates to unborn children. Should, in your opinion, the relevant sections of the act - and I can give you section 21 of the act with reference to unborn children - be strengthened to allow mandatory referral to support services rather than waiting for the mother's consent to allow intervention to provide protection for unborn children?

COMMISSIONER: Is that by the RE or someone else?

MS BATES: Well, the consent is required to involve the RE. I will seek some instruction.

COMMISSIONER: I guess I just wanted to know whether you had in mind intervention by the department without the RE or intervention by the department with the mother's consent of the RE's involvement.

MS BATES: I think we're trying to focus here, Mr Commissioner, on the second issue of the mother receiving some support and some investigation into the issue regardless of the issue of her consent.

COMMISSIONER: So some form of involuntary intervention?

MS BATES: Yes, Mr Commissioner.

COMMISSIONER: So you understand the question?

DR PARRY: Sorry, back to me. Yes, I was just looking at - was it subsection (4) of section 21A?

MS BATES: The entire section 21A.

DR PARRY: Yes, at the moment the way the legislation reads is that these - help and support can be offered to the pregnant woman, but only if the pregnant woman agrees to the consultation taking place. So the question is around do
we - - -

COMMISSIONER: Dispense with consent.

DR PARRY: Yes, so should it - yes, does this - I think it is a - I mean, having practised in other states and territories, it is a quirk of the Queensland legislation that there's mandatory reporting for children after birth but not for children before birth.

COMMISSIONER: But you'll see in the section there's a concern not to be seen to be interfering with human rights, and that's why the rationale is sort of expressly stated, which is also a quirk of that piece of legislation. Usually they don't justify why they put something in the text within the section itself.

DR PARRY: I guess the question is the human rights of the mother versus the human rights of the foetus, isn't it?

COMMISSIONER: Well, that's becoming a jurisprudential question as to what rights an unborn child has in our system, which is another complication. But I think the question is from a medical point of view do you see it being advantageous to in some circumstances have a mandated intervention regardless of whether the woman consents or not, because the child or she needs it?

DR PARRY: Yes, it's a difficult question, isn't it?

COMMISSIONER: So it's a needs-based rather than rights-based question.

DR PARRY: Yes, and I think maybe as analogy, if you have a suicidal patient - you identify that someone is suicidal - you can't give them a choice about that, you've got to help them. In this situation we've got a mother that's making bad choices, drinking excessively when pregnant, and you've got an unborn baby there who will one day be a child

and an adult which if not protected from the effects of this alcohol is going to be a person that has all kinds of problems in their life.

COMMISSIONER: Yes, so the unborn child in utero is at risk of harm.

DR PARRY: Definitely.

COMMISSIONER: And so the question is how does the system intervene appropriately in a balanced way to protect the child without overriding too much the rights of the mother and others? But if an injustice has to be done to somebody's rights, should it be an injustice to the adult's rights or the child's rights?

DR PARRY: Mm.

COMMISSIONER: And so the question is suggesting or implying that the child's rights and interests should override the mother's because of the consequences to the child - - -

DR PARRY: Yes.

COMMISSIONER: - - - if intervention doesn't occur.

DR PARRY: Yes, and this question relates not just to Aboriginal people, but to all people.

COMMISSIONER: I think it's a general question.

DR PARRY: Yes. But from the point of view of the Aboriginal population, it's obviously - an intervention has to be the right intervention and - - -

COMMISSIONER: That's the next question. Should you be able to intervene whether the pregnant woman consents, agrees, or not? How you do that is another question, but you're being asked at the moment whether from a medical viewpoint the law should give you that authority. You don't have to answer it if you're not comfortable.

DR PARRY: I just wonder if I get the final say on this. I think I'd have to advocate for the rights of the unborn, as a paediatrician.

MS BATES: It seems to be consistent with your evidence you led before about breaking the cycle at some point. There needs to be some form of intervention to in effect keep history repeating itself in terms with - - -

COMMISSIONER: Of course, the more difficult question is what sort of intervention; for how long; and how you actually enforce an unwanted intervention. Maybe we can

leave that for another day.

MS BATES: How old are the young females presenting pregnant?

DR PARRY: What's the youngest? (name withheld)? 12?

MS FERGUSON: I think, 12.

DR PARRY: That's, what, this year?

MS FERGUSON: Yes.

DR PARRY: Yes.

MS BATES: Is Queensland Health recording whether or not these young females are Aboriginal and Torres Strait Islander?

DR PARRY: In terms of the ones that are - - -

MS FERGUSON: Not necessarily, no. Obviously it would be in their medical chart.

MS BATES: You stated in your concluding paragraph in your statement that, "Improved protection of our children requires a well-trained, culturally sensitive and collaborative workforce." In your opinion is the current workforce lacking in cultural sensitivity; and more importantly, how could this be implemented within service delivery specific to this region?

DR PARRY: I think we've assembled a good team here in the paediatric department in Mount Isa. I think we are, as a team, working towards - continuing to improve the way we provide service and health care. We don't always get it right. We try and learn from our mistakes as well. But I think what I'm getting at there is because we're a stretched service we don't have our three full-time permanent paediatricians on the service, so we have locums or temporary people coming through filling those gaps, and they always take time to learn about what happens here in our district and how things are done. We get locums from the USA and New Zealand, Germany. So obviously there's a - when you're cobbling together a service from such diverse places it does take time for them to become culturally acclimatised; geographically as well. I'm just talking about medical staff, so to run a unit you need a complete workforce; nursing staff, admin staff, allied health staff. And I think the challenges are always there; people come, people go. The longer you spend - this is what I'm finding - the longer you spend in a place where the services are stretched, the less time there is to attend to your own personal training needs, because medical education is a life-long process and you have to keep up to date. It's

difficult when everyone is under pressure.

MS BATES: So you would agree that therefore cultural competence is a continuing developmental process?

DR PARRY: Yes, I totally agree.

MS BATES: I have no further questions.

COMMISSIONER: Thanks, Ms Bates.

MR CAPPER: I have no questions (indistinct)

COMMISSIONER: Thanks, Mr Capper. Ms McMillan.

MS McMILLAN: I have nothing further. Might these witnesses be excused, Mr Commissioner?

COMMISSIONER: Yes, certainly.

Thank you both very much for your evidence that you've given and the answers that you've tried to give, help us in trying to work out what the root of some of these problems are and how we can deal with them with what we've got. We appreciate that. Thank you. Good luck.

MS McMILLAN: Particularly for Ms Ferguson, who didn't know she was going to be giving evidence until - - -

COMMISSIONER: She did very well without any notice, yes. Sometimes that's the better way to go, I think. Thanks again.

WITNESSES WITHDREW

COMMISSIONER: We'll stand down.

THE COMMISSION ADJOURNED AT 11.54 AM UNTIL 12.14 PM

THE COMMISSION RESUMED AT 12.14 PM

COMMISSIONER: Yes, Ms McMillan.

MS McMILLAN: Thank you, Mr Commissioner. Mr Anderson is giving evidence now.

**ANDERSON, GREGORY SCOTT** affirmed:

ASSOCIATE: For recording purposes, please state your full name, your occupation and your business address?---Gregory Scott Anderson. I'm a regional director for the government department of Aboriginal and Torres Strait Islander and Multicultural Affairs at Sturt Street in Townsville.

COMMISSIONER: Mr Anderson, thanks for coming and welcome.

MS McMILLAN: Mr Anderson, have you prepared a statement in relation to this inquiry, dated 5 October? That's a copy of it?---Yes.

The contents are true and correct?---Yes.

Thank you. I tender that, Mr Commissioner.

COMMISSIONER: Thank you. That will be exhibit 88.

ADMITTED AND MARKED: "EXHIBIT 88"

COMMISSIONER: I'll direct publication?

MS McMILLAN: There's no reason it can't be published, Mr Anderson?---No, absolutely.

Thank you.

COMMISSIONER: Yes.

MS McMILLAN: Mr Anderson, could I ask you, firstly, I believe you were sitting in listening to the evidence of Dr Parry this morning and also the child protection liaison officer, weren't you?---Yes, that's right.

All right. So far as your role is involved and your experience in that coordinating role, do you have any comments to make about matters you heard them give evidence about this morning?---I think there were a few things that are sort of covered off in my statement, as well as some of the comments that were coming out today.

Well, perhaps could you drawn from your statement what you think might be relevant to perhaps address some of those issues raised?---Sure. I think part of the health promotional work that they were talking about this morning, particularly around the things like access to services,

connectiveness with services, that's one of the things that we are constantly working with community and also the providers around. In a child protection context, one of our strategies in terms of running engagement activities, running coordinated activities for the community is around using almost serendipitous opportunities for families to connect with service providers on an ongoing basis, trying to - - -

What sort of examples could you give us?---Yes, so we've got a play group in the park as one of the projects that we operate and that's one of the ones in Pioneer, that we operate here. Part of the strategy for that is not just to help the kids with their development and provide a social outlet for the young mums, but also to enable them to experience contact with health service providers or Centacare as a family group so that they become more comfortable and confident in dealing with those services. It is also another way in which a service provider can have an external viewpoint for the kids and the mum, and be able to have that informal conversation perhaps about things that might be impacting on them that they can see without having to wait until a problem might escalate to become a formal notification for child safety.

And how is that take-up rate with that play in the park? ---Well, there are about 15 there on that particular project, that one in Pioneer.

Yes?---We have a series of projects and activities across our area, but primarily we're focusing on Pioneer and Normanton. This is for the non-discrete community, so this excludes Mornington and Doomadgee, but for those particular locations. We've chosen those because they've got a high concentration of public housing stock, low socioeconomic - well, socioeconomic disadvantage, a high proportion of Aboriginal and Torres Strait Islanders in the population, so they show all those sort of macro indicators of disadvantage. So a range of things that will try and connect community with service providers, particularly schools. I think you asked the question. Schools can provide a great deal of support provided the kids go there.

Yes?---So one of the things that we do is really work hard with the schools and with the community to try and improve that interaction between the schools and the community.

I see in Doomadgee, it's about a 50 per cent attendance rate at school?---It fluctuates, as it does on both of the discrete communities. You know, it has fluctuated between about 50 and 75 per cent over an extended period of time. School attendance on the remote communities is impacting on a lot of things. In dry season a lot of people tend to travel a bit more, so they may go out on cultural trips to country, to outstations. Both of those communities over the last few months have been really hit hard by the sorry

business, so there has been a number of deaths that have resulted in extended leave for family members as part of that, as the grieving process and to attend to cultural protocols around funerals. That's probably one of the reasons. But, as I said, if we can continue to provide a bridge and to make the connections so that the community feel - there are a number of services around that are providing the sorts of supports to families that may enable them not to proceed down that track of tertiary child protection involvement and so part - as I said, we really are working hard to try and break down the barriers so community members feel a lot more comfortable with those services and can access them as early as possible.

You talk about Pioneer. Pioneer is here in Mount Isa, isn't it?---Sorry, that's a suburb of Mount Isa.

Yes, right. For those who are not locals?---Yes.

In terms of, say, Doomadgee and Normanton, what are you doing there in terms of trying to - I think you use the word "bridge" the local population and service providers?---In Doomadgee and Mornington, they're - to get a bit technical here, they're called a remote service deliver location.

Yes?---Both of those are where the Commonwealth and the Queensland government have signed off on a formal agreement through COAG, so where they have a single government interface; the technical term for an officer at both of those communities who represents both the state and the Commonwealth to try and cut down on the duplication and to also - - -

Is this FaHCSIA, it's known as?---Well, FaHCSIA and DATSIMA are the two respective agencies that do that.

Yes, right?---They're called the gecko that lives under the rock, but - you know, all the acronyms. It's a government engagement coordination officer. So that's the single point of government contact, if you like, in those communities. They're on the community, as well as Indigenous engagement officers who are employed by the community, so from the community. They're responsible for intensively working with the communities and the service providers around service mapping, planning, coordination, driving very grass roots place based community consultation. There are a range of processes from service mapping to local implementation plans which are all put in place designed around those things. There's a significant investment. For example, alcohol was one of the things that was raised significantly in terms of the FASD stuff. There's a 5-million-dollar investment about to go into Doomadgee and Mornington through Mission Australia, which is called Breaking the Cycle. That's around building community capacity to drive solutions for alcohol

consumption in both of those locations and to work as intensively as possible with the community to have the discussion around alcohol and substance abuse, to look at how services that support the community - what do they need, what would the community like to access - and to work in each of those locations to come up with a community-drive response with that additional money available for services.

So it seems a key plank, doesn't it, that there needs to be community engagement for any of these projects to be successful?---If you do a literature review about research on what works and doesn't work in Indigenous communities - and that's not just in Australia. That's around the world - one of the key success factors that comes through nearly all the academic research is that communities have to be involved - not just consulted, but involved - in developing and implementing the solutions for them to gain traction and to work.

COMMISSIONER: And involved at, what, every stage of the process?---If possible and practical, absolutely.

So that would include either influencing the decision or actually making the decisions?---Depending on what it is. So, for example, at the moment the - you know, we've announced the process of alcohol management plan reviews. The minister has given the councils a number of criteria about how that needs to be done of which management of harm and management of those sorts of things is a significant part, but essentially it is up now to the individual council to lead a process in the community to say how alcohol is best managed and to - - -

So it helps them consult with the community and then represent the community view?---Yes, absolutely; yes, but, as I said, literature around this stuff is that the maximum community involvement in the sorts of solution building, program development, implementation has sustainability and can drive better outcomes. So, you know, it's not always possible but - - -

What about in the child protection realm? Could you do something along the same lines as the alcohol management plan in a different context?---Both of the communities that we're talking about in terms of Mornington and Doomadgee have what's called a community safety planning process in place which was also - it's much broader than just child protection but again was looking at a broad definition of "community safety" in each of those locations and teasing out and looking a priorities, things that can happen, how can the community and government work better to - what are additional services that might be required? So there's a range of processes that have been - and some are long term, some are short term that are designed for community consultation around those things. Safe houses is one of those services that came as a result of some of those, but, you know, like any community, whether it's discrete or mainstream, the things that we're talking about are contentious. They're contested. It's a contested space within a community and within a family group sometimes. So somebody has still got to be the final decision-maker, but it is possible to be able to work up a community based solution, as I said, and certainly, you know, the formation and development of strong women's groups, family centres, the child family centres that are just coming out in both of those locations, are sort of based on that wherever possible.

What about the federally funded Family Relationships Commission?---Well, the FRC at this stage only operates in Coen, Mossman Gorge, Aurukun and Hope Vale so the FRC is in most - - -

I mean that model?---Yes, the FRC empowers community members to make decisions for currently a very closely defined set of triggers, but it's - and the formal evaluation for some of that stuff is yet to be worked through.

But the indicators, the signs, are promising, aren't they? ---Certainly in terms of one of the goals of that program was restoring traditional or community authority and by having the FRC in place, being able to have a position - and Aurukun is a great one where the commission talks in Wik so it's in the language, then that restores - automatically restores some of the indigenous authority in terms of traditional ways of coming to decisions in a community setting. The issues around cost benefit - you know, how expensive is it, how easy is it, what support

services are required to make the FRC effective in a broader context if we're talking about this, that's for others to - - -

Then how sustainable it is?---That's right. That's for others to give an opinion, but certainly in terms of getting greater community involvement in, you know, the process around that it obviously does that so there's no problem.

You need to design a framework within which all these services were sat and managed from, wouldn't you?---So in those locations a combination of the Wellbeing Centres and the FRDS are doing a lot of the service coordination and providing the case management for individuals that come through the FRC. Mornington and Doomadgee have both got plans and processes in place for the establishments of Wellbeing Centres. That driver though to support the FRC is not there so it's a driver around supporting the community and better coordination so - they could evolve into that. Again it's not for me to make a determination about resourcing and capacity and all of those.

Sure, okay.

MS McMILLAN: Thank you.

At paragraph 15 of your statement, the last substantive point, you refer to a new Outreach midwife service and then further down you talk about wellbeing services established in Doomadgee to deliver integrated community based and culturally appropriate counselling and locally developed support programs addressing drug, alcohol and social emotional wellbeing issues. What are the wellbeing services? Are they like an outpatient clinic or are they - can you explain just what they are?---That was really what I was just talking about there, Wellbeing Centres.

Yes, but what are they in essence?---They're a location where a lot of allied health services are primarily delivered from.

Yes. So might that be speech pathology or - - -?---Yes, ATODS services.

ATODS?---But they're an alternative front entry, if you like, to some clinical delivery as well. The model in Doomadgee has yet to be fully rolled out. Certainly in other locations - the ones I can speak of best are Aurukun and Hope Vale where, you know, they are used both as a location for visiting services - you know, as the health people said before, we haven't got a whole pile of specialist services that are located in the communities so they have to be - there has got to be a place where people can come. If they don't require a very formal clinical setting, then Wellbeing Centres are seen to be a more

appropriate way in which people can access those services rather than go through the barriers that can happen if you're presenting at a more formal clinic or a hospital. In many instances community members see hospitals as places where people go and they may not come back from and so Wellbeing Centres are more holistic - an attempt to drive a more holistic health response and health in its broadest context, if you like.

Thank you. Can I ask you - we heard quite a bit about young people, including under 18s who are giving birth to babies with foetal alcohol spectrum disorder and there are those other issues like sexually transmitted diseases. Can you speak from your experience what sort of education is being done both here in Mount Isa but particularly at these or more remote communities?---Yes, limited experience in my - first-hand about those particular communities, but from working in others the sexual health stuff is - again it's another contentious space. If I can talk about Hughenden perhaps as an example, Hughenden had a dramatic spike in young mothers giving birth, a big spike in transmission of STI's, so working with the - trying to work with the community there about better promotion for sexual safety, safe practices and the free dispensing of condoms was a real issue, particularly for the elders in the community who were basically saying we're promoting sexual activity rather than - so there's a big debate, I think, in a lot of places around harm minimisation versus those.

Managing the risk?---Yes, but there are still promotions that are happening in both of those locations through the health workers, the public health workers, that are there and the schools in an attempt to deal with this - that's in terms of the sexual transmission. Both of the communities are technically dry, if you like, for alcohol. Obviously they're accessing alcohol through a range of means but the restrictions are there, but even without restrictions people under 18 are not meant to be able to purchase and consume alcohol in any event so - - -

Can I ask you - do you think part of a solution for these young women who we've just described in that age set - is the process of engaging them in activities that perhaps might increase their self-esteem, all of those sorts of issues that are present for any adolescent girl probably in terms of engagement, activities, good self-esteem, that might perhaps look at addressing issues that perhaps feed into this prevalence of pregnancy and also transmission of sexual diseases?---There's a range of initiatives about working with young girls. A lot of the things that we talking about would be - can be addressed if the girls are feeling a lot more confident; that got a lot more self-worth; they're are engaged in education, training or employment; if they can see options for themselves and remain engaged with community and culture, but also with positive aspects about - rather than feeling that their

options have closed off. So certainly things like the indigenous hip-hop program that's been happening over a number of communities here - Normanton, Mornington, Doomadgee and Mount Isa - which has been a great way for the young women in particular to express themselves, express their feelings about community life, what's important, positive aspects of those. A lot of work done within the school and educational setting to try and keep the young girls reengaged. There is a big drop off in engagement with girls when they hit puberty, so a lot of them withdraw from activities; they withdraw from organised recreation.

And you're not just talking about indigenous - - -?---No, that's across the board.

- - - girls, are you, you're talking about across the board, yes?---But it's probably more profound in indigenous communities, particularly the remote ones, because the options for alternative activities at an organised level drop off dramatically. So there are still activities around, particularly rugby league and touch and those sorts of things for a lot of the males, but - so there's a lot of work still being undertaken that has to be done to engage young girls in the more positive aspects of community life.

Okay. Can I just ask you a couple of things. At paragraph 23 and you say:

> *Agencies have advised that confidentiality provisions within the Child Protection Act and also the recruitment of indigenous employees continue to be a challenge to the departments.*

Can you just expand a little of the confidentiality provisions?---Yes, that's probably - - -

What you mean by that is a challenge?---That's more about, gain, trying to share information at the front end of the entry into the child safety, rather than the back end. So once it gets to that SCAN process and there are very formal processes in place, then everyone is - those key players are prepared to share information and drive, but it's about trying to work in a more informal setting at the front around a particular family that we know may be - or service providers come in contact with, that they have concerns about, that that's when it becomes difficult to share information.

By those service providers and the department, for instance?---Yes, that's right. So, you know, we need - and again this is what service providers are telling us when we are trying to lead processes around better collaboration or integrated case management around those families in need - that there has to be some level of informed consent or consent-driven information exchange to get better outcomes.

And also, too, because I imagine it is important that culturally the idea of family is obviously different in different communities as opposed to, say, also non-indigenous Australians. Correct?---Absolutely.

So the idea of confidentiality perhaps is a relative issue also, isn't it, about who you regard as family, for instance?---And again, when it gets down to the formal setting of child protection, you know, there are nominated family members and those things that will get involved. But as was indicated in previous statements, the concept of family is very different; it is a much broader - for some

families. And again, there's a bit of a generalisation. There are some indigenous families that are relatively dysfunctional anyway and the safety net of the extended family had has fallen away for a variety of reasons. But wherever possible that concept is still around and if it thrives then it's a great way of building on the internal support for the section of the family that may be struggling.

What do you say about the blue card issue? You say it's been raised with you that it's a significant barrier. Can I ask you in relation to that, is it your experience, too, that indigenous populations, particularly in the communities that you're talking about, they can be quite transient, too. So that say, for instance, a member of a household who's undesirable and would preclude someone from gaining a blue card may not of course be there in a couple of weeks' time, or if that's the reason they perhaps could be moved on. Do you have any ideas about how that could be addressed: on the one hand the safety issues about having some check, if you like, or clearance in relation to a potential carer; as opposed to the issues you've raised? ---The blue card one is really a - the problem comes about from three things: one is the requirement for all adult carers to - sorry, all adult members present in the household to obtain the blue card. And as you rightly say, issues of transient - but also just the general make-up of households, you know, all the evidence says that Aboriginal and Torres Strait Islander families are much more prone to overcrowding than anybody else, so there's a number of adults present in a house rather than the nuclear - what is it, 2.2 - traditional family. The second one is that a lot of - particularly on communities - the over-representation in terms of the justice system generally means that there are a lot more people as a percentage of the population that might have offences than is (indistinct) and again there's numerous studies and the reality around that. And the third one is the blue card itself, the process of getting it. And more importantly, the process of being able to negotiate if there are offences that come up that, say, how do we assess the community members to be able to do that? I think again getting back to the sort of self-regulatory role or capacity or whatever you were talking about previously, there may be a way in which communities may be able to self-regulate some of that themselves. I'm not sure.

Perhaps through the recognised entity or perhaps - - -? ---Yes.

- - - something like the Commissioner model where they could perhaps have some feed in?---But the reality is that it is a significant barrier to carers, to the attraction. And that's despite the efforts of the commission, who have been great partners in a number of these communities - in Mornington, Doomadgee and Palm - in going out there,

explaining that process, assisting people through that initial application.

I was going to ask you: is it properly publicised, what the - - -?---Yes, and I think - well, it's one of those things you've got to keep publicising and keep publicising and keep working through. And there have been numerous attempts, and some of them with some success in the communities, to be able to drive that through, but it still needs more work.

I'll just ask - - -?---Sorry, and that's not just on remote communities, that's as much a barrier in even regional locations like Mount Isa then it is out there.

All right. Recruitment of indigenous employees: is there, do you think, some opportunity there, or should it be taken up on-the-job training, perhaps, and emphasising some more of - if I can put it this way - life experience rather than formal academic or tertiary qualifications, so that you might have traineeships, for instance, that would allow perhaps more opportunity for indigenous employees to be taken up?---Yes to all of those things. I think there are - at this point of time there is still - as everybody is aware - a significant over-representation of Aboriginal and Torres Strait Islander kids' families in contact with the child protection system. One of the ways in which that whole system - particularly child safety - can become more culturally competent or the community are able to interact, is to drive up the numbers of indigenous staff. Particularly with the structured decision-making tool, that takes away an element of discretion for people, then perhaps the requirement for the professional qualifications could be looked at. That's one of the ways.

Mind you, some 700 pages, you need a fairly advanced reading level or comprehension to - - -?---Sure. Yes, absolutely.

- - - make sense of it?---But I think there is - and again, not every level, not for every job - the child safety support officers, it was an attempt - - -

A number of them are indigenous, rather?---Well, in one of the service centres in Mount Isa all of the staff are indigenous in that particular level, which is a great result. I mean, if that could be replicated across the rest of the state, that would be terrific.

All right, thank you. I've nothing further for this witness.

COMMISSIONER: Thank you. Mr Selfridge.

MR SELFRIDGE: Yes, thank you, Mr Commissioner.

Mr Anderson, at paragraph 19 of your statement; there's been some discussion before the commission, as you've heard this morning, about is it feasible, practical - about organising or coordinating meetings with leaders and Elders within the communities and organising to meet with them and to discuss issues concerning and related to child protection. That was organised in Mount Isa in July 2011, so just over a year ago.

Are there any future such arrangements in place or is that something that's going to be an ongoing thing?---Sorry, I'm not sure about whether it will be ongoing as a specific activity.

Yes?---But there's no reason why it can't be. That is one of the ways in - and we often will use again an event somewhere else, it might be a barbecue in the park, as a broad engagement mechanism, but then plug in other services and things around them to talk to the community generally around those things. If there's appetite, if the community say, "We are really interested in having a focused discussion about child safety or child protection matters generally," then that's something we can do.

Those elders and leaders, where did they come from? Were they elders and leaders from Mount Isa itself?---Yes, they are Mount Isa based.

Do you see some scope for the same type of arrangement within Doomadgee or - - -?---Well, there are similar - under the child safety planning activity that I - - -

Yes?---Sorry, the community safety planning activity that I mentioned, that's where those things are captured and discussed with community, in those particular locations. In terms of Mount Isa, we have ongoing groups and ongoing consultation with community that other government agencies often plug into. I think given the awareness of the commission, it's likely that child protection matters will be raised and escalated in those forums over the next few weeks and we're certainly happy to organise another one with a child protection focus working in the with the child safety.

In terms of moving forward in relation to those issues that the Commissioner has expressed and Ms McMillan has asked you questions in relation to, do you see this as a useful vehicle?---Absolutely. I mean, I think one of the - because of the highly contested and emotional space that child protection is when it gets to that tertiary end of the system, anything that - it often needs a third party to come in and start the conversations going. Not about individual cases, but about the whole system and how it works, and what are the mechanisms, what are the service supports that are there?

A third party such as?---Such as us.

Yes, okay?---DATSIMA.

So you mean between the elders, the leaders and the Department of Communities?---Yes, so we can help take the sting out of it, manage some of the - as I said, the emotion that comes up in - you know, nearly everybody has got a relative that has got a war story somewhere about it or a personal anecdote that they want to - and so we might help manage that and act as an honest broker, if you like, in terms of getting those discussions going. That is certainly a role that we fulfil well and it's part of the process that we do.

When you say an honest broker, a facilitator in effect? ---Yes.

How welcome was that? Was it welcomed? It obviously took place - - -?---Yes.

- - - but was it regularly welcomed by those elders and leaders in the community?---Absolutely. It came as a result of a discussion with them in the first instance.

Okay. And you state at paragraph 220 that that was something that was done in partnership with the Department of Communities?---Yes. We obviously - in the machinery of government we were part of the Department of Communities.

Yes?---So what we were developing before the last machinery of government changes was a series of things we called Indigenous local service delivery plans.

Yes?---And that basically is where we sit down with each of the service centres for the former component, of which child safety is one of them, bust up their business model - sit down and work out how we can work in partnership to get better outcomes for Indigenous families and individuals within each of the service teams. So there are a series of activities that emanate out of that and this is part of that process that we're doing.

Thank you. I have no further questions of Mr Anderson.

COMMISSIONER: Thank you. Yes, Ms Bates.

MS BATES: Thank you. My name is Jay Bates. I'm with the Aboriginal and Torres Strait Islander Legal Service. I just have a few questions for you. Throughout your statement you've made reference to the need for cultural appropriateness and sensitivity throughout the inquiry. ATSILS, the Aboriginal and Torres Strait Islander Legal Service, has highlighted the need for child safety to be culturally sensitive or achieve a lack of cultural competency. It is evident in your statement that a great deal of your work relates to cultural competency. In your opinion, how would you describe cultural competency or cultural appropriateness?

COMMISSIONER: First all, the terminologies - they're different, aren't they? Cultural appropriateness is different to cultural competency, as I understand it. I'll tell you what I think they are. To be culturally appropriate is to positively include and take direction from Indigenous culture on any issue or decision. That's how you are culturally appropriate. To be culturally competent depends on the degree of effectiveness in the community of behaving appropriately. Culturally appropriate is to make appropriate decisions. Culturally competent has more to do with practically applying the appropriate decision within the community in the appropriate way. That's how I interpret those terms, but if you want to put a different terminology or treat them as coterminous, that's fine; but, as I say, I think culturally appropriate is to know what's appropriate, culturally competent is to do what's appropriate.

MS BATES: Thank you, Mr Commissioner.

COMMISSIONER: Sorry, you wanted to say something - - -

MS BATES: Just to specify, could I just refer you to your statement and the context with which you use those terms in your statement, and the meanings - or how you would explain those terms?---Yes. Most of the time when I'm talking about that - because, I mean, again if I go to the literature, you can get pages of contestability about what they actually mean. To break it down to its simplest thing, it is around having staff who are empowered and have knowledge to deal effectively, respectfully and have an understanding of the culture of the clients that they're interacting with. From a client perspective, that they walk in and engage with one of our services and feel culturally safe in doing that. They can disclose that they are feeling comfortable enough to able to deal - and respect the service and the people that they're dealing with, as well. I think it's around cultural knowledge, understanding and respect, and that can be a lot of different things for a lot of different people depending on where they have to be in the service system; but that's sort of my layman's attempt at trying to do that.

In your statement you give evidence about an Indigenous local service delivery improvement plan - - -?---Yes.

- - - that has been developed with Child Safety for the benefit of the inquiry, particularly how Aboriginal and Torres Strait Islander practice is integrated and coordinated. Are you able to provide a copy of this to the commission to inform service delivery in this region? ---Yes. Absolutely, yes.

You mentioned before staffing in the area with respect to child safety. Is the Mount Isa and Gulf Child Safety Services staffing structure in terms of Indigenous employment across all levels, helpful to provide insight into cultural competency of staffing levels across the state?---Sure. I mentioned that the - but in saying that, all the government departments and agencies out here, their staffing profile wouldn't reflect the population which we're dealing with, but the Mount Isa service centre here is - for child safety, is one of those that has a good profile in terms of Aboriginal and Torres Strait Islander staff. It is a challenge across the state government out here to recruit, attract and retain skilled Aboriginal and Torres Strait Islander workers. It has got better since we've had the change in the recruitment directive, which enables us now to do targeted recruitment for Aboriginal and Torres Strait Islander people without having to have the position identified. I think in my statement I refer to that as P2800, but effectively it means that we can get approval for the process to be for Aboriginal and Torres Strait Islander people only rather than the position. That is something that we have used in North Queensland across the former Department of Communities and now in the respective agencies as a major recruitment tool to try and

drive up our numbers for Aboriginal and Torres Strait Islander staff.

So you would suggest that that should be applied across the state?---It's available to be applied across the state now. It's a Public Service Commission directive.

So it's much more flexible in its approach in terms of creating pools of applicants. The application process does not need responses to specific selection criteria. So it was based on feedback and research about why there were barriers to attraction, recruitment and retention of Aboriginal and Torres Strait Islander staff so certainly it's available for use everywhere.

Thank you. In paragraph 17 of your statement you refer to providing a more culturally appropriate service centre and increasing opportunities for Aboriginal and Torres Strait Islander children to stay connected to their culture whilst in care. You may be aware of legislative provisions that seek to preserve and enhance culture?---Yes.

Therefore, given this legislative framework, we are quite interested in the results in terms of Aboriginal and Torres Strait Islander children and connection to culture. Can you give your opinion on what these results are?---Well, this process has only been going for about 12 months so I'm not sure that we can necessarily point to any immediate outcomes. There are some practical examples in there, one involving the art project that Barbara Sam led at a local level. So part of that is around again using whatever local resources we have to meet the objectives of connectedness to culture and to try and support agencies, whether they're funded or non-funded, direct government service or not, to meet those. So that's really around us doing quite practical things on the ground.

So consistent with your statement, you would support a concerted effort and resources funding allocation continuing in this area?---Absolutely.

Do you have any implementation as to how results are measured?---Under those local service delivery plans or just generally in that regard?

With respect to the projects aimed at connection with culture?---I can't answer that, sorry. I could find out. I'd need to go back to the source documents for them.

Can you provide that on notice, if required?---Sure.

Thank you. With respect to paragraph 18 of your statement, you highlight the importance of Aboriginal and Torres Strait Islander professionals and you speak again of project 2800 which you've just referred to?---Yes.

We see that the department in this region has embraced this policy. The Aboriginal and Torres Strait Islander Legal Service accepts this is a positive. However, we are interested in your thoughts about the key policy advisers or regional indigenous advisers recently being made redundant. What do you think the impact will be on the department's level of cultural competency?---In terms of -

sorry, I'm not familiar with those positions that were made redundant.

Recently a senior indigenous resource officer based in Townsville was made redundant in this area?---Okay, yes, I know the position that you're talking about now. Look, one of the concerns or one of the outcomes of the recent restructuring, job reduction, budget management strategy, however you want to point to it, has been a loss of Aboriginal and Torres Strait Islander staff across the region and across all service streams and departments; you know, for example, we lost 31 positions for the Department of Education - sorry, for DETE which was employment and training. A number of those were indigenous staff. I'm concerned across the impact on that in-service delivery, cultural appropriateness or cultural competence of the public sector as a whole, not necessarily just isolating that to child safety. I think we have a lot of work now. We've lost a lot of corporate and cultural knowledge by losing indigenous staff who we can't re-employ for a period of time now under the redundancy provisions so, yes, it's one of my concerns about the current restructure.

Would you expect within this region either regional director or regional executive director level to provide or to consider a full briefing of the importance of these indigenous roles prior to making decisions in relation to redundancy?---That's a bit of a hard one for me to answer. I mean, at the end of the day it's up to those respective agencies to make a decision based on whatever the criteria was they were using for redundancy. I can only say that in terms of my - you know, I came from that department. In my view the North Queensland region was the leading region in terms of recruitment, retention and promotion of Aboriginal and Torres Strait Islander staff. We are certainly the region that was leading the charge in terms of taking up the provision. We had a number of processes that were going on around trying to work more effectively with indigenous staff across all the service streams.

Are you aware that a redundancy in that category would be of the whole position, not just the staff member involved? ---Yes, my understanding is it's a position rather than just the staff member.

The Aboriginal and Torres Strait Islander Legal Service is accepting of the current Queensland government's initiative to reduce a top-heavy public service and we anecdotally accept that this redundancy initiative could be achieved whilst maintaining cultural competency. What's your opinion of the possibility of losing vital Aboriginal and Torres Strait Islander roles?---I think I said that before. I mean, where I'm sitting from in terms of looking at the system or the whole of the public section I am concerned about the loss of Aboriginal and Torres Strait Islander staff services, specialist services. Part of what we're

doing is now working intensively across all agencies, not just in the Department of Communities to work out how we can look at some way in terms of replacing some of those services or being able to work with the community in the public sector to more effectively keep service retention and provide services to the community.

In paragraph 19 of your statement you give evidence of meeting with the elders in the Mount Isa region that raised questions and concerns about child protection. Can you elaborate specifically on what those concerns and questions were?---No, not necessarily, not now, but I can again get that information to you about the specifics for that meeting. In terms of - I've said before that the general issues around staffing, you know, numbers of indigenous staff, communication, of which that was one of the things that the meeting was called for, are the things that are broadly raised, but I can get you the information from that meeting. I'm happy to do that.

Thank you. In paragraph 24 of your statement you state that the community was very vocal regarding the governmental lack of understanding of Aboriginal and Torres Strait Islander family structures and cultural practices. Do you accept and agree with these concerns?---Yes, and a lot of that comes back to that issue about understanding family structures, how family - how decisions are made within families, and that's primarily the basis for that conversation, so getting back to the broader concept of how siblings are involved in decision-making for the family and that extended support network. That's really what that is around and so the legislation of who is the family and who to deal with and - that's one of the barriers at a legislative viewpoint, but at a practical level it is also around how easily can information and consultation happen with a family group around a particular child or a particular parent.

In that same paragraph "community suggests legislative changes". Do you have a record of these?---That was really what I just said, around the legislative change around the definition of "family".

So it's only specific to the - - -?---That was the specific one that was raised and has been raised on a number of occasions.

Anecdotally the Aboriginal and Torres Strait Islander Legal Service are aware that within the gulf region in particular English may be a second or third language. In your work with FaHCSIA, have you become aware of the National COAG Indigenous Interpreters Framework?---Yes.

And importantly the benefits of that framework to community. You would support such processes then being engaged in the child protection arena such as family group

meetings utilising interpreters as mandatory to engaging community?---If required; if it is a language issue. I'll be honest, I don't often come across that in Doomadgee and Mornington anywhere near the same extent as other. Aurukun, as I said before, is a community where the language of choice and the language of transactions, whether it's business, commerce or anything in that, is in Wik. But certainly if there's a language barrier, commonsense would dictate that you'd need to overcome that in terms of using an interpreter.

Just leading on to paragraph 26 of your statement where you highlight early intervention, you continually feel obligated throughout your statement to raise cultural appropriateness and competency. Why is that so important when working with Aboriginal and Torres Strait Islander people?---It's about to get traction, to get results there's got to be effective engagement, and particularly if we're talking about a case management framework, you know, the practitioners in the room will explain that to actually achieve results you need - best practice is if you can get the family to endorse and work within that case management that you're doing. And the earlier that can happen, the less intrusive, the less adversarial the process is, and to have effective engagement with Aboriginal and Torres Strait Islander families - again, what we've been saying - requires that people have an understanding of family make-up, the value system, what's important, to be able to form effective partnership with the families. And just as important as it is for the Department of Child Safety or any government agency to have those skills and value sets themselves. It is just as important, if not more so, for funded NGOs that are in this space for us to be able to demonstrate those same skill sets, values and attributes when they're dealing with indigenous families.

We've heard a lot about the deficiencies in child protection with respect she Aboriginal and Torres Strait Islander children, and you were clearly agree that it is important to raise the inquiry's awareness of the strengths, resilience and positives in Aboriginal and Torres Strait Islander communities. What do you see as the significant strengths in the Mornington Island community?---It's an interesting question. I think Mornington is one of those communities that still has a lot of traditional values of kinship, extended family support available there. In terms of its - and some of those - by its isolation a lot of the people are within the community and have been there for a long time. The recent native title determination has made access to country and culture easier. It also has the cultural centre there doing all of those cultural practices and activities, both within the school and performing around the world, which elevates and escalates the importance of culture and showing it as a guiding light for that community. They have a number of - you know, a lot of community involvement in places like schools. Mornington, as many communities does, has got a - it's around the strength of family, the strength of community, and how that embraces itself and manifests itself in a range of stuff.

And what do you see as the strengths of the Doomadgee community?---Similar things, I suppose. I think particularly the indigenous hip-hop stuff for girls that came through and the sorts of performances and the pride that they had in themselves and their community life was great. The way in which the community can do cultural

things together, I think is a terrific thing and doesn't happen as easily or readily off the discreet communities. It is much harder to do that in a place like Mount Isa or Townsville.

Could you add any specific comments to the Normanton community and/or the Mount Isa community?---In the context of - - -

The strengths of the community?---Okay. No, not anything else that I haven't really covered in those other ones, I'd say. In terms of Normanton, it is got a - obviously a very strong and vibrant housing organisation that's community-controlled. There are community-controlled health services in Mount Isa and community-controlled organisations here. And Normanton also has a number of traditional owner groups that are working in a range of activities as well as the Mayor.

Can you give any insight on these, and would you view them as appropriate investments that would increase family functioning and general community harmony leading to better child protection within Aboriginal and Torres Strait Islander communities?---Sorry I don't quite - insight into - - -

The community strengths?---Sure. As far as I'm concerned it really goes back to that initial thing - statement that I said, that literature, practice, evidence will tell us all that for programs, services, activities to have any life and sustainability on communities you need to maximise and drive community ownership and involvement; and as far as possible devolve decision-making to that level. That's the philosophy that we try and work with and drive other agencies to do as well.

No further questions.

COMMISSIONER: Thanks. Mr Capper.

MR CAPPER: Thank you. Craig Capper from the Commissioner for Children and Young People and Child Guardian. I just really want to canvass one main area with you, which is the issue of blue card that you've raised?---Yes.

You identified that the commission had undertaken quite a significant amount of work in this area, particularly in the regions of build partnerships in those areas?---Yes.

Particularly in Doomadgee, Mornington, all of the remote communities. Is that correct?---Yes, absolutely.

And certainly the Commissioner acknowledges that there's always more work to be done and there's always more we can do. But in relation to that, you say that there are

certainly three main areas that you've identified, which is all of the adult members having to have a blue card and the transient nature. Now, keeping in mind that the Commissioner for Children and Young People Act firstly has paramount interest being the best interests of the child. That's the paramount consideration for anything that we do in relation to blue card?---Yes.

Do you accept that?---Yes.

And keeping in mind that the intention of that blue card screening process is to ensure that persons who are deemed as inappropriate to reside, particularly in an intimate-type environment such as a home, with persons - or persons who are there who may harm children or who may impose risk of harm to children. Surely you would accept that it is an appropriate safeguard to ensure that those people continue to get screened, particular from criminal history perspective? Do you agree with that?---Yes.

Thank you. Now, in relation to process, obviously the process of getting a blue card, we can always fix process. We can make them easier, better, appropriate. Are there any particular areas in that that you can make any suggestions and recommendations from, from what you've heard, or is it something that we could perhaps work with - - -?---Again, I think it's identifying and working with the local partners on the ground in whatever location that might be. So that would be justice groups who can actually provide real practical assistance for people to be able to complete the application, particularly where there's low literacy levels but, you know, we still require people to be able to participate effectively in community life, whether that's as a carer or a guardian or as a volunteer with the local footy team.

So the bigger issue there is really just making sure that we can engage at local level to get a blue card applications and those things done and build partnerships and relationships at that level, and that can overcome that concern?---Yes.

Okay. And in relation to communities, you say that the over-representation in the youth justice, criminal justice system, obviously that's in relation to lower-level offending as opposed to more serious offending, wouldn't you agree with that?---In a handful of instances, yes.

Which would generally not include people being excluded from blue card?---No, but what it means is that people think they are, so that is a barrier to - - -

Of course. But again, it is a perception that we've got to overcome?---It's a barrier to completing the application in the first place.

Okay, thank you. And in relation to the self-regulatory model that counsel assisting put to you, you were asked to comment on whether or not that was an option. When you say that it might be an option, I guess the concern that the commission has, obviously we conducted an independent process at this stage; certainly the CMC report indicated that the notion of the agency being responsible for screening as well as the agency been responsible for creating placements created this tension where you could say, "Well, there is a risk there but" - and there was certainly evidence to the CMC inquiry that there was a risk there that - "but albeit there's a risk, we are prepared to take the chance because we really need this carer," wouldn't that tension still exist if we went down that self-regulatory model as well?---Sure. I think the issue there is that again, it goes back to the premise that I've been saying around valuing the local input in design and implementation, and so I think the Commissioner said it could be the family responsibility commissioners, for example, who if they were available in those communities to provide another avenue. Really, it's just trying to overcome the structural impediments that are - as you say, are as much about perception than anything else.

Okay?---I think they're the key - - -

So would you agree though, it could also be a situation where it may just simply be that the blue card process and the engagement with community needs a little bit more tweaking, as opposed to necessarily from the baby out with the bathwater, as it were?---Yes, could be.

Thank you.

COMMISSIONER: Thanks, Mr Capper and Ms McMillan.

MS McMILLAN: I have nothing further. Might this witness be excused?

COMMISSIONER: Mr Anderson, thanks very much for coming. I appreciate your time and the information you've given us.

WITNESS WITHDREW

MS McMILLAN: Mr Commissioner, that's the evidence for this regional sitting.

COMMISSIONER: All right. I'll adjourn the hearing to Tuesday 23 October, 9.30 am in Rockhampton. See you then.

THE COMMISSION ADJOURNED AT 1.16 PM
UNTIL TUESDAY, 23 OCTOBER 2012