Submission to the Queensland Child Protection Commission of Inquiry 2012

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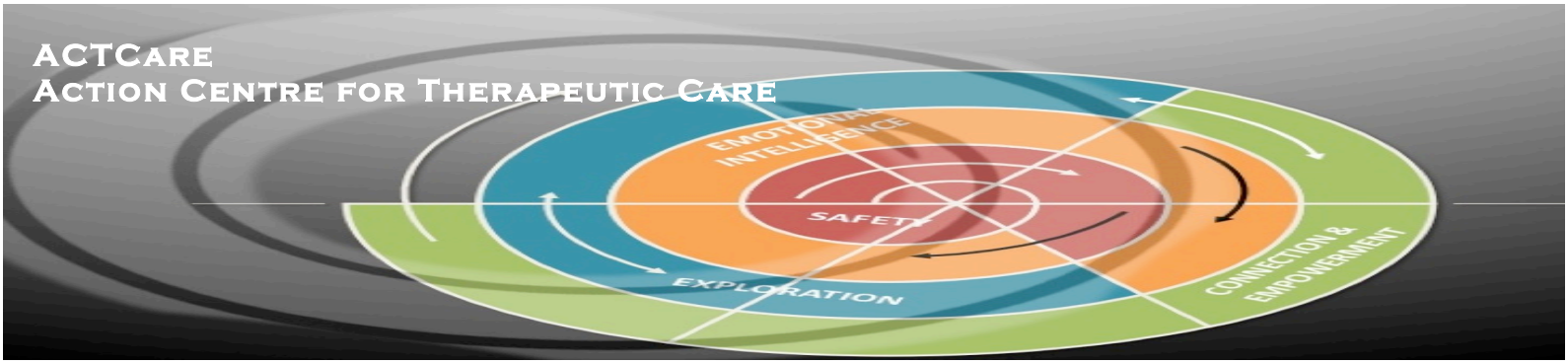

The Honourable Tim Carmody 28.9.2012
SC Commissioner
The Inquiry into Queensland's Child Protection System
BRISBANE QLD 4001

Dear Commissioner Carmody

I currently work in northern and far northern Queensland as a consultant, trainer and family therapist. My main areas of work are:

- Therapeutic residential services in Cairns and Townsville (Uniting Care Community)
- Entry to care assessment program, the First Response Project, an entry to care placement and assessment pilot program in Cairns (Uniting Care Communities)
- Therapeutic support for vulnerable foster care placements, where placements are in danger of breaking down, or for children with complex needs moving to new placements – Cairns, Cape York and the Torres Strait Islands
- Complex assessments of children in care, to assist the Department of Communities, Child Safety to make decisions about children's placements, and court reports, or reports on Matters of Concern (Cairns and Townsville)
- Literature reviews and practice frameworks, which are often requested by organisations wishing to expand their services or develop new programs. To date I have written these on the following topics:
    - Professional foster care
    - Children under 12 in residential care
    - Sibling groups in care
    - Every Child Every Chance and Child First – innovations in child protection practice
    - Therapeutic residential care
    - Indigenous residential care
    - Attachment and Identity: Indigenous children in non-indigenous placements
    - High risk adolescents

This submission to the Inquiry is based on my current work and research, and my interest is to bring into focus the needs of children, from the perspective of practice in the child welfare field.

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Recommendations for the improvement of the placement and family support sector in Queensland

- Outsourcing of the placement sector, with better resourcing and pay, access to research and evaluation, an emphasis on practice frameworks, and the inclusion of therapeutic/clinical services within the placement sector.
- The development of an independent, stand alone research and practice development organisation, perhaps tied to a peak body rather than a university, where current evidence-based and evidence-informed practice can be generated for the use of the Non-Government sector. Research and evaluation should be built into every program, and an independent research organisation could conduct this.
- A reduction in the number of placement providers, with a focus on resourcing and capacity building for a few organisations who have excellent track records in providing good care for children, and other services for vulnerable families. These organisations should then co-locate early intervention, family reunification, therapeutic and placement services together so that children and families receive a stream-lined service and there is less chance of drift. Connecting placement services and family support/reunification services would reduce the tendency for favoring either the foster care placement or the family. This smaller number of providers should be NGO's, with community accountability, rather than private or for-profit providers with no community accountability in the form of committees or boards of management.
- A focus on collaborative practice, where Care Teams for each child in care meet regularly, share assessments, agree on interventions, share the anxiety and the risks.
- The introduction of professional therapeutic foster care. These carers would work with children entering the care system, those with complex difficulties and be available to work with, coach and support natural families. This would require extensive reorganisation but save money in the longer term.
- Extending and improving residential care services. All residential care should operate from a therapeutic model. There should also be a range of longer term residential options such as long term group homes for large sibling groups, or other children who cannot live with their own families, but don't fit well with foster care, specialised residential services for children with Fetal Alcohol Syndrome, sexualised behaviours and sexual offending, as well as some provision of secure

and semi-secure care for young people who are at risk of harming themselves or others. Specialist residential services should also be provided for vulnerable young women and their babies, to prevent those children going into long term foster care placements. Family work should be a major part of all residential services.

- A reorganisation of the placement sector so that professional foster carers and high quality residential services become the first placement for the majority of children. Entry to care assessments can then be conducted while work is going on with the natural family, and good planning for placements, therapeutic and other intervention, further assessment, and family support and family work can be undertaken. If children are to stay in care, those needing intensive therapeutic placements could stay with the professional carers and residential services, and have some of their difficulties resolved before being placed in kinship or general care. This would free up the voluntary care sector, and children could be placed after many of their difficulties have been addressed, resulting in better matching and fewer placement breakdowns.
- A process of six monthly reviews for all children in care, to notice improvements and deteriorations in child and/or family functioning, with the aim of providing interventions before crises occur or placements breakdown.
- Therapeutic services such as Evolve may be better placed in the NGO sector, alongside placement services and family reunification services. This would provide clinical thinking across all these services and allow workers to access qualified mental health practitioners as required. These services should have a much greater emphasis on family and systemic therapies, to assist children with their families always in mind.

Creating a better functioning system would require a re-distribution of costs in the early stages, but see a definite return for that investment, with a result of fewer children in long term care, fewer children with complex emotional and behavioural difficulties, fewer child deaths, reductions in incarceration of children, and of adults who have been in care, reductions in violent and criminal behaviours, reductions in intergenerational child abuse and neglect. Any government achieving these aims would be highly regarded internationally and locally, but this will require a long-term view.

What works in child welfare:

There are many problems with the current child protection and out of home care sector in Queensland, which I am sure will be outlined in detail by many of the people who are interviewed by the Inquiry. My comments in this submission are directed more toward the family support and placement areas than child protection itself. My desire in formulating this submission is to offer some insights into what does work, and what could work more effectively for the children, families and caregivers involved in the system. Child protection and out of home care is an incredibly difficult service system to get right, however much is now known about effective ways to work with vulnerable children and their families, the majority of which is not implemented in our service system. The reasons why not are worth exploring, and include:

- A lack of knowledge in the sector that is not helped by a lack of ongoing evaluation, research and exploration of national and international outcome studies. The majority of services funded by the Department of Communities are not required to evaluate the effectiveness of their programs. In particular there is little focus on children's recovery from abuse and neglect, no tracking of incremental change and little focus on lasting change. Data that is collected tends to be very general and focuses on outputs rather than outcomes, and so we do not know which programs, services or organisations are doing effective work. Some of the large organisations internally fund their own research and evaluation, and while this is a good step, it is not widespread.
- The Department of Communities funds organisations to provide services without setting any practice guidelines for those services. Guidelines focus on program structure, but rarely on practice, which means that organisations have to make their own judgments about what may be the best approach for each client or each client group. This is fine in a well-resourced organisation where there is a focus on ongoing development, on practice frameworks and on internal evaluations, but there is no requirement that this takes place. Funders should be aware of current research indicating which interventions, programs, service types and practice will be the most useful to specific groups of vulnerable children and their families.
- There appears to be a lack of knowledge in the Department funding sector about evidence based practice, funders really should know what the research says about different interventions, so that services can be chosen and advised based on good evidence.
- The sector is deeply stressed, with too many children entering the care system for foster carers to cope with, and too many children with very

complex emotional, behavioural and mental health difficulties. Departmental case loads are high, collaborative practice is low, and the stresses turn into blame and mistrust that can circulate in a system with very negative results. This increases the stress on all workers, and reduces their capacity to engage in best practice.

Many of the organisations providing out of home care and other services are not well resourced, nor are they necessarily well structured internally. Private business providers, who have no community accountability in the form of boards or committees of management have few checks and balances to ensure that the money they receive from government is well spent.

Promising programs:

Entry to care assessment:

Entry to care assessment programs or services are essential for service improvement in the child protection and care sector. An entry to care program like Uniting Care's First Response Project (currently running in Cairns) is providing a service that fills a number of gaps, including:

- Base line assessment of children as they enter care
- Engagement, assessment and brief intervention with natural families/parents at the point of crisis, as their children enter care
- Comprehensive mapping of the child's family and networks, which aids in finding kinship carers
- Recommendations for further assessment, specialist intervention and family work, or for placement matching

The First Response Project uses the Child In Care Assessment tools (ChiCA), which are comprised of:

- An Observation Tool for carers to fill out several times during the twelve week period of the assessment
- An Assessment Tool for workers to fill out, that has two sections, a child assessment and a family assessment
- A Wellbeing Plan that puts together a formulation of the child and family, and recommendations for further placement, assessment, intervention and family work

The Child in Care Assessment framework also has a Carer Training and Appraisal Matrix that assists carers to increase their knowledge and skills, also across the 7 ChiCA domains.

The package of assessment and intervention is then comprised of:

- Comprehensive, yet brief and time efficient assessment of children across the seven domains of Identity, Relationships, Stress, Socialisation, Health, Development and Learning
- Brief assessment of the natural family across the same domains
- Assistance for care-givers, who are supported to support, coach, and mentor family members during family contact and at other times
- Intervention with natural families in the form of engagement at the point of crisis (entry to the care system), to create change that will allow the safe parenting of their children
- Training and support for caregivers to complete the assessment tools, care for the children, and help manage the anxieties of the children and families
- Collaborative practice with the Department of Communities – Child Safety, to share the information collected and assist in decision making

So far in Cairns the First Response Project has seen far more children go home or go to kinship placements than is the norm for entry to care cases, and far more support going to natural families at the time it is needed. While it is early days, and some of these children may re-enter care later, it is a very promising result. First Response has also encouraged much greater collaboration between the placement services, Child Safety and ongoing support services such as Family Intervention (FIS).

Those children who have stayed in care have either stayed with their first placement or moved on to suitably matched placements where they are most likely to get their needs met.

The First Response project offers support through an assessment process to families in this early stage of their involvement with the care system, and this highlights a number of very interesting issues:

- Parents/families do not feel safe with Child Protection staff at this point in time, and so do not disclose all the relevant information, fearing that if they do tell the whole story they will be seen as not coping and never get their children back.
- Parents often don't disclosure all the available kinship options at this

point, also due to fear – that Child Safety will take their relative's children, or that they will send their child to someone in the family, and they will never get them back.

- There is often little communication with the parent, from Child Safety, due to the need for legal processes, being too busy and relying on the parent to approach them (which they are unlikely to do if they are frightened).
- If work is done in this crisis period, there is often an opportunity to resolve issues, stop substance abuse, have mental health needs attended to, provide supports, connect with community networks and services, because there is a motivation to change and to have children return. This is incredibly important for infants and young children, whose attachment with their parents can be harmed by lengthy stays in care. It is not unusual for parents to lose hope when there is no quick resolution.
- There are very few relevant, free and effective counselling options for parents during this phase. The Family Intervention Services (FIS) don't get involved until later, when there is a case plan outlining family reunification, parents are not usually eligible for counselling through early intervention services such as the RAI programs, as these services stop when a child enters care, and GP clinics, community health and other welfare services usually offer a time-limited service. Parents with entrenched difficulties often find they need support to attend services or counseling at times of crisis, and this support is rarely forthcoming from Child Safety, who are in a forensic Investigation mode.

Entry to care services could be expanded from a small placement service to a team who could provide the assessments and family work across all the children who enter care in a region, whether they go to foster care, kinship care or residential options, and could also be extended to 6 monthly reviews. With the baseline assessment already in place, six monthly reviews would pick up both progress and deterioration in the child and family functioning.

Therapeutic care

Therapeutic foster care has not yet been trialed in Queensland, although some organisations provide some form of it on their own. This is a missing link in the service provision for vulnerable children in care and has shown very good results in Victoria (the Circle Program). As with therapeutic residential care, therapeutic foster care will work best with a coherent practice framework, trained clinicians and placement support workers and well trained and supported foster carers.

Therapeutic residential care, on the other hand, has been trialed in Queensland, with great promise but mixed results. These services are mostly very new in Queensland, and have not yet completely stabilized. Therapeutic residential care is very different to other forms of residential care and it takes a long time for a service to select, train and mentor appropriate staff. It can take up to two years for a service to begin getting good results for young people, but once it does, the results are excellent, with young people able to rejoin their families, move into foster or kinship placements, return to school and reduce problematic behaviours.

Relationships between the therapeutic residentials and the Department of Communities, Child Safety are also not yet stable in every region, which means that inappropriate referrals are sometimes made. Until Departmental personnel understand that the therapeutic residentials are not set up to be treatment centres, or psychiatric inpatient centres, they will continue to refer some of the very high risk young people who have significant mental health, criminal and substance use problems. Unfortunately these young people tend to lead others astray, and form a group who become very difficult to work with. Therapeutic residential staff are not trained psychiatric or substance use clinicians, and will struggle to contain and form relationships with this group of young people (see comments on high risk adolescents). Some of the other difficulties in setting up therapeutic residential care include:

- Lack of trained staff who can provide a therapeutic response to young people, with structure, limit setting and high levels of nurture. The workforce who can do this well is growing, however we still do not have a robust group who can stick with these young people in the way therapeutic care requires. There is a particular lack of Indigenous residential care workers, and this could be a specific focus for the improvement of therapeutic residentials.
- Lack of a pool of trained managers, teams leaders and clinician/therapists who understand therapeutic care models and are able to lead their teams to good practice. This means every new person coming into these services takes time to be trained up before they are really effective.
- Pay rates, particularly for managers and clinicians, where some NGO's are bound by work place agreements that do not have pay levels that are competitive with government or Queensland Health.
- Organisational frameworks that are not completely compatible with the provision of therapeutic care, for example have poor provisions for training, supervision or team meetings (staff are not paid for their time except when they are actually working in the residential in some services).

It is also possible to provide therapeutic residential care at less cost than the major TRS services, for example, in Cairns there is a girls residential run as a therapeutic service on general (slightly higher than normal) residential funding (Uniting Care Community's Sunbird House). This is a very interesting experiment that is providing a therapeutic service for young women who are in the high needs to complex group, who have been removed from or rejected by their families, but for whom family reunification is a real option. This two year old service is now operating very effectively, with young women (80% of whom have been Indigenous so far) moving on to independent living, returning to family or moving to foster care. Interestingly this service does not do well with young women with more extreme behaviours, particularly extreme aggression, as they do not have the staffing levels (awake shifts at night, extra staff to do one-on-one work, or to separate young people), to cope with this kind of behaviour. Moving toward all residential services operating as therapeutic residentials has been Queensland's aim, and this service is an example of doing just that.

Therapeutic residential services have good outcomes in the overseas research literature (Anglin, 2004, Bloom, 2005,Kendrick, 2008,Ward et al, 2003), and the evaluation studies from the Victorian initiatives (http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/712868/therapeutic-residential-care-report.pdf) are also proving them effective, but this form of care needs ongoing support, careful attention and evaluation for it to be more effective in Queensland.

Other practice improvements:

Collaborative systems work

Currently Queensland Child Protection services, including out-of-home care, do not have any coherent framework for collaborative practice. There is no requirement for CSO's to meet regularly with out-of-home care or other practitioners, to discuss case plans, care plans, concerns or directions for children and families involved in the system.

A useful approach when working with complex young people, families and systems is to work as part of a care team. This is essentially a coordinated group of people who meet on a regular basis to think, plan and together provide support for the young person and their family. The care team provides an opportunity for key people to come together to reflect, share their thinking and understanding and coordinate each person's role in supporting the young person and family. These meetings can also make sure that what is planned is actually carried out.

The main difference between a care team and other meetings or forums (such as case conferences, professionals' meetings or stakeholder meetings) is the development of the care team as a 'working group' which promotes an attitude of collaboration and information-sharing. It is useful for those who are working closely with a young person to meet in this way to share the work, so that recommendations and plans can be individualised and implemented by those who know the young person and family. Young people and, where appropriate, family members, should be invited to these meetings, and given an opportunity to contribute or at least to be informed of agendas, decisions and plans.

A care team approach increases collaboration and reduces conflict and splitting. It is a forum that can be used to help each member to manage the anxieties and concerns that are often a part of the complexity of child protection and care work. Worries and fears about a young person can be put on the table, so that the concerns can be shared. Care team approaches cut down on conflict, misinterpretations, and increase the possibility that everyone will be on the same page.

In a care team the focus on the changing needs of the young person allows for a consistent approach. In practice this means that the young person experiences consistency in their interactions with everyone in the system.

High risk adolescents

It is very difficult to provide adequate care for this group of young people once they are on a downward spiral. They usually present with substance mis-use, mental health difficulties, aggression and violence, criminal activities, and have very little trust in adults due to multiple experiences of abuse, neglect, rejection and disappointment. These young people cost our society huge sums to contain and support, and they inflict suffering on themselves and others.

This is a group of young people who have usually been in the care system for some time, and really should be picked up much earlier, before they have slipped so far. It is not difficult to predict, from abuse histories and current presentations, at age 10 – 12, which children will move into adolescence with such high needs. However, because our current system can only see the here and now, and looks at current needs and behaviours, not at complex attachment and mental health problems, or at abuse histories, and cannot think clinically about children and families, they will only provide intensive services after a serious decline has begun, after important foster or kinship placements have broken down and young people are already failing.

A typical presentation at age 10 – 12 is a child who is several years below grade average or potential academically who is starting to spend more time

away from their home (foster or kinship) without permission, is wagging school, is starting to spend time with undesirable peers, is becoming oppositional and defiant to authority and parent figures, is starting to self harm, engage in criminal activities, aggression, experimenting with drugs and alcohol, is displaying emotional difficulties, is hard to connect with, is grieving and pining for biological family, and that this is all becoming progressively worse. We should have a red flag system to identify these young people before they move into the residential care system.

To stop this slide we need a change of thinking and completely different practice. We need:

- Thorough assessment on entering care, so that we have a complete picture of what has happened to this child and how they and their family have responded, and a base-line to track later improvement or deterioration
- Interventions based on the child's history as well as their current presentation
- A focus on trauma and attachment difficulties, not just behavioural problems
- Ongoing, six monthly reviews of all children in care, to notice the beginnings of difficulties and provide interventions before extreme deteriorations

Once a child has begun to display the kinds of difficulties described above, a range of interventions should be put in place, such as:

- Thorough appraisal of natural family to see if there is a possibility of the child returning home, and what supports would be needed for that to be safe, or at least having better relationships and more contact with biological family members (it can be issues of identity and belonging that fuel the downward slide, particularly for Indigenous children)
- Therapeutic interventions in the foster or kinship placement, focused on the relationships between the child and caregivers, not just individual therapy for the child, and support and guidance for the foster/kinship parents
- If the placement is very fragile, or the above intervention has not been effective, placement in a therapeutic residential program, while continuing to work with the foster/kinship family or natural family, with a view to the child returning
- Therapeutic residential placement with a view to a new foster, kinship or group home placement afterward

If problems are so entrenched that it is too late for the above interventions, a range of options also needs to be available. Assessment and trial of different environments will assist in determining the best approach for these young people, but it is very important to understand that care options are not the main solution for this client group. Collaborative systems approaches have been shown in national and international research to have the most effect on improving the life chances of high risk adolescents, where a concerned and committed group of professionals and caregivers meet regularly to discus, share risk and share the anxiety generated by them. Collaborative practice that provides good linkage for young people into youth services is also recommended.

The kinds of care options available could include:

- Supported return to family
- One-on-one residential
- Secure or semi-secure residential
- Treatment foster care
- Residential and fostercare working together to prevent burn out of caregivers
- Care options away from towns and cities, farm/outback/outstation approaches

Some of these young people will do well in highly contained and supportive environments, others will do better in less restrictive environments, and it is hard to know which until they are tried.

In general it is not a good idea to place high risk adolescents together because of contagion factors, they will run away together, use substances together, engage in criminal activity and violence, and will bond with each other, rather than with caregivers.

To do this well, we need to up-skill our workforce, and focus on collaborative systems work.

Professional foster care

Professional foster care has been spoken of in Australia for some time, however as yet there is little movement towards this. The literature from national and international research indicates that as our foster care system continues to be overloaded and fails to support children with very high needs, something else must be done. The key findings from this literature state:

- No Australian state has as yet introduced professional foster care in any systematic way, with Victoria seeming likely to in the near future

- The discussion of professional care in Australia is centred on the residential care sector
- Out of home care is in crisis, there are not enough caregivers to meet the demand for placements for children and young people who cannot live with their own families due to abuse and neglect
- Children and young people in out of home care currently experience high levels of mental, emotional, relational and behavioural health issues, rate poorly in educational assessments, struggle on leaving the care system, and have generally much poorer life outcomes that their peers. These children and young people are more likely to experience unemployment, homelessness, early pregnancy and parenthood, as well as the problems listed above
- Foster carers are currently struggling to care for children and young people with extensive problems
- Professionalisation of out of home care has two themes, the professionalisation of the field of out of home care, and the provision of payment for the work caregivers do
- The professionalisation of foster care is happening in Australia, particularly the ongoing professionalisation of the field of out of home care, but this is happening in an ad hoc manner, it is being driven by the introduction of therapeutic care, and is not systematic, therefore there are only internal agency models, guidelines and practice frameworks being developed for paid professional foster caring
- There are a number of complex issues and theoretical debates to had in relations to professionalisation of foster care, for example, the place of kinship care and implications for Indigenous children and families
- In the overseas research literature, paid professional foster care is reported to increase stability of placements, due to the capacity of caregivers to support the natural family, and makes a large difference in the rates of reunification of children with birth families – this alone makes it worth pursuing

For a professional foster care system to be effectively implemented in Australia, it would seem that there primarily is a need for whole of systems reform. Bringing in payments to caregivers without also restructuring the system to provide a professional system of care would seem a half-way measure only, and potentially a waste of resources. Systems reform should bring a recognition of the different needs of groups of children within the child protection system and we must get better at making accurate assessments, giving families a chance to change while also working on permanency, particularly for infants and young children (Redding et al, 2000). The work done in the UK on concurrent

planning (Kendrick, 2010, Barbell & Freundlich, 2001) highlights a useful way forward for many children. Concurrent planning is essentially a system that provides intensive therapeutic interventions with children and birth parents, using foster carers to connect with birth families and provide coaching and other interventions, while also working with the foster family to consider long term placement if reunification is unsuccessful. It is most commonly used with infants and very young children.

While it is challenging to think of moving Australia's out of home care sector toward a professional system of care, with paid foster carers, there may be no other choice. As the system continues to fail children, their birth families and foster carers, there is increasing pressure on governments to reform out of home care and provide for paid care giving. Reforms are under way in most Australian states, with the provision of more group homes, better resourced residential care, therapeutic residential care, and secure care, all of which cater for children who have not succeeded in foster or kinship care.

Family reunification

Currently family reunification does not have particularly good outcomes in Queensland, although it can be hard to track how successful reunifications are, as there is little available data on the numbers of children successfully returning home from a period of out-of-home care, and being able to stay at home safely.

Family reunification services, particularly the Family Intervention Services (FIS) are not usually run from a therapeutic perspective, but focus on family support to meet the goals set out by Child Safety. They very rarely work with the children and parents together, and very rarely employ trained family therapists. Family therapy is an obvious practice direction, however this is hardly ever done. Many FIS services do not even employ qualified social workers or psychologists, let alone those with a specialization in family work. It would seem logical that the desired change in families is more likely to occur if the workers involved had the skills to engage the whole family and work on safe family relationships. Services undertaking family reunification should be much more specialised, have much greater access to the higher pay rates needed to employ qualified and experienced staff, have therapeutic practice frameworks, clinical supervision and ongoing professional development in specialised family work.

Practice frameworks and training

Practice frameworks are a relatively new concept in Australia, however services and programs who use them find that they have automatic ways of improving the quality of service provision. Workers are trained in the actual practice used in the service, and have a 'map' and set of practice processes to guide them.

Workers then have structure, which is very helpful for unqualified or recent graduates. Without a practice framework workers are guided by their own knowledge and skill base, and their own values, which may be good, or maybe incompatible with current evidence based practice.

There is currently a strong emphasis and call for more training in the child welfare sector, particularly for residential care workers. This is fine, and the workforce is generally under-skilled, however it is very important to have some unified approach to training that takes into account current research on evidence informed practice. Ideally training should follow the preferred practice framework, with entry level, basic and advanced training modules for workers who develop their practice over a period of time. Training should always be tied to supervision structures, on the job learning, coaching, mentoring so that each individual practitioner is held to a learning plan, and taken through their learning in relation to their actual practice. Far too much training is conducted away from the workplace, on topics of marginal relevance, and without connection to preferred practice. This leaves workers confused, as there are a myriad of theories, practices, approaches in the sector that have conflicting advice for practice.

Too many training modules, workshops and presentations focus only on knowledge building, without a focus on translating theory into practice, and so are of little use to workers on the ground.

It is also important that a team of workers all doing the same job are exposed to the same training, so that their practice, values and knowledge line up with the preferred practice framework, and the team is working together to build their practice. Clients should receive a similar service from whoever their worker is, not a different service due to different values, knowledge and practice, as happens if workers are operating from their own practice framework or lack thereof.

It is true that many workers in Queensland's child welfare service sector are under qualified and under-skilled for the jobs they are doing. This is particularly true in residential care, in Indigenous child protection and care services, in foster care placement support, in family support, prevention and intervention, and family reunification services. In Queensland it also seems that the further from a major city you go, the less qualified and experienced the workforce is. In view of this, it is even more important that government and organisations take seriously the development of practice frameworks and internal training programs for their workers.

Indigenous child protection

Again, others making submissions will be able to draw the Inquiry's attention to these issues more ably than I, however there are a few major issues I would like to comment on.

Indigenous issues are incredibly complex, particularly in Cape York, and a fresh approach that truly listens to the view of Indigenous people is sorely needed. Some possibilities include:

- Indigenous child protection could be outsourced to Indigenous people and Indigenous organisations, particularly in remote communities, as is done in North America and Canada. This could be done over a period of time while capacity was build in the communities, and would improve self determination and provide pressure to make the communities safer for children.
- Governments must then provide adequate resources, and a collaborative plan to build the capacity of Indigenous communities and Indigenous workers to look after their own safety, and their own children, with an aim to keep children in their communities and support vulnerable families.

In regional centres and cities, particularly in northern Queensland, there is a great need for more Indigenous workers in the service sector, programs like the ACT for KIDS Workforce Education Initiatives for Indigenous People, have proved very successful and could be expanded to include residential care work, foster care, placement support and other aspects of the child protection and care sector.

Biography, Laurel Downey

(RN, RPN, B.Ed, Grad Dip Family Therapy, Master Family Therapy, currently enrolled in PhD program with Latrobe University)

Laurel is a Family Therapist with over 20 years experience in child and adolescent mental health, including work in the Non-Government, Community and Child & Adolescent Mental Health systems. Before relocating to Far North Queensland she spent 5 years as the Manager of Practice Development and Training with Take Two, a Berry Street program which provides a mental health service to children in the care of the Victorian Department of Child Protection. Laurel is an experienced child and adolescent mental health clinician, with a specialization in child trauma and attachment difficulties, and she has extensive experience in the development of practice frameworks as well as the design and delivery of training for the child protection & placement sectors, including Indigenous placement organisations.

Laurel is currently the Principal Consultant for ACTCare, the Action Centre for Therapeutic Care, a private consultancy, training and therapy service.
Laurel is also the author/co-author of a series of publications, including "Calmer Classrooms: A guide to working with traumatised children", "Caring Classrooms: A guide to understanding traumatised children and young people – for parents and the school community", "Yarning Up On Trauma: Healing ourselves, Healing our children, Healing our families", for Indigenous communities, "From Isolation to Connection: Understanding and working with traumatised children and young people", which was designed for workers from child protection to police, and "Above and Beyond: .

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