Queensland Foster and Kinship Care

Queensland Foster and Kinship Care Main Submission

Child Safety Commission of Inquiry

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Queensland Foster and Kinship Care

Queensland Foster and Kinship Care (QFKC) is a not-for-profit Peak Body organisation for foster and kinship carers and their families, including children and young people in care in Queensland.

QFKC has been established since 1976 with the Board of Governance, Management Committee, who all bring lived experience of providing foster and/or kinship care in Queensland and who currently have more than 200 combined years of experience in family-based care for children.

Across the state, QFKC represents over 6,000 carer families, including foster, kinship, and provisionally approved carers, who provide family-based placements for children in need within the child protection system. The organisation's goal is '*To contribute to the development of an inclusive, responsive and fair foster care system'*, by committing to providing support, advocacy and training facilitation to carers and agency staff on child protection procedures and processes. QFKC is present throughout a carer's journey from recruitment, support, and advocacy, through to exiting.

QFKC is unique among peak bodies as the organisation provides direct service delivery to carer families. This enables QFKC to identify systemic issues from a practice-based perspective which can then be used to advocate for change at a systems level. The organisation's unique perspective, grounded in the lived experiences of carers, enables QFKC to highlight clear systemic issues in this submission.

To assist the Commission in understanding the service delivery arm of QFKC, which will assist in informing these submissions, the following provides a short summary of each program offered by the organisation.

Recruitment and Exit Program

Established in 2014, the Recruitment and Exit program is a statewide program that responds to initial enquiries from community members interested in becoming carers. The Recruitment Coordinator overseeing the program provides enquirers with information to enable them to make an informed decision about progressing their interest in caring. Once decided, the coordinator will then refer community members on to foster and kinship care agencies across the state.

When carers exit the system, our Exit Program involves foster and kinship care agencies to notify QFKC of a carer's exit. From there, QFKC contacts the exiting carer to invite them to participate in an exit interview, which are collated in a yearly report to Child Safety. The insight and data of these two programs will be referenced throughout this submission.

Brisbane and Moreton Bay Recruitment, Assessment and Training Program

The Brisbane and Moreton Bay (BMB) Program was established in late 2024 and currently has three assessment officers and support staff covering the BMB region. QFKC is the first service to be funded under the new Foster Care Specifications for recruitment, assessment and training of foster carers. As stated above, the Recruitment Program provides information and refers interested community

members to foster and kinship care agencies. However, with the establishment of this program, individuals residing within the BMB region are redirected to the BMB program, for which QFKC are then responsible for the training and assessment of these applicants. QFKC has had carriage of this program now for 12 months and will reference our experience in recruitment, training and assessment of new carers throughout this submission.

Returning Carer Assessment Program

The Returning Carer Assessment Program was initially established in 2020 in response to COVID-19, when QFKC submitted a proposal to Child Safety to promote the return of carers to the system – similar to other industries such as Qld Police and Qld Health. QFKC proposed a streamlined process for carers to return to caring. This program was initially funded for 12 months; however, it ceased in 2021 before returning in June 2024 with two full-time assessors. Since the re-establishment of the Returning Carers Assessment Program, in June 2024, 47 carer families have been approved to return to a carer role in providing family-based care at the time of writing this submission. At this stage, this program is not recurrently funded.

Case Officer Program

Established in 2006, the Case Officer Program has six full-time case officers who cover the state of Queensland. QFKC case officers provide support, advocacy and advice to carer families on complex carer matters that are unable to be resolved within the immediate care team (foster and kinship care agency and Child Safety). Whilst carers receive their day-to-day support from foster and kinship care agencies, carers can contact a QFKC case officer to support the resolution of a matter. Case officers complete monthly reports on the types of issues encountered when working with carer families, and this data will be drawn on in this submission. Among the six cases officers, the number of carers families on average in any given month is approximately 180 to 200, with an average of 80 new carers each month reaching out for assistance. Casework data and scenarios will be relied on throughout this submission to support the understanding of the complex matters carers face that require intervention from QFKC.

Retention and Development Officer Program

The Retention and Development (RD) program was established in 2024 and has three full-time RD officers. These positions are not recurrently funded. Each Retention and Development Officer (RDO) covers two regions, and their role is to identify systems issues within the individual Child Safety Service Centre (CSSC) and across the regions as a whole, and to work in partnership with Child Safety and foster and kinship care agencies on strategies focused on carer retention. Carer networks and connections are a pivotal component within the RD program, in which the RDOs have established a network of carers through a Carer Reference Group. This program draws on the rich source of lived-experience knowledge and has been relied on for consultation on retention initiatives; their views have also been sought to inform various parts of this submission.

Region	*No. of Carer Reference Group Members*
Brisbane and Moreton Bay	46
Sunshine Coast and Central	17
South East	35
South West	32
Far North Queensland	17

North Queensland	24
Other (carer has not identified region)	3
TOTAL	174

Table 1. Carer reference group member numbers[1]

The RD program supports the development and delivery of practice-based training, with a focus on upskilling foster and kinship care agency staff through an online training package containing information to assist agency staff to support carers effectively. Whilst in its infancy, this program has developed resources, training, and networks of carers that has contributed to carers feeling heard, valued, and retained.

QFKC Support Team

QFKC's Support Team was established in 2002 and comprises of carers who are trained and supervised by QFKC staff to provide support, advocacy, and advice to fellow carers. The QFKC Support Team are supported by the Retention and Development officer for the region they support. QFKC currently has 16 Support Team members across the state who provide support to fellow carers, assist in the training of carers and are an invaluable source of consultation for QFKC.

Counselling Program

The Counselling program, established in 2024, has one full-time counsellor to develop a Service Delivery Model for a statewide counselling program for carers to access. The proposed Service Delivery Model was presented to Child Safety in January 2025, following extensive consultation with carers, foster and kinship care agencies, and other jurisdictions that have successfully delivered the program, and as well as QFKC's own service testing. QFKC has not been funded for the proposed model and was instead provided funding for one further year. Attached (refer to Attachment A) is a copy of the proposed Service Delivery Model in which QFKC has identified as the most appropriate model to meet the counselling needs of carers. QFKC will be drawing on data and de-identified examples of carers who have accessed the counselling service to inform this submission. As of the end of November 2025, 137 carers had accessed the counselling service, being mindful that this program is managed by one full-time counsellor.

Legal Program

The Legal Program, established in 2019, followed from submissions by QFKC over a 10-year period to establish a service for carers to access free legal advice and representation in review matters before the Queensland Civil Administrative Tribunal and in Child Protection Act 1999 Section 113 matters in the Children's Court. QFKC has partnered with HUB Community Legal Services to provide one 3-day-a-week lawyer position to cover the state through Child Safety's funding. QFKC will draw on data and de-identified examples from our legal program to inform this submission.

Summary

It is clear that the services provided by QFKC extend from the moment a member of the broader community decides to enquire about becoming a carer, through to training, assessment, support,

[1] Queensland Foster and Kinship Care, "Carer Reference Group Members" (Unpublished internal dataset, SharePoint), accessed November 2025.

advocacy, retention, and exit. These programs encompass the entire carer journey and place QFKC, as a Peak Body, in a position to provide an extensive and well-informed submission on behalf of the carer community.

Introduction

The Child Safety Commission of Inquiry calls for a submission in respect to the Terms of References as published in an Extraordinary Queensland Government Gazette on the 23rd of May 2025. QFKC will respond to those Terms of References (TOR) that are relevant to family-based care.

In preparing this submission, it is essential that QFKC, as the Peak Body for carers, accurately represent the lived experiences of carers. To achieve this, QFKC's submission will be informed by the following sources of information:

- Biennial Carer surveys facilitated by QFKC
- Exit Survey Data
- Service delivery programs de-identified scenarios and data
- Carer Reference Group
- 2025 Lived Experience Survey created for this Submission

QFKC needs to acknowledge that there are many examples of good practice undertaken by Child Safety on the ground with families, children and carer households. The very nature of QFKC's service delivery is that carers contact our programs because they have not had a positive experience with the system.

These examples will be referred to throughout this and future submissions; however, as a Peak Body, QFKC would also like to acknowledge the hard work, dedication and commitment of Child Safety staff.

As an overall observation relevant to each of the Terms of Reference, it is QFKC's view that the Queensland Child Protection System framework is not broken. The legislation, policies and procedures that should inform practice provides clear intent on how the system should respond to Child Protection as a whole. It is QFKC's experience that on the ground practice does not always reflect the purpose of these best practice frameworks.

It is important, when considering each of the Terms of Reference, to assess whether the framework already exists to support best practice, and whether focus should be on how we achieve this rather than changing legislation, policies, and procedures that already support the outcomes the sector is striving for.

Terms of Reference

Queensland Foster and Kinship Care (QFKC) will be addressing Section 3a, 3b and 3c of the full Terms of Reference under the *Commissions of Inquiry Order (No.1)* 2025, in relation to foster and kinship carers:

- Fixing a broken system: reviewing the effectiveness of Queensland's child safety system to keep children safe.

- Safer Children: failures both systemic and policy that have impeded the ability of the Department responsible for the Child Safety portfolio (the Department) to provide support to families and protection to children at risk of harm in Queensland.
- Reviewing Queensland legislation about the protection of children, including the *Child Protection Act 1999* and *Adoption Act 2009*.[2]

Fixing a Broken System

i. The practices and procedures of the Department, specifically focussing on investigation, assessment, case work and reunification

The following response will specifically address casework and reunification for the purposes of this TOR.

Case Planning

Children come into care because they have or are at risk of experiencing significant harm. This harm is likely to have been caused by someone with whom the child shares a significant relationship and who is a primary attachment figure. Given that a child's trauma has been caused in the context of a relationship, the most important source of healing for a child will be through the development of a stable and secure relationship – their foster or kinship carer.

Child Safety should view foster and kinship carers as the central source of therapy and healing for a child and a central stakeholder in the case planning and reunification for the child. If viewed in this way, carers would be valued, consulted, listened to and supported.

The right for carers to participate in case planning for children is outlined in the Child Protection Act 1999 in various sections as follows:

- Section 51L (1) (d) – 'who should be involved in a case planning meeting': this section provides approved carers as an example of 'other persons with whom the child has a significant relationship with'. [3]
- 51 W (1)(d): this section of the act speaks to the review of case plans and once again, provides carers as the example of someone with whom the child has a significant relationship and, therefore, should be consulted with.
- 51N states the responsibility of the convenor for a family group meeting where a case plan is developed to obtain the views of persons who are not attending. Therefore, whilst it is recognised that it is not always appropriate to have a carer present at a case plan meeting, there is still an obligation to consult for the views of those people outlined in Section 51L.

In addition to the Child Protection Act 1999, the Statement of Commitment speaks to 'supporting and facilitating the participation of foster and kinship carers in the decisions affecting the life of the child

[2] The State of Queensland, *Queensland Government Gazette*, Vol. 399 No.16 (The State of Queensland,2025), 1, https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/20a4ca84-077f-4bab-bc99-09e2517ce1aa/23.05.25-16-extra-gazette.pdf?ETag=901b06f5cca7b23a3359024da03f9c9e.
[3] *Child Protection Act* 1999 (QLD), s. 51L (1)(d).

or young person in their care' and have the carers 'share their knowledge and opinions to inform decision making processes to ensure the best interest of the children'.[4]

Amendments to the Child Protection Act 1999 under the Child Protection Reform and other Legislation Amendments Act 2022, strengthened the responsibilities for Child Safety to provide relevant information to carers under Section 83A of the Child Protection Act 1999; include the following:

- the provision of information about why the chief executive has custody or guardianship of the child,
- information about any special needs for the child, the proposed length of the placement and
- information the carer will reasonably need to ensure the safety of the child.

In addition to these amendments, further amendments were made that provide examples in legislation under Section 83A subsection 2 (a) - 'of information a carer may reasonably need to provide care for a child under this act'. An example of information reasonably required by a carer provided is a copy of the child's case plan.

The amendments also include the following under Section 83A subsection 6 –

> 'The chief executive must ensure the information given under this section is;
>
> (a) comprehensive; and
>
> (b) in a form that will be easily understood by the person to whom the information is given.'[5]

These amendments leave no doubt in the legislative intent for Child Safety to share information with carers.

Carers' experiences regarding the receipt of case plans and their involvement in case planning consultations have been documented through biennial surveys and a recent survey conducted in September 2025 for this submission. Carers told us the following:

- 56% of carers in 2020 (1139 sample) and in 2022 (770 sample) reported either only *sometimes* or *never feeling satisfied* in their ability to engage in case planning for children in their care. [6,7]
- 51% of carers in the September 2025 Lived Experience Survey (sample 652) reported that they were not kept informed in relation to the progress of reunification and were not consulted during the reunification journey. [8]
- Only 25% of carers in the 2025 Lived Experience Survey reported either *mostly* or *always* receiving case plans for children in their care. [9]

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[4] Department of Children, Youth Justice and Multicultural Affairs, *Statement of Commitment* (n.d), 4, https://www.qld.gov.au/__data/assets/pdf_file/0014/152321/statement-of-commitment.pdf.
[5] *Child Protection Act* 1999 (QLD), s. 83A.
[6] Queensland Foster and Kinship Care, *Carer Survey* 2020, (Brisbane: Queensland Foster and Kinship Care, 2020). https://www.qfkc.com.au/resources/2020-carer-survey-report.
[7] Queensland Foster and Kinship Care, *Carer Survey* 2022, (Brisbane: Queensland Foster and Kinship Care, 2022). https://www.qfkc.com.au/resources/2022-carer-survey-report.
[8] Queensland Foster and Kinship Care, *Lived Experience Survey,* internal report, (Brisbane: Queensland Foster and Kinship Care, 2025).
[9] Queensland Foster and Kinship Care, *Lived Experience Survey*.

The journey of reunification requires a concurrent plan that all care team members, including the child or young person (where age appropriate), are aware of. The requirement to undertake concurrent planning was introduced into the Child Protection Act in 2018, Section 51B (2)(b) – *A case plan must include the following matters 'if returning the child to the care of a parent of the child is the goal for best achieving permanency for the child, an alternative goal in the event that the timely return of the child to the care of the parent is not possible'*.[10]

The introduction of concurrent planning was an outcome of the Carmody Inquiry. The Commission highlighted their *concern '…at the high number of children and young people subject to multiple short-term orders because this could indicate that many children are 'drifting' in care without achieving either reunification with the family or long-term out-of-home care.'*[11]

In summary, legislation supports concurrent planning and allows carers to have a copy of the case plan to assist the care team in working towards the stated goals. The Statement of Commitment further emphasises Child Safety's responsibility to collaborate with foster and kinship carers through concurrent planning, ensuring children and young people achieve permanent care arrangements within the required timeframes, with reunification to parents as the preferred outcome. Therefore, it should be standard practice for carers to receive the case plan and to be actively consulted and informed about the child's concurrent, including their specific role in the process. This practice does not reflect the above.

Case Study

A scenario which reflects the above, relates to kinship carers who QFKC provided support to through our Case Officer Program. The grandparents were approved kinship carers and were able to view court documents through their daughter who was the mother to the children. In the case plans, the carers were listed as 'invited but did not attend'. The Kinship carers advised never being invited to attend case plan meetings and when they raised this with Child Safety, they were told that the drop-down boxes on the plan were limited and there was no option to reflect the carers not being invited. The kinship carer was left dismayed that official records repeatedly indicated they have been invited to these meetings, in accurately portraying them as disinterested in participating in such an important process.

In the 2025 QFKC Lived Experience Survey, carers were asked if they had been consulted and/or advised if there is a concurrent plan in place (if reunification does not occur). Of the 658 responses, only 16.7% said they had been consulted and were aware, 33% stated that sometimes they were, and 50% said no, they were not.[12]

When key messaging around case planning lacks clarity and transparency, it can have significant impacts and lead to serious consequences for carers and the children they care for. QFKC Case Officers work with carers who, at the time of placement, were told that children on short-term orders will not go home. Rightly or wrongly, this messaging may inform how a carer attaches to a child and how they

[10] *Child Protection Act* 1999 (QLD), s.51B (2)(b).
[11] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A roadmap for Queensland Child Protection*, (State of Queensland, 2013), 222, http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0017/202625/qcpci-final-report-web-version.pdf.
[12] Queensland Foster and Kinship Care, *Lived Experience Survey*.

consciously or unconsciously support the goals of the case plan, particularly reunification. When the initial messaging then changes and a carer is now informed the child is transitioning to a kinship carer or being reunified, the emotional impact on the carer can be significant and detrimental. This is the type of practice that leads to carers exiting the system, as they are unable to manage the emotional impact that has resulted from inaccurate and inconsistent messaging.

Case Study

A de-identified case QFKC would like to share in respect to the above, relates to a matter that was managed through our Case Officer Program. A foster care family were newly approved and had their very first placement, a baby placed with them at birth. The baby had siblings who were placed with approved kinship carers; however, were unable to care for another child at the time. The foster care family supported contact between the child placed with them and the kinship care family, inclusive of the siblings. When the child was 18 months old, the foster carers were approached by Child Safety and asked whether they would consider a permanent care order for the child, which they expressed their willingness for. However, Child Safety had not yet ruled out the possibility of transitioning the child to the kinship care family with the siblings, who had since indicated their readiness and ability to care for the child. Even after the kinship family had also expressed their willingness to have the child transitioned into their care, the foster care family continued to receive messaging from the Chid Safety Officer (CSO) that Child Safety were still supportive of the foster carers becoming the child's guardian.

Ultimately, in accordance with legislation, a decision was eventually made for the child to transition to family, by this stage the child was 3 years of age. The foster family were left devastated by their loss. The initial and consistent messaging they had received from Child Safety led them to envision caring for the child long-term, shaping their attachment and parenting approach. Consequently, the carers did not accept another placement for two years and were in the process of resigning from fostering altogether due to their experience. However, after many months of reflection, it was decided they would continue their fostering journey as they were aware of the need for family-based placements. This case scenario clearly demonstrates the importance of concurrent planning and transparent communication, as required under the Child Protection Act, when these practices are not followed, the emotional impact on families can be profound.

The need for case planning, inclusive of concurrent planning, to be purpose-driven and not compliance-driven will be the key to ensuring that those children who can be reunified safely home to their parents can be, and children who are unable to will be provided with the opportunity for permanency either with family or, if not possible, a suitable person.

Permanency Planning

Despite the Carmody Inquiry highlighting in the 2013 report the need for better permanency outcomes for children and young people that encompass relational, physical and legal permanency, resulting in strengthened permanency legislation amendments to the Child Protection Act in 2018 and 2023, children and young people are still not achieving permanency in its complete sense.

As of March 2025, there were 8,116 children and young people subject to Long-Term Orders; 6,106 (75%) were subject to Long-Term Guardianship Orders to the Chief Executive (LTG to CE).[13]

These outcomes can be linked to the lack of effective case planning and the absence of concurrent planning, resulting in Child Safety as a matter of course applying in the Children's Court for the least preferred permanency option for children and young people when a short-term order is due to expire. QFKC has many case examples of these situations where approved grandparents, aunts, and uncles have not even been approached to see if they would consider guardianship. The application for a Long-Term order to the Chief Executive is sought instead, despite this being the least preferred permanency option for children under the Child Protection Act 1999.

QFKC has attached two scenarios (refer to Attachment B) that demonstrate the drawn-out processes, lack of planning, and the impact of not undertaking permanency planning in accordance with the Act. The scenarios in this attachment reflect an example of both a kinship carer and a foster carer who have given permission for their stories to be shared.

Carers were asked as part of the 2025 Lived Experience Survey whether they were currently caring for a child on an LTG to CE order. Of the 620 carers who answered this question, 54% confirmed they were. Carers were then asked whether they had been approached to be assessed as a suitable guardian; of the 328 who answered, 47% had been approached. Carers were asked whether they would like to be considered as a suitable guardian, and of the 600 who responded 78% (468) said they would. Finally, carers were asked 'What do you consider the barriers to legal permanency for children and young people?' 488 carers responded to this question; their responses are attached (refer to Attachment C).[14]

In QFKC's experience, achieving permanency has not been prioritised for children and young people as data clearly shows the least preferred option of permanency is being sought, Long-Term Guardianship to the Chief Executive, when a short-term order expires for non-Aboriginal and Torres Strait Islander children and the third least preferred option for Aboriginal or Torres Strait Islander. This indicates that a final child protection order is in place, and the only way it can be varied in favour of a suitable person is through an application by the Director of Child Protection Litigation (DCPL), a parent, or the child themselves. This application requires extensive work and is not prioritised due to the critical nature of other Child Protection matters. For example, in a recent QFKC casework matter, an Aunty and her teenage niece requested a suitability assessment for Long-Term Guardianship but were told that the application process would take longer than the time of the young person had left on the current LTG to CE order, which was three years.

The intentional practice of meaningful concurrent planning, where two simultaneous plans occur side-by-side, would require pieces of work before the expiry of the short-term order that identifies whether the primary carer is willing to become a guardian and assess their suitability for the role. This ensures the most appropriate order is applied for in a timely manner, preventing unnecessary delays and additional work. This practice also further supports meeting the permanency requirements for children and young people in care in accordance with the Child Protection Act 1999.

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[13] Department of Families, Seniors, Disability Services and Child Safety, "Improving care and post care support", Our performance, access November 2025, https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/who-we-work-with/children-on-orders

[14] Queensland Foster and Kinship Care, *Lived Experience Survey*.

It is also important to highlight the benefit of the correct order being applied for at the right time in respect to the overall pressure on the Child Protection system in Queensland, as follows:

Type of Long-Term Order	Legislative Requirements	No. of Children	Time to complete legislative requirements *(Hypothesised)*	Total no. of hours for all children under order per annum *(Hypothesised)*
Long-Term Order to Chief Executive	*Requires monthly home visits*	6,106	2 hours *(1 hour visit and 1 hour travel)*	146,544
Long-Term Order to a Suitable Person	*Requires 1 home visit per year (at the same time as the yearly case plan review)*			3,138

Table 2. The reality and hypothesised number of hours required to meet legislative requirements for Long-Term Orders

The estimated hours identified above do not account for the two case plan reviews required per year and for day-to-day administrative and case work tasks that a CSO, must undertake in respect of decision-making and other case plan requirements.

Whilst QFKC understands that all 6,106 children subject to an LTG to CE order will not have a suitable person able to take on the guardianship role, even if one quarter of these children were to have a suitable person willing to be their guardian, this could reduce the necessary workload of Child Safety by at least 36, 636 hours.

Taking this a step further, if the most appropriate order for the child or young person is a Permanent Care Order (PCO), then no home visits or case plan reviews will be required, and no allocated hours per child to a CSO. Currently, only 5.4% of all children on Long-Term Orders have a Permanent Care Order granted, despite legislation introduced in 2018 supporting PCOs as a permanency option for children and young people.

Summary of Concerns: Casework & Reunification

1. Carers' Central Role Overlooked

- Foster and kinship carers are not consistently valued or consulted as central figures in case planning and reunification, despite legislation and policy stating they should be.

2. Insufficient Consultation and Information Sharing

- Many carers report dissatisfaction with their ability to engage in case planning.
- A significant proportion are not kept informed about reunification progress or provided with case plans for children in their care.

3. Concurrent Planning Not Effectively Implemented

- Although legislation requires concurrent planning (having a backup plan if reunification isn't possible), practice often falls short.
- Carers are frequently unaware of concurrent plans, leading to confusion and emotional distress.

4. Emotional Impact of Poor Communication

- Inconsistent or unclear messaging about case planning and reunification can cause significant emotional harm to carers and children, sometimes resulting in carers leaving the system.

5. Lack of Prioritisation for Permanency

- The least preferred option for permanency for non-Aboriginal and Torres Strait Islander children and third least preferred option for Aboriginal and Torres Strait Islander children (Long-Term Guardianship to the Chief Executive) is often chosen by default, rather than

exploring family or suitable person guardianship as the legislative preferred option for all children and young people.

- Many family members are not approached for guardianship assessments, despite being willing.

6. Systemic Workload and Resource Issues

- Ineffective case planning increases the workload for Child Safety Officers (CSOs), with thousands of hours spent on home visits and administrative tasks that could be reduced with better permanency planning.

7. Legislative Intent Not Reflected in Practice

- Despite strong legislative frameworks supporting best practice, actual practice on the ground does not consistently achieve intended outcomes for children and carers.

These concerns highlight the gap between policy intent and real-world practice, emphasising the need for more purposeful, transparent, and collaborative case planning that genuinely includes carers and prioritises permanency for children.

Recommendations

- **The Introduction of a Reunification Court**

  For case planning to be effective, it is essential that there be active monitoring and intentional, purposeful reviews of case plans. In South Australia, a 'Reunification Court' was established to achieve this. The Reunification Court is where the judge meets with the parents and the caseworker to review progress towards reunification as agreed in the case plan. It is important to note that the Reunification Court is more relaxed than Care and Protection hearings, as everyone sits at the bar table and discusses the case plan or report. The judge then checks on whether the parents and the Department of Child Protection are doing what they agreed to and that the case plan is being followed.

  The Reunification Court meeting occurs every 6-8 weeks and includes the equivalent Child Safety, parents, the child representative and, if applicable, the Aboriginal Youth Justice officer. The judge can also allow other support services to attend. Other points of interest for the Reunification Court include:

  1. A carer or grandparent has a right to be heard and make a submission to the Court. This can be done either in person or by written submissions.
  2. A child will have a lawyer who speaks on their behalf, however if they would like to attend, they can. If the child wants to say something to the judge a time can be arranged for the Jude to speak to them privately. Children can also write letters to the court.
  3. The same judge attends every hearing.
  4. The hearings occur for around 15-30 minutes.[15]

  Whilst QFKC was unable to locate specific data that provides a cross-sectional examination into the success of the Reunification Court, a media release spoke to a 2022-2023 Report on

[15] Courts Administration Authority, "Reunification Court Resources FAQs", Courts Administration Authority South Australia, 2025, https://www.courts.sa.gov.au/going-to-court/court-locations/youth-court/care-and-protection-jurisdiction/rc-resources-faqs/.

Government Services which showed that "96 per cent of children who exited out of home care to either reunification or a third-party placement, did not return to the care system within a 12 month period, this is the highset result for all jurisdictions and 8 percent above the national average".[16]

- **Resources**

  Resources should be made routinely available to support effective concurrent planning. This includes investing in suitability assessments whenever concurrent planning identifies a potential suitable guardian. These assessments must be completed before the expiry of the short-term order, ensuring that, if reunification is not possible, the most appropriate long-term guardianship order can be applied for upon expiry of the short-term order.

  Resourcing to be provided to undertake suitability assessments for those current primary carers for children subject to Long-Term Guardianship to Chief Executive orders, where they would like to be considered for Guardianship. Whilst current legislation allows a child to apply to vary an order under Section 65, the reality is that it is unlikely that a child or young person is either aware that this is a possibility or is able to take the steps necessary for the application to be made. For the views of children/young people to be genuinely considered in this section, legislation must provide the option of an adult making an application on behalf of a child or young person. The application on behalf of the child or young person would need to be approved in the first instance by a magistrate to be heard, to ensure that the hearing of the application would be in the best interests of the child or young person.

- **Additional Legal Assistance for Carers**

  QFKC is in the process of finalising a submission to Child Safety with a request to increase funding to the organisation's Legal Program. When the program was initially funded in 2019, the funding provided for one full-time lawyer; however, due to CPI not being applied for four years and award rate increases, the funding QFKC currently receives only covers one lawyer for three days per week. Given QFKC's Legal Program is the only free legal service available to carers across Queensland, this part-time position does not meet the need for carers in both the QCAT and Children's Court settings. This legal submission, completed for the purpose of increasing funding, is relevant to this section, as it would allow more carers to be provided with advice and/or representation under Section 113 of the Child Protection Act 1999 to participate in court proceedings relating to permanency planning for children and young people, for whom carers provide care for. The Attachment B scenario regarding the Kinship carers demonstrates the value of this independent legal program in achieving outcomes for families that would not have been achieved otherwise.

[16] Government of South Australia, "New data shows strong improvements in child protection and family support system responses", South Australia, n.d, https://www.premier.sa.gov.au/media-releases/news-archive/new-data-shows-strong-improvements-in-child-protection-and-family-support-system-responses.

ii. Tertiary child protection interventions, including adoption, case management, service standards, and decision-making frameworks.

QFKC has referenced case management above, highlighting concerns in relation to the impact of lack of case planning and resulting impact.

Adoptions

On 23rd March 2021 amendments to the Child Protection Act 1999 were passed in Parliament to 'enhance the governments approach to permanency for children who require alternative long term'.[17] The Child Protection and other Legislation Amendment Act 2021 delivered the government response to recommendation 6(b) of the findings of the Deputy State Coroner's inquest into the death of Mason Jet Lee.[i] In summary, the recommendation was for the Department to review its policies and procedures to ensure that, in accordance with the Government's acceptance of Recommendation 7.4 of the Carmody Inquiry:

(i) adoption is routinely and genuinely considered as a suitable permanency option for children in out of home care where reunification or unification is unlikely and should be pursued in those cases, particularly children under the age of three years.
(ii) Adoption is routinely and genuinely considered by Child Safety officers as one of the permanency options available to them when deciding where to place a child in out of home care.[18]

The coroner recommended that the Queensland Government consider the New South Wales (NSW) Adoption amendments, which require children to be placed within 24 months of entering the Department's care. Child Safety were to report to the Coroners Court of Queensland the number of children adopted and the details of those matters every six months for the next five years.

The amendments to the Child Protection Act introduced adoption as the third option of permanency for a child or young person who does not identify as an Aboriginal and Torres Strait Islander and as the last preference for a child who does identify as an Aboriginal or Torres Strait Islander.

QFKC does not view this inclusion of adoption in legislation as a legitimate permanency option that is considered or even understood by the carer community and some front-line workers. As of March 2025, out of a total of 8,116 children and young people subject to Long-Term Orders:

- 6,106 children and young people were subject to Long-Term Guardianship to the Chief Executive orders,
- 1,569 were subject to Long Term Guardianship to Suitable person and
- 441 were subject to Permanent Care order.[19]

[17] Department of Families, Seniors, Disability Services and Child Safety, "History of Child Protection", Department of Families, Seniors, Disability Services and Child Safety, accessed November 2025, https://www.families.qld.gov.au/our-work/child-safety/about-child-protection/history-child-protection#section__legislative-amendments-2021.
[18] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A roadmap for Queensland Child Protection*, 229.
[19] Department of Families, Seniors, Disability Services and Child Safety, "Improving care and post care support".

Adoptions Queensland has confirmed that as of November 2025, there have been no children previously subject to Child Protection Orders who have been adopted by following the permanency hierarchy outlined in Section 5BA of the Child Protection Act 1999 in the last three years.[20] Therefore, it indicates the option of adoption as a permanency preference on paper only and not a supported pathway in practice.

The process of adopting a child is not achieved through the Child Protection Act and requires an approved foster or kinship carer to be assessed as a suitable adoptive parent; the adoption process takes place under the Adoption Act Qld 2009. The statistics of no adoptions in the past three years demonstrate no change in practice since adoption became part of the permanency hierarchy.

The option of adoption as a permanency pathway does not align with many of the core principles of the Child Protection Act 1999, particularly those that emphasise the critical importance of preserving a child or young person's identity and their ongoing connection to their family of origin. Child Safety continues to have obligations under the Child Protection Act section 74A to children and young people when Long-Term Guardianship Orders and Permanent Care Orders have been granted, which ensure children and young people know their rights and the next steps if these are not being met. This includes the right for children to be connected to family. Long-term guardians and permanent guardians also have obligations under Section 79A of the Child Protection Act, these obligations specifically refer to 'preserving the child's identity and connection to the child's culture of origin; and to help maintain the child's relationships with the child's parents, family members and other persons of significance to the child'.[21] If guardians do not meet these obligations, the Director of Child Protection Litigation (DCPL) can make an application to vary the order for both the Permanent Care Order and the Long-Term Order, and a parent and/or child can also make an application to vary a Long-Term Order.

An Adoption Order is a final order that cannot be revoked upon application by DCPL, a parent, a child or a young person. There is a level of risk associated with adoption, as children may lose connections with their family and siblings. However, the availability of other orders that a Magistrate can grant helps ensure that guardians remain responsible for meeting their obligations under the Child Protection Act relating to connection to family and culture.

The 'My life in Care Survey' undertaken by Child Safety in 2024 highlighted the importance children and young people place on their connections to siblings, the family they live with, and family they do not live with. Of the sample (991), 59% of children and young people identified their siblings as the people they would trust the most, 51% identified the family they live with and 51% identified the family they did not live with (children were able to tick multiple).[22] These results are significant, as they demonstrate that, in addition to legislation requiring children to be and feel connected, children and young people themselves recognise the importance of these relationships.

Summary of Concerns

QFKC has sought to highlight the disconnect between legislative intent and practice. Despite the recommendations from the Coroner supporting the recommendations made by Carmody (in 2013)

[20] Adoptions Officer, Email message to author, November 17, 2025.
[21] *Child Protection Act* 1999 (QLD), s. 79A.
[22] Department of Families, Seniors, Disability Services and Child Safety, *My Life in Care Survey 2024 Results*, (Queensland Government, n.d), 13, https://performance.dcssds.qld.gov.au/_media/documents/my-life-in-care-survey-2024-results.pdf.

that Adoption be considered as a genuine option for children and young people, and despite the Queensland Government's acceptance of this recommendation and implementation into legislation, no adoptions have occurred. It is critical that legislative intent is genuinely supported in practice. If adoption is not a legitimate permanency option supported by Child Safety staff, and there are other clear pathways for children and young people to achieve permanency that supports the ongoing connections to family, then consideration should be given to the purpose of retaining adoption as a permanency option in legislation.

Recommendations

- Remove Adoption as a permanency option for children and young people in the Child Protection Act 1999.
- Child Safety to invest genuinely in achieving permanency for children and young people through Long-Term Guardianship to Other (LTG-O) option or Permanent Care option as previously recommended in this submission.

iii. The management, training, supervision, and ongoing oversight of case work within the Department.

Training

In 2026, QFKC has been operating as a Peak body for 50 years. Our role in the training of Child Safety staff has seen many changes over the years. As a peak body, the organisation has witnessed different training models, most notably the transition to predominantly online training.

From 2004 to 2010, QFKC delivered training to new Child Safety Officers (CSOs) as part of their Induction training held at Warilda Conference Centre in Wooloowin. CSOs received six weeks of face-to-face training, during which QFKC was allocated a 9 am-12 pm timeslot in the final week of the training. CSOs were required, as part of their competency when back in their CSSC, to spend a few hours with a carer in their home without having casework responsibility, to gain perspective and allow CSOs to be curious with carers about their role. Carers who volunteered to open up their homes reported positive experiences; some of these carers continue to sit on QFKC's Management Committee today and still speak fondly of those days. QFKC's President, Hazel Little, remembers CSOs coming to her home in the afternoon, often the busiest time for a carer's household and reminisced about how beneficial it was for both the CSO and the carer, as it really helped a CSO to understand the role of a carer and build positive relationships during times that were not crisis-driven.[23]

The face-to-face training undertaken by QFKC always included a QFKC staff member and at least one carer, ensuring the carer perspective was represented. During these training sessions, topic areas include how to approach carer concerns, the importance of communication, the development and impact of purposeful placement agreements and opportunities for CSOs to explore any questions they have for the carer. Hazel also represented the carers' voice at the CSO training and recalls the training as being very much needed for CSOs. Hazel remembers CSOs attending training with very little understanding of the carer role, with many being new graduates who identified they had no experience in caring for children. Listening to the lived experience of carers helped build a foundation of understanding. QFKC's current Chief Executive Officer, Bryan Smith, was the President of the then

[23] Hazel Little, in conversation with author, November 14, 2025.

Foster Care Queensland Association in 2004 and also remembers delivering training – first as the Association's President and then as an employer with a lived experience of foster care.

QFKC had no input into the CSO training when this training model ceased in 2010 – the decision to exclude the voices of carers in this initial induction training potentially built a culture from the outset that carers are not a priority focus area. Yet, the relationship between child safety and a carer who provides family-based care, should be seen as one of most important areas of prioritisation.

Currently, CSO training is regional based. Through the RD program in Far North Queensland, QFKC has been partnering with local foster and kinship care agencies and carers to deliver a full-day training session for CSOs in the Far North Region since 2024. Topic areas covered in the training include:

- A session with the Regional Director and a carer to share a personal account from a carer on relationships, communication and valuing the role of carers
- Information on 'Money Matters' covering financial entitlements for carers delivered by Child Safety Business Support Officer
- Information on the Statement of Commitment, Placement Agreements and Foster Care Agreements, which is delivered by QFKC staff and QFKC Support Team Members
- The role of a carer support agency delivered by a Foster and Kinship Care agency
- Information on the Standards of Care delivered in partnership by QFKC, Child Safety and the agency.

The feedback provided from CSOs who have attended this training has been highly positive, with CSOs reporting increased knowledge and some acknowledging they had no prior knowledge of the topics. CSOs reported hearing the carers' lived experience was valuable, and comments included suggestions for more training in this area for CSOs to become more proficient.[24]

This will likely be extended to the Northern Region following discussions with regional staff. QFKC aims to deliver training to CSOs, in partnership with Foster and Kinship Care services and carers, in all regions. New CSOs must receive early messaging about the critical role that carers play in the lives of children, and view carers as an integral part of the care team. This can only be achieved if Child Safety prioritises the inclusion of carers in a CSO's induction training.

The RD program conducted a survey with Department staff in late 2024/early 2025, to explore from a Child Safety perspective, the key challenges Child Safety staff were experiencing. As part of this survey, QFKC asked Child Safety staff about their experience of training. The following insights were gained (sample 144):

- 44% of staff had only worked in one CSSC, 56% across multiple CSSCs
- 43% of those who worked across multiple CSSCs identified a difference in the training provided. Comments included that there were fewer opportunities for remote staff, leadership experience impacted on the quality of training received.
- 76% of respondents reported they had completed Child Safety's GRO induction training (CSO induction training) – the overall rating given by CSOs was an average of 3.1 stars. Several comments from Child Safety staff reported that the training was outdated in the GRO Learning

[24] Queensland Foster and Kinship Care, "Training Evaluation Forms," unpublished forms, 2025.

and Development Program. Staff identified the need for more practical aspects relating to being a Child Safety Officer. [25]

The common feedback Departmental staff identified they would like more training on was:

- Trauma-related behaviour management
- How to have difficult conversations/stakeholder communication
- How to implement Child Safety policy and processes
- Further training on Court processes and expectations of writing affidavits[26]

CSOs were asked what they wished they had learned early on in their time in Child Safety, the main themes identified were:

- Self-care, work-life balance and dealing with vicarious trauma
- Working within a Care Team approach
- How to write affidavits/court and legal processes
- Information on working in practice (example templates) with regard to implementing processes
- Opportunity for mentoring/work shadowing when first starting as a CSO
- Training and mentoring in how to have difficult conversations[27]

A continuing theme from the 2021 Queensland Child and Family Commission Deep Dive study, supported in QFKC's survey, was that staff felt high caseloads make it not always possible to undertake supervision, so they are not always supported in reflecting on their practice and in developing their skills and expertise.[28]

Supervision

QFKC is not in a position to provide an in-depth overview of the supervision of Departmental staff, as this is not an area in which, as a Peak Body, the organisation would have the level of insight required to merit any position held.

As an observation, however, it is essential to highlight that those holding leadership positions should have the necessary knowledge and skills to lead teams of Child Safety Officers. Through QFKC's Case Officer Program, QFKC has identified many case examples where the knowledge held by the Senior Team Leader in casework activity has not accurately reflected legislation, policy or procedure. For example, Senior Team Leaders provide the following advice:

- Advising CSOs that a carer is not entitled to a copy of the case plan.
- Advising a QFKC Case Officer that Positive Behaviour Management plans are only for children and young people on NDIS plans.

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[25] Queensland Foster and Kinship Care, *Departmental Survey* 2024, internal report, (Brisbane: Queensland Foster and Kinship Care, 2025).
[26] Queensland Foster and Kinship Care, *Departmental Survey 2024*.
[27] Queensland Foster and Kinship Care, *Departmental Survey 2024*.
[28] Queensland Family and Child Commission, *Respecting the workforce: How did the Queensland Child Protection Reform Environment impact the frontline Child Safety workforce?*, (The State of Queensland, 2021), 9, https://www.qfcc.qld.gov.au/sites/default/files/2022-06/Deep%20dive%202%20Respecting%20the%20workforce%20report.pdf.

- Advising a carer that they need to provide receipts to qualify for a higher payment allowance.
- Advising CSOs that Child Safety must first seek an LTG to CE order for at least a year prior to going on an LTG to Suitable Other.
- Advising carers that they are unable to record a harm report interview. [29]

The above are just a few examples; however, they illustrate the impact of inaccurate information held by a leadership team member. The sheer volume of information that a leadership team member within the Department needs to know is significant.

QFKC staff, who manage a wide range of complex issues, from the point of application to becoming a carer, through QCAT, Children's Court, financial matters and case planning, are advised that unless they can be 100% certain of the advice provided (i.e. verified legislation, policies and procedures as the source), they must take onus for sourcing the information and ensuring its accuracy. Too often, the wrong information is shared within workplaces, and it becomes the reliable source, rather than the actual source. This inaccurate information can sometimes lead to the whole CSSC practising in a particular way, i.e. carers attached to a particular CSSC will not receive copies of case plans, or a view is formed within a CSSC that it is a carers responsibility alone to transport children to and from family time, or an office will as a matter of course apply for a Long-Term Guardianship Order to CE as a first option, because this practice has always been done.

The manager of a CSSC is responsible for the supervision of all Senior team members. Given the crisis nature of the work being undertaken in Child Safety, QFKC are unsure as to whether these supervision sessions are prioritised, nor are we aware of the supervision model is expected of managers. In any case, given the critical nature of the work undertaken, the risk of burnout, vicarious trauma and the supervision load alone that Senior Team Leaders have of their own CSO's, QFKC believes that an external supervision model should be made available to Senior Team Leaders to allow opportunities for reflection and professional development outside of the fast-paced, crisis driven nature of the CSSC.

Summary of Concerns: Training & Supervision of Child Safety Officers

1. **Loss of Carer Voice in Training**

Earlier, QFKC and carers were directly involved in face-to-face induction training for new CSOs, which helped build understanding and positive relationships. This model was discontinued, and QFKC no longer has input into initial CSO training. The absence of carer perspectives risks creating a culture that fails to see carers as a priority, despite their central role in child safety.

2. **Regional Inconsistencies and Gaps**

Training is now regionally based, with some regions (like Far North Queensland) benefiting from a collaborative, carer-inclusive training. However, this is not consistent across all regions, leading to variable experiences and knowledge among CSOs.

3. **Outdated and Insufficient Training Content**

[29] Queensland Foster and Kinship Care, *Case Management,* internal data source (Share Point), November 2025.

Staff surveys reveal that much of the current induction (GRO) training is outdated and lacks practical content. CSOs report a need for more training in trauma-related behaviour management, stakeholder communication, policy implementation, and court processes.

4. **Lack of Early Practical Experience**

New CSOs wish they had received more early guidance on self-care, work-life balance, care team collaboration, legal processes, and practical templates. There is a desire for mentoring and shadowing opportunities when starting.

5. **High Caseloads Impact Supervision and Development**

High caseloads mean CSOs often cannot access supervision, limiting their ability to reflect on and develop their practice. This was also highlighted in the Queensland Child and Family Commission Deep Dive study.

6. **Leadership Knowledge Gaps and Inconsistent Advice**

QFKC has observed that some Senior Team Leaders provide advice that does not align with legislation, policy, or procedure (e.g., misinformation about carers' rights to case plans, requirements for higher payments, or harm report processes). This can lead to entire service centres adopting incorrect practices.

7. **Unclear Supervision Models for Leaders**

There is uncertainty about whether supervision for leadership team members is prioritised or what models are expected. Given the high demands and risk of burnout, QFKC recommends that external supervision be available to Senior Team Leaders to support professional development and reflection.

The concerns highlight a need for more consistent, practical, and carer-inclusive training for CSOs, better support and supervision (especially for leaders), and a stronger focus on accurate, up-to-date knowledge and reflective practice. These improvements are seen as essential for building a culture that values carers and delivers better outcomes for children and families.

Recommendations

- All regions adopt the current training model being undertaken in the Far North Queensland Region, where CSOs are provided with a day of training supported by current carers, QFKC and Foster and Kinship Care agency staff.
- Those leadership team members who have not had the benefit of attending any direct training supporting the role of carers in the care team are also required to participate in the training.
- Implementing an external supervision model for Senior Team Leaders and prioritising advanced learning opportunities.

iv. Departmental delivery structures including organisational culture; management structures and operations of regional service delivery (in each region).

As a Peak Body that operates and provides direct service delivery statewide, QFKC can speak directly to the inconsistencies that exist across CSSCs and regions. For many carers who offer placements across CSSCs, the experience of inconsistent decision-making, operations, and organisational culture is something that they must live with on a day-to-day basis.

QFKC has worked with carers who live in regions where they may be offered placements from a range of different CSSCs, and they will refuse to accept a placement for a child attached to a particular CSSC due to prior experiences with that CSSC. For carers who do not offer placements across different CSSCs, the presence of social media and carer-led groups means that carers are finding out about these inconsistencies through their carer networks.

Case Study

A recent example of this is a carer who approached QFKC for support in having their High Support Needs Allowance (HSNA) reinstated after it was cut off without a conversation. This was not the first time the carer had faced this issue, and it was not the first time QFKC had encountered this when advocating for carers to have the allowance paid on their behalf. The carer reflected with sadness to QFKC that she reads on social media platforms, carers who are attached to other CSSCs, where the CSSC approves HSNA for all carers and yet here she is having to provide spreadsheets to Child Safety about every penny she is spending to justify receiving what has already been determined previously as being reasonable, with no changes to the situation. The CSSC to which that a carer is attached should not determine the level of financial or other support they receive; the circumstances of the carer's household should determine this.

The experience of equality and fairness is something we all expect; laws drive this in the workforce and in society as a whole. It is the experience of being treated equally and with fairness that makes someone feel valued. In the workplace, this results in satisfied employees who want to stay in their positions. When QFKC works alongside a CSSC whose culture reflects fairness and consistency in decision-making, we see carers who will speak positively about being a carer and the care team that surrounds them. These experiences directly impact on the retention and recruitment of carers.

In the Lived Experience Survey, carers were asked whether they provide placements to children across multiple CSSCs; 212 (out of 608) stated they did. These carers were then asked whether they had identified any inconsistency in decision-making across the different CSSCs they worked with, and 87% said they had.[30]

When asked to identify the main areas of inconsistency, carers identified the following *(carers were able to identify multiple answers)* in the table below:[31]

Area of Inconsistency	Number of carers
Financial decisions	125
Family contact decisions	144
Case planning decisions	133
Standard of Care/Harm Report decisions	69

Table 3. Area of CSSC decision-making inconsistencies based on carers lived experience

Carers were provided with the options of providing comment – other themes included:

- Communication
- Differences in views and assessments from one CSO to another in the same CSSC
- Staff's interpretation of policies
- What decisions sit with carers as day-to-day decisions
- Timeliness of responses

[30] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[31] Queensland Foster and Kinship Care, *Lived Experience Survey.*

- Decisions relating to education, therapy
- Gathering views and wishes of children

Carers were then asked, 'what have been some of the differences you have identified if any', a total of 129 responses were recorded, these responses are attached (refer to Attachment D).

Some comments provided include:

> *"I have worked as a carer with 7 different service centres across the past 20 years. Some are renown for being very supportive of carers and prioritise support for children and carers, particularly with complex needs/HSNA etc. Others are known to be (unnecessarily) difficult to work with, as a long term carer, I will actually consider the service centre a child is attached to when making a placement decision, as it can be a game changer if the child is case managed by a good centre"*
>
> *"Decision making not consistent. One STL/CSO makes a decision and if you get a new STL/CSO decisions are different, eg reunification process, sleepovers, yes/no"*
>
> *"Financial support, one is upper hard to get CRCs paid for, other support private school when it is important for a child's identity and integration into the family and school is better equipped to support child's needs."*
>
> *"Sometimes it is not even different service centres. I can't tell you how many times what a CSO discusses comes from a personal opinion rather than policy or practice. Communication is different from each office. I have emailed several times with the same enquiry since May and not once have I got a reply email, then they don't answer phones either. For the last few months if we try and call we get told we are triaged and if they deem it is important enough they will get back (not good enough)."*

Summary of Concerns: Inconsistency across CSSC and Regions

1. Inconsistent Decision Making

Carers experience significant differences in decision-making, operations, and organisational culture across CSSCs and regions. This inconsistency can affect a carer's day-to-day experience of providing care and can result in outcomes such as a carer's willingness to accept placements from particular CSSCs. This type of outcome directly effects on placement options for children.

2. Spread of Information

Even carers who do not work across multiple CSSCs learn about inconsistencies through social media and carer networks, which amplifies dissatisfaction and mistrust within the system.

3. Financial Support Inequities

There are disparities in financial decisions, such as approving higher payments with some CSSCs approving HSNA for all carers and other CSSCs applying a stringent approval process. Carers in the Lived Experience Survey reported a high level of inconsistency in financial decision-making in particular.

4. Fairness and Retention

Perceptions of fairness and equality are crucial. Where CSSCs demonstrate fairness and consistency, carers feel valued and are more likely to remain in their roles, positively impacting retention and recruitment.

These concerns highlight the need for greater consistency, transparency, and fairness across all CSSCs in the regions to ensure carers feel supported and valued, ultimately benefiting children in care.

Recommendations

- Carers have referenced in the Lived Experience Survey of working alongside CSSCs, where they readily accept placements due to their experience of support. It is crucial to explore best practice models of service delivery within CSSC's and role model these to other CSSC's.
- Child Safety to review policy and procedures relating to the support and services provided to carer households where practice is reflecting a discrepancy amongst Service Centres in the application of the policy and procedure in practice, for example Dual respite, High Support Needs Allowance, Complex Support needs allowance.

vii. Whether Departmental frontline staff are resourced and supported to do their work and outline any deficiencies in the level of support, decision-making frameworks, caseloads, and court and tribunal processes.

It is QFKC's view that, on the whole, Child Safety frontline staff intends to make a positive difference in the lives of children, young people and their families. The burden of working within a statutory organisation can make this task extremely difficult due to competing priorities, red tape, decision-making frameworks, high caseloads, and, of course, administrative burden. To put it in context, it is unlikely that a CSO would deliberately ensure consent is not provided for a young person to engage in a school activity that requires Child Safety consent. It is also unlikely that a CSO would deliberately fail to follow up on the necessary steps to obtain a passport for a child or young person so they could travel overseas with their carer family. However, the instances where children and young people miss out on activities and holidays because of these very reasons are ones that QFKC comes across a lot.

What can already be seen as a big task for a person in the community becomes an extraordinary task when it must be completed in the context of the Child Protection system. For example, QFKC has developed a passport guide outlining the steps carers, parents and Child Safety staff must take to obtain a passport for a child. The attached guide (refer to Attachment E) illustrates the complexity of the processes involved in parenting within the Child Protection system.

Again, it is important to highlight that the system is not designed for Child Safety to be the long-term decision makers for children and young people. The Child Protection Act 1999 identifies this clearly through the permanency hierarchy under Section 5BA (4).

Of the 13,336 children and young people currently in care (*as of March 2025*), 60.8% of are subject to Long-Term Orders.[32] QFKC have provided hypothesised data, on page 12 of this report, stating the hours of casework required for home visits for this number of children, for each child, when the Chief Executive has responsibility for guardianship. There is no doubt that CSOs workloads would become unmanageable. Of the 39.2% of children and young people who are subject to Short-Term Orders, Child Safety has a significant responsibility to provide every opportunity for reunification to occur. Section 5B of the Child Protection Act 1999 outlines general principles that should guide decisions relating to the safety, wellbeing and best interests of children. Principle 5B(f) states –

> *'If the child is removed from the child's family, support should be given to the child and the child's family for the purpose of allowing the child to return to the child's family if the return is in the child's best interests' [33]*

Essentially, this means that if Child Safety removes children, the Department has the responsibility to work alongside the children's family with the provision of identified support so that the children can be safely returned. Families who have had their children removed from their care are not going to be in a position to manage this alone and will often withdraw in the initial stages of removal due to experiencing grief, loss and other overwhelming emotions. Child Safety must be able to demonstrate effective efforts to support the family throughout the entire duration of the order, not just the initial months and final months. The ratio of Short-Term Orders to Long-Term Orders reported by Child Safety over a five-year period has remained relatively stable at 40% Short-Term Orders and 60% Long-Term Orders.[34] These statistics indicate that reunification rates for children and young people are not improving.

The Children in Care Census Report provides insight into the reunification attempts for children and young people who have had more than one reunification attempt and are currently subject to orders, a total of 24% of children and young people. [35] Child Safety reports that children and young people who have had more than one reunification attempt "have higher levels of complexity compared to children who have not experienced a reunification attempt" and "are more likely to have a suspected or diagnosed mental illness and be self-harming". [36]

The report goes on to state that "children who have experienced more than one reunification attempt are much more likely to have been in care for more than 5 years in total and will be older than children who have experienced one reunification attempt or no reunification attempts".[37]

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[32] Department of Families, Seniors, Disability Services and Child Safety, "Improving care and post care support".
[33] Child Protection Act 1999, s 5B (f).
[34] Department of Families, Seniors, Disability Services and Child Safety, "Improving care and post care support".
[35] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024*, 4, https://performance.dcssds.qld.gov.au/_media/documents/2024-children-in-care-census-full-report-for-publication.pdf.
[36] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024*, 41.
[37] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024*, 41.

This data highlights the need for increased support for carers who are accepting placements for children where reunification attempts have been unsuccessful. If a carer is not supported appropriately to manage the increased complexities of behaviours and Child Safety has identified children who have experienced multiple reunification attempts, these placements are more likely to break down. Further resulting in even more trauma to the child or young person as they continue to experience placement disruptions.

QFKC has recommended earlier in this submission the introduction of a Reunification Court, which is currently operational in South Australia. This recommendation ensures the reunification processes are intentional through an effective monitoring process, where decisions are monitored and reviewed not only by Child Safety but also by all key care team members – such as the child's lawyer, family members and the carers.

Tribunal Processes

QFKC has a long history with the Queensland Civil and Administrative Tribunal (QCAT), dating back to the Children Services Tribunal (CST) era, and therefore, can provide observations on this system over the years and its impact on the Child Protection system.

The tribunal processes are designed to be accessible to the public in a way that promotes equality, with an emphasis on processes that do not require or encourage legal representation. In QFKC's view, during the CST era, this was, by and large, how carers experienced the process. CST provided an opportunity for carers to be heard regarding review matters, and carers were mostly able to navigate the process either with the support of QFKC or on their own, with the help of CST registry staff and panel members. Any system issues experienced by key stakeholders were resolved through quarterly stakeholder meetings comprising of: QFKC, Legal Aid, Child Safety Court Services, Blue Card Services, and CST members, often including the CST President.

In 2009, CST was merged into the super tribunal, QCAT, and over the past 16 years of operation, QFKC has observed that QCAT has become increasingly difficult for carers to navigate without legal support and/or representation. In 2019, after many years of advocacy, QFKC successfully secured funding from Child Safety to partner with a local community legal service (HUB Community Legal Services) to provide free legal support to carers. As of 2025, whilst QFKC receives recurrent funding for this position, it is equivalent to one 3-day-a-week position, which is not sufficient to meet the increasing demand for this service. At the time of writing this submission, QFKC case officers were supporting 41 applications in QCAT and five matters relating to Section 113 of the Child Protection Act 1999.[38] QFKC are in the process of working alongside our community legal partners to complete a submission for additional funding that would ensure QFKC's ability to provide adequate legal services to all carers requiring legal support.

With QCAT, managing so many jurisdictions through its Human Rights Division, Civil, Administrative and Disciplinary Division, and Client Services can lead to delays in response times. In QCAT's 2023-2024 Annual Report, QCAT reported managing 75,580 calls and scheduling a total of 24,978 proceedings.[39]

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[38] Queensland Foster and Kinship Care, "Case Management". 2025, SharePoint Database (internal data).
[39] Queensland Civil and Administrative Tribunal, *2023-2024 Annual Report* (The State of Queensland, 2024), 14, https://www.qcat.qld.gov.au/__data/assets/pdf_file/0018/821322/qcat-annual-report-2023-24.pdf.

The annual report records the average wait time for a member of the community to speak to a QCAT representative as 16.79 minutes (an increase of nearly 10 minutes from 2018-2019 – 7.82 minutes).[40] QCAT's 2023-2024 Annual Report announces a funding increase that would provide for a "resource injection which would make a real difference in QCAT seeking to achieve its statutory objectives".[41] The 2024-2025 annual QCAT report was not available at the time of this submission, as it would have provided insight into whether this injection of funding has begun to achieve the desired outcome.

Case Study

> From a carer's perspective, the QCAT process can feel like another bureaucratic system that can be affected by significant time delays, and most obviously one where a carer feels the imbalance of power in trying to navigate a legalistic system alone. This scenario illustrates the experience of a kinship carer, a grandparent, who had to navigate the QCAT process after her carer certificate of approval was cancelled. The grandmother received support from a QFKC Case Officer and received representation through our legal service. The process took 18 months and led Child Safety to change its initial decision, allowing the grandmother to care for her grandson again. During the course of the QCAT proceedings, the child aged 7 years had been in a residential care facility. This grandmother did not believe she would have achieved this outcome without QFKC's legal services and described the QCAT process as 'intimidating'. During the process, she would need to speak to QFKC's lawyer after any proceeding had taken place, as she had no idea of the next steps, why decisions were made, or why paperwork had to be filed.

If the Tribunal is to be promoted as a fair and just process for carers to seek administrative reviews under the Child Protection Act, it must be perceived and experienced as an even level playing field. It is QFKC's experience in supporting carers through QCAT processes that this is not their lived experience.

Children's Court

It is important to note that, unlike QCAT, QFKC staff do not play any active role in Children's Court proceedings. Of note, however, is that funding for QFKC's Legal program is to provide advice appointments and representation for carers in respect to Section 113 – Applications under the Child Protection Act (applications to join as a non-party to the proceedings).

The Director of Child Protection Litigation (DCPL) was established under the Director of Child Protection Litigation Act 2016 on the 1st of July 2016, as an independent statutory agency within the Department of Justice portfolio, reporting directly to the Attorney-General and Minister for Justice and Minister for Integrity.[42] The establishment of DCPL was a result of Recommendation 13.17 from the Queensland Child Protection Commission of Inquiry *Taking Responsibility* report, published in 2013.

The purpose recorded on DCPL's website is to 'improve outcomes for at-risk Queensland children and their families by providing greater accountability and independent oversight for child protection order applications proposed by the Department of Families Seniors, Disability Services and Child Safety (Child

[40] Queensland Civil and Administrative Tribunal, *2023-2024 Annual Report*, 14.
[41] Queensland Civil and Administrative Tribunal, *2023-2024 Annual Report*, 5.
[42] Queensland Government. "About DCPL," Director Child Protection Litigation, accessed November, 2025, https://www.dcpl.qld.gov.au/.

Safety), and ensuring that applications filed in Children's Court of Queensland are supported by good quality evidence, promoting efficiency and evidence-based decision-making.'[43]

QFKC would like to highlight data in respect to DCPL applications for 2023-2024 regarding Long-Term Guardianship orders in the table below:

	Number of Child Safety assessments and % total		Number of applications made and % total		Number of applications determined and % total	
Long-term guardianship to a suitable family member	69	6%	76	7%	118	12%
Long-term guardianship to another suitable person	64	6%	56	5%	69	7%
Long-term guardianship to the chief executive	1019	88%	1032	89%	836	82%
Total	1152	100%	1164	100%	1023	100%

Table 4. DCPL data on Long-Term Guardianship Orders on assessments, applicants and determined applications in 2023-2024
Note: This table was adapted from multiple tables within the annual report, specifically, Table 76 and Table 110-112.[44]

It is important to note that whilst Child Safety has the responsibility to undertake assessments and make recommendations to the DCPL, the DCPL have a role in ensuring 'greater accountability and independent oversight for child protection order applications proposed by Child Safety'.[45] With Child Protection legislation clearly outlining the preferred order in which Long-Term Orders should be considered, it is concerning that during 2023-2024, 82% of all Long-Term Guardianship Orders applied for by DCPL in the Children's court were to the Chief Executive.

Whilst QFKC understands that one of the goals in establishing DCPL was to reduce the lengthy delays experienced by children, families and carers in the Children's Court, feedback from the carer community suggests that this goal has not been achieved. In a recent matter managed by QFKC, we supported a kin carer to be assessed as a suitable guardian for her 15-year-old niece. The views and wishes of the young person have been made clear – she wants her aunt to be her guardian. However, one of the reasons given to the carer family for not progressing the assessment was the expectation that a final order could not be achieved before the young person turned 18 due to protracted delays in the Children's Court. This statement by a Senior Team leader suggests that obtaining a Long-Term Guardianship Order to Suitable Person order within a three-year timeframe is considered unrealistic.

When Carers were asked in the Lived Experience Survey what they consider to be the barriers to legal permanency for children and young people, one carer wrote:

> *"The time it takes for children to progress from an interim order to short term order to long term order. We care for a now 1 year old who has been with us since birth, no contact has occurred with parents for over 8 months and we are no closer to progressing to a short term*

[43] Queensland Government. "About us," Director Child Protection Litigation, accessed November, 2025, https://www.dcpl.qld.gov.au/about-us.
[44] Queensland Government, *Annual Report 2023-2024 Office of Director of Child Protection Litigation*. (The State of Queensland, 2024), 84, 115-116, https://www.dcpl.qld.gov.au/__data/assets/pdf_file/0009/822996/annual-report-2023-2024.pdf.
[45] Queensland Government. "About us," Director Child Protection Litigation.

custody order. We have been advised it may take years to progress to a short-term order and then LTGO."[46]

Summary of Concerns

- QFKC is unable to comment on whether the introduction of DCPL has had the intended impact, in respect to applications relating to Short-Term Orders.
- There remain significant concerns in relation to Children's Court matters being drawn out, with children and young people subject to interim orders for excessive periods of time.
- Long-Term Guardianship Orders to suitable person have not increased since the establishment of DCPL. During the Carmody Inquiry, LTG to CE rates were around 75%, and this remains to be the case in 2025. The most recent data show that majority of Long-Term Orders applied for during 2023-2024 were to the Chief Executive, with only 12% in favour of a family member and 7% in favour of another person, most likely a foster carer. It is therefore reasonable to conclude that the introduction of the Office of the Child and Family Official Solicitor (OCFOS) and DCPL has not resulted in children and young people in Queensland achieving permanency in accordance with the Child Protection Act.

Recommendation

- QFKC has referenced earlier in this submission the need for carers to have access to appropriate free legal advice services to enable them to make applications to join as non-parties to proceedings under Section 113 when deemed appropriate by the magistrate. This may assist the courts in determining whether a more suitable permanency option that is, in fact, being presented to the courts.

viii. Investigate the role of the privacy provisions of the Child Protection Act 1999 and whether the provisions hamper transparency around system failures.

QFKC will speak to this Terms of Reference as they relate to and impact family-based care. As referenced throughout this submission, the Child Protection frameworks that currently exist within the Child Protection legislation, policy, and procedures are often sound; it is the practice that requires significant improvement. Information sharing is a clear example of this.

Currently, the following frameworks exist that support the sharing of information between Child Safety and carers:

1. Section 83A Child Protection Act 1999– Giving Information to carers and children.

   This section provides in-depth information about what information should be provided to a carer, as follows:

   - Provision of information to a carer prior to a placement to ensure the proposed carer can make an informed decision about accepting the placement with an outline of examples of what should be provided.[47]

[46] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[47] Child Protection Act 1999, s83A (1)(a).

- When a child is placed with a carer, the provision of information that the carer reasonably needs to provide care for the child must be provided. Examples include:
    - A copy of the child's case plan.
    - Information about the child's goals, preferences, and behaviours.
    - Information about any special behaviour management needs.
    - Information about the child's family, culture, and background.
    - Information about any arrangements for contact between the child and the child's family group.
    - Information about the cultural needs of the child.[48]

- Provision of any information to ensure the safety of the child, the carer, and other members of the carer's household.[49]

2. Statement of Commitment, legislative requirement under the Child Protection Act Section 7 (j), Child Safety commits to:[50]
    - Provide foster and kinship carers with timely and ongoing information about a child or young person, including information about the child or young persons' medical, emotional and developmental needs, to provide a safe, healthy and protected environment for them, the carer and the carers family
    - Provide information about the child or young person's family to support ongoing connection and where necessary to mitigate any risks from family members who may be distressed or aggrieved by decisions made about the child or young person in their care
    - Where foster and kinship carers have been a party to a process, provide copies of reports, case and other records that are held in Child Safety and/or agency files, such as providing meeting minutes to carers where they have been participants in a meeting'.
    - Assist access to records through Right to Information or Administrative access if required
    - Provide clear, written goals and expectations for each child or young person through case plans and care agreements.

As previously outlined in this submission, the 2022 amendments to the Child Protection Act under Section 83A further enhanced Child Safety's capacity and obligation to share information with carers. These recent legislative changes, along with existing frameworks, make it clear that Child Safety intends to ensure carers receive the information they need to fulfil their roles effectively. However, in practice, this intention is not consistently realised as demonstrated in the following examples:

- QFKC's Lived Experience Survey asked carers, 'Are you provided with sufficient information at the time you are offered a placement in order to make an informed decision about acceptance of the placement?' A total of 570 carers responded to this question, and 69.8% stated they did not.[51]

[48] Child Protection Act 1999, s83A (2)(a).
[49] Child Protection Act 1999, s83A (2)(b).
[50] Department of Children, Youth Justice and Multicultural Affairs, *Statement of Commitment*, 5.
[51] Queensland Foster and Kinship Care, *Lived Experience Survey*.

- The Lived Experience Survey then asked carers whether there had been times when they were aware of information known to Child Safety about a child that was not shared, which would have impacted their acceptance of a placement. A total of 563 carers responded to this question, and 66.6% stated yes.[52]

Carers were able to provide comments on this question, which has been attached (refer to Attachment F). Themes of the comments centred on behaviours of children and diagnosed disabilities being withheld.

Carers were then asked to provide comments on the impacts on their family and the child or young person when Child Safety did not share all the information. The attached document (refer to Attachment G) contains the comments provided by carers. Clear themes articulated by carers included:

- Placement breakdowns
- Safety concerns for family members
- Harm to household members
- Unsustainable stress and pressure on households

It is clear that the Child Protection Act allows information to be shared with carers; however, the real barriers to sharing lie not in legislation, policy, or procedure, but in everyday practice. When vital information is withheld, the consequences fall most heavily on children and young people. Carers have described how this lack of transparency leads to instability and breakdowns in placements, which can be profoundly disruptive and traumatic for those in care.

Data from the 2024 Children in Care Census report underscores the scale of this issue: 38% of children and young people had experienced more than four different placements, while only 29% had remained in a single placement.[53] The situation is even more difficult for those in residential care, where 73% had endured more than four placements. Such instability can undermine a child's sense of safety, belonging, and trust, making it harder for them to form secure relationships and heal from past trauma.[54]

In contrast, children and young people placed with kinship carers were most likely to experience stability, with 41% having only one placement.[55] This highlights the critical importance of supporting family-based placements and ensuring that carers have the information they need to provide consistent, nurturing care. Ultimately, when information is not shared effectively, it is children and young people who bear the brunt of the system's shortcomings, facing repeated disruptions that can have lasting impacts on their wellbeing and development.

Lack of information sharing can also be attributed to a carer's experience of systems harm, where the impact of this practice is seen in the lived experience of carer families. For example, a carer family member is harmed because of inadequate information sharing, which placed the carer family in unsafe situations. Systems harm is a further contributing factor to carers exiting the system and the

[52] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[53] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024*, 15.
[54] Department of Families, Seniors, Disability Services and Child Safety, 15.
[55] Department of Families, Seniors, Disabilities Services and Child Safety, 15.

experience they then share with their community is not positive. The 2024-2025 QFKC Carer Exit Report highlights the broader impact of these issues: only 21% of foster carers and 25% of kinship carers leaving the system said they would recommend fostering to a friend.[56] This low rate of recommendation reflects the negative experiences many carers have had, often due to inadequate information sharing and challenges that result. Since word of mouth is a key driver for recruiting new carers, these negative experiences can further reduce the number of available family-based placements, ultimately affecting the stability and wellbeing of children and young people in care.

There is a need to provide clear practice advice, mentoring and education to Child Safety staff so they are confident in the information they can share. Carers were asked in the Lived Care Experience Survey whether they were confident that the CSOs they work with are clear about what they can and cannot share with them as a carer. Of the 580 carers who answered the question, only 16% (93) reported that CSOs were clear (yes); another 34.5% answered sometimes, and 49.8% stated no.[57]

Child Safety staff will cite confidentiality provisions under the Act when deciding to withhold information from a carer; however, it is unclear which provisions they are referring to. The Child Protection Act has many sections that speak to the sharing of information, and if the intention of the sections is not understood or interpreted appropriately, it is very reasonable that a CSO would err on the side of caution and not disclose for fear of consequences.

Summary of Concerns: Information Sharing in Family-Based Care

1. Legislative Frameworks Exist, but Practice Falls Short

- The Child Protection Act 1999 (Section 83A) and the Statement of Commitment clearly outline what information should be shared with carers, including case plans, details about the child's needs, family background, and safety considerations. However, these frameworks are not consistently implemented in practice.

2. Carers Often Lack Sufficient Information

- Surveys show that nearly 70% of carers did not receive enough information at the time of placement to make an informed decision.
- About 67% of carers reported instances where Child Safety withheld information that would have impacted their decision to accept a placement.

3. Consequences of Poor Information Sharing

- When information is withheld, carers and children face significant risks:
    - Placement breakdowns
    - Safety concerns for family members
    - Harm to household members
    - Unsustainable stress and pressure on carer households.
- These issues can lead to instability and trauma for children, with data showing high rates of multiple placements, especially in residential care settings.

4. Systemic Harm and Carer Attrition

- Inadequate information sharing contributes to "systems harm," where carers and their families are put at risk, leading to negative experiences and higher rates of carers leaving the system.

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[56] Queensland Foster and Kinship Care, *2024-2025 Carer Exit* Survey, unpublished raw data, 2025, SharePoint.

[57] Queensland Foster and Kinship Care, *Lived Experience Survey*.

- Only 21% of foster carers and 25% of kinship carers leaving the system would recommend fostering to a friend, reflecting the impact of poor information sharing on recruitment and retention.

5. Lack of Clarity and Confidence Among Staff

- Many Child Safety Officers (CSOs) are unclear about what information they can legally share with carers. Only 16% of carers felt CSOs were clear on this point, while nearly 50% said CSOs were not.
- Staff often cite confidentiality provisions as a reason for withholding information, but the relevant sections of the Act actually support information sharing when interpreted correctly.

Despite strong legislative intent, everyday practice does not consistently deliver the transparency and information sharing required to support carers and ensure stable, nurturing placements for children. This gap leads to placement instability, carer burnout, and ultimately impacts the wellbeing of children in care.

Recommendations

- Training and education that is practice based on the information sharing framework Child Safety staff can rely on in their practice. This training would need to be repeated on a regular basis to drive a culture within offices that supports sharing of information and ensures new staff are equipped with the knowledge they require.
- Creating a culture where CSOs are enabled to share information, where resources are visible and available to CSOs and where the narrative is to share information to keep families safe and informed for example, posters in the staff room, toilets, shared common areas, messaging in Child Safety's Unify system.
- Direct line supervisors explore information sharing as a key component to regular supervision sessions to ensure that CSO's are sharing information in accordance with Child Safety's Information sharing guidelines.

xii. Review the effectiveness of the existing Complaints Process.

QFKC has worked alongside Child Safety's Complaint Unit, most notably in the past five years, in an attempt to gain better insight into the policy and procedures that drive the complaint process so that QFKC is better positioned, as a Peak Body and service delivery organisation, to educate and support the carer community through these processes. QFKC developed a training module on complaint processes, in partnership with Child Safety's Complaint Unit. A live webinar was recorded, stepping carers and stakeholders through the process of complaints. QFKC has made this webinar available as a training resource. With this level of knowledge, QFKC feels well positioned to provide insight into the effectiveness of the existing complaint process.

In practice, it is QFKC's experience that the introduction of First Attempt at Resolution (FAAR) is largely productive, with positive outcomes for the care team. This experience is reflected in Child Safety's Data on Complaint Processes recorded between 1st July 2024 and 30th June 2025, with a total of 2656 matters raised as FAARs, all identified as requiring further action, and no matters outstanding for the

financial year.[58] This data represented a 22.1% increase (2,175) in FAAR recordings from 2023-2024 data, and could demonstrate increased community awareness of their ability to resolve issues through this process.[59]

QFKC has some concerns regarding the accuracy of the data; however, with respect of the 2,656 matters recorded as resolved, we would ask whether the persons who raised these matters would also consider them resolved. In the Lived Carer Experience Survey, the following comment was provided by a carer in one of the areas relating to a question as to whether they were satisfied with the outcome of a complaint:

> "*My complaint (what I deem a serious matter) was referred to the service centre as a FAAR (first attempt at response). I am still trying to get someone to take the complaint seriously"*[60]

Nevertheless, QFKC are supportive of this approach to early resolution and frequently uses the language of raising a FAAR to address issues at a local level. The experience of QFKC's Case Officer team is that these processes are mainly positive.

In contrast to the FAAR process, QFKC's experience of the complaint process through the carers' lens has highlighted significant systemic flaws, where the outcomes received by carers appear to be more focused on defending a position as legitimate to protect an institution, rather than providing a truly objective response based on the views of all parties involved. It is worth reflecting on the data provided by Child Safety in respect to complaints: of the 493 complaints received during the 2024-2025 financial year, Child Safety identified 106 as not finalised, 47 requiring further action, and 340 requiring no further action. To put this data into perspective, out of the 387 finalised complaints, Child Safety reached an outcome, that in 87.8% of these matters, no further action was required, whereas in the FAARs, 100% of the matters were identified as requiring further action. It is difficult for QFKC to accept that in 87.8% of the complaints raised, there was no need for Child Safety to do anything differently.[61]

Child Safety's Complaint Unit is, for many matters, the only available pathway for having decisions reviewed by carers. This is despite the significant consequences of these decisions for carers, both within their role as carers and, more recently, outside it.

A clear example of this is the available pathway for a carer to have a Harm Report outcome reviewed as follows:

- The carer receives an outcome of Substantiated Harm, in the letter they are provided with their review rights, which is only through Child Safety's Complaint process.

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[58] Department of Families, Seniors, Disability Services and Child Safety, *Complaint Report 1 July 2024 to 30 June 2025*, (Queensland Government, 2025), 1, https://www.families.qld.gov.au/_media/documents/contact-us/complaints/s219a-publishing/complaints-data-2024.pdf.

[59] Department of Families, Seniors, Disability Services and Child Safety, *Complaint Report 1 July 2023 to 30 June 2024*, (Queensland Government, 2024), 1, https://www.families.qld.gov.au/_media/documents/contact-us/complaints/s219a-publishing/complaints-data-2023.pdf.

[60] Queensland Foster and Kinship Care, *Lived Experience Survey*.

[61] Department of Families, Seniors, Disability Services and Child Safety, *Complaint Report 1 July 2024 to 30 June 2025*

- Substantiated Harm reports as of 20th September 2025 must be reported to Blue Cards by the carer under new self-disclosure laws within 7 days of the receipt of the outcome. The outcome of a substantiated Harm will likely lead Blue Cards to review the suitability of the carer to hold a Blue Card and may result in the cancellation of a Blue Card.
- If the carer requests a review of the Harm report, this review will take place almost entirely through what is identified as a 'desktop review'. This means a Senior Practitioner or Regional Practice Leader will review the information recorded in Child Safety's Unify system to determine whether the outcome was justified.
- If the carer has additional information, they would like the review to consider in the process, they are mostly advised that this is not possible due to the review being a desktop review and a 'point in time assessment'. This means they will only consider information provided during the original process, even if the essence of the complaint is that the original process omitted vital information in the assessment.
- In cases where the Harm report outcome has resulted in a suspension, cancellation of a carer certificate of approval, and/or removal of a child and the carer has lodged applications in QCAT to review these decisions, QCAT has no jurisdiction to review the outcome of the Harm report. It has been QFKC's experience that the Complaints Unit will also not review the outcome of the Harm report, reporting it is 'out of scope' due to the matters being in QCAT. Whilst the Complaints Unit cannot review decisions around removal and cancellation of carer certificates due to these being out of scope, Harm report outcomes are not out of scope, however the outcome of harm is so clearly aligned with the subsequent decisions of removal and cancellation, that it becomes problematic for the Complaints unit to objectively review the Harm Report outcome without potentially placing their own Department in an adverse position in QCAT regarding their decisions. There is a clear conflict of interest here that has profound implications for carers' experiencing procedural fairness.
- This issue extends to carers' Blue Cards. If the substantiated outcome of harm results in a carer losing their Blue Card, it is not the role of Blue Cards to re-investigate the allegations of harm and/or form a position as to whether the outcome is valid or not. The Blue Card System relies on their colleagues in Child Safety to reach a fair and just outcome, and this is the outcome they use to decide whether someone is suitable to hold a Blue Card.

The above provides just one area in which a carer may seek review through the complaint process, demonstrating that the complaint system is not effective nor aligned with principles of procedural fairness.

Carers who have participated in the complaints process report to QFKC that, rather than resolving their concerns, the process can intensify their negative experiences and worsen their situation. One carer QFKC has worked with who has given permission for their example to be used in this submission, explained his experience of the complaints process –

> *"I knew there was a 99.9% chance that filing a complaint wouldn't lead anywhere. Still, I went ahead—because this time, it involved a deeply significant and serious incident concerning my*

eldest grandchild in our home. It was a matter of safety, and what happened should never have happened." [62]

When the Carer submitted the complaint and statutory declaration, the outcome received was: "Not substantiated. Not substantiated. Not substantiated." The Carer said the reason provided was because there was nothing in the system to confirm what he had said.

The Carer had submitted a sworn statement of events, yet the absence of documentation in Child Safety's system led to the carer's complaint being dismissed. The Carers said that when he received the outcome, he could not help but think "*What's the point? the outcome made me feel like I was being treated as if I were lying".*

A major issue with organisations conducting their own investigations is their dependence on internal information systems to determine outcomes. These systems are only as comprehensive as the information entered by staff, which often reflects the viewpoint of the individual recording the data rather than the full range of perspectives involved.

Case Study

An example of this relates to a complaint matter where QFKC were supporting a foster carer through a Standard of Care process and subsequent complaint process. The allegation in the complaint was listed as –

"*…following a SOCR being finalised the carers. assert that the CSSC agreed to write a new SOC outcome letter and this task has not been acted on."*[63]

The response provided in the outcome letter was that the "*…reviewer identified that the SOR-R letter was provided to the carers on 18th August 2023 is important and relevant, however, could have been delivered more sensitively, it could not be identified in departmental records that the department agreed to provide a re-written letter."*[64]

In response to this outcome, the carer provided a written response to advise that others were present (the QFKC Case Officer and a foster and kinship care agency support worker) at the SOCR outcome meeting and could attest to the commitment made by the CSSC staff to rewrite the letter. The response back from complaints was to say "*…the department's complaints process does not include a forensic investigation involving contacting other people or agencies…"*. This particular allegation was never resolved with Child Safety, and no new findings letter was issued.

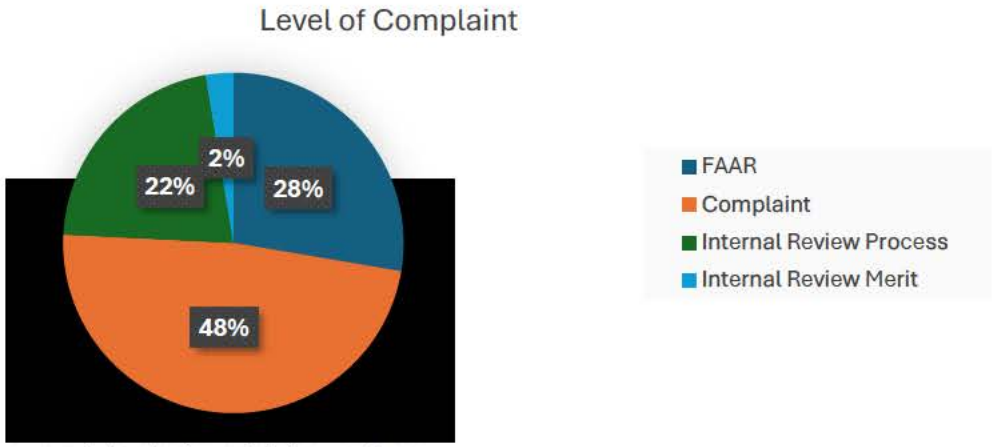
The example above highlights the Complaints Unit's heavy reliance on internal systems, and records to determine outcomes. When the complaints process does not include gathering relevant third-party information or witness accounts and instead relies exclusively on departmental files, it fails to meet the principles of procedural fairness.

[62] Queensland Foster and Kinship Care, "Case Management", 2025, SharePoint Database (internal data).
[63] Queensland Foster and Kinship Care, "Case Management". 2025, SharePoint Database (internal data).
[64] Queensland Foster and Kinship Care, "Case Management".

As part of the Lived Experience Survey, carers were asked a range of questions relating to the complaint process. Of the 580 carers who participated in the survey:

- 392 (67.6%) advised they were aware of the Complaint process
- 207 or 35.6% of respondents confirmed they had accessed the complaint process[65]

The below provides a graph as to the process the carers have experienced.[66]



Graph 1. Percentage of a carers by level of complaints experience

Carers were then asked whether they were satisfied with the outcome of their complaint, 76.6% said no, they were not and then asked if they would support access to an external avenue of complaint – an overwhelming percentage of 97.2% said Yes (sample 575).[67]

The absence of an independent complaint system available to carers and others affected by Child Safety's decisions, including children and young people and their families, is not acceptable. Whilst QFKC acknowledges the existence of the Ombudsman as the next step for carers to take when not satisfied with an outcome reached by Child Safety. The Ombudsman only has the power to recommend, not direct, State agencies. QFKC are not aware of case examples with carers where accessing the Ombudsman as an external avenue of complaint has resulted in a changed outcome. This is not to say they do not exist; however, QFKC has not been involved in one.

Data from the Queensland Ombudsman for 2024-2025 is as follows of the 12,399 contacts received by the Ombudsman[68] –

- 4,526 were considered out of jurisdiction and referred to the appropriate agency
- 7,006 complaints received that were considered in jurisdiction:
    - 3,899 of these complaints related to state agencies (55.6%) [69]
        - 400 of these complaints were directed to the Department of Families, Seniors and Disability Services and Child Safety, and

[65] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[66] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[67] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[68] Office of the Queensland Ombudsman, *Annual Report 2024-2025* (The State of Queensland, 2025), 37, https://www.ombudsman.qld.gov.au/ArticleDocuments/262/QO%20Annual%20Report%202024-25%20-%20PUBLIC.pdf.aspx?Embed=Y.
[69] Office of the Queensland Ombudsman, *Annual Report 2023-2024*, 38.

        - 247 directed to the previously known Department of Child Safety, Seniors and Disability Services (647 in total for the financial year)
    - 600 of the state agency complaints (inclusive of State departments and State authorities) had the following outcomes:[70]
        - 139 No further investigation warranted
        - 361 No error identified
        - 91 Rectified (89 – informally resolved, 2 – finding of administrative error)
        - 39 Withdrawn

The Ombudsman made 185 recommendations to agencies. Most recommendations asked agencies to:[71]

- review a decision (21%)
- provide a better explanation or reasons for a decision (17%)
- improve a policy or procedure (36%)
- change a decision (8%)

Whilst the above provides clear data on the likely experience of a carer contacting the Ombudsman, it is important to present a lived experience to capture what this process looks like and feels like for a carer. QFKC has attached a case scenario from a carer (refer to Attachment H) who has shared her experience from the point of complaint to the CSSC, right through to attempts to resolve with the Ombudsman.

It is critical that an external avenue of complaint process is afforded to those affected by Child Safety decisions and actions, and that those who administer the process has both the knowledge and expertise to investigate the complex nature of Child Safety complaints and the ability to issue directions.

It is also important to bring to the Commissioners' attention to barriers that carers face when considering lodging a complaint in the first instance. Through QFKC casework experience it has been identified that carers can be reluctant to raise a complaint for many reasons including, but not limited to:

- Fear of consequences, i.e. Standard of Care matters being raised, children being removed from their care, and financial disadvantage.
- Unable to commit to the time required to navigate a complex complaint process.
- A sense of imbalance of power and therefore reluctance to engage in such a process.

Complaint processes are explored in QFKC's biennial carer surveys. The comments below have been taken from the 2022 Carer Survey reports, which QFKC has previously lodged with the Commission and wishes to highlight for the purpose of this Terms of Reference: [72]

> *"Carers are busy and I am not sure that making a complaint actually helps. Rather it just becomes adversarial. I would like to make a complaint to effect change, but from my experience*

[70] Office of the Queensland Ombudsman, *Annual Report 2024-2025*, 43.
[71] Office of the Queensland Ombudsman, *Annual Report 2024-2025*, 11.
[72] Queensland Foster and Kinship Care, *2020 Carer* Survey, unpublished raw data, 2022, SharePoint.

carer-departmental relations are worse now than ever. When I make a complaint it is only for something very serious - like one child in my care was not seen for six months. This was irrefutable and validated; however, the natural consequence of casework not being completed and orders wallowing in limbo meant significant distress to the child in my care and vacillating legal decisions. This was not validated. Interesting and complaints made to the department tend to be lenient to the department"

"I would not have time to complain so would just give up. I know we have a lot to offer children in our care but when the bureaucratic requirements take more effort than the care of the children I am starting to lose interest."

"It was some time ago but I still don't have any faith in the system of complaints. It is a biased process and favours departmental personal because they hold the power and have the knowledge and resources to use the system to their own advantage. We are also 'penalised' if we complain."

"I feel like no one will listen to my complaint as I have not been heard so far."

"I feel putting in a complaint and it goes to the same service centre should not be the way it happens ... it should be a different office/area/zone."

"Repercussions and threats to remove the children in your care make it impossible to make a complaint and have that heard and addressed."

"The processes skewed and geared towards either a) child safety refusing to take responsibility for the actions of foster care agencies that they fund and b) thinking their staff could never do anything wrong!!"

"Noone has done anything. I've spent so much time trying to follow the complaint up. They promise to get back and no one does. Noone holds child safety accountable and they know this. The system needs a massive overhaul. Is shameful adults know about the issues and no one does anything for the poor kid."

"When discussing concerns with OPG about lack of support by the Department for the placement, negative rude comments were then made to me by the CSO instead of any support or collaboration to resolve any concerns"

"When you make a complaint about the office, it is referred back to the office to investigate. That's a conflict of interest and leads to no change."

"I did have a situation where I felt a child was reunited with a parent which was clearly unsafe. I spoke to and wrote to our agency but I did not feel I had the opportunity to make an official complaint and I would not have done so as I would be afraid the CSO would penalise myself and partner for doing so."

"Due to the significant power imbalance between myself and the Manager of the CSSC I will not make a complaint."

"There is nothing positive I can say about complaints being managed at a local level. It is impossible to describe how poorly we have been treated by CSO's, team leaders and managers at times. Only a government department with layers of protection could operate with so little accountability."

"I sent an email to the ministers office when my young persons speech therapy was cancelled by cso for funding reasons. We'd been on the wait list for months. Ministers office forwarded it to service centre and I got in trouble."

"Complaining to the department is just a waste of time they internally assess the compliant and bury it."

Summary of Concerns: Complaint System Framework

The review of the Child Safety's complaints process reveals both strengths and significant areas of improvement. The introduction of FAARs has generally led to productive outcomes, with data showing that all FAAR matters required further action, indicating responsiveness at this early state. However, in contrast, the formal complaints process has highlighted systemic flaws: carers are often left dissatisfied, and a disproportionate number of finalised complaints resulted in no further action, raising concerns about the objectivity and effectiveness of the complaint process. Carers frequently perceive the process as more focused on defending departmental positions, than on genuinely resolving issues.

There are clear barriers to a fair review system. The reliance on internal information systems and 'desktop reviews' can limit the consideration of new or overlooked evidence and/or information. This approach, combined with potential conflicts of interest, undermines carers' confidence in the fairness of outcomes, especially when decisions have significant personal and professional consequences, such as the loss of a Blue Card.

Carers report barriers to even lodging an initial complaint, including fear of repercussions, the complexity of the process, and perceived and real imbalances of power. Many feel that complaints are not taken seriously or lead to meaningful change.

Many carers report that engaging with the complaints process can worsen their experience, intensifying feelings of frustration and powerlessness. Survey data indicate that most carers are dissatisfied with the outcomes of complaints, and nearly all support the need for an independent avenue for complaints. Whilst the Ombudsman provides an external review option, its powers are limited to making recommendations, rather than directing agencies and carers rarely see their concerns resolved through this channel in QFKC's experience.

In summary, while initial resolution mechanisms show promise, the broader complaints process requires greater transparency, independence, and support for carers to ensure fair and effective outcomes. An external complaints avenue, supported by experienced specialist workforce who

understands the complexity of Child Protection work, is required to deliver an effective, transparent and accountable complaints management system.

Recommendations

- The establishment of an independent complaints body that has both the knowledge and independence to appropriately review complaints.
- Harm report outcomes to become a reviewable decision in the Queensland Civil and Administrative Tribunal.

Safer Children

i. Review the decline in foster care and treatment of foster carers by the Department and by service providers contracted by the Department.

It is not easy to think of another volunteer cohort that reports the experiences of treatment that foster and kinship carers do. For over 15 years, QFKC, as a peak body, has been conducting carer surveys to gather information about carers lived experience. Survey data continues to reveal a high proportion of carers reporting negative lived experiences, such as:

- They do not feel their views are considered (59% 2020 and 60% 2022 felt views were only sometimes or never considered),
- There is a lack of consideration given to the carer family as a whole (63% 2020 and 59% 2022 reported consideration only sometimes or never),
- The department provide a supportive environment for carers to undertake their role (55% 2020 and 52% 2022 reported this only sometimes or never occurred)
- There can be a lack of respect (40% 2020 and 42% 2022 felt respect was given sometimes or never).[73,74]

To provide some contrast, QFKC explored satisfaction rates amongst State Emergency Service (SES) volunteers. In 2016, 307 SES volunteers participated in the Volunteer Satisfaction Survey, during which 86% of respondents reported general satisfaction with their role.[75]

Word of mouth is commonly known as the best source of recruitment in any industry; in fact, in the SES volunteer survey, respondents were asked where they first learnt about volunteering opportunities through the SES, and 63% reported word of mouth.[76]

At its essence, volunteerism is altruistic, with motivations largely driven by a desire to make a difference and help their broader community. 70% of the SES volunteers reported their motivations for joining the SES were to contribute to their community, 69% wanted to help people, and 57% wanted

[73] Queensland Foster and Kinship Care, *2020 Carer Survey.*
[74] Queensland Foster and Kinship Care, *2022 Carer Survey*.
[75] Richard Bishop and Caitlin Manche, *Queensland Fire and Emergency Services Volunteer Satisfaction Survey 2016,* (Queensland Government, 2016), 10, https://www.fire.qld.gov.au/sites/default/files/2021-04/QFES-Volunteers-2016-SES-Central-Report.pdf.
[76] Richard Bishop and Caitlin Manche, *Queensland Fire and Emergency Services Volunteer Satisfaction Survey 2016*, 41.

to make a difference.[77] This is compared to other, less altruistic motivations, such as wanting to improve a resume at 9% and feeling as though it was a citizen's duty at 17%.[78] These statistics are relevant and comparable to volunteerism among foster carers as evidenced consistently in QFKC's surveys of carers exiting their caring role.

In the 2022-2023 Exit Survey, 92% of respondents identified a desire to help children in need as one of their main motivating factors; in the 2023-2024 survey, 85% did so.[79,80] When reviewing all previous Exit Report data, dating back more than a decade, 'the desire to help a child in need' is consistently the most selected box.

One of the options provided to carers is 'thought it would increase our family income', this box is rarely ever chosen. Any belief that carers are motivated to undertake fostering for monetary reasons is, in QFKC's view, not supported by the realities of fostering, where, if anything, carers will report consistently being out of pocket. The Queensland Government's website recognises that the fostering allowance '*…may not cover all costs associated with caring for a child…'*.[81]

The Queensland Child Protection system depends almost entirely on volunteers to sustain family-based care, which is considered the best option for children and young people who cannot safely remain at home. However, this foundation is under strain, as Queensland is seeing a significant increase in the number of children and young people placed in residential care. Residential care does not offer the supportive environment needed for children to develop stable, secure relationships, and it also places a substantial financial burden on the sector.

QFKC's casework experience shows that many carer households lack the necessary foundations for success. Insufficient placement agreements, limited financial support, inadequate responsiveness to the needs of children and young people, and poor communication all contribute to considerable stress for carers. Instead of providing the support required to maintain stable placements, these gaps often lead to placement breakdowns, resulting in children and young people being moved into residential care settings. If foster or kinship carers—and even birth parents—were given the same level of resources allocated to residential placements, the outcomes for children could be significantly improved.

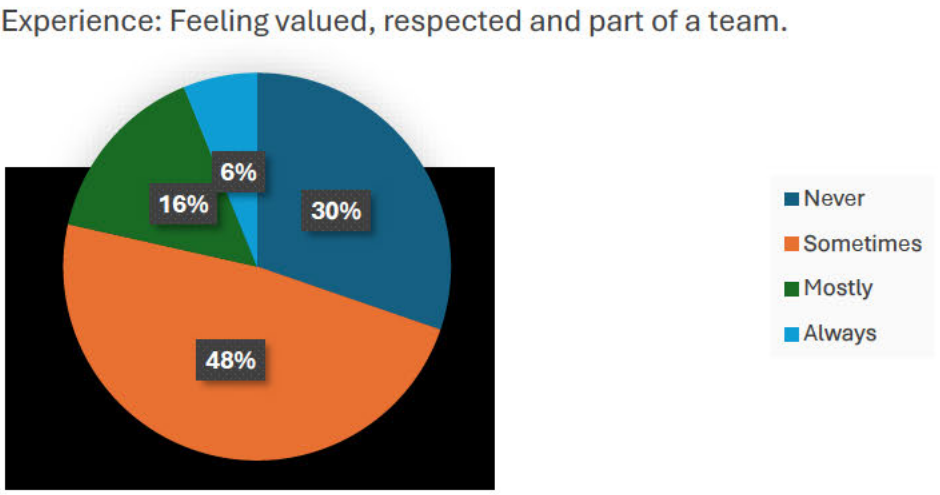
Case study

A de-identified QFKC case work example of this relates to a foster care couple who were caring for a sibling group of three children aged eight and under, the children had all been placed with the carers since birth. The carers contacted QFKC following the removal of all three children from their care into a residential care facility, following the carers relinquishing care of the eldest child due to feeling they were no longer in a position to meet their increasing needs and following countless requests for support. The Department's response to the carer

[77] Bishop and Manche, *Queensland Fire and Emergency Services Volunteer Satisfaction Survey 2016*, 42.
[78] Bishop and Manche, *Queensland Fire and Emergency Services Volunteer Satisfaction Survey 2016,* 42.
[79] Queensland Foster and Kinship Care, *2023-2024 Carer Exit Survey*, raw data, 2024, SharePoint.
[80] Queensland Foster and Kinship Care, *2022-2023 Carer Exit Survey*, raw data, 2023, SharePoint.
[81] Queensland Government. "Carer Allowances", Queensland Government, accessed November 2025, https://www.qld.gov.au/community/caring-child/foster-kinship-care/information-for-carers/money-matters/carer-allowances.

relinquishing care was to take all three children and place them in a residential to keep them together. The carers were distraught when they contacted QFKC and had since told Child Safety that one of them would give up working in order to meet the needs of the eldest child, so that they could all come back. This offer was refused. The carers requested contact with all three children and were denied contact for over 6 weeks, with the rationale being that the children needed to settle into the residential care. Through QFKC's intervention with the Regional Senior leadership, the children were returned to the care of the foster carers, with an agreement reached on the supports required to sustain the placement. The removal of the children in this scenario could have been avoided altogether if the necessary supports had of been provided to the family in the first instance.

To support the need for current and up to date data for the Commissioner for this Terms of Reference, QFKC directed specific questions to carers in the 2025 Lived Experience Survey on the treatment of carers from their perspective. The following results were gathered, carers were asked in their experience whether they felt valued, respected and part of a team:[82]



Graph 2. Breakdown of carers who feel valued, respected and part of a team (%)

78% of the 568 respondents reported that they only *sometimes* or *never* felt valued, respected and part of a team.

Carers were then asked 'what they feel are the biggest challenges for carers on the ground' – in this answer, carers were asked to rank the answers with five main areas provided to choose from, the following overall rankings were identified:[83]

Ranking:

1st	Communication with Child Safety
2nd	Managing complex behaviours of children and young people
3rd	Financial burden of fostering
4th	Not feeling valued, respected or part of a team

[82] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[83] Queensland Foster and Kinship Care, *Lived Experience Survey*.

5th Threats of Standards of Care and Harm report processes

Carers were asked to comment on other challenges; 375 carers provided written responses, which are attached (refer to Attachment I).

Some highlighted comments include:

> *"Trying to juggle life with own family and meet the constant changes CSO ask, getting permission all the time to take child when in their eyes you are their family"*
>
> *"…I have regularly rescheduled appointments to facilitate being available for CS (at their request) only to have them not show and not offer any explanation or provide a courtesy call, hours wasted, I would loose my job if I treated my customers the way I am treated by the CS department…."*
>
> *"being lied about and having our integrity, loyalty, honesty and everything else questioned"*
>
> *".....treated like we as carers are the problem, red tape in access and decisions regarding the welfare of grandchild, lack of access to support services"*
>
> *"Feeling like a criminal asking for finance and documents for children"*
>
> *"Getting burnt out, not getting supported, communication not being valued. Our voices are not heard, our children's voices are not heard, especially when it comes to children with complex needs, trauma and family contact"*
>
> *"Lack of communication with child safety, always hearing information second hand"*
>
> *"No superannuation due to inability to work, no income, constant calls from the school saying pick up the child, weekly therapy appointments, home visits, family time visits etc. it's a full time job just being a foster carer, you can't have a career or social life. Friends and family rarely visit and you are not welcome at their house due to the children's behaviours"*
>
> *"Being exposed to a system that places the needs of adults before children and is significantly under resourced, that does not acknowledge the burden of care or vicarious trauma and is adopting external management via ngos, leaving poor connectivity and CSOS with workloads that are unhealthy and unmanageable, affecting Australian children badly"*

As stated at the beginning of this submission, QFKCs' contact with carers is often tied to complex situations, where carers need to reach out to QFKC for support to resolve issues. QFKCs main business is resolving issues; this means we are not receiving phone calls from carers who wish to share their positive experiences. We do, however, know these experiences occur. When we hear through our Retention and Development program about examples of best practice, we acknowledge and celebrate them with the CSSC and Region.

Carer Story

A carer has permitted for QFKC to share her story for this submission. This carer is a single carer who has dedicated 14 years to fostering and was at the brink of walking away due to feelings of not being valued, financial hardship resulting from fostering, and not being heard. During a carer morning tea where QFKC was present, QFKC staff sat down, listened to her story, and provided guidance to the foster and kinship care service and the carer on steps they could take to work through the issues they were experiencing. Some months later, QFKC were delivering a workshop in the region on a new Communication Guide initiative, the carer presented very differently to the morning tea only months before. When conversing with QFKC staff again, the carer shared her story of meeting with the CSSC manager one-on-one and leaving the meeting with a new sense of hope. She felt heard and valued, and the practical elements of her fostering journey were resolved in that meeting. She had also taken on the advice from QFKC provided at the morning tea earlier in the year and had a very positive experience. The carer went on to be a significant voice in the Communication Guide Initiative and experienced the success of the care team working together with a shared understanding. The carer is currently caring for four children and is very happy in her role and no longer wants to walk away; rather, she is spreading positive messaging about fostering.

How one is treated in any role they undertake in society will determine how they present the role to their community. We accept that word of mouth is our most valuable tool for recruitment; we must therefore ensure that the experience of those fostering is one that balances the tough aspects of the job with its rewards and supports.

QFKC, as a matter of course, ask carers in our exit surveys whether they would recommend fostering to a friend. In the 2015-2016 Exit Survey report, 31% of respondents said they would recommend fostering to a friend, 34% said they would not, and 35% said maybe they would.[84] When comparing data 10 years on, in 2023-2024, the percentages were almost the same: 27% said they would recommend, 39% said they would not, and 34 % said they might.[85]

Based on the above, it would be fair to draw some conclusions regarding to the treatment of carers who play a role in the decline of carers; however, this is certainly not the only factor. The traditional foster care role was adopted during a time when there was predominately a stay-at-home parent available to meet the daily care needs of their own children, as well as the additional needs of a child in care.

The President of QFKC's Management Committee is a classic example of this era. Hazel Little has been a carer for 43 years. Her journey as a carer began when she was a mother to young children, and she considered she had the capacity to care for more children who needed care. Hazel did not return to the workforce when her biological children grew older, as she continued to provide primary care to many babies, toddlers and small children. Hazel had the capacity to support the children's appointments during the day, including contact, therapy, Child Safety visits, and eventually foster and kinship care agency visits. The type of carer Hazel was, and still can provide, soon became the

[84] Queensland Foster and Kinship Care, *2015-2016 Carer Exit Survey*, raw data, 2016, SharePoint.
[85] Queensland Foster and Kinship Care, *2023-2024 Carer Exit Survey*.

expectation placed on carers; however, this has not been a sustainable expectation, as the realities of households over the past 10 years, in particular, have seen the need for parents to be in the workforce to keep up with the cost of living.[86]

QFKC has submitted a submission to the Australian Institute of Family Studies on carer payments to the Commissioner on the 21st of August 2025. This submission provides details regarding the changing demographics of carer families, the impact on employment resulting from fostering, and the overall financial impact. QFKC would submit that this submission is considered in the context of this Terms of Reference.

Providing family-based care is a complex undertaking, and it is important to recognise that Queensland Foster and Kinship Care (QFKC) does not believe that an entirely professional care model is the solution for building a strong family-based care sector. While there is certainly a place for professional care for some children, the heart of foster and kinship care must remain rooted in altruism—a genuine desire to help children in need.

However, good intentions alone are not enough. For placements to be successful and sustainable, carer families need comprehensive, wrap-around support that goes far beyond a monthly visit from a fostering agency or a basic fostering allowance. Too often, the system has focused on what carer families can offer to the system, rather than considering what the system can do to support and enable these families to foster. This mindset needs to change if we are to achieve stable placements and support both foster and kinship care households effectively.

The decline in foster care is not due to people being unwilling to help; rather, it stems from the increasing pressures—both anticipated and unforeseen—that families face when considering fostering. Many individuals are interested in becoming carers, but the reality of the demands placed on them often makes the prospect feel overwhelming. To address this, the system must do more than simply encourage people to foster; it needs to actively reassure families that they will be fully supported throughout their journey as carers. This means providing practical assistance in the home to help manage daily responsibilities, ensuring that carers are not left financially disadvantaged, and offering access to emotional support through both foster and kinship care services, as well as independent, free counselling. It also means genuinely treating carers as part of a care team, with their experiences, views and feedback are given the validation and consideration they deserve. Ultimately, Child Safety must communicate clearly to the community, that any barriers, real or perceived, that might prevent someone from enquiring about fostering will be addressed. Only by making this commitment can we hope to encourage more families to step forward and provide family-based care that is so urgently needed.

The next TOR is closely aligned with the above, and therefore, possible solutions will be identified in the context of placement breakdowns.

[86] Hazel Litte, phone call with author, November 14, 2025

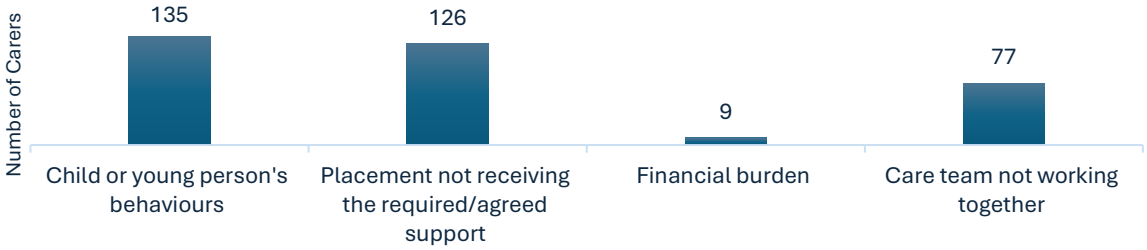
iii. Review Child Placement breakdowns, with a focus on cases with more than four placements in a child's life.

QFKC's casework activity involves direct involvement with carers; QFKC indirectly advocates for children and young people through carer families. However, we do not follow the journeys of children and young people, but rather those of carer households. For this reason, we are unable to provide any specific examples of children or young people who have experienced more than 4 placement breakdowns; however, we can comment more broadly on our experience of the factors that contribute to placement breakdowns from a carer perspective.

As part of the Lived Experience Survey, carers were asked whether they had experienced a placement breakdown. 568 carers responded to this question, and 60% (343) of respondents confirmed they had.[87] To put into perspective, 343 carer families out of 568 reported they had to end a placement unplanned, that is, at least 343 children or young people in this small sample whose lives were disrupted, who experienced hurt, a sense of rejection and yet another home where they were unable to stay. The system manages placement breakdowns daily; it has become a norm, an expectation, a common language used amongst peers in the industry, and yet the experience for a child or young person is anything but normal: it is life-changing, heartbreaking. It can reinforce internal messages of shame and worthlessness. The system needs to stop normalising what is not normal; we need a system that treats placement breakdowns as rare rather than a common daily occurrence.

There are many factors that contribute to placement breakdowns, and many of these factors are avoidable. Carers were asked in the Lived Experience Survey what they felt were the contributing factors to the breakdown in their placement. Four main areas were identified, with the option of carers writing a response if the reason did not fall into one of the categories or if there were additional factors. 347 carers were able to put their answers into one of the four categories with, 106 additional written responses, which are attached (refer to Attachment J).

The results with respect to the categories are as follows:



Graph 3. Additional attributing factors to placement breakdowns.

Some of the written responses provided by carers included:

> *"Failure of everybody, ourselves included, to recognise carer burnout. We were cooked, but didn't realise why. If we had been offered respite for 3-4 weeks, the placement would likely not have broken down"*

[87] Queensland Foster and Kinship Care, *Lived Experience Survey*.

"All of the above, these are not 'behavioural issues' prenatal drug and alcohol exposure, requires proper diagnosis, intervention and NDIS support to manage. We are setting children and families up for failure by ignoring the facts and continually treating this as 'behavioural challenges'. Lifelong brain injury is not behaviour issues."

"Our inexperience at the time was a factor, we did have good support from the department at the time"

"We manage complex children with increased diagnosis and very challenging behaviours, very little respite for most children. We get told there is definitely no respite available for heightened difficult teenagers. Carers feel like only the focus is mostly on the child's needs, the foster carer matters even less"

"My disagreeing with the manager resulted in the breakdown"

"I ticked one, but the other three also apply"

Placement Agreements are a legislative requirement under Section 84 of the Child Protection Act 1999 stating the following –

84 Agreements to provide care for children

(1) If an approved carer agrees to care for the child, the chief executive and approved carer must enter into a written agreement for the child's care
(2) The terms prescribed under a regulation must be included in the agreement[88]

The Child Protection Regulation 2023 includes details as outlined in Section 84 (2) of the Child Protection Act, as follows –

5 Agreement to provide care for a child – Sect 84

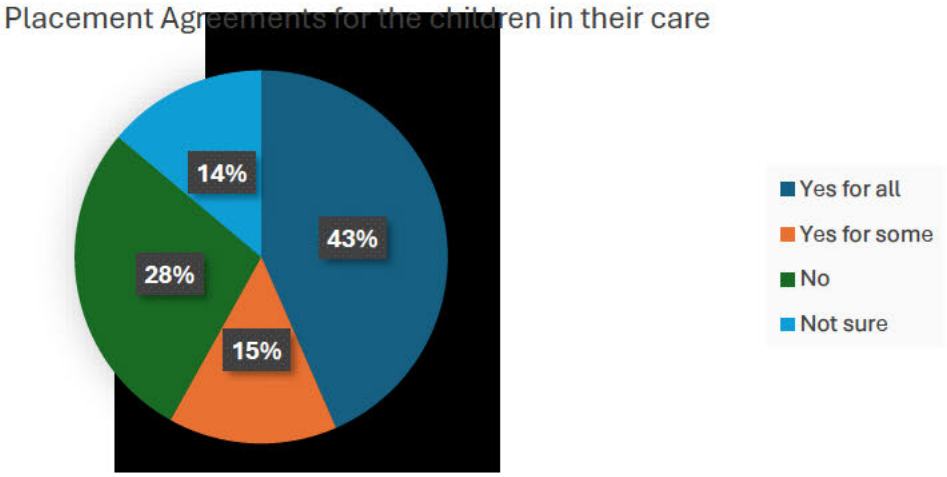
(1) For section 84(2) of the Act the following terms are prescribed –
(a) The time for which the agreement is to have effect
(b) The time for which it is intended that the approved carer will care for the child
(c) Information, from any case plan the chief executive prepares for the child, about mattes involving or affecting the approved carer
(d) If a notice provision applies in relation to the child-
(i) Whether the chief executive has complied or intends to comply with the notice provision; and
(ii) If the chief executive has complied or intends to comply, with the notice provision, the information given or intended to be given to the child's parents under the notice provision
(e) Arrangements for contact between the child and the child's parents or other members of the child's family, including for example, the child's transport arrangements
(f) The responsibilities of the chief executive and of the approved carer in the provision of dental, medical, therapeutic, schooling and other serv ices to the child;

[88] Queensland Child Protection Act 1999, s 84.

(g) Information about any special needs of the child, including information about –
(i) any special health needs; and
(ii) any special behavioural management needs; and
(iii) the resources needed to meet the special needs
(h) the amounts to be paid to the approved carer for the child's care and maintenance
(i) arrangements for ensuring the child's connection with the child's culture of origin
(j) for an Aboriginal or Torres Strait Islander child – arrangements for ensuring the development and maintenance of a connection of the child with the child's family, community, language and'
(i) for an Aboriginal child – Aboriginal tradition; or
(ii) for a Torres Strait Islander child – Island custom[89]

QFKC have provided this level of detail in the submission, as placement agreements are a central element in ensuring placement stability. They are a legal requirement and a document that Child Safety reviews when a determination is reached that the Statement of Standards under Section 122 of the Child Protection Act have not been met for a child. Yet they are not prioritised within care teams and have become more compliance-driven when completed than purposeful. Placement agreements that are not completed in collaboration with the care team or copied and pasted from previous placement agreements are not fit for purpose. Whilst Child Safety statistics may represent a high percentage of placement agreements, there would need to be scrutiny of the quality of these agreements.

In the Lived Experience Survey, carers were asked about placement agreements – 649 responded to the question, 'Do you have a current placement agreement for children in your care?'



Graph 4. Percentage of carers who had a Placement Agreement for the children in their care

In summary, less than half of the carers surveyed have placement agreements for all the children in their care, despite placement agreements being a legislative requirement and the very document reviewed when Standards are not being met for a child or young person. 42% of carers reported either not having one or being unsure if one was in place.

[89] Child Protection Regulation 2023, s 5.

Carers who did have a placement agreement were asked whether they were involved in its development – 50% said they were and 50% said they were not.[90] The Child Protection Act 1999 states 'the chief executive and approved carer must enter into a written agreement for the child's care'.[91] Placement agreements should always be done in partnership with a carer. The areas to be covered as set out in the Regulation of Care Act 2023 cannot be sufficiently explored and met without the participation of the carer.

Carers were then asked in the Lived Experience Survey what they considered were the major consequences in their experience of not having a placement agreement. The following responses were provided (carers were able to select multiple boxes):

Consequences	Number of carer participants
Child or young person's needs are not met	423
Carers needs are not met	376
Additional financial burden	293
Roles and responsibilities not clearly defined	378
Standards of Care/Harm Report matters arise	106

Table 5. Major consequences experienced by a carer who does not have a placement agreement

Carers were provided the option of providing an open response, 86 additional responses were provided, and these responses are attached (refer to Attachment K).

Some of the additional responses provided were as follows:

> *"Child safety not having an accurate idea of where the kids are at"*
>
> *"Clearly you as the carer try to do what you think is the right thing but that's not how it always pans out because the department have completely different expectations that they haven't' made you aware of."*
>
> *"We don't even have an updated safe contact plan so we cannot ensure contact or safety plans"*
>
> *"Up until the change in government, we hadn't seen our CSO in person or rarely heard from her for two years"*
>
> *"Child safety say you have agreed to things but you have never signed off"*
>
> *"No real effort goes into creating the placement agreement, they just update it and ask you to look through it, I don't understand its purpose"*
>
> *"Emotions and mental state of children and carers are heightened"*
>
> *"haven't seen any consequences"*

[90] Queensland Foster and Kinship Care, *Lived Experience Survey*.
[91] Child Protection Act 1999, s 84(1).

"Child Safety have no accountability"

"Team are forced to operate reactively instead of proactively"

When considering the role of a CSO and the enormous administrative burden that it comes with it, QFKC does not believe it is a matter of CSOs intentionally avoiding placement agreements or refusing to undertake them; rather, it is a matter of prioritisation and worth.

CSO's are expected to undertake the following plans:

- Case plans as prescribed in the Act
- Placement agreements as prescribed in the Act
- Cultural Support Plans as prescribed in the Act, policy and procedure
- Education Support plans as prescribed in policy and procedure
- Positive Behaviour support plans as prescribed in policy and procedure
- NDIS planning as prescribed in legislation, policy and procedure.

The above represent just some of the requirements needing to be undertaken for each child and young person in care. If CSOs are not able to see the value and/or purpose in these documents, then they are less likely to be prioritised and completed. If leadership teams are not driving a culture where CSOs know what they should be prioritising and why, then, once again, the documents are likely to be undertaken as a tick box task or not at all.

Giving meaning to these plans/agreements requires CSOs to see the true value in completing them, and this requires CSOs to be in a position to offer the resources necessary to make the plans meaningful. CSOs have no financial and little decision-making delegation; therefore, completing placement agreements becomes an exercise in which the CSO has no ability to confirm any level of support beyond what is generally provided to carers. What is generally provided to carers as a rule of thumb in 2025 is no longer enough for the average carer family to manage financially, socially, emotionally and practically.

Envisioning Enhanced Support for Carer Households

Imagine a system where Child Safety Officers (CSOs) could access a resource pool—traditionally reserved for residential care settings—but now extended to support family-based care. In this model, the non-government sector would employ Family Support Workers (FSWs) at various levels, tailored to the specific needs of each carer household:

- **Family Support Level One:**
  FSWs at this level would assist with daily activities such as transporting children to contact visits, supervising family time when needed, facilitating access to therapies, helping with household duties, and providing babysitting support. The required qualification would be at the Diploma or Certificate level.
- **Family Support Level Two:**
  In addition to the responsibilities listed above, Level Two FSWs would deliver therapeutic

interventions, including training and coaching for carers and therapeutic support for the entire family. These workers would hold degree-level qualifications.

- **Family Support Level Three:**
  This level would be dedicated to families caring for children or young people with complex or extreme needs. Intensive family support would be provided through advanced therapeutic interventions, and the FSW would coordinate multidisciplinary teams—such as NDIS and Evolve—to address the full spectrum of identified needs. Level Three FSWs would be highly experienced and hold degree-level qualifications.

This approach envisions a flexible, needs-based support system for carer families, ensuring that resources and expertise are matched to the complexity of each placement. By adopting such a model, the system could better sustain family-based care, improve placement stability, and ultimately enhance outcomes for children and young people in care.

The Queensland Child and Family Commission projects that, without immediate reform, the state's residential care system will cost Queensland $7 billion annually within just five years.[92] This alarming forecast is based on an 85% surge in the number of children placed in residential care over the past five years.[93] While the idea of employing Family Support Workers to assist family-based care may depart from traditional family-based models, it is increasingly clear that the system must evolve to create environments that empower kin and community members to provide care. Responding proactively to family-based arrangements — through preventative measures rather than crisis intervention when families reach breaking point—is essential to sustaining family-based care as the preferred option for children and young people.

It is important to recognise that there will be families from one end of a continuum requiring support to another, there will be families that identify they do not require any level of additional family-based support, others that require intensive support and families who may at different times require different levels of support. The key to sustaining family-based care is listening to carers tell the system what they need to provide care, not having the system tell carers what they need, or what they can or cannot have.

Summary of Concerns

- Despite Placement Agreements being a legislative requirement under the Child Protection Act with expectations set out in the Regulation of Care Act 2023 as to what they must cover, Placement Agreements are not a document that is being prioritised for completion – this could be one of the contributing factors to the rate of placement breakdowns.
- An overwhelming number of carers who responded to the Lived Experience Survey reported placement breakdowns, highlighting their occurrence as a normality rather than a rarity.

[92] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market*, (Queensland Family and Child Commission, 2025), 21, https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Paper-Buyer-Beware-How-economic-forces-are-shaping-Queenslands-residential-care-market.pdf

[93] Queensland Family and Child Commission, *Buyers Beware: How economic forces are shaping Queensland's residential care market,* 1.

- The impact of placement breakdowns on children and young people cannot be underestimated, with the consequence of system harm for children and young people experiencing multiple placement breakdowns
- CSOs have little decisions-making delegations to independently undertake placement agreements and approve required supports for carer households.

Recommendations

- The system must change the way we approach family-based care from 'what can a family offer fostering' to 'what can the system offer a family to enable them to foster'.

  This will require a new way of thinking where the system accepts that families in today's world are unable to operate as they did 20 years ago. As caregivers will likely need to work, levels of support will likely be required to maintain family-based care. The level of support required will depend on the child or young person, and individual families' need should be driven by the family, not Child Safety.
- The implementation of a family support model that enables families to provide care with the lens of a tailored approach to the specific needs of each carer.

iv. Investigate the contributing factors for breakdown of placements due to lack of support for kinship carers.

The vast majority of kinship carers start their journey off as Provisionally Approved Carers. The intent behind provisionally approving kinship carers is child centred as it aims to prevent children and young people from having to be placed into either foster care or residential care. When children are removed from their families, not only have they likely experienced harm in the context of what are meant to be safe relationships, but the removal itself is often an extremely traumatic event. The ability for children to be placed directly with family members, who Child Safety has assessed as able to meet the child's immediate safety needs can be a positive experience for the child.

However, unfortunately, the experience for kinship carers can be one that sets families up to fail, and result in further disrupted relationships for the child or young person, some of which become irreparable.

A Provisional approval template consists of the following under the 'Assessment information' section of the document: [94]

- Brief interview with applicant in their home
- Household Safety Study part 1 mandatory safety requirements
- ICMS (Unify) review for CP History
- Discussed self-disclosures of criminal, traffic, DV and CP history with applicants
- Discussed relevant health and wellbeing issues with applicant and how to manage
- CSU outcome/urgent Criminal history applicant and adult household members (RD can approve where CSU checks are not back)

[94] Queensland Government, *Provisional approval assessment*, (Queensland Government, 2025), 2, https://cspm.csyw.qld.gov.au/resources/template/Provisional-approval-assessment/504fd091-ce28-4b74-b19c-794c766fdc4b.

- Manager to manager endorsement where the child is being placed in the area of another CSSC

Further, details within this approval template includes:[95,96]

- Brief assessment of the applicant's ability to meet the statement of standards *(Child Protection Act 1999 Section 122)*
- Brief assessment about applicant's suitability to be a provisionally approved carer in accordance with the Child Protection Regulation 2023 section 24.
- Views of child about proposed arrangements or the reasons why the views have not been obtained.
- Views of the parents about the proposed arrangements or the reasons why the views have not been obtained.

Unlike initial or renewal assessments, carers are not provided with this document to read and sign, to ensure the information obtained and provided in the assessment accurately reflects the information provided.

The template requests that the assessor identify any risks and vulnerabilities, and potential strategies and supports to mitigate them. The identification of these supports and strategies should be limited to areas of risk and vulnerability; any new kin placement comes with vulnerabilities, and, as a matter of course, kin must be provided with support from the outset, tailored to the family's needs.

The newly introduced Kin specifications are an excellent example of Child Safety thinking differently in this space. Having NGOs funded to map, assess, equip, and support kin families provides a foundation on which kin should expect support from the beginning – the challenge is then to ensure that support is maintained through adequate resourcing to meet the changing needs of the carer family.

The Child Protection Act's Regulation of care was built around a system with a primary focus on foster care. There is no differentiation between the legal requirements that make a foster carer suitable and those that make a kinship carer suitable, other than that a kinship carer is not required to undertake mandatory training. However, the foundational elements of these two types of care are fundamentally different, from what brings them into the system, to the complexity of the relationships, to what the role of a kinship carer would expect to undertake when caring for one of their own. And yet, the expectations of both do not differ; from decision-making to suitability to information sharing, there is no practice difference.

It is important to put the above into context by providing a lived example. QFKC has the carer's permission to give this de-identified scenario.

Case Study

QFKC worked with an Aboriginal carer who applied to be a foster carer and was approved. Not long after their joint approval with her husband, they were approached to provide care for their nieces and nephews; they did not hesitate. The carer spoke to QFKC about being shocked by the little say she had as the aunt to her nieces and nephews. The carer expected that decisions such as immunisations and taking children on holidays for children that are not

[95] Queensland Government, *Provisional approval assessment*, 3.
[96] Queensland Government, *Provisional approval assessment*, 1.

related to her in any way would not sit with her but was completely dismayed when she found she could not make any of these decisions for her nieces and nephews because those decisions just came naturally to her as their aunt.

The carer recalled them needing to leave their nieces and nephews in Queensland (Qld) to go over the boarder for sorry business, where they were not permitted to take the children to attend also, which meant the children not only were left with strangers for respite, but also missed out on a significant cultural ceremony in respect to the passing of a family member. The carer spoke of how being a kinship carer was too difficult because she was not provided with the environment to care for her niece and nephews naturally, which resulted in tension and conflict. When the carer's nieces and nephews were reunified, the carers swore they would never take on the care of family again due to the stress. This experience was 14 years ago; the carers continued to be approved as foster carers in Qld.

Last year, the carer family were approached by family to take on the care of a newborn baby, subject to orders in New South Wales (NSW). The carers agreed, and a sibling was subsequently also placed under NSW approval with the carer family. The family then asked the carers to care for a third sibling who was subject to orders in Qld and was at the time being cared for by foster carers. The carers were hesitant due to their lived experience of kinship care 14 years ago but believed it had changed and felt a sense of duty and obligation to their family. The carers have told QFKC that their experience has not been any different to what it was 14 years ago, with the carer stating they were unable to leave the state for four and a half months, despite most of their extended family being over the border. For the NSW children the carers are caring for, they do not require permission to do this, but for the child subject to Qld orders, not only was permission needed to go over the border, but the carers were asked to provide Child Safety with the names, dates of birth and addresses of all family members they intended the child to have contact with. The carer spoke about this being completely culturally insensitive and unsafe, with some of the family members being elders, where it would not be appropriate for the carers to ask such questions. This left the child unable to visit her great-grandmother because the carer refused to obtain the requested information.

The carer spoke of the difference in providing care to her two nieces, subject to NSW orders, compared to the one child that is subject to a Qld order. Contact was one example, where she is trusted to supervise contact between family members, with the NSW Department only making decisions in relation to contact where a risk is identified, i.e. parental contact. Another example provided by the carer concerned her ability to make medical decisions for NSW children, i.e., immunisations.

This example highlights how kinship carers are often excluded from meaningful decision-making and the consequences this has on their experience. Kinship carers consistently report that being directed by departmental staff—who frequently change, lack established relationships, and do not possess a deep understanding of the family or child—is challenging and disempowering. Many kinship carers have shared with QFKC that they feel unable to voice concerns or advocate for the children in their care, fearing that doing so may result in the children being removed or that they themselves will be perceived as difficult.

The Statement of Standards are a set of standards set out in the Child Protection Act s122; it provides an expected standard of care for children and young people in care that sits above the average community standards of acceptable parenting. For example, the Statement of Standard that refers to Corporal punishment –

> '*For subsection 1(g), techniques for managing the child's behaviour must not include corporal punishment or punishment that humiliates, frightens or threatens the child in a way that is likely to cause emotional harm'* The Criminal Code states under S280 *is lawful for a parent or a person in the place of a parent, or for a schoolteacher or master, to use, by way of correction discipline, management or control, towards a child or pupil, under the persons care such force as is reasonable under the circumstances'*[97]

The Queensland state has passed legislation in the Education and Child Safety Acts that prohibits the use of corporal punishment by carers and teachers; however, the law stands as stated above for parents providing care in the community. While QFKC supports the position of no corporal punishment for children in care who have already experienced trauma, it is essential to consider the context when assessing situations, such as when a grandmother disciplines a child in care with a smack on the hand or bottom compared to similar actions by a teacher, youth worker or someone unrelated to the child.

The system must consider whether children are better off in foster care and/or residential care where Child Safety can expect a level of care that foster carers and residential care workers are trained in and agree to provide, or a model of kinship care where the standard of care may not meet the threshold of the Statement of Standards, but where the child is safe from harm and risk of harm and where the care provided is good enough.

A further challenge with the Standards of Care is that, as currently prescribed in legislation, they primarily reflect Western parenting practices and do not adequately consider the diversity of cultural approaches to caregiving. Examples of these can be seen as follows:

- A typical example cited by Child Safety regarding the respect of a child's dignity and rights is the expectation that each child should have their own room for privacy. However, this perspective overlooks the realities of many cultures, where sharing bedrooms or beds is the norm and isolating a child in their own room could actually make them feel afraid or rejected.
- Another example is some of the words used in the Statement of Standards are unable to be translated into relevant languages spoken by carer communities. For example, QFKC has been advised that in some of the Pacific Islander languages, there is no translation for 'positive self-regard'. This makes it difficult for our fostering and kinship care services to support carers in understanding what it means to provide care in line with the Statement of Standards on a day-to-day basis.

Recent data show an increase in the number of Standards of Care (SOCs) and Harm Reports raised in relation to Kinship care families. Our most recent exit data (2024-2025) further evidences an increase in exit referrals, where a carer has been subject to either a SOC or Harm report. SOC rates amongst exited carers have increased from 7.9% to 9.5%, and Harm Reports have increased from 5.8% to 7.2%.[98] The increase in Harm reports does not appear to be a foster care issue, rather a kinship care issue

[97] Child Protection Act 1999, s 122(1)(g).
[98] Queensland Foster and Kinship Care, *2024-2025 Carer Exit* Survey.

mostly. In comparison to reporting periods, carer exits where the carer is subject to a Harm report are approximately double for kinship carers vs foster carers. The incidents of exiting foster carers subject to a SOC are relatively consistent but are trending upwards for kinship carers. Overall, the data points to an ongoing and concerning pattern and reinforces the strain on kinship carers.

As referenced above, a key difference between what is expected of a foster carer and a kinship carer is the delivery of mandatory training. Whilst the intent of not making training for kinship carers mandatory was well-intended and aimed at not creating barriers to families caring for their own, the unintended consequence of this is that we have kinship carers coming into a role that still holds the same expectations as foster carers, but without the information and knowledge to undertake the role.

The Queensland Family and Child Commission's (QFCC) Blue Card and Foster Care Systems Review published in July 2017 listed recommendation 28 as –

> *'…the Department of Communities, Child Safety and Disability Services develops a training program specifically for kinship carers:*
>
> - *recognising the unique and varying nature, culture and challenges of kinship care*
> - *with flexible delivery modes (for example, online modules, attendance by video link, or one on one delivery methods)*
> - *requiring all kinship carers to begin the training within six months of their first placement.'*[99]

Child Safety accepted 42 recommendations; however, as of 2025, there is no such training available. On 1st October 2025, Child Safe Standards came into effect, the QFCC website states –

> '*The Child Safe standards and the Universal principle under Queensland Law aim to make prevention of harm to children and young people a collective institutional responsibility. They align Queensland with national and international child protection standards, ensuring we are leaders in safeguarding children'.* [100]

One of the 10 Standards, Standard 7, states –

> 'Staff and volunteers of the entity are equipped with the knowledge, skills and awareness to keep children safe through ongoing education and training'[101]

This particular standard place accountability on Child Safety and on foster and kinship care services, which provide support to kin carers, ensuring they have the training and information necessary to undertake the complex role of being a kinship carer.

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[99] Queensland Family and Child Commission, *Keeping Queensland's children more than safe: Review of the foster care* system, (the State of Queensland, 2017), 56, https://www.qfcc.qld.gov.au/sites/default/files/2022-08/Review%20of%20the%20foster%20care%20system.pdf.

[100] Queensland Family and Child Commission. "Background Child Safe Standards", Queensland Family and Child Commission, accessed November 2025, https://www.qfcc.qld.gov.au/childsafe/background.

[101] Queensland Family and Child Commission. "Standard 7", Queensland Family and Child Commission, accessed November 2025, https://www.qfcc.qld.gov.au/childsafe/standards/standard-7.

Reviewing Queensland legislation about the protection of children, including the Child Protection Act 1999 and Adoption Act 2009

QFKC has referenced in this submission our position that Section 65 of the Child Protection Act 1999 should allow a person to make an application on behalf of a child, rather than requiring a child to make an application in their own right. This option is available to children and young people for the purpose of reviewing applications under Section 99P of the Child Protection Act 1999. An application under this section can only be made with the president's permission, the president may give permission only if the president considers –

(a) The person is not, on the person's own behalf, entitled to apply for the decision to be reviewed by the tribunal;
(b) it is in the best interests that the application be made; and
(c) it would be inappropriate for, or unreasonable to require, the child to make the application himself or herself. [102]

It would be QFKC's position that a similar measure would need to be in place, if available for the purposes of variations of orders in the Children's Court.

The Child Protection Reform Act 2017 introduced principles for achieving permanency for a child. As part of this reform, the Child Protection Act introduced three dimensions for achieving permanency – relational, physical and legal.

Relational permanency in the Child Protection Act refers to the right of the child and young person to experience and have an –

> 'ongoing positive, trusting and nurturing relationships with persons of significance to the child, including the child's parents, siblings, extended family members and carers…'[103]

Despite the Permanency Principles referencing the importance of the child's relationship with carers, there is no legal right for foster carers to request contact with children following a placement ending with them when the child continues to be subject to a Child Protection order under the Child Protection Act. All kin have the right to have contact decisions reviewed through QCAT; however, this review right does not extend to foster carers under the Schedule 2 Reviewable Decisions and aggrieved persons of the Child Protection Act 1999 –

> '*refusing to allow, restricting, or imposing conditions on, contact between a child and the child's parents or a member of the child's family (Section 87 (2))*'[104]

This section has been tested in QCAT, with foster carers previously making applications under this section.

Case Studies

In 2018, QCAT decided in favour of a foster carer who applied to have a decision reviewed around restriction of their contact with a child they had provided care for over five years and

[102] Queensland Child Protection Act 1999, s 99P (2).
[103] Child Protection Act 1999, s 5BA (1)(a).
[104] Child Protection Act 1999, Schedule 2 (7).

> Child Safety appealed this decision on the basis that the foster carer did not meet the legal definition of family under Section 87(2) of the Child Protection Act and therefore was not entitled to have the decision reviewed. The appeal was upheld, and the application for review was dismissed in a decision handed down on 24th July 2019. The basis for the decision was that the foster carer did not meet the legal definition of parent or kin under Section 87 of the Child Protection Act and therefore had no review rights under the Act. [105]

For children who have been placed with carers for many years, where children are transitioned to live with kin or are removed due to an outcome of a Harm Report, Child Safety can effectively decide not to support any form of contact. There is no ability for the carer and/or the child to seek any external or legal review of this decision. QFKC have worked with many foster carers who have been denied any form of contact following significant lengths of placements.

The following provides just some examples:

- QFKC worked with a carer who had taken a newborn home from the hospital after being born prematurely. At the age of 8, the child was removed due to a Harm Report where other children were the subject of a harm report relating to an adult household member and then subsequently allegations in respect to the male carer. The female carer was initially permitted unsupervised contact; this was then restricted to supervised contact due to concerns about the child's behaviour upon returning from contact (the child was reported as distressed), and the decision was made to stop contact. The carer was advised to seek a review of the decision through the complaint process. When these steps were taken, the complaints unit advised that it was out of jurisdiction, as matters relating to the child's removal were before QCAT. The carer could not seek any external review of this decision; the carer had never been found to have harmed this child.
- A carer couple supported a transition for a child whom they had cared for, for two years to live with their sibling, with the understanding they would be involved in the child's life, offering respite and attending special family occasions. Upon this transition, the arrangement was not upheld, despite the carer family accessing the complaint process to raise their concerns about the impact this would have on the child. There was no change in the decision, and the carer family was no longer to be part of the child's life. In this case, there were never any Standard of Care or Harm Report concerns with respect to any household members.
- A foster carer had cared for a child from a Culturally and Linguistically Diverse (CALD) community as one of her earlier placements. Fifteen years later, this now mother (foster child) had her own children come into care. The foster carer had maintained a relationship with the now mother since she had been placed with her. When their children came into care, the children were placed with the foster carer whilst Child Safety explored kin. When Child Safety located a kin option, the children were transitioned. The foster carer requested to continue to see the children due to the already established relationship, but this was denied. The kinship placement was reported to have broken down just 3 months later.

QFKC would like to see an insertion in the Child Protection Act that supports Section 5BA regarding the relational permanency between carers and children and young people. Section 87 of the Child

[105] *Department of Child Safety, Youth and Women v PJC and The Public Guardian*, QCATA 109/2019 (Queensland Civil and Administrative Tribunal, 31 August 2018).

Protection Act could be extended to include a provision for Child Safety to consider contact between a person of significance to a child who does not meet the definition of Kin, for example, a foster carer.

The child or young person should be at the centre of this decision, as the person affected by the decision, and therefore the aggrieved person for the purposes of review. If a child or young person cannot make the application in their own right, a significant person, i.e. a foster carer, could make an application under Section 99P of the Child Protection Act on behalf of the child for the restriction of contact to be heard. This would ensure applications were only heard where the President of QCAT was satisfied that the child or young person could not make the application in their own right and it was in the best interests of the child or young person for the application to be heard.

Recommendation

- Introduce legislative change to allow a child or young person to have a review right in respect to contact decisions for people of significance to them that do not meet the definition of kin.

Any other matter relevant to the inquiry

Kinship Suitability – QFKC's Position

The Orphanages Act 1879 was the first to consolidate legislation governing the care of children in Queensland. The Orphanages Act 1879 permitted destitute or deserted children under the age of 12 years to be sent to an orphanage and to remain there until they reached 12 years of age, unless boarded out with a 'trustworthy and respectable person', hired out or apprenticed. A child could be hired out or become an apprentice at 10 years of age. At this time, the state subsidised orphanages in Brisbane, Rockhampton and Townsville, and an inspector of orphanages was appointed. Parents or relatives of children living in these institutions were expected to contribute to their support.[106]

This earliest version of legislation, which sought to protect children and young people and provide alternative care arrangements, made no mention of kinship carers. The approval and regulation of family-based placements were designed around foster care.

In an article published in 2008 titled 'Children in out-of-home care in Australia: International comparisons', it was reported that in Queensland in June 2005, there were 99% of children in out-of-home care in family-based placements - 27% in kinship care and 72% in foster care.[107] Only 1 % were in residential care. For Aboriginal and Torres Strait Islander children, the percentage of children in kinship care was slightly higher at 36%. The article reported that Queensland had the lowest level of kinship care in Australia.

Five years later, in 2013, the Commission of Inquiry into Child Protection explored kinship care in the final report, 'Taking Responsibility', handed down by Carmody. The report highlighted that as of the 30th of June 2012, there were 1,555 households with at least one child place in kinship care, which equated to 34%.[108] This percentage was reported as being well below the national average of 46.7%, which the report identified "as concerning given the clear benefits kinship care can bring".[109] The

[106] Department of Families, Seniors, Disability Services and Child Safety, "History of Child Protection".
[107] Clare Tilbury and June Thoburn, "Children in out-of-home care in Australia: International comparisons," *Children Australia* 33, no.3 (2008): 5-12, https://doi.org/10.1017/S1035077200000262.
[108] Queensland Child Protection Commission of Inquiry, *Taking Responsibility*, 257.
[109] Queensland Child Protection Commission of Inquiry, *Taking Responsibility*, 257.

report stated that "much of the evidence for the low rate of kinship care points to the failure of the child protection system to recruit, support and retain kinship carers, especially in comparison with the support received by foster carers".[110]

The report identified two responses as being required in order to improve the rate of recruitment and retention of kinship carers, both in indigenous and non-indigenous communities:

1. Kinship carer should be provided under a stand-alone framework, instead of being treated as a subset of foster care.
2. Identification of possible kinship carers could be improved through the mandated use of genograms and eco-mapping.[111]

The report highlighted many barriers to the recruitment of kinship carers, including the requirement for kin and their household members to hold Blue Cards. The report handed down two recommendations in respect to kinship care:[112]

> **Recommendation 8.3**
>
> That the Department of Communities, Child Safety and Disability Services build on efforts already began to articulate the uniqueness of kinship care and its importance as a family based out of home care placement options to that kinship carers feel they are part of the team.
>
> **Recommendation 8.4**
>
> That the Department of Communities, Child Safety and Disability Services engage non-government agencies to identify and assess kinship carers.

It is encouraging to see advancements in kinship care since Carmody's report was handed down in 2013, with kinship carers now benefiting from dedicated support services and, more recently, the introduction of Child Safety's kinship care specifications. These specifications aim to identify and address the unique support needs of kinship carers through a tailored mapping and equipping process.

However, despite these improvements in the support system, the assessment framework for kinship carers remains unchanged. It continues to be based on the model originally designed for foster carers in Queensland.

Child Safety's performance data in the past five years continues to evidence an upward trend in the number of children and young people being cared for by kin. In 2020, 41% of children and young people were placed with family; by March 2025, this had risen to 45%.[113] Whilst the rates of children in kinship arrangements continue to rise, the family-based system continues to be designed around foster care.

The Centre for Excellence in Therapeutic Care published a research paper in 2022 on 'Understanding the needs of kinship carers in Australia', which QFKC has attached (refer to Attachment L). This research

[110] Queensland Child Protection Commission of Inquiry, *Taking Responsibility*, 257.
[111] Queensland Child Protection Commission of Inquiry, *Taking Responsibility*, 283.
[112] Queensland Child Protection Commission of Inquiry, *Taking Responsibility*, 260.
[113] Department of Families, Seniors, Disability Services and Child Safety, "Living arrangements of children", accessed November 2025, https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/what-we-do/living-arrangements-of-children.

paper provides a great level of insight into how "…State and Territory child welfare policy and practice was previously geared towards placing children in foster care arrangements, rather than with family and kin".[114] The policies, legislation and practices that were set up around placing children in foster care arrangements then became the same polices, legislation and practices that were expected of kinship care arrangements, despite the two being very different.

Kinship carers requiring a BlueCard provides an example of how the uniqueness of family caring for family did not appear to be considered different to that of a foster carer providing family-based care. The requirement for carers to hold Blue Cards was introduced in stage 3 of the legislation reforms following the CMC inquiry, via the Child Safety (Carers) Amendment Act 2006. The requirement to hold a blue card meant that carers were considered to be engaged in a 'child regulated employment'.

QFKC, among other organisations, advocated the removal of Blue Cards for kinship carers during a review of the Working with Children's Act 2022. In a media release published by the Queensland Family and Child Commission (QFCC) on the 1st of November 2023, QFCC called for the removal of the Working with Children screening for kinship carers, noting it would remove barriers for Aboriginal and Torres Strait Islander kin caring for their family members. The QFCC reported that "the current universal Blue Card system is designed to assess suitability for child-related employment, not suitability to care for family members. Cultural kinship care is family caring for family, it is not employment".[115]

In September 2024, the Working with Children (Risk Management and Screening) and Other Legislation Amendment bill was passed, removing the need for kinship carers and their adult household members to hold a Blue Card. At the time of this submission, the requirement for a kinship carer to hold a Blue Card continues, as the alternative risk assessment framework that Child Safety is required to implement prior to the proclamation of this change has not been made.

Despite the requirement for kinship carers to hold a Blue Card, this significant shift in legislation should pave the way for Child Safety to review other legislation, policies and procedures in which kinship carers have been automatically included, but where they do not align with what it means for family to care for family. The Statement of Standards set out in Section 122 of the Child Protection Act 1999 is an example of this.

The Statement of Standards was introduced into the Queensland Parliament through the Child Protection Bill 1998, in Chapter 5, Regulation of Care, Section 123 and was later passed in the Child Protection Act 1999. The Standards were developed to provide a framework for assessing the quality of care and to ensure the care environment was suitable for the child's development and wellbeing. Now set out in Section 122 of the Child Protection Act, some 26 years later, the legislation continues to read the same despite significant advances in the Queensland Child Protection landscape.

There is no question that when children and young people enter care, the system has a fundamental responsibility to establish frameworks that foster safety and healing. However, when these frameworks are not clearly understood by those responsible for implementing them and are instead

[114] L Macpherson, J Mitchell et al. *Understanding the Needs of Kinship Carers in Australia*, (Centre of Excellence in Therapeutic Care, 2022), 3, https://www.cetc.org.au/wp-content/uploads/2022/07/needs-of-kinship-carers-in-australia-research-brief.pdf.

[115] Queensland Family and Child Commission. "QFCC calls for reform to kinship care assessment," Queensland family and Child Commission, published November 1, 2025, https://www.qfcc.qld.gov.au/news-and-media/qfcc-calls-reform-kinship-carer-assessment.

perceived as punitive tools when standards are not met, their original purpose is undermined and ultimately lost.

As discussed earlier in this submission, despite the Queensland Family and Child Commission recommending that Child Safety develop a purposeful training for kinship carers to complete within 6 months of approval, this has not occurred. There are also currently no resources on Child Safety's website that support any carer in understanding what it means to meet the Statement of Standards. QFKC has advocated for one for many years, and we are pleased to advise that a resource is currently being developed to support a better understanding of what it means for the care team to meet the Statement of Standards.

It is QFKC's view that the focus for children and young people placed with kin must be more simplistic; kinship carers should not be assessed against the Statement of Standards, instead they should be assessed against what defines a Suitable person as outlined in Section 24 Regulation of Care:[116]

a) Does not pose a risk to the child's safety and;
b) Is able and willing to protect the child from harm; and
c) Understands and is committed to the relevant principles; and
d) Has completed any training reasonably required by the chief executive to ensure the person is able to care properly for a child

The focus must be on ensuring that a kinship carer can provide a safe environment for a child, is protected from harm and the risk of harm. This environment would be one in which Child Safety would reunify a child. Providing training to kinship carers will support them in growing their knowledge and understanding of providing a trauma-informed care environment. The newly established Kinship Care specifications will focus on how organisations can best equip and support kin families, with a focus on safe care that is free of harm and risk of harm, rather than an idealistic set of parenting standards never designed for family caring for family.

Recommendation

- Kinship Carers are provided with the appropriate information and the required training to best equip their role in caring for family.
- Kinship carers are assessed against the legislative requirements to provide care as set out in Regulation of Care Act 2023 only and not against the Statement of Standards as set out in Section 122 of the Child Protection Act 1999.

QFKC's Recommendations

Fixing a Broken System

Queensland Foster and Kinship Care recommend the following for the Terms of Reference, 3a:

- The introduction and implementation of a Reunification Court.
- Additional resources to support effective concurrent planning and investment in suitability assessments when a concurrent planning identifies a potential suitable guardian.

[116] Child Protection Regulation, s 24.

- Changes in legislation under Section 65 of the Child Protection Act 1999 to expand the inclusion of adults having the ability to complete an application on behalf of the child or young person.
- Investment in the expansion of legal assistance for carers to access, especially for matters related to Section 113 of the Child Protection Act 1999.
- Remove Adoption as a permanency option for children and young people in the Child Protection Act 1999.
- Child Safety to invest genuinely in achieving permanency for children and young people through Long-Term Guardianship to Other (LTG-O) option or Permanent Care option.
- The adoption of a training model, as undertaken in the Far North Queensland region, across all regions across the state where CSOs are provided a day of training supported by carers, QFKC and Foster and Kinship Care agency staff.
- Leadership team members are provided the opportunity to undertake direct training (same training as the CSO training) as part of their professional development.
- Implementation of an external supervision model for Senior Team Leaders and prioritising advanced learning opportunities.
- Explore best practice models of service delivery within CSSC's and role model these to other CSSC's.
- Review of Child Safety policies and procedures relating to the support and services provided to carer households where practice is reflecting a discrepancy amongst Service Centres in the application of the policy and procedure in practice. For example, Dual respite, High Support Needs Allowance, Complex Support needs allowance.
- Training and education that is practice based on the information sharing framework Child Safety staff can rely on in their practice. This training would need to be repeated on a regular basis to drive a culture within offices that supports sharing of information and ensures new staff are equipped with the knowledge they require.
- Creating a culture where CSOs are enabled to share information, where resources are visible and available to CSOs and where the narrative is to share information to keep families safe and informed.
- Direct line supervisors explore information sharing as a key component to regular supervision sessions to ensure that CSO's are sharing information in accordance with Child Safety's Information sharing guidelines.
- The establishment of an independent complaints body that has both the knowledge and independence to appropriately review complaints.
- Harm Report outcomes to become a reviewable decision in the Queensland Civil and Administrative Tribunal.

Safer Children

Queensland Foster and Kinship Care recommend the following for the Terms of Reference, 3b:

- The system must change the way we approach family-based care from 'what can a family offer fostering' to 'what can the system offer a family to enable them to foster'.

Any other matter relevant to the inquiry

Queensland foster and Kinship care recommend the following for the Terms of Reference, 3c:

- Kinship Carers are provided with the appropriate information and the required training to best equip their role in caring for family.
- Kinship carers are assessed against the legislative requirements to provide care as set out in Regulation of Care Act 2023 only and not against the Statement of Standards as set out in Section 122 of the Child Protection Act 1999.

Conclusion

Queensland Foster and Kinship Care (QFKC) would like to thank the Commission of Inquiry in providing the opportunity to share the lived experiences of foster and kinship carers across Queensland. As the peak body representing this vital demographic in family-based care, QFKC is committed to ensuring that every child and young person is supported and never left behind within the Child Protection system. We remain deeply dedicated to advocating for systemic improvements that prioritises the safety, wellbeing, and the voices of children and young people, while recognising and valuing the essential role of carers in achieving these outcomes.

[i] Mason Lee Jett aged 22 months old died on the 11th of Jue 2016, as a result of injuries sustained by his stepfather. The family were subject to Child Safety intervention at the time of Mason's death. Twelve Child Protection staff faced disciplinary actions for 'their errors of judgement' and three service staff were stood down. A Coroner's inquest was ordered in respect to Mason's death, Deputy State Coroner, Jane Bently, delivered her findings of the inquest on the 2nd of June 2020.

CARER ASSISTANCE PROGRAM

Queensland Foster and Kinship Care Funding Submission

Contents

Queensland Foster and Kinship Care

Queensland Foster and Kinship Care (QFKC) is a not-for-profit Peak Body organisation for foster and kinship carers, their families including children and young people in care in Queensland.

QFKC has been established since 1976 with the Board of Governance, Management Committee, who all bring a lived experience of providing foster and or kinship care in Queensland and who currently have more than a combined 200 years of experience in family-based alternative care for children.

Across the state, QFKC represent over 6,000 carer families, which include foster, kinship, and provisionally approved carers, who provide family-based placements for children in need within the Child Protection System. The organisation's goal '*To contribute to the development of an inclusive, responsive and fair foster care* system', hence our commitment in providing support and advocacy work for carers and facilitate training for carers and agency staff on child protection procedures and processes.

QFKC is present throughout a carer's journey from recruitment, support, and advocacy, through to exiting.

Background

The Foster and Kinship carer role is a unique and specialised volunteer role. Becoming a carer requires commitment, stability, a profound level of responsibility and emotional resilience. Carers must possess a particular set of skills which require them to navigate at times complex challenges, such as understanding and managing the effects of trauma, advocating for a child or young person's needs, and working within the complex child protection system. The level of a carer's emotional involvement in a child's entire ecosystem requires a level of flexibility and understanding that is not typical of most volunteer roles.

Given the intensity of the role, it is essential that Foster and Kinship Carers receive tailored support that is designed specifically for their needs. The access of free counselling is a critical resource for carers to prevent burnout and ensures the emotional well-being of a carer is supported, which in turn will assist in retaining Foster and Kinship Carers in the system. Providing this essential support ensures Foster and Kinship Carers feel valued, equipped and supported in their invaluable work and recognised for the complexity of volunteering for the child protection system.

The *Statement of Commitment*, a document outlining the commitment that Child Safety makes to all approved Foster and Kinship Carers, Queensland Foster and Kinship Care

(QFKC) identified that counselling support specifically for Foster and Kinship Carers were not being utilised.

The extract from the Statement of Commitment states that Child Safety will

> "*work with foster and kinship care services to meet the counselling needs associated with the caring responsibilities of Foster and Kinship Carers".*
>
> (Queensland Government, 2022, p. 5)

As part of the Queensland Government's review of residential care services in 2023, *A Roadmap for Residential Care in Queensland*, one of the identified domains for change was to improve support for Foster and Kinship Carers. One of the actions outlined in the roadmap report is to 'expand access to counselling, intervention and support services to carers' with the overall goal of retaining carers and children being cared for in family-based placements (Department of Child Safety, Seniors and Disability Services, 2024, p. 18).

In 2024, Queensland Foster and Kinship Care were successful in attaining funding for a 12-month pilot program of their Carer Assistance Program – a counselling service tailored for Foster and Kinship Carers. As part of this funding, QFKC were tasked with developing a proposed service delivery model to identify the needs of a state-wide counselling service.

Queensland's Carer Assistance Program

Other State Programs

Victoria and Western Australia currently provide a counselling service for Foster and Kinship Carers. The Counselling Assistance Program (CAP) in Victoria is under the implementation of Victoria's foster care peak body – the Foster Care Association of Victoria (FCAV). This program has been granted ongoing funding and commenced in 2020 to offer free therapeutic support to Victoria's foster, permanent and adoptive carers. FCAV's CAP program received 189 referrals from Foster and Kinship Carers in their first 2-year period with this number growing as the knowledge of the service grew amongst the carer cohort.

In Western Australia in 2020, the Australian Childhood Foundation commenced their OurSPACE program and have been granted ongoing funding to continue to offer telephone or videocall counselling and support for all Foster and Kinship Carers in the state. This service works closely with the peak body in Western Australia – The Foster Care Association of WA, to best support their carer community of approximately 3000 Foster and Kinship Carers. The OurSPACE program currently employs 3 Full-Time Counsellors/Therapists and receive approximately 105 referrals each year.

Service Delivery Testing

QFKC ascertained to provide a well-rounded therapeutic service for Foster and Kinship Carers, testing and understanding of the service was required through feedback consultations. Feedback and insights were obtained from the following sources:

- Foster and Kinship Care Agencies
- Foster and Kinship Carers
- Aboriginal and Torres Strait Islander Peak Body and Community Controlled Organisations

QFKC's employment of a full-time Counsellor provided the opportunity to develop the Carer Assistance Program of which includes several avenues of referral pathways and the delivery of a limited counselling service. Within the first 6 months of the testing period, the Counselling Service has provided over 100 hours of individual, couple and group sessions.

Since the commencement of the service testing period from July 2024 (6-month period), the following has been achieved:

- Contact with all Foster and Kinship agency Managers in Queensland to seek their feedback and recommendations regarding a statewide counselling service specific for carers.
- Contact with QATSICPP and Aboriginal Community Controlled Organisations to seek feedback and recommendations.
- Consultation with approved Foster and Kinship Carers via a live Webinar/survey directly to seek their feedback and recommendations about a counselling service for Queensland.
- Consultation with Foster and Kinship agency staff members via a live Webinar/survey to seek their feedback and recommendations about providing a counselling service for Queensland.
- An anonymous evaluation survey sent to carers who were accessing the counselling service seeking their feedback about the service.
- Providing a limited counselling service

Carer Assistance Program

From the commencement of the pilot program (July 2024 till December 2024) QFKC's Counselling Assistance Program has:

- Received 33 referrals
- Facilitated over 100 counselling sessions, including couple and individual sessions. *Note: This was a limited capacity service due to the testing period and not operating at maximum capacity.*
- On average, carers have accessed over 3 sessions per individual or couple.

- Developed and delivered online therapeutic group sessions for carers

The main reasons for referral to the QFKC counselling service were:

- grief and loss,
- stress,
- burn out,
- vicarious trauma,
- disempowerment and
- lack of trust with the Child Safety system.

Feedback from Counselling Service Users

Foster and Kinship Carers

> *"It's a safe place to share, and I have been given some very valuable tools. A place where I am listened to and feel validated. Excellent advice. Thank you. I hope this service continues so it can help other carers in need".*
>
> (Foster and Kinship Carer)

> *"I have appreciated being able to just let down my guard and speak freely. And it's so good to know you are there if I have a wobble."*
>
> (Foster and Kinship Carer)

> *"I had tried EAP in the past but they did not understand the child safety system. I am so grateful that I could get in to see a counsellor immediately as I don't know that I could have waited a month".*
>
> (Foster and Kinship Carer)

Feedback from Carer Agencies whose carers have accessed the service

> "*We have received positive feedback directly from our Carer so far and this Carer has recommended other Carers be referred. We are very excited about this service and think it has been so helpful already that our Carer could get in so quickly to receive the support when they needed it."*
>
> (Foster and Kinship Agency, Far North Queensland)

> *".... it's important the service understands the system. The feedback from our Carer is that they were so thankful they did not have to explain any of the Child Safety processes."*
>
> (Foster and Kinship Agency, North Queensland)

Case Examples

QFKC, as a peak organisation in the Child Protection System, has a range of involvement with Foster and Kinship Carers from recruitment, support and advocacy, and when a carer has exited the system. During the Carer Assistance Program's trial period, some Carers were directed to the counselling service whilst being involved in various other support services facilitated by QFKC. Other Carers were referred from their Foster and Kinship Agency, Child Safety or by self-referral. The below cases studies are provided below.

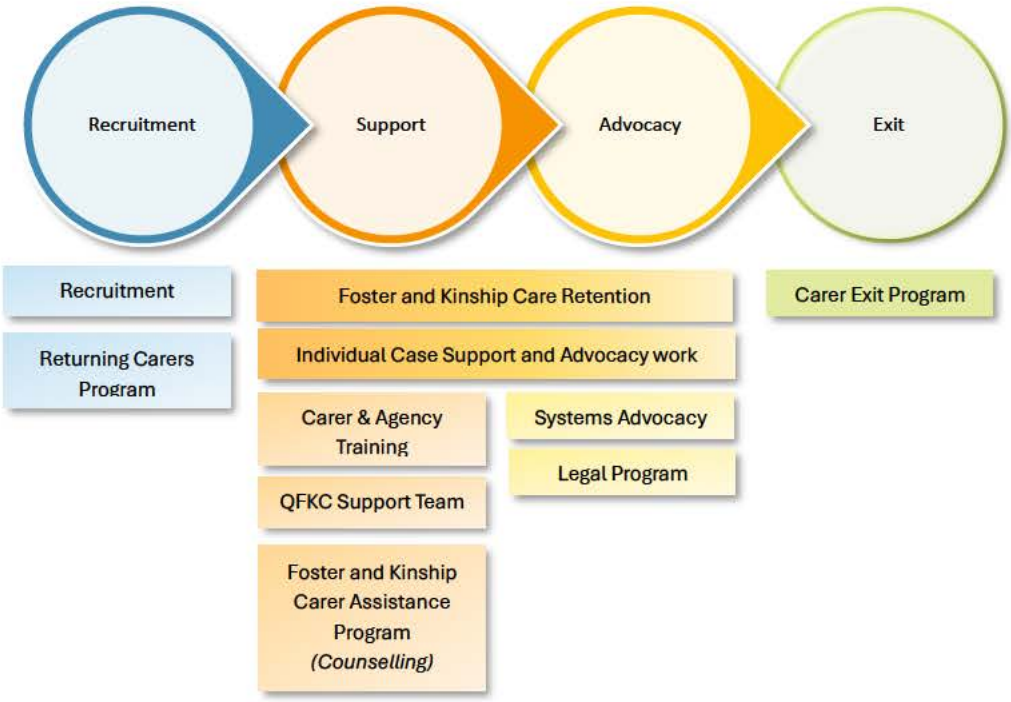

Figure 1. Queensland Foster and Kinship Care Services

Case Study 1: A grandparent couple (kinship carers) were advocating to have their two grandchildren move from a Residential alternative care program back into their care. These kin carers received support from QFKC's Case Officer Program (Individual Case Support), Legal program, and Carer Assistance Program (Counselling) and were successful in having their grandchildren return to their care. At the end of their time in the Counselling program, the Kin Carers shared that they finally felt valued and supported and now felt empowered by having more knowledge, skills and confidence to support their grandchildren.

Case study 2: A Foster Carer couple had been referred to the counselling service due to going through a challenging reunification process for a child in their care. The couple had decided that once the child reunified, they would no longer continue as carers due to the impact that working within the child protection system had on their marriage and their wellbeing. Upon exiting from the Counselling program, the couple shared they felt proud

of how instrumental they had been in the successful reunification process and were going to continue to be part of that child's life. The couple also made the decision to continue to provide care in the form of respite care into the future.

Case study 3: A First Nations Kin Carer had been referred to the Counselling Service from a QFKC Retention and Development Officer located in their region, following a death in their family and a Harm report. Counselling support was provided over a number of months to address the grief and loss that the Carer and family had been experiencing, whilst the Retention and Development Officer worked with the Carer to navigate the Harm report. Upon exiting the Counselling Service, the Carer shared that everything she had learned during the sessions had a flow on effect to her partner and the children in their care, which helped them to feel more connected as a family through their challenging time.

Whilst these case studies are only several examples of the scope of QFKC's intervention across their multiple internal programs, it highlights the significant role QFKC plays in the outcome of the retention of Foster and Kinship Carers. Without this intervention, children may be placed in Residential care instead of remaining in a family-based placement.

Current Counselling Access for Foster and Kinship Carers

From consultation with Carer agencies across Queensland, QFKC are aware of two main options are currently being offered to Foster and Kinship Carers that are seeking counselling support – the Employee Assistance Program (EAP); and a Mental Health Treatment Plan from a GP to access external mental health support.

Employee Assistance Program (EAP)

An EAP counselling service is provided by employers to their staff to support their staff's emotional and psychological wellbeing (Eap Assist, 2022). This option is being recommended to Foster and Kinship Carers to access through their Carer agency's organisational EAP plan. The EAP service has however been designed for paid employees and as Foster and Kinship Carers are in a specialised volunteer role, the matching of this service to the carer community is not ideal.

Feedback from Carers and Carer agencies have been that the EAP service is "too general" with the Counsellors having little to no knowledge of the child protection system, making it challenging for some Carers to feel properly understood in their role. The session flexibility is also limited to 3 hours per calendar year (Eap Assist, 2022). Feedback shared by a Carer agency, stated that it could be a difficult internal process to obtain approval allowing a Carer to access further sessions.

GP Mental Health Treatment Plan (GPMHTP)

To be eligible for a GPMHTP, a doctor needs to diagnose a patient with a mental health condition to create the plan (Queensland Health, 2024). This eligibility criteria may result

in a patient not being able to access the treatment plan due to not presenting with a mental health disorder. Carers have provided feedback directly to QFKC of instances where they have not been eligible for a GPMHTP due to this. Carers have also shared concerns that they are hesitant to access these mental health plans due to the impact it may have on their employment (employment related medicals) and their health insurance.

> *"There is a huge barrier for carers to access a MHCP through a GP. And if carers are utilising this for carer specific issues, then they won't have any left if they need that for any other personal concerns. There is also a stigma of accessing mental health plan and will be on their My Gov record. There could be implications for this if the carer is going through a separation for example."*
>
> Foster and Kinship agency - South East region

Consultation and Feedback from the Aboriginal and Torres Strait Islander Peak Body & Community Controlled Organisations

Consultation with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) occurred, with the goal to seek support in engaging with their members. Feedback was provided by some Aboriginal Community Controlled Organisations (ACCO) in Queensland and QFKC will continue to prioritise engagement with all ACCO's through this testing period with the hope to gain further responses.

The feedback provided, showed that EAP was being recommended to First Nations carers for counselling support, with a culturally appropriate option being sourced should the Carer request that. The responses received from ACCO's showed their willingness to refer to the Carer Assistance Program, with a preference for a culturally appropriate option, and their belief that Carers would access this service due to its tailored approach.

> *"I think carers would benefit from a counselling service that is external to child safety and our agency, it could provide a neutral and independent space helping to build greater trust and openness."*
>
> (Community Controlled Organisation, Far North QLD)

> *"I believe that carers would greatly benefit if the service was easily accessible – emergency appointments, wait lists were minimised."*
>
> (Community Controlled Organisation, North QLD)

Feedback from Foster and Kinship Care Agency Managers

Results from the Foster and Kinship Care agency manager consultation show:

- The main source of counselling recommendations from agencies to their Carers was through the agencies internal Employee Assistance Program (EAP).
  Note: Not all agencies had access to this option however and some would pay out of pocket costs for carers to access external mental health support.
- Collective agreement from all agencies contacted that a state-wide counselling service would be beneficial for all Foster and Kinship Carers
- 100% of the responses received from agencies would refer Foster and Kinship Carers to this service and encourage Carers to access it.
- 100% of the responses received from agencies believe the service would be best sitting independently of Child Safety and Carer agencies.

Managers were provided the opportunity to share thoughts on whether a counselling service will be beneficial and where it would it be best placed within the sector, the following stated:

> *"Yes that is an amazing concept. Carers will feel safe and not judged having it sit within QFKC knowing that QFKC uphold the rights of carers and understand them"*
>
> *(South West region)*

> *"I think sitting within a non-biased organisation would be a good option."*
>
> *(South West region)*

> *"Yes, having a service that already understand the carer process would be fantastic"*
>
> *(Brisbane & Moreton Bay region)*

> *"It would be beneficial to have the service within QFKC. EAP has limitations with being too general and having wait times."*
>
> *(Brisbane & Moreton Bay region)*

> *"Yes I feel this would be extremely beneficial for our carers to have access to a counselling service that has a true understanding of their specific challenges and the Child Protection System."*
>
> *(Brisbane & Moreton Bay region)*

> *"Yes, QFKC would be the best place for it to sit under as you are the peak body for carers."*
>
> *(South East region)*

"Yes 100% we need a counselling service for our carers to access. I'm surprised it has not happened earlier. We have had deaths and suicide in this region and it is very limited for services."

(Central QLD region)

"Yes it would be very beneficial as carers know QFKC as a carer specific support service. EAP counsellors do not have that knowledge and I don't think carers are as keen to access this due to the counsellor not having experience in the field."

(North QLD region)

Feedback from Foster and Kinship Care Agency Staff

Results from the Foster and Kinship Care agency staff consultation show:

- 94% of agency staff members had recommended counselling to the Foster and Kinships carers they work with.
- EAP and an external counselling service were the main options offered to carers by agency staff.
- The main reasons for carers requiring counselling were grief and loss, stress, managing stress, burnout and vicarious trauma.
- Time, finances and lack of services available were the main barriers agency staff believed to be for carers not accessing counselling.
- 89% of agency staff members believed that a counselling service should sit independently of agencies and Child Safety.
- 88% of agency staff members confirmed they would refer carers to a carer specific counselling service.
- Carer agency staff chose 'Knowledge and experience of the child protection sector' to be the most important attribute for a Counsellor to have.

Feedback from Foster and Kinship Carers

Results from the consultations with 123 Foster and Kinship Carers across QLD show:

- 81% of Carers would access a counselling service specific for Carers
- 91% of Carers preferred the counselling service to sit independent of their Carer agency and Child Safety
- The main reasons Carers would access a Counselling service are due to stress, trauma, burnout, support, Child Safety, and frustration.
- Self-referral was a popular option for how Carers would like to be referred.
- 64% of Carers stated they would attend a carer therapeutic group session.
- 70% of Carers stated they would like the flexibility of more than 10 counselling sessions available to them
- Carers chose 'Knowledge and experience of the child protection system' as being the most important attributes in a Counsellor.

Proposed Counselling Service Delivery model

Based on the success of Western Australia's Carer counselling service model, QFKC would like to propose a similar model. As previously stated, Western Australia's OurSpace Counselling program oversees approximately 3300 Foster and Kinship Carers in which the service has 3 full-time counsellors, one full-time counsellor per 1000 carers. Whereas in Queensland there are approximately 6000 approved Foster and Kinship carers, and therefore QFKC would propose one full-time counsellor per 2000 carers I Queensland or 3 full-time counsellors.

QFKC acknowledges the population of carers in QLD is double the amount in Western Australia (WA). However, the support of Carers differs between the two states, as QLD Carers are supported on a day-to-day basis by their Carer agency staff unlike most WA carers. Whilst QLD Carers are supported by their local agency staff, the role of an agency staff does not exceed to a role of a Counsellor. The Counselling program provided in Victoria, Western and the testing period in Queensland (by QFKC) recognises the tailored independent service offered is required in addition to a Carer's agency support. The right to access therapeutic support without stigma and additional cost should not be a burden on an intense volunteerism role, such as Foster and Kinship Carers.

Ensuring the needs of Foster and Kinship Carers and the carer community are met whilst maintaining the sustainability of an ongoing service for carers, QFKC are seeking funding to:

- Continue the QFKC Carer Assistance Program full-time and increase the capacity of the service by employing two additional full-time Counsellors. This ensures the service delivery can remain uninterrupted.

The service will:

- Provide a flexible number of sessions per Carer whilst acknowledging that this service is a short-term intervention service. *Where required, facilitate referral for ongoing therapeutic support to an external provider.*
- Provide a total of 1755 hours of direct counselling hours per year. This is based on each Counsellor facilitating 3 direct counselling sessions per day on a 9-day fortnight with 1 day utilised for intake and administrative tasks. Any remaining hours will be composed of session preparation, group sessions, resource development, professional development and supervision.
- Facilitate quarterly therapeutic Foster and Kinship carer group sessions per year.
- Continue to provide state-wide access through online and telephone service delivery.
- Provide P2i reporting to ensure a continuing high-quality service, meeting the needs of carers.

The below requirements and considerations will provide an overview on the Carer Assistance Program meeting the current Child Protection (Support Services) Investment Specifications:

Requirements – Counselling and Intervention
Counselling services must deliver support designed to: • Provide targeted therapeutic responses to carers conducted in a confidential and safe setting – via online video calls and/or phone – by qualified practitioners. Practitioners listen attentively and patiently to the feelings and circumstances of Foster and Kinship Carers and perceive challenges from carers points of view to facilitate choice and positive change in their lives. • Increase stability of care placements and support to families where ongoing intervention by the department is required or to support reunification, where it is safe to do so. • Increased retention of Foster and Kinship Carers. *Referral pathways* • All approved Foster and Kinship Carers across Queensland can be referred to the service via three pathways: - Referral by CSSC or Foster and Kinship Carer agency - Referral internally through QFKC's multiple programs - Self-referral *Case planning and management* • The carer's participation in counselling support must be voluntary. Signed consent is required from carers to willingly participate in counselling and the purpose of the Carer Assistance Program is thoroughly explained. • Service offers short term intervention and support, and referrals received for Carers with significant mental health needs or psychiatric disability will be referred on to specialist mental health services. • Carers who have exited the system can access counselling support for up to 12 months from their exit date. This provides a safe space for exiting Carers to work through any issues resulting from their experience as a carer and could prevent carers potentially discussing concerns in community because an appropriate alternative platform has been provided to debrief.
Considerations – Counselling and intervention
Case planning and management • Counselling service may assess suitability of referral where Carers consent to being part of an action plan by the Department. • Flexibility of session times and frequency will be managed by the individual counsellors and will depend on the nature of the referral made and the level of support required. Hours of contact are flexible within the working week and sessions will be facilitated via online video call or phone call. • Brokerage will be available for First Nations Carers to access counselling where an identified First Nations Counsellor is the preferred option and QFKC is unable to provide one through a permanent full-time position.

History of Funding Provided and Funding Sought

CAP Funding Provided	2024-2025	Ongoing with CPI Increase (3.5%)
Salary	$95,000	$285,000
Super	$10, 925	$32,755
On Costs (incl. monthly external supervision	$24,000	$202,245
Total	$129, 925 per annum	$520,000 per annum

Counselling Assistance Program (CAP)
Program Logic Model

Program Objective: To provide short-term therapeutic intervention for foster and kinship carers to support their mental health and wellbeing, as well provide online resources and facilitate therapeutic support groups.

Issue

Carers are often hesitant to seek therapeutic help through their agency or departmental worker.

EAP is not an appropriate counselling avenue for carers due to limited tailored support on a carer's role.

Carers need therapeutic support from professionals that understand the system.

Carers are exiting the Child Protection System.

Children and young people are placed in residential homes before being placed in a family-based environment due to shortage of carers in the system.

Input

- 3 (3FTE) Counsellors with Child Protection experience and are accredited through the Australian Counselling Association (ACA)
- External Supervision (External provider)
- Funding
- QFKC Policies and Procedures
- Counsellor Policies and Procedures
- Child Protection Act 1999
- Information Privacy Act 2009
- Virtual Call System –Microsoft Teams

Carer Self-referral

Child Safety Referrals

Foster and Kinship Care Agency Referrals

QFKC Internal Referral

QFKC Casework Program

QFKC Exit Program

QFKC Retention & Development Program

Outputs

Activities

Direct counselling mailbox

Consent Forms provided

Therapeutic Session/s (flexible)

First Nations Counsellor preference

Long-term counselling needs

Therapeutic Support Groups

Feedback

Participation

Queensland Foster Carers

Queensland Kinship Carers

Former Foster and Kinship Carers (up to 12 months of exit)

External Provider

Outcomes

Short-Term

- Carers inclined to seek therapeutic support without stigma, bias, or repercussions.
- Carers mental health becomes more stable.
- Reduction of carers stress and isolation
- Carers feel valued, appreciated, and heard.
- Increase in knowledge around therapeutic topics.

- Relieved and supported foster/kinship carer

Long-Term

- Reduction of carer exits for those considering.
- Increase retention rate of carers in Queensland Child Protection System.
- Reduction of placement breakdown.
- Reduction of children referred to residential care placement.
- Reduction of marital breakdowns.
- Carers feel supported and heard.
- Increase of social connectedness
- Reduction of burn-out, compassion fatigue and stress.
- Carers are aware of their emotional capacity.

Children and young people have carers who are well equipped with supportive strategies from therapy.

Children and young people quality of care is not impacted by the mental health of the carer.

Children and young people have stability in their home.

Increase long-term family-based placements for children and young people in the Child Protection System

Key

Brokerage used to externally provide an identified counsellor for First Nation Carers

Assumptions:

1. Carers will utilise the service and engage with QFKC's counsellors in therapeutic activities.
2. Carers will access services for a variety of reasons relating to their well-being and mental health.
3. Stakeholder organisations, such as departmental, agencies and other peak bodies will actively promote QFKC's Counselling Assistance Program to increase carer awareness of the available service.

External Factors:

1. Funding for 3 contracted counsellors to cover 1-1 counselling and facilitate therapeutic support groups with an external provider providing supervision.
2. Interest in program will be dependent on carers need.
3. Other services carers can access themselves to meet their needs.
4. Counselling capacity to provide service to carers.

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ATTACHMENT B: Two Long-Term Guardianship Scenarios

Scenario One – Foster Carer

1 Foster carer has been approved as a carer for 17 years.

2 Foster carer is an Occupational therapist.

3 Foster carer had two siblings placed in her care at birth who at the time of writing this submission are now 12 years and 9 years old.

4 The eldest child was subject to a short-term order for approximately four years and the youngest for only approximately 10 months.

5 The orders automatically sought by Child Safety for both children were Long-Term Guardianship to Chief Executive (LTG CE).

6 The Foster carer approached Child Safety on multiple occasions to request long term guardianship and was told that this would not be a good idea due to the father's mental health and inability for the carer to manage any level of family contact. This was never assessed or tested, rather the carer was just told this was the reason as to why she was unable to be considered for Long Term Guardianship.

7 Carer continued to experience challenges in not being able to make decisions for children that she was providing long term care for. Case plans continued to state that the children would be with the carer until they were 18 years old. There were never any attempts by Child Safety during the 6 monthly reviews to assess the suitability of the Long-Term order.

8 In 2018, the carer made the decision that she would pursue her requests to be guardian for the children. The father had ceased all contact and therefore the carer felt that the reason provided by Child Safety initially for guardianship not to progress, was no longer a barrier.

9 Despite this request in 2018, the process of a suitability assessment did not progress until the carer was able to evidence that the one of the children was being disadvantaged in their NDIS plan by Child Safety refusing to seek a review of the child's NDIS plan which disadvantaged the child significantly.

10 One CSSC Manager viewed the children being on NDIS as a rational for not supporting guardianship to the carer, advising the carer that the required supports would not be able to be provided in the event that she was the guardian.

11 On 17th January 2023 QFKC attended a meeting with the carer and it was agreed that the CSO would commence a LTG to Other suitability assessment. This assessment was commenced by the CSO, and the carer received a date for the Practice Panel. Upon meeting with the CSSC Manager after this date, the carer was advised that the Practice panel was not to determine whether LTG to suitable other should be progressed, rather it was a review under Section 51X(4), the newly introduced legislation that compelled the Department to revisit whether children and young people subject to LTG CE orders for more than 2 years were on the most appropriate order. Child Safety in these instances were going back to view whether Reunification with parents was an option.

12 The carer was advised in this meeting that they were unable to locate the CSO's suitability assessment and that it would need to be redone. A new CSO had to undertake the new assessment as the previous CSO had left.

13 The carer was seeking the CSNA 3 to continue as well as financial support to keep the children in the private special schools they were attending that had been deemed necessary for their disabilities needs.

14 Eventually approval was granted for these financial supports to be included in a case plan for LTG to suitable other, however the new assessment was not completed until September 2024 and was presented to the Practice Panel.

15 Once approved by the Practice panel, the matter was then referred to OCFOS in October 2024.

16 In May 2025, QFKC received an update from the Senior Team leader that Child Safety had spoken to DCPL and they were aiming to file the application to vary the order on 16th May 2025 – the application was lodged.

17 At the time of writing this submission, the variation of the order had not been granted and the children remain on Long Term Guardianship to the CE. The matter has been adjourned on four occasions to allow opportunity for the parents to be contacted and seek legal advice.

18 The children have been with the carer for 12 years and 9 years

19 The foster carer spoke about the whole court process 'sucking the joy' out of the experience. They had hoped as a family to celebrate the making of the order with a yearly commemoration of such an important outcome; however, it has continued to drag on without any certainty of an outcome.

Scenario Two – Kinship Carer

1 Maternal grandparents were approved as kinship Carers for their grandchildren

2 Maternal grandfather is a qualified social worker and has previous experience working for Child Safety in a Team Leader capacity around 20 years ago for approximately 12 months. The Maternal grandfather has worked in the Child Protection field in Australia both in a front-line setting and University teaching setting for approximately 10 years.

3 The Maternal grandmother is a registered psychologist, entry age group for sessions with the maternal grandmother is high school age all the way through to adults.

4 Two of their grandchildren were placed with them at birth and are now 6 years old and 4 years old

5 The maternal grandparents also had an elder granddaughter formally placed with them at around a year old, however had been living with the grandparents informally since she was around 2-3 months.

6 Each of the children have different fathers

7 Short term custody orders were granted for all three, upon expiry, the orders were extended for another two years. The grandparents advised that despite constant requests for concurrent planning to occur for all three, this did not happen. Their eldest granddaughter was reunified with her father at the age of 6 years old with no transition and two days' notice, following a QCAT hearing where the department were ordered to increase the mother's contact by 50 percent.

8 When the subsequent short-term orders were due to expire for the younger two, the kinship carers made it very clear that their wish was for them to be granted Long Term guardianship. Child Safety made applications in the Children's Court for Long Term Guardianship to the CE – the maternal grandparents were not aware

this order had been applied for until their daughter (mother to the children) advised them.

9 The kinship carers advised that the Team Leader in the matter 'persisted in recommending LTG CE up until a matter of no more than a month before LTG to suitable person was finally granted on 12th August 2025. Whilst the kinship carers advised that the Senior Team Leader did not support guardianship throughout most of the process, they believe the Senior CSO who commenced the LTG O suitability process did state her support on a few occasions but was clear that this was not the Senior Team Leader's position.

10 The kinship carers were provided with a copy of the Social Assessment completed for Children's Court for the purposes of supporting Child Safety's application for LTG to CE. This Social Assessment was shared with the kinship carers by their daughter (mother to the children) after she sought advice from her solicitor. The kinship carers spoke of how upsetting it was to read this report due to the way they had been represented in the report by Child Safety i.e. the CSO making statements that the children's behaviours were such due to the 'chaotic home environment' The carers spoke about their concerns that Child Safety can represent carers in such a way without the carers either knowing or having the ability to respond.

11 The kinship carers were advised that the barriers to them being considered for Long Term Guardianship initially was due to the nature of their relationship with their eldest daughter's father, questioning how they would manage contact between the siblings.

12 The kinship carers acknowledge there had been no communication between them and the father due to the Child Protection history and complexity this often creates with kin families.

13 Despite these complexities, this was something that the kin carers were able to work through and they currently maintain a positive relationship with the father and enjoy a relationship with this granddaughter, which includes family time for Christmas, birthdays and regular contact. The kinship carers advise they were able to work through these complexities themselves, despite Child Safety putting up barriers to communication in the past.

14 The kinship carers advise that despite being very clear about their views and wishes to have guardianship of their grandchildren, this was not a position supported by Child Safety as evidenced by DCPL's application for a Long Term Guardianship to CE order.

15 The kinship carers sought assistance from QFKC and were referred to QFKC's legal service for free legal advice. It was only through their involvement with QFKC and legal appointments that the kinship carers were made aware of their ability to join the Children's Court proceedings under a S113 to be heard on the type of order that was being applied for. This provided an opportunity for the kinship carers to present their views and wishes and respond to various reports where information relating to their suitability as guardians were presented to the Children's Court.

16 The kinship carer advises one of the pivotal points for them was when QFKC arranged for them to meet with the Legal Service, the carer said 'if it hadn't been for the legal advice, clarity and confidence I gained from those sessions, despite already being reasonably confident in this space, I doubt we would've achieved the S113 participation'

17 It was the kinship carers S113 application and subsequent participation in proceedings that resulted in suitability assessment being ordered and ultimately the Long-Term Guardianship order being granted in their favour in August 2025.

18 The maternal grandfather intends on providing his own submission to these proceedings and is happy to be contacted to give evidence.

Attachment C: Lived Experience Survey – Question 11 Open Question

Question: What do you consider to be the barriers to legal permanency for children and young people?

Answered: 488 Skipped: 185

#	Responses
1	cOMPLEX NEEDS PAYMENT WILL NOT BE OFFERED for permanent placement. Neither will funded respite
2	Under staffed
3	There are no adoption laws in qld. We are hounded by child safety every home visit to go log, and every new CSO. This is annoying and does not help the situation.
4	We have PCI's for 1 child
5	We were denied guardianship by the cultural panel because we are not indigenous, despite every family member and CSO being in favour of us having it. Every kin mapping attempt (5 I think to date) has come back "no connection found". We are supporting their cultural needs and mum does not want to reunify.
6	the department has stated that parts of the current funding of the children's needs would no longer be paid for by the department. By becoming the guardian of the children in our situation would place an impossible financial burden on us. By becoming the children's guardian the department should continue all funding the children have at the time, by doing this no further burden would be placed on the Carers who opt for Guardianship of the children.
7	Our government
8	Child is of aboriginal background and we are not
9	What my rights are
10	The barriers are not following the previuos inquiry recommendationsof capping a child's time in foster care to 2yrs, plenty of time for biological family to be pursued by department/agency or come forward. Then, genuinely prioritising child's need for attachment stability and placing into most suitable permenancy plan. It's well know this can be done with biological family inclusion, cultural respect and safe natural social environment contact supervised if need be, with the child's "family" network now being a wonderful extended family. It is well known here in Cairns and Atherton - the whole region really that there are some very corrupt circles of long term staff who actively work against long term carers who want to offer permenancy. As one of the amazing very strong advocates in this region once said "they isolate kids from their long term carers on purpose, as there's no money in permenancy". because there's no money in permenancy. We wish one day to see instead - no money available for uprooting children after 2yrs of care, just money for getting their lives set up for future stability, healthy brain development and an equal chance in life to other kids
11	The time it takes for children to progress from an interim order, to short term order to long term order. We care for a now 1 year old (has been in our care since birth), no contact has occurred with parents for over 8 months and we are no closer to progressing to a short term order. Have been advised it may take years to progress to a short term order, then LTO.
12	Parents coming into the children lives after being out of their lives for years and really confusing the children.
13	CSO not approachable or willing to assist even though child in care has been evaluated as being long term still currently on monthly orders after 18 months
14	Departmental delays. Lack of assessor's for long term assessments of carers. Not listening to children's and carers voices.
15	The biased approach by case workers and twisting the truth. Searching for any family disengagement without finding out reasons or legal position why this occurred. Not acknowledging history and facts from another state . Pushing for contact with biom after years of no contact based on medical and specialist recommendations, creating significant trauma. Disregard for children's wishes and best interests.

16	Department giving parents too many chances
17	Kids do belong with a parent, being away from a parent or family can cause additional trauma. Financial burden and support especially for children with high complex needs. Everything moves slowly which creates additional stress for all involved, including the children.
18	Lack of communication with Child Safety
19	Natural parents not agreeing and keeping the child ' hanging', taking too long to reach agreement, changes in CSO, too much say given to natural parents who are unable/ unwilling to care for the child,
20	Red Tape slows every thing down, the child and the carer are left in Limbo
21	The current laws
22	Too hard.
23	The pressure put on carers for child/children in care with no real regards to carers needs and own family needs and emergencies or care, as well as child in care is taken care of
24	Not enough due diligence or support
25	All the red tape and multiple chances biological parents get given time and time again. The poor children suffer waiting on protocols and chances.
26	I dont have it but Q8 didnt allow for 'i have no clue' as an option
27	Young people not having a voice
28	A complex system and lack of consultation from Child Safety
29	We have asked to become the guardian but keep being fobbed off. This child has many siblings also in care some 8 years. Theses carers also still waiting. CS don't need to be the guardian when a good carer wants to be. CS dont see this child on a daily basis. Barriers is there needs to be a designated person at each site to do the paperwork plus an official time frame and guideline for the carer to become guardian. CS dont still to current flyer that says 12 months.
30	In fact, the child still wants to be with their parent no matter what circumstances and the parent being abusive to the carer. We also have the issue that the child is being alienated from their sibling due to the abusive mother.
31	Indigenous status. If a child identifies as indigenous, it's extremely hard to get permanency. These children can spend their entire 18 years with one carer and still be under the Dept. When a child is in a stable long term placement, there should be some form of permanency available.
32	As Kin we are not included in determining the best outcome. Financial impact
33	Support
34	Child is aboriginal
35	Financial, child has many behaviours that result in damage to my home, property and car. NDIS not meeting his needs requirements
36	The reliance on contact with biological family even when the family let the child down consistently.
37	The process seems too big given current caseloads, family appear to be a hurdle
38	Child safety not agreeing. I have put in a cross application against DCPL, I should not have had to do that.
39	Child safety & culture
40	Inconsistency of CSO's Rights of Parents are a focus rather than Best interests for the children Adjournments of court cases Financial costs involved
41	No help from the department for the child
42	Maintaining family contact with abusive/aggressive biological parents
43	Reunification is always the main focus regardless of whether thst is in the child's best interest or not
44	Family/ parents put before the needs of the child. Extremely long process
45	The failure of Child Safety to provide adequate support
46	Aboriginal and Torres strait Islander children cannot be under the guardianship of a white carer
47	Financially
48	I don't know. We want it. The kids want it. Child Safety seems to want it. It's a matter for the courts, I guess?

49	Loss of financial support for child, esp if the child has high and/or unknown needs for the future.
50	Loss of support for YP's needs
51	Nationality Bio logical parents rights not about the children Personality clashes
52	Not explained, supported and miss conceptions
53	Even though legislation changed several years ago to prioritise permanency, there is so much red tape to permanency and aome magistrates are not fully across the legislation priorotising permanency so it seems that many child safety service opt for the seemingly straight forward option and default to applications to just award guardianship to the CEO Child Safety. This however, is not in line with legislation which prioritises permanency to a kinship carer or other, over CE. This is NOT the same thing as permanency for children...a child can still be continually moved of a guardianship to the CE order and still does not have their 'own permanent family. There needs to be a separate department within child safety who work to support the permanency process for the 50% of young people in care who can never be reunified with their biological parents. Given that this relates to such a significant percentage of children in care, it needs alot more attention and support - otherwise these children end up in residential care, instead of in families.
54	Lack of investment in the childs well-being from Child Safety
55	After nearly nine years and us asking to apply for guardianship they always find excuses. Which we can prove them wrong with.
56	Financial with high needs
57	Too much red tape. Bio parents. Financial aids
58	Indigenous status, department workers, financial assistance
59	The lack of support with the child's needs.
60	Other family members.
61	Child services lack of accurate documentation
62	Red tape
63	the dept do not listen
64	I don’t see any
65	Child safety falling to follow up or provide updates on cases
66	To much trying to reunificiate with parents and family who are not changing bad habits and have little ability to care for children. No plans are made to help children get stability. Carers aren't involved in long term management. Carers are not given enough worth by child safety.
67	The true parents..not giving concent yet they do not have children in their care....
68	The fact that we are unable to put our foster child on a long term or permanent order because they are indigenous and we are not is ridiculous. They have lived in their area for a very long time and there is no hopes of them returning to any of their biological family’s, however the department would rather continue to pay us instead of allowing us to adopt them is a complete waste of resources and money for a couple who meets and goes significantly beyond for their foster child every single day. Just because they are not indigenous is why they can not adopt even though the foster child is essentially award of the state.
69	Financial Dealing with difficulty family members and conducting family visitation
70	Financial assistance
71	Financial restraints
72	Financial strain on carers to support ongoing care needs and the needs of the yp in daily life as they age.

73	The fact that child safety do not listen and take into consideration what the carer or children have to say or even ask for input from them. Child safety is more concerned with covering their own butts and please the parents than they are about the children and their safety. They are all about getting the kids off the books no matter the consequences or damage it may cause the children
74	The dept does not follow up on children's /carers wishes and desires to have permanency orders put in place
75	ALL stakeholders are not consulted or communicated with, despite Departments own policy of inclusion.
76	Cooperation- parents and child safety
77	The process to determine parents unfit is very long no matter how obvious it is that they will never be fit.
78	still has supervised visits with the mother loss of financial support
79	Being able to make appropriate parental decisions and where the law makes things very difficult to allow you as the guardian to be a guardian without so many rules.
80	Lack of recognition, diagnosis and support for long term disabilities due to prenatal alcohol and substance exposure. The effects are lifelong - not just childhood. These children need support across the lifespan.
81	Too much red tape and hurdles. Returning the child to family is prioritised over needs of the child.
82	The financial costs involved.
83	The process and the departments inability to do the application due to being too busy. Withdrawal of school support
84	Unstable parent
85	Seeking parents approval The children make decision on other topics why if they are on long term orders you should just be approved guardian
86	When they get to the teen age years and seek out biological parents, self place, it is very had
87	Change of CSOs and no continuation of work
88	Not being listened too by child safety as they are too hell bent on reunification or kin care
89	Too much emphasis on the parents wishes, not the childs.
90	Family members having issues about the care they receive thinking they would do a better job
91	The Child Safety system is broken and CSOs are extremely young, inexperienced and just plain useless.
92	The department not having enough paperwork to help identify that the biological parents cannot look after their children and taking to long to decide if long term plans orders are appropriate for their child's needs which the carer is on hold with supporting the children with longer term plans and direction.
93	Court orders can be vague, which occasionally leads to children being reunified when they should not be
94	The court system. We've been in court for 3 years fighting for permanency, and the bio mother is able to continuously get it adjourned. We've had it adjourned 5 times and the court system allows her to continue to find every loophole possible to be able to exploit and not allow the child to have stability and permanency.
95	Systemic and Bureaucratic Delays Insufficient or Inadequate Family Services Challenges in Finding Permanent Families Youth Resistance or Lack of Voice Racial and Cultural Bias
96	The process, child safety does nothing quickly

97	We were told about the PCO process however the CSO had not completed the appropriate documentation for the court proceedings. This process has taken longer than a year and the judge requested that the parents be served the paperwork again.
98	Not sure
99	Lack of enthusiasm from CS
100	The fact that there are unlimited chances for a parent to have their child back in their care. This is damaging to the child, always living in false hope that they will go back one day and always feeling displaced, never feeling at home, nor part of the family in the carer's home, despite the carer family's best efforts to include and make at home.
101	Not being a Frist Nation.
102	Lack of financial help .ongoing respite
103	The department has to recommend you so if the CSOs doesn't like you , you won't be asked or successful. The department want all kids under the crown even when they have been in your care for years , and the ATSI placement principles are not aheared to even by the courts.
104	Basically what we get told is the children are safe and stable so it's not a priority to get it
105	We are legal guardians - it took us a long time to progress and we used the public guardian ultimately to progress. I feel the barriers to legal permanency are two fold. Firstly the LTG to other states the governement completely steps away except for annual payment. For some careers, mental health costs, and othe medical costs may put them in fear of progressing. The annual review process - is not transparent and how it operates to the information in the act is inconsistent on sunshine coast. Other services - medicare - do not understand orders - we have tried numberous times to have our childs medicare card issued correctly. Child safety say one thing and meidcare says another - we end up with an ongoing unresolved issue. In addition permanency needs to be managed to have access to biological family. Careers should be supported on these models - it could be as simple as contact once a year. So child in care is connected to family and not making up stories in their mind. Alternatively we manage a relationship with our daughter and her biological mum. Nevertheless the obligations and responsibilities need to be established so child, biological family and guardian can feel heard and protected.
106	My age & my inability to keep up with the psychological help many of the kids need & should be getting!
107	TSI CHILD REARING CUZTOMS AND PRACTICES
108	They are being lied to by child safety and treated like idiots by care agencies
109	We are awaiting a LTG and it is dragging on for years even though the parents, the dept and us all agree to nit
110	Cso taking years to complete paperwork still not done many excuses such as holidays sick etc
111	..
112	Court costs for grandparents, bias towards unfit parents
113	We are on LTGO order. I believe carers are worried about the lack of support provided to carers on LTGO. There is also a stigma around carers that are interested in LTG, with case workers perceiving those carers to be more interested in having kids of their own than providing a safe and secure home for children in need. We have also found that more challenges for the kids have emerged over time as they get older and the chance of this happening, and no support from the Department, May turn carers off LTGO.
114	[redacted] office said yes to LTG-O but office changed and [redacted] and [redacted] said we were white we would never get an indigenous child
115	Uncooperative biological family
116	There have been no conversations about it. We haven't been made aware of this pathway over the past 5 years.

117	Financial support - I need Child Safety to stop chopping and changing on HSNA and CSNA, letting it expire and having to fit to be backpaid (I was backpaid $12,000 last year!! That's how long I was out of pocket for!) and making me feel like I'm only doing this for the money - but rather that if they appropriately supported the children's needs, I would be able to confidently manage on my own, and not need to work full time. I am a single carer, originally only approved for short term emergency and respite care. I now have two sisters in my care, one originally as respite, the other originally as emergency, for nearly 3 years and 2 years respectively. Both children have complex needs. One child has diagnoses of RAD, ADHD, ODD and suspected CPTSD (likley also at risk of FASD however to my knowledge has never been assessed), the other child has FASD and an intellectual impairment. The younger child was removed at 3 months old and was never reunified, only went LTG-CE at the age of 6.5 years old, nearly 7. She is now 9 years old. I've been told there would be nowhere for them to go but resi. Due to the complexities of the children, I have gone from working full time to having to drastically reduce my work hours last year because I was at a point of burnout. I work in the sector myself. I went from 38 hours a week, to an average of 17 hours a week, from $50+ ph to $35 ph. To support children who were at risk of being suspended from school and to take them to their multiple appointments (one child has NDIS), to "be there" for them, to support their attachment instead of having a single carer working full time, relying on babysitters, youth workers and OSHC. Child Safety have recently reduced the children's HSNA and CSNA to CSNA level 1. I am reliant on this to support the children to access therapeutic supports not covered by the NDIS or in shortfall (e.g. funded for only monthly OT, so I pay privately for fortnightly). I have had to return to full time work. However I have negotiated with my workplace to take an unpaid day per fortnight. I cannot work full time due to the children's needs, and my workplace is very clear that they can only support a flexible arrangement for 3 months only. I am not sure what I am going to do come January. I have no meaningful savings or assets. I am a renter. I am in a very vulnerable financial situation. However, I am very skilled at caring for children who have experienced trauma. I have worked for the peak body for child protection in Queensland. I am trained in TCI, PACE and TBRI. I have a bachelors degreee with honours in social science and am completing my Master in Social Work. I am an experienced case worker with a foster and kinship care support agency, and have worked in residential care and family intervention service. I've been a carer for coming on 6 years. I am happy to facilitate family contact and I am proud of how we have worked to get this to be organic and natural, watching swimming lessons, playing mini golf, attending sporting events, I do all the transport and am intentional about building relationships with lots of empathy and grace for the kids' family members. I know how important stability and permanency is for our kids in care. I hate how they don't have a 'normal' childhood, with their guardian being the state of Queensland. 'Sorry, need to ask Child Safety to sign that form'. 'Sorry, can't go hang out with friends this afternoon, the CSO is coming for the monthly home visit', 'Sorry, it hasn't been approved yet'. I absolutely adore these children and am committed to being there for them, not giving up on them, and seeing them through until adulthood (and beyond - they can stay as long as they need). They have already been through multiple placement breakdowns and I am desperate to stick with it so they know they are worth it. Honestly, if Child Safety would just whack them both on CSNA-2 or CSNA-3 and be done with it forever, I would stop arguing over play therapy invoices and orthodontic payment plans (the older child age 14 has braces) or who would theoretically pay for high school or trips to see family members interstate. I would like LTG-O. But I would like to know that it's sustainable, and for me unfortunately I'm not in a position of privilege financially, and I can't demonstrate my independence while I'm worried about my employment situation and whether Child Safety will stop funding HSNA and CSNA. But if they came to me tomorrow and said what would you need guaranteed financially to see you through until the kids turn 18, and if that meant CSNA-2/3 indefinitely, I would 100% want to pursue it.
118	They still consider the mother's wishes even if she has not been in the children's lives at all. Or very minimal and has abandoned some of their kids. And just leaves them without worrying about them at all because they are with family.
119	Financial and behavioural needs worsening as the child gets older with no real support
120	Bio parent objection
121	CSO - time to implement, Bio Family not agreeing or supporting, cultural factors. Fear of unknown expenses in the future for child
122	- CSO biased input - parents are still hopefully after many years of trying for reunification - duration is long and wonderful - parents become bitter
123	Having child safety support the needs of the child when additional supports are required

124	The inability to get the biological parents to engage with Child Safety to be able to discuss this and so many children of different relationships involved in 1 families case.
125	Not enough support with High Complex Needs children
126	Inconsistency in support for carers - CSO working with the child move on regularly. Feels like it is too hard - too many hurdles to jump through for Child Safety and for carers.
127	I have asked many times to get the process started now because I know it takes a long time. I believe the main barrier is in regional areas there is not enough funding and staff to facilitate the process and get the paperwork done. I think that there needs to be far more funding and hours provided to get this done faster. It would save so many man hours and so much money in the long run if a child goes onto guardianship to other or on a permanency order.

28	In my experience, the agency
129	I have guardianship of 4. Two took way too long
130	They're not done soon enough. It's not easy to understand the ongoing supports that are available. We have one 17yo child currently and at this point it would be pointless to have guardianship.
131	Court process
132	Financial burden and dealing with bio family
133	Depends if this is best outcome for the child we had 5 LTG children
134	I am not sure.
135	the foster care agency and contact
136	Uncertain
137	CSO driving their own agenda, not listening to Carers and child on what's in their best interest or views and wishes
138	long drawn out process.
139	If needed I would look after my grandchildren long term. Have been doing so on interim orders for 11 months.
140	Some of these children could've been adopted at their very young age. Unfortunately the Dept were intent on re-unificuation which didn't happen meaning youngest child now eleven years old sits in residential care.....
141	Lack of communication from Child Safety
142	Not sure what the situation would entail in the short and long term.
143	financial
144	Child Safety not listening to the carers and the children
145	if extra support is needed from department for the said child you don't get it
146	Child safety not making timely and appropriate decisions
147	The time taken to go through the process, child would be 18 years old and LTG unnecessary.
148	As a long term guardian you really don't have any support from the department it same's to me that once you take on fulltime guardianship everything that you may need is your problem. eg; medical and school cost but different if young person is under department umbrella.
149	If the child is from a different race to the carers
150	The department seems to be structured to priorities the biological parents' needs and desires over the child's.
151	Constantly dealing with the department, potential lack of support from the department, potentially being left to deal with the biological family on my own. Decisions not being made quickly etc... the list could go on and on really.

152	It takes a really long time, lots of paperwork, and the files seem to be passed from CSO to CSO. Sometimes this means that the process gets restarted over and over. It is exhausting
153	I'm not aboriginal or blood family
154	Hasn't come up for us as yet so not applicable
155	Black and white thinking that does not take into consideration important childhood development wisdom like attachment theory in mitigating harm to children and places the rights and wishes of adults before harm to children.
156	Child safety officer's opinions and self importance. Ignoring carer!s feedback. Systemic teachings within the centre. Legislative barriers.
157	Outdated laws
158	Costs and family
159	The push for reunification, no matter the cost or detriment to the child.
160	LTG CE means that the child will never feel like they belong and are real part of a foster family because foster parents can't make decisions for them even though they know them better than anyone else (in cases child has been placed for a long time). For us this is a big barrier as we don't think we could care for a child for 16 years and not make decisions for the child. The constant visits would be a constant reminder for the child of his situation and creates all sorts of emotional complexities that most foster parents and children are unable to cope with resulting in placement breakdown. Another barrier we face is that child has been deemed aboriginal without meeting section 5 of the child protection act. We are not aboriginal and therefore we are not being considered for LTG to other even though we have cared for child continuously since birth, no other family members have been identified except mum who is willing but not able. This situation made us realize that many foster children who are aboriginal have fantastic carers who are not aboriginal and whilst of course it is ideal that the child goes fist to keen for many children that is just not possible and then they are subject to intrusive departmental intervention until they are 18 when they don't need it. The lack of involvement of people who really know the child even if they are carers in planning. The constant change of workers is such a massive barrier. Almost all information about the case is lost everytime there is a change and this affects how decisions are made for children. Some workers are very inexperienced, are rude, have unrealistic expectations (maybe because they have had limited contact with children themselves and have no idea of what involves day to day care) and carers burn out. Many times I've heard carer say that they would look after the child for ever because trauma and all that's the easy part, dealing with the department is the hard part. The whole policy and culture is adult focused and not child. More often than not we hear things like mum doesn't want to miss another christmas, mum wants a picture of child, mum this and that but, the child also needs to receive pictures of their mother, deserves to have a holiday with the family who cares for them and not be left behind with strangers (possibly lovely respite carers but regardless a very scary experience to be left with someone you don't know when you are 0,1,2,3,4,5-6 wondering if your carers are ever coming back etc) The way the practice manual was written I am sure was thought that it was beneficial and in paper looks good but in real life it doesn't really work. Child safety provides a lot of training to officers but forgets to teach about basic things like for example the impact in a child to have to stay behind or to live with a family who can't make decisions. Most child safety oficers don't know much about kids and it is a real challenge to try to explain and for them to consider things like emotional regulation, attachment, bonding, development, sensitivity, co-regulation etc.
161	No formal way of applying for guardianship, no clear path to guardianship
162	Child Safety, the biggest barrier to legal permanency and emotional stability! A place where our most vulnerable children in Australia are treated like nothing but a #number, handed around in an overwhelmingly overcrowded and outdated system. All our young people deserve better, they deserve stability & consistency!
163	Birth parents, department
164	Not sure
165	behaviour management and finding suitable long term carers who are willing to try and manage those behaviours
166	The parents
167	Financial support and guardianship education
168	Children come into care for a reason, yes the parents work hard on getting their children back, however most of their obligations are online courses. Courses which they cannot fail due to it not going to the next page without the correct answer and unlimited attempts. The Parents still have to much say compared to a carer regarding the child, I understand that they are the parents, however they are not parenting the child

	everyday. Carers should have more control over their decisions as they know what is happening with the child in their home and their behaviours before, during and after visits. Parents should have to work on themselves for a period of 12 months minimum to ensure that they can care for themselves before adding additional responsibilities to them, this helps them to have the tools to successfully reunify permanently. The court system is to lenient on the parents, removing children should be the first step, depending on what has occurred there should be criminal punishment for their actions as this isn't always the case and the parents continue the cycle once reunification has occurred leading to children being placed into care again. Which isn't in the best intrest of the child/ren. There needs to be ramifications for the parents actions also towards carers, we dont deserve to be treated the way that we are and we should have rights to our privacy by not having our personal details given out to the parents.
169	Department staff ignoring both child and carers opinions and needs
170	Children being reunified too early
171	.
172	Children's views and wishes aren't taken into account from child safety it seems
173	That they will try everything for the kids to go back to their parents even when we can clearly see that the parents are still not meeting requirements and yet they don't listen to our views as we see more than they do but get the blame for most things because they have to look like they are doing the right thing for the parent, not the child/ren. The CSO is the barrier.
174	origins eg indigenous child I have raised since birth is now 9 years old but I am not indigenous.
175	not considering the wishes and voices of children and young people
176	Mixed communication between families and carers and if family is a safe haven once the child is returned to them
177	Kin
178	The department are more interested in rocking boxes. They are completely reactive and do not put the child's needs first. Particularly First Nations children, it has become nothing but a box ticking exercise. When did culture become more important than the child's safety? It truly is concerning!
179	Why does everyone have to have a blue card in the house
180	Child safety officers and their managers being incompetent!! Making decisions for young people instead of having conversations
181	Child safety not actioning plans not going forward
182	Educational needs not met if orders change
183	I applied for PPG a few years ago, we did all we had to, kids were interviewed, meetings with all who needed. Then never heard another word from our CSO or saw her physically for about 18 months, when I asked why we hadn't gone to court, I was told that at some stage the childs parents stated they were aboriginal. This was not the case and was easily verified. So I decided I was not going through all of that again and neither did the children.
184	Being indigenous Overwhelmed cs staff - time poor Not seen as a priority
185	Child services not focused on child wellbeing just on reunification no matter the cost to the child or carer
186	Financial and liasing with parents
187	Systematic bias against adoption. The door never really closes on reunification
188	Unknown future challenges of the child, particularly mental health wise and taking on the full financial burden of care as these children have higher needs and costs associated with their care
189	My age is not suitable to take on guardianship
190	Our system needs to give parent/s a time frame to reunite with their child/ren. After this, if no progress, we need to adopt the children to suitable homes. The children struggle to be known as foster children which causes confidence issues etc. There are so many people in our own country that would love to adopt. This will take the pressure off the system. Carer of 20 years.
191	The barriers facing non Indigenous carers proposing legal permanency for an Indigenous child in their care. Despite there being far more children in care than there are foster carers that identify as Aboriginal or Torres Strait Islander. And despite the department doing very little to actually help non Indigenous carers ensure children are able to connect with their culture. For example by having structured, immersive experiences for the children beyond NAIDOC week etc

192	1.Children that identify as Aboriginal cannot have a non-Aboriginal foster carer as their guardian. 2. Concerns that plans, including supports, that are agreed to by the current CSO/team leader/manager for YP with Foster carer as guardian do not appear to have to be honoured if new CS staff or budget constraints put in place. CS can threaten that it would be considered a break of placement if foster guardian could not continue without these supports etc.
193	Being often keeped in the dark on what really is happening
194	I don't know much about it and haven't experienced it but it seems that often the children's views and reactions (where they can't express their views) often aren't taken into account. By living with their carer for months and years, they have had permanency. When the law says they MUST find kin or allow a parent to reunify after many years, it seems like it might not be the best option all the time.
195	Child safety not being entirely honest.
196	Child Safety staff complain about amount of work required
197	Parents that dont see the children for years then all of a sudden their enter their life's again .wanting contact
198	Child Safety
199	Complete lack of respite care in my area
200	The legal system
201	Age
202	Dept have focused on how old our house is (it requires repairs that are more expensive than we have income for) rather than whether we are providing love & care to our foster child.
203	After over 5yrs of interim orders and no outcome likely as still pushing for reunification when parent has not completed anything asked of them.
204	Law placing more emphasis on children being placed with bio or kin rather than what might be better for them or where their attachment is.
205	No avenues to explore adoption. Lay people for carers with limited knowledge of their rights. Adoption is never an option.
206	No avenues to explore adoptions. Lay people as carers. Never an option
207	Kin connections trumping all even in cases of healthy stable attachments. Kin is important but not at the expense of healthy long term primary attachments
208	Lengthy process
209	When CSO'S change more often than I have hot dinners, then they don't do a handover to new to the case CSO, who then only sticks around for a few months, they promise you supports for the children in your care (when attending the rare monthly home visit) but they don't note any of this down after the home visit, so it's just your word against the CSO! I'm currently experiencing this as we speak. Told by 1 CSO I could take YP to a private paediatrician as it was too stressful attending the QCH every few months with ASD lvl 2, ADHD comorbid behaviours trashing everything in sight at the public paediatric visit but was so much more regulated at private paediatric visit it was so much easier on YP emotional state, for context YP is 6almost 7 and been in care with me since birth. But…… [redacted] CSSC CSO [redacted] says to me, this office [redacted] CSSC) doesn't support seeing a private paediatrician as it's a 2nd opinion ,G. I've been a carer for 30 years this year and have also just received my very first SOC review from the same CSO. 30 years and NEVER had an SOC raised again me, but after only a few weeks with this person as my YP CSO, and wham. Coincidence I think not!
210	Bio parents not consenting and the department not bothering
211	Takes too long. We applied 7 years ago and then applied again 3 years ago and we have only now been told it has finally been accepted to go to panel.

212	Not sure how to answer this question
213	The length of time taken before a long term order is in place. Inadequately dealing with complex kinship circumstances for paternal and maternal families
214	Process, changeover of CSOs during process
215	Child safety not doing their actual job
216	When or if a teenager decided to leave your care -no one knowing and understanding their situation and needs - not knowing if they are in a safe place/ or being able to bring them home - family that has the right to take the child at an age the child can self place knowing there are great concerns
217	We had asked and were told no, as she is Aboriginal and we are not. This was the decision of the CPA at the time, who had never met our young person or even spoke with her about her views first (as the request actually came from her, not from us). She was 13 at the time.
218	Change of CSO and no continuation of work.
219	In my experience thus far the Young person is not given clear guidelines or any voice to advocate for themselves. They are left confused , disregarded and moved on from carer to carer with little notice.
220	No clear lines of what a carer has and has not to do.
221	the Dept
222	The Department's expectations.
223	Natural parents and dept.
224	Serial changes in team leaders and CSOs/service managers. This leads to significantly poorer outcomes especially when essential information is not handed over when caseloads are passed to different teams. It is exhausting having to start again, having carers and young people falling through the gaps- with my experience as a carer, making me feel responsible for doing child safety's job, as well as caring for several children. This led to carer burnout, and mistrust of child safety.
225	In the past the barrier has been thinking children should be with family
226	Provision of respite to carers who children have special needs and / or multiple children sibling group.
227	Trying to get the Dept to actually complete the paperwork necessary for it to be considered.
228	Carer burnout Bio parents rights, YP's internal drive towards bio Family,
229	We have a young first nation person who has lived with us for nearly 15 yrs but we were told we could never get a LTG of him as we were white and we also have another young person we would consider also for LTG which because he is non indigenous is ok to apply for which is very sad for the first nations young person which makes for a very unfair system.
230	The Department has refused to do the paperwork.
231	Changing of Child safety Officers all the time. Always starting from the beginning again then another change of officer. No one follows up from where the paper work was started. Not knowing the whole situation of a child.
232	They need to see how happy they are with the carers and take into account the children bond and how long they have been with the carer
233	Department are control freaks and when they ask what support you need in place they use this against you and insinuate you are not coping but my motto is it take a village to raise a family
234	I've had my ltg-ce placement for 12 years. He is now 15. I want to be his legal guardian but he is complex. I'm told by his care team I won't win against child safety lawyers.

235	Department and agency going for highest funding options- unsuitable or unsafe kinship placements and finding to train kin who don't have basic skills to provide even basic care. They don't respect that LTG kids identify us as family, extended family but yes family.
236	Financial assistance and transport support for working carers.
237	Bio family contesting
238	Children do not often get permanency as the bio parents have a huge say and this often deters carers. There is also the financial burden in the current climate for taking on more children.
239	organising contact with biological parents who hate me
240	Approved 10+ years ago. No action taken. Stun on lgto ce. Oldest has aged out. Causes considerable ongoing harm telling young person yes lgto o or pct approved and then no action.
241	delayed court dates
242	Biological parents are unlikely to agree
243	My daughter has been with me since she was 2 she is now about to turn 8. Diagnosis of asd level 2 and ADHD Reunification has been and gone. Parents both have never meet requirements. I have met all of my requirements. Still I am on a short term order. My Daughter has voiced she wants me to be her guardian once understanding what that is and she herself when I explain I am what's called a short term foster carer has said 'but you are my mum' I've been the only regular adult since she was a bub. She has not another mother figure nor father figure other than I and her Foster Dad. We have waited years now. She just views us as Mum and Dad and her Foster brother her brother.
244	I don’t trust the system, the government make it look like they are helping when they are not really
245	The biological parents. Too many different CSO’s and constant staff changes
246	Not sure
247	Our age
248	Rights of the family to the detriment of the children
249	In our case it will be considered when the 2 eldest young persons age out of care. We will consider it for the younger siblings. The barrier is the objection that the older siblings have as they worship their mother.
250	Access to support for high and complex needs
251	CS were my barrier, and the fact that the children are indigenous and I am not, when I tried to go guardian, CS didn't help me they decided to again start searching for indigenous kin and really worked against me so QFKC advised me to not proceed with Guardianship
252	The fact the young person is indigenous and we are white ,even though he has been living with us for over 14yrs.we were advised this would never happen.
253	Financial costs...both increases to daily living expenses and professional therapy expenses if required. A lack of support available if heightened behaviours & circumstances arose. Biological family causing ongoing issues.
254	Not being able to financially able to meet their needs
255	Information and child safety level of support
256	The birth mother still has guardianship and therefore has a say as to what happens with the child

257	* birth parents are given way too many opportunities * the bar is so low for birth parents to be reunified they have to dig a hole in order to step over it * foster parents get disillusioned and really sad/feel used with the complete lack of regard for what we do in providing care 24/7
258	Child Safety not looking at what is best for the child. Our child has been with us since a baby, is now nearly 9 years old. Reunification failed, placing with siblings failed multiple times due to child safety and continued change of CSO,s, Team Leaders and acting managers. Biggest concern is always having to start at the beginning again, no one knowing the case fully or understandings of what has previously taken place. Communication between parties is terrible. Kin Mapping was done 3 times for one child, 3rd time took nearly 2 years hence Guardianship was taken off the table.
259	Reimbursement.
260	The department. I have approached the department of child safety for guardianship for a child who will not be reunified with his parents for various reasons of serious nature. I was denied guardianship based on culture although I have sought all cultural aspects of his care myself with very minimal assistance or resources from the department and was told my efforts were “pretty light going” although manager [redacted] could not offer any further strategies or resources and declined to fund a trip for myself and the child with the support of his CSO to the TSI to assist in meeting his cultural needs and was a RECOMMENDATION from the “Walking together collective” as part of child safety.
261	Dragging on of court cases for years on end
262	Poor support from CSO’s to carers and children
263	First Nations Placement Principle for non-indigenous carers caring for First Nations children
264	Lack of respite and support
265	* Parent delaying the court process * Legislation slowing down or preventing what is best for the child/children’s best interests over the parent wishes * Not prioritising issues in a hierarchy of importance * Absent parents who have no inclination of reunification not being allowed to dictate care when they are not actively involved * Not allowing private specialist reports to be disregarded and a 2nd public report required when public specialists will not examine/assess children due to them being seen by a private specialist. * Not allowing carers to enrol children their care into schools within their catchment due to parents requesting a school closer to them. * Withholding basic information (adjourned court) with an excuse of ‘we are not sure why it was adjourned’ * NOT even acknowledging an email - this should be a code of conduct issue. An email should be acknowledged within a 2-4 business day period, a call if requested should be made within 5 business days. If these are not meet then a report should be made against the case worker. ** If these guidelines lines cannot be met then PLEASE employ more case workers or admin to sort and assign emails to be followed up with the timeframe as per a new legislation.
266	Safety, financial burden
267	Not applicable to our situation at the present time.
268	The department Turnover of csos Legal delay, lack of suitable progress.
269	Attitudes of some of the Child Safety Officers and legislative hurdles
270	The extended time it takes to grant orders
271	Lack of clarity for the children. definition of the role of parents (if any) in the continuing process of the children's needs and wants.
272	Lack of support when needed.

273	I consider the barriers to legal permanency for children and young people to include lengthy and inconsistent legal processes, fluid decision-making, and poor communication between stakeholders, all of which undermine stability. Trauma bonding often leads children to tell the courts they want to return to unsuitable or unsafe homes, which drags out proceedings and prolongs instability. This not only negatively impacts the child's wellbeing but also places enormous strain on carers, whose resilience has limits. In these circumstances, placements that may have been a good long-term option can be permanently broken down due to the uncertainty and pressure created. Ultimately, these barriers mean that decisions are not always made in the best interests of children, as the lack of clarity and stability compounds trauma rather than supports healing and permanency.
274	Push for children to be reunified with parents who are living complex unstable lives and where the forcing of a continued relationship during which the parents manipulate the minds of the children.
275	To be a foster carerer
276	Who makes the decisions for them
277	In QLD, the child protection legal framework heavily favours the parents right to raise a child, which i agree with foenthe first two years. After that, the law still supports the parents rights rather than considering what is best for the child.
278	Information, finances
279	Financial Support is lost and it takes at least 2 years for the process.
280	Biological parents not having the children's wishes or needs at the forefront. Biological parents having way to much authority when children are placed in care. When children are taken it should be a team effort for the best outcome for the child. Child's needs/wants first over parents needs/wants
281	With Special needs, more heads are better than one
282	I'm too old now
283	Cultural heritage in our case.
284	Child Safety not listening to the family and keeping the children in separate places and apart.
285	they are forgotten, not listened too. Child Safety does not respond, Holidays are left to the kadt minute, Carers time is not considered.
286	Parents have to much say
287	The length of time it takes child safety to complete paperwork and plans to then go through all the steps as a kinship carer it takes a long time to be able to move forward and give the children and us a sense of permanency. There is a lot of paperwork and steps involved and our caseworker takes a long time to process things and this is holding up all of us moving forward and giving the children the permanency they deserve.
288	unifortunilty to become a guardian we would need to facilitate contact with biological family and unfortuntly both parents have a history of crime and violence and we are not prepared to do this without the departments intervention in this area. Mum also has extensive mental health issues and does not see she may require ongoing treatment
289	Department resourced stretched. Lack of knowledge from Child Safety Officers.
290	They are not consulted enough
291	Suitability between child and carer.
292	currently going through the process of LTG-O assessment and the time it takes is overwhelming and seems excessive. This process needs to be reviewed and streamlined.
293	They take too long to try and then the children push boundaries causing problems and it all stalls

294	lack of communication from cso
295	Reluctance of Child Safety to apply for LTG CE (one of our children has been in our care since 2019 on concurrent Short term orders. (LTG CE currently being sought. Idea that kinship carers can include strangers to the children that are very loosely related (e.g. the adult children of a step grandfather in another town the children had never met-placements broke down quickly). Kinship carers should be significant to children and not just anybody so Child Safety can tick a box.
296	the length of time wasted by staff on this
297	CSO not listening to the wants and needs of the child
298	Financial burden
299	Parents refusal
300	Child Safety. We have asked about it several times, but nothing progresses.
301	Support for children when they are older
302	CSOs are young and unintelligent if someting isn't in the textbook then they don't know what to do. Most are born into white privilege with no experience of life in general and are young spoilt brats or fit in to one of the 5 Ms, Missionary, Mercenary, Misfit, Madman, Machiavellian.
303	Too many attempts to reunite. The children end up more damaged - it's all in the interest of the parents, not the kids. Also CSOs change so much. We are on our 5th in 12 months, so you can't get anywhere with conversations. We have asked about it, the kids have been in care for 6 years and child safety just say 'we will look at it later down the track'. We are the most stable, traditional family environment they have had and probably ever will. The fact that they aren't taking action with us, means they must not be proactive or supportive for any. We tick ALL boxes and there are no Kim for these girls.
304	Child safety not wanting to go back to court
305	The system is too in favour of the parents when they are not always the best choice
306	Child's needs. Support ongoing from child safety.
307	Processes that are in place and the length of time it takes
308	Cultural barriers
309	Unfortunately it's unsupervised family contact. Most often due to staff shortages.
310	Dept not willing to engage in the process
311	Child Safety not taking carers concerns seriously
312	Do not know
313	Too many chances given to bio parents and not enough consideration given to the effects of the short/interim care orders on the children.
314	The law is extremely biased. It is bio parent based. It is not clearly defined to help the children in care. Children are not considered.
315	I have been waiting nearly 4 years for the cultural identity of my child to be decided so that's been the major barrier so far. My understanding is if he is First Nations then it will be very difficult for me to get guardianship as a non indigenous carer.
316	In my case the fact the children are indigenous means regardless of how serious parental dysfunction, substance abuse or DV is Child Safety still wants them reunified.
317	Poor time management and communication.
318	Future financial outlays - therapy costs as children age and unknown future needs of young children

319	Do not know!
320	Lack of staff dedicated to this area. Too many CSO changes and also child safety unwilling to do the extra work.
321	Parents given too many chances to prove themselves capable. Case managers not following up on what's in the child's best interests.
322	We have been told for three years now that they are going to do LTG-O, keep getting told it's going to get done, but so far nothing has happened
323	Tricky question - we would love to, but the biological family is so erratic, it just doesn't feel safe not to have the support of the Dept.
324	Being of Aboriginal or Torres Straight Islander Department deciding without consultation not to discuss PCO/LTGO with carer Department staff have a personal issue with carer and opt for LTGCE
325	My foster grandson is aboriginal so we can not be his guardian. His brother is in a residential so I am hopeful that at some point they will be together again
326	Biological parents wishes put before the children's best interests and welfare.
327	Extending short term orders to give parents more time when reunification isn't even close example still on supervised or semi supervised visits. No sleep overs have started
328	Department of child safety and their agencies
329	Moving overseas to our home country with the child because we are Kinship Carers. Just making it easier and user friendly especially when they may have to go back in the system if they are left behind because the system.
330	Lack of cooperation or contact from bio family. Child Safety not gathering appropriate evidence due to high turn over and lack of proper handover of/between CSO's. Red tape in the legal process.
331	Parents and lawyers
332	Parental Rights. Departmental inaction. Indigenous children unable to be to other race for guardianship.
333	The process is too long, Child Safety is parent focused & not child focused.
334	Aboriginal issues! Child's health needs Alot of concerned
335	Parents have more rights than children. Child safety knowling move children home to a bio knowing its not going to work, even with children who have been with careres since birth.
336	Wider family members. Eg. If a family member cannot hold a blue card but does not live in the home they are still seen as an obstacle
337	Child Safety is the barrier to our moving forward - they keep refusing to start the LTG process. We require the permanency be set in place to protect our great nephew from being removed from our care. A recent quote from a CS Snr Practitioner is that children in care suffer through an average of 36 placements - this statistic is entirely unacceptable!
338	No idea after 10 years!!
339	Too many chances for birth parents Birth parents not engaged with child safety so their opinion cannot be given
340	Financial complications, family contact issues and strained relationships, plus concerns if something goes wrong and the support isn't available given the complex need of my child.
341	Child safety

342	Differing cso's have differing opinions. Too many times we change too often to develop relationships that show your capacity. Sometimes we've had cso who are strongly against carers having guardianship. I've been told that sometimes the paperwork is too much and they don't have the time. Also, the high complexities of disabilities we have indicates that the children would need extra support, yet for over 12 years from this first statement before we had any kind of support either financial or physical. Even though there is significant levels of challenges, the children have expressed that their need for permanency is stronger and I believe the necessary levels of support could have been written into the guardianship plan to protect the children's needs, while giving them the security they need.
343	Not being approved by one member of the panel who has not met us or the child in care and is going against those the do know us and want the LTG to be granted. Very frustrating and drawn out process that has cased undue stress the child in care.
344	Being First Nation
345	Child Safety are more concerned for the birth parents needs and demands, rather than taking into consideration what is best for the child/ren.
346	Children are indigenous and I am not.
347	Parents have been given our home address by cso despite dangers
348	Complete lack of action by Child Services. Over 10 years ago one of the first caseworkers applied for LGTO, PCO. That caseworker has now had three children in is back to work and is restarting the LGT/PCO process. The children in Care are furious and horrified at Child Services actions or should I say in actions. Biological family have supported this since day one.
349	Nationality
350	Child is indigenous
351	Dept not giving children permancy when they have been in permanent care in one place almost all their lives.
352	Indigenous children not being able to have permanency because carers are not indigenous
353	For us it's the need for us to be in contact with the child's biological parents who are very toxic and have caused issues in the past for siblings carers to the point of that child being moved for safety. We asked if the organisation (not child safety) could continue supervising family contact if we have guardianship. QFKC said this is possible, our child safety manager said no. No discussions just no. So it seems this poor child has to be at the whim of others (some who have never met him or us) for decisions about his life for a long time yet.
354	I approached being the legal guardian over 18 months @go and have heard nothing since. I now will now not be seeking Guardianship as I have zero faith in Child Safety and wi#h I had never commenced this caring journey
355	The belief that biological family is always preferable
356	Ethnicity and lack of paperwork
357	Different rights to adoptive parents
358	Non biased representation Haunted by historical concerns that happened over 10 years ago.
359	Financial
360	The children are First Nations and we are not.
361	Not child focused. Lack of support for volunteers ie: General Foster and Kinship Cares. Long drawn out process. Financial Strain
362	The changing medical status of children resulting in higher financial burden. In some situations the relationship between carer and child's family.
363	Trying to get the staff to work on the necessary paperwork so it can be processed and considered.
364	N/A

365	Child safety staff or lack there of to do the job and court paperwork
366	The dept
367	None
368	Even when it's in the child's best interest and will give the child stability and a sense of belonging child safety still go by what the parents want
369	Time and that carers are not allowed to be part of court proceedings. Often the last to know
370	The children are just a number and have no rights.
371	Financial hardship when child needs extra support, biological parents having more support and care than people caring for child, repeatedly having the child's needs put last, too much pressure put carers without support
372	The department and carers being recognised for being parents..but instead being treated as babysitters and a taxi to appointments
373	The many hoops that carers have to jump through. Lack of support & agencies such as DCJ, merely "ticking the boxes" for compliance rather than being invested in the child's welfare and future
374	I've been advised as a white carer of Indigenous children, I will NEVER be considered for LTGO as that is the blanket policy of the CSS we are with. It's a joke and I consider it racist.
375	Unsure
376	That the young person in our care is aboriginal, however us being no indigenous carers we are told it's not culturally appropriate
377	Long drawn out court experiences Slow assessments for suitability
378	Thorough and individual assessments. Information not readily available. Misinformation or misdocumented being used in decision making.
379	Child safety. Specifically Inala child safety and their managements personal views towards carers (us) because we have advocated and fought for the YP rights. Resulting in harder work for them.
380	Not dealing with Child Safety
381	Child Safety not having capacity to do the body of work required to assess & plan for legal permanency.
382	In our situation none. The issue stopping it was due to things being missed by the cso and constant change to cso!
383	Slowness of the process
384	The rights of parents even after failed attempts of reunification, the child is second in all this aslong as boxes are checked , watching a function child turn into a different human because they keep pushing the process upon him/ her is terrible
385	Parents have too many rights and welfare of child not cared about
386	Indigenous children with non indigenous carers even if the carers meet all cultural needs. If child safety believe the parents need an unlimited amount of chances to change and step up.
387	Culture. I would love to be guardian to my little girl but because she's indigenous & I'm not, I've been told it will never happen.
388	Lack of willingness to allow indigenous children to have permanency by child safety
389	Carer capabilities, carer numbers, carer skills and training, CSO capabilities, CSO caseload, CSO supports and capacities

390	children identify as indigenous is a huge barrier to… even though i've had said child for 16 years told there's no point which actually cso can't be bothered way to much work for them. i'm actually Indigenous… the only one that cares is me child has no family contact.
391	Too much emphasis placed on the "rights" of biological parents regardless of the level of hands on involvement they currently have and irrespective of the harm they have contributed to in relation to the children
392	Not knowing what the future holds for my child and not having someone to report matters and seek support.
393	Legislation CSOs who do not have enough worked experience CSOs who do not consider all the factors Parents who don't prioritise the children's best interests
394	I feel all the decisions are up to department not the judge. In a case I was involved in the judges report which the mother gave me clearly didn't think the child should be with the grandparents but because the department had already moved him he would leave him there
395	The hoops that need to be jumped - the legislation, the courts sticking to the legislation- no adoption- big drive at the moment for Kin however if you have child from birth should we then be considered kin? Kin should only be sort if suitable but children can be pushed into kin that a clearly not suitable but they "need" to do it
396	Child Safety
397	Had children since birth told not appropriate for LTGO as they are indigenous. However one is now aged out and dept couldn't get me to sign guardianship papers fast enough. It's [redacted] Other service centres are allowing ltgo and PCO for indigenous kids with Cpa blessings
398	The push for kin placement. We have had children in our care for years that have been traumatised by reunification but than pushed onto kin. In many of these cases kin don't want the children of are unable to meet their care needs and ages is also not considered ie a newborn with ongoing medical needs given to 65+ grandparents. We are all about family relationships but kin placement most of the time are not best. You would also have more carers if they were willing to put the children into long term care placements. It would also be beneficial to the children. Children need consistency and a stable environment. Child safety pit to much emphasis on reunification and kin and not the best interest and long term care of the children.
399	Dept not doing their role correctly as in HIGH turnover
400	Every time we get a new CSO officer this gets asked, but the answers change each time we ask questions about it. So cannot trust what each CSO tells us.
401	Because to me child safety are to much for bio family and do seem to realise children need stability love all the time not bio parents coming in and out of there lives
402	Complete lack of communication from Child safety regarding any inquiries to them about the care of the child. Absolutely no communication regarding the status of the protection order.
403	Reduction in the support they receive at school. Assessment process and time frames Lack of financial support for support services
404	Child safety taking too long to complete documents or can't be bothered at all
405	Having to gain approval for everything, including medical, schooling, everything
406	- lack of future support if serious issues arise.
407	Race- if carers are not of aboriginal descent they are not considered for legal permanency if the child/children are of aboriginal descent. The courts could change this rule. The courts give families years and years to try gain back custody of their children when they could have been placed permanently with a carer and felt a belonging the whole time, instead of not knowing where they will live in the future, causing further trauma.

408	Child safety actions (lack of). I have a 15 y.o whose views and wishes weigh heavily. She has made it clear since day one that she wants permanency with us and doesn't want a CSO knowing her "business". We are still sitting on LTGE orders due to lack of action from child safety. I have strongly advocated for this too. CSO visits are sporadic which I think contributes to lack of documentation on their end to support LTGO. We are by no means a difficult case so I feel that we have been forgotten about a lot and our case is lacking because of it.
409	The parents rights are always above the childrens
410	Family issues
411	The department
412	Complexity of trauma and behaviours causing safety risk
413	Child safety and their willingness to consider us for permanency.
414	CSO workloads too high. Only time for them to respond to crisis and not do the bread and butter work
415	The amount of time everything takes to go through the court system
416	Cost of living. Child has disabilities and a horrendous NDIS package some when the money runs out Child Safety needs to help. As I can not work as they need high level of care.
417	Child safety not commencing the process. Carers being told it isn't an option as we don't facilitate transport to and from contact
418	Not enough support for carers. A continuation of feeling unsupported by the department when matters regarding safety and wellbeing of the children arise.
419	I wasjed when the children were 5 to become legal guardian. We said yes. Six years later it still hadn't progressed. We approached this again 5 years ago and they said it wouldn't take more than 18 mths. Still not done and kids are due to turn 18. Appalling.
420	getting financial help for medical needs
421	Child safety do not put the needs of the child first. Future financial responsibilities
422	Contact with family, especially if they are incarcerated and you live away from the prison and work
423	Complex behaviours and disabilities requiring the additional support and financial help that aren't given when on legal permanency. All responsibilities fall back on carer.
424	Indigenous status
425	The system that breaks the children and carers in it
426	Paperwork and lots of steps
427	Culture
428	permanency is often delayed or disrupted not just by systemic and family issues, but also by the failure to truly listen to and prioritise the child's own wishes and best interests, which can result in placements that feel unsafe or unwanted but also because the carers have no rights, we open our homes, hearts and get financial burdens for a good cause and to change the children's futures and are met with zero rights or input.
429	The parents get to much say
430	The court system. It does not prioritize the children and make sure that they are at the fore front of the system. We are currently facing court system abuse by a bio parent because of all the loopholes and work around she has found. 3 years we've been in court for permanency. Too much emphasis is put on parents and not nearly enough consideration goes into what these children go through.

431	Unclear or incorrect instruction from cso and/or team leader regarding the steps for us as carers to take to obtain guardianship of our little people who have been with us since birth. We already tried three years ago, was instructed to have the mother at our house for contact to show we were willing to facilitate a continued relationship. However that blew up in our faces when she lost it and couldn't control herself at our home, frightening the kids and breaking our front door. We now have to start again from scratch apparently with no consideration given to the efforts we've already taken and have continued to take.
432	Child safety keep going for interim orders after the short term custody order for two years is up because they haven't got the paperwork ready for court
433	Incorrect information
434	When you are not of first nations heritage and the children in your care are. A lot of people involved in the process and so many different interpretations of what should be happening.
435	Culture. Caring for children of Aboriginal descent, we do not identify, and the barriers to providing permanent care for this child because of this reason. The department failing to provide specific information about culture and mob in order to connect the child to community. Yet this is seen as our fault because we are of a different culture. It is assumed we fail to keep them connected, when in fact the biological family and the department put these barriers in place by failing to share all relevant information.

436	The rights of the parents are placed above the rights of the child.
437	The biological parents wishes for the children over the wishes of the children
438	Child Safety often want to tick the boxes and don't care who they walk over in the process.
439	The consideration of bio parents in so many decisions in child life still. CS vendettas against foster carers and lack of supports for children once on permanent orders
440	How to continue to have family contact - what to do when contact is going wrong - how to facilitate.
441	Constant Change in staff
442	Lack of suitability assessments, court adjournments
443	Bureaucracy and process - I understand within two years a child or young person should be assessed to see if returning home or to Kin is viable. If not then permanency should be key to both the child and carers. If it is child number two, three and upwards, these decisions should be made Quicker. Decide and act. Connection with family should be maintained - overseas models are straight out adoption, open adoption, long term permanency - connection with family twice a year so they know who is family - but let the children and young people move forward with a stable base from which to heal and grow.
444	Process and time
445	One major barrier is the repeated opportunities given to parents to reunify, even when there is little evidence of lasting change. Each time, the child's hope is reignited that their parent will recover and be able to provide full-time care. When this cycle continues for years, it becomes deeply damaging, the child experiences ongoing disappointment and finds it harder to move forward positively. While permanency decisions will always involve grief, a clear and final ruling earlier would prevent children from enduring years of uncertainty and false hope.
446	The major barrier to legal permanency is the funding. I foster only severely disabled children that need extra support, food, medical supplies, medications, equipment etc. I would have taken guardianship years ago but I wouldn't be able to afford 2 lots of funding options for children.
447	Financial support and lack of knowledge

448	I haven't been approached. I have had to push the department to recognise the child/ren's right to permanency. The department has done everything that they can to stall and stop this process. 3 years ago, I had a completed LTG-O assessment completed and it was glowing. The department didn't complete it, and now I am having to go through the whole process all over again. I have had the Chief Practitioner ([redacted]), outright tell me that 'I cannot imagine that the department would ever support you in being (name's) guardian'. I have had this child in my care for 4 years 11 months. He came to my care at age 4.5, I am his 5th primary placement, as he was previously repeatedly relinquished, due to his behavious. The department has withheld authority for medicaiton for this child, they knowingly sent him to a resi respite where it was known that they would overdose him on his medication. The barriers are that the department refuses to act under Section 51VAA, s5BA and s65 of the CPA. The department appears to act as if, 'permanency' as an optional extra, not that it is the child's right to have permanency if it is available to them. The department will withhold guardianship as control and as punishment and retributions against carers.
449	Child safety not prioritising these opportunities or conversations
450	Initially Family members who do not work towards reunification effectively. Foster carer assessment, Court approval & case planning timelines.
451	The change of CSO and her being against us applying when we already had views of parents and children. CSO stopped it all.
452	Cort costs if the young people decide to leave care
453	Too many continuous short term orders.
454	N/A Respite carer

455	The law. The attitude of the case workers. Consulting not child centred purely focused on birth parents rights not child rights.
456	Parents Rights, Complacency of Dept, Ethnicity eg Aboriginal continued referral for Kin even when their birth families wish them to remain with their non aboriginal Carer.
457	We asked for 7 years for LTG-O, and the Team leaders and CSO's never did their job to progress it.
458	Biological family having to much controll and taking "ownership" not considering best interest of child who is young person not an object
459	The department appear to want children to stay under their care for financial reasons that benefit their service centre, or their KPIs. They're not proactive working with carers to move children to permanency, carers are typically the ones pushing to make it happen & in many cases seeking costly legal advice/representation to do so. The process of permanency takes way too long and many children have to live without the comfort of knowing they're stable in a "forever home", constantly reminding them they are in care & in turn causing more trauma
460	Reluctance of CSSC to do the work. We've been waiting over 5 years and panel has approved, then reapproved. Constantly told workers are too busy to do the work. Or fresh graduates don't know how to and no one senior to mentor them. 8 or 9 new cso's over the five years. Only 2 had done the paperwork previously. Kids have been in my family for over 14 years
461	Child Safety Department
462	The very slow moving process which is hampered by turn over of staff!
463	Numbers of decent carers willing to provide a permanent home Age of carers Willingness of Child Safety to promote permancy for children Biological parents have too much involvement with decisions Biological parents given too many chances to reunify Department workers are too difficult to work with
464	Not enough medical and, mental health care plan for our children
465	Not being Indigenous.

466	Court-ordered Guardianship. Had to get the kids away from the paedophile (and his mentally-deficient & involuntarily institutionalised mother first) that DOCS placed them with.
467	Child Safety do not like to lose power & control of LTG CE.
468	Child identifies, I don't. Totally unfair child has been with me since birth, it shouldn't matter that the child is indigenous, he should be able to have a life without child safety, he has never known any other life he is now 7.
469	Lack of understanding and care to ensure the best outcome for the child
470	You do the Permancy Assessment abd the assessment is absolutely Amazing for permancy for a young person then Child safety don't recommend you they want all kids under the crown. I'm not going to go on trial for doing all the work for the last 5 years and have Litagation from child safety tear me down.
471	Financial burden and bio parents involvement
472	Changing of PCO,s then you start all over again. Cross misinformation and a total incompetent mess .
473	The length of time of the process and limited communication on what is required or occurring
474	Financial - Child Safety refusing to pay CSNA for child with complex needs moving towards PCO - so PCO is not able to progress at practice panel despite no other barriers to moving forward
475	Being indigenous
476	The process takes too long. We (the family and me and the child in question) have been on this process for 4 years!!! The family is fully on board with me getting an PCO. Only within the last 3-4 months have we been transferred to the permanent care team. We are still waiting for CSO to write report for lawyer, affidavits have not yet been done. And the child is desperately wanting to have all of this finalised and for me to be his legal mum.
477	Unsure as it hasn't properly been discussed
478	Una re
479	So many factors but in my experience mishandling of existing family connections and bureaucratic favouritism toward women over men as carers.
480	No support provided for children who's behaviours increase over time.
481	I'm a non indigenous carer caring for indigenous children x 5
482	not considered culturally suitable by dept however family are supportive of my ability to provide on all areas of care including culture
483	The cultural gap. I am not indigenous but the kids in my care are.
484	We have no CSO and haven't for more than 6months. We have had 5/6 Csos over the last few years , some we never even met. No one wants to start the process as it's too much work for them . The eldest 2 of our 6 LTG CE children have been with us 12+ years and want permanency desperately . They are Indigenous (I am too) and that is the excuse the dept uses to not do their job
485	Sector staff mindsets and their personal preferences for the easiest way to do their job
486	The time frame and lack of answers given by department staff
487	Childsafety are the barriers ie they just automatically go for ltgce and carers have to fight for ltgo assessment

Attachment D: Lived Experience Survey – Question 15 Open Question

Question: What have been some of the other differences you have identified if any?

Answered: 129 Skipped: 544

#	Responses
1	No difference in their appreciation and treatment of carers. They all treat carers badly, children recklessly, and parents too leniently.
2	There is not enough support for children and carers, definitely no incentive to keep fostering
3	Parents having more rights , not carers and children feeling's and needs being considered.
4	Duty of care from Child Safety towards their children. That are under their guardianship. No mediation with the Carers that have been long term Carers for their Children.
5	Decisions that are made without any consultation with me as their carer, lack of support shown to carers when they do not know what is available and CSO dies not give them info.
6	Constant staff changes and lack of information given to myself as a kinship carer. Unable to organise for the siblings to see each other regularly
7	Each office has different rules and ideas. Same as every cso is different. Also younger cso have no life experience and common sense on what children need. They turn a blind eye to what's not acceptable as its the parent. But if a carer did it we would be in trouble.
8	Lieing by parents and cso believing parents over carers
9	One CSO says the service centre cannot transport the children to see their parents. The children's parents are young, don't drive and have no reliable family. I, as the carer, drive to the parents house 45m away, pick them up, drive another 20m to the CSSC and drop them off for their supervised contact and then drive the parents back home. New CSO took over the case, in the same office and said "Oh yeah, we will transport the children"
10	Support for yp Not Attending school
11	Lack of financial support for Medicaly complex placment: 1 service centre is extremely supportive. Another has left a child without vital medical support for over 6 yrs due to cost. Lack of knowledge or investment in learning about children who require NDIS supports: 1 service centre attends all meetings & medical appointments, cso & csso have attended therapy sessions to understand child's needs. Sign service agreements asap. Second service centre has a child with an inactive NDaiS plan that is 9 mths old because no one will make decisions or sign service agreements. We are still privately funding allied health supports!!!!! Lack of open communication about case plans: 1 service centre has open communication between Carer & Team Leader regularly. 2nd service centre has zero communication with Carer about case planning & contact. Regularly has Parent pick child up from daycare for "appointments" without Carers knowledge.
12	I have worked as a carer with 7 different service centres across the past 20 years. Some are renown for being very supportive of carers, and prioritise support for children and carers - particularly with complex needs/HSNA etc. Others are known to be (unecessarily) difficult to work with...as a long term carer, I will actually consider the service centre a child is attached to when making a placement decision, as it can be a game changer if the child is case managed by a good centre.
13	Grandkids sleeping on mattress with no door, 3 x open access to anyone in or entering house, constant nits, while in child services care, no cloths that fit, no dental check current, lack of response after sexual abuse, inconsistent treatment of us as grandparents prior to placement
14	Medicare cards and birth certificates come at different stages some have to wait up to 9 months

	which means their Dr bills and medication need to be paid by carers instead of bulk billing. Some children have all their expenses paid when travelling for medical by child safety other are expected to be paid by foster carers. Their is little incentive to take on high needs children as some have extra payments others don't. Some parents are given higher priority to see children than other parent of child. Children are expected to see parents even if they appear traumatized after visits. The most I've ever had is a phone interview with a independent agent otherwise have not been consulted
15	Some do home visits others do not. Some communicate sparely others not at all
16	Centrelink paying debt back that wasnt my fault due to reunification
17	Just having contact with the department
18	Staff turnover
19	Overall communication and organisation. Some centres clearly have more cases and are overloaded. I have had a child in my care for 3 months and no home visit from CSO.
20	The comfort level when you walk in…most are cold business rooms. No warm welcome.
21	Just different CSO see things differently
22	Communication.
23	Ver little respect as a care and never think about the ather children in the home
24	Consistency and clarity in communication
25	Lack of care between CSO to carer
26	If the CSO likes you or not likes you
27	Going on leave without letting us know who we can contact while I leave having a team leader and the Csso girl at the same time
28	Decisions around unification Decisions NOT always made in best interests of the child Too much pandering to parents Kids left in homes where drug taking is prevalent yet Child Safety say it's ok! As long as there is a safety plan in place!
29	The culture and mentality of the case workers at the two service centres was very different. The case workers at [redacted] were very negative towards us, put the biological parents needs over those of the children, including in our opinion keeping them safe during contact, and were unprofessional in the way they dealt with us as carers and the parents. In one example, when we were transitioning to LTGO, we are fairly sure a support worker suggested to the biological parents that they could appeal, which they did. As a result, we spent $10k in legal fees defending the children's interests while the biological parents didn't even turn up to the appeal hearing.
30	Copy and paste. Wrong information. Never properly updated
31	There are many inconsistencies primarily caused by constant change of cso's. Every time we get a new one which is every 6-12 mths we experience many changes in standards. Consequences in negative impact on child and our household due to anxiety and stress.
32	Financial decisions. The contrast between [redacted] CSSC and [redacted] CSSC & [redacted] CSSC is crazy. I have cared for I think 13 children over 6 years and I'm with [redacted], I've only had 1 [redacted] Child.
33	They say one thing at a home visit which never seems to be documented. Then when asked about it again they say they know nothing about what you're talking about. And tell other family members a different story to what you have been told. I don't trust child safety as having children's best interest in mind.
34	Time it takes for cso to respond some service centres are better than others
35	Communication, difference in attention to detail- lack of care between cases
36	Communication Efforts of relation with carer Lack of resources or knowledge Turn around times are increasing
37	Every time my youngest foster daughter would get a new CSSO things seemed to start all over again. Her parents would get to start from the beginning again with contact opportunities even though they had previously shown that they werent willing to attend contacts that they were offered. This happened several times with several CSSOs as they were given the benefit of the doubt with each new CSSO until inevitably each CSSO came to realise on their own (instead of looking at the history) that they were not going to do what was necessary to progress.

38	Rude Cso's at some centres - eg [redacted]
39	Dictatorship by CSO and lack of flexibility for Carers who work
40	family cotact arrengment, comiunication with child safty
41	Level of information received, consideration of carers as partners in caring
42	Communication, trust of carers
43	Laxed communication, high turn overs, staff shuffling, withholding important placement information
44	Child safety say one thing to the carers, another to the parents and something different again to the child/ren. They constantly dismiss a carer and a child when raising concerns as at the moment ot is all about closing the file and getting reunification finalised even of the parent or the child are not ready. Child Safety have denied conversations that have CCTV evidence or make false claims against carers because carers have raised concerns about the information received. Child Safety say another thing to the carer's support provider then claim it was not said when asked by the carer.
45	Decisions around unification.
46	Very little communication, decision making not across the board, stakeholders should be held for young persons so everyone is in the same page, daycare, schools, carers and therapists etc
47	No return phone calls.. Needing permission for child's needs, take to long, specially if parents have all the say..
48	Transportation assistance for family contact, notification of family contacts.
49	One office has urgent things dealt with within a week. Another still not initiated after 3 months. Possibly staffing or maybe the CSOs not being given the authority to actually look after the children they have and constantly having to wait for managerial beaurocracy.
50	Communication styles and decision making
51	Home visits
52	Poor communication between agency, carer, Child Safety
53	Infighting between centres such as we had a child placed with us from Brisbane and they transferred her file to [redacted] but [redacted] refused to take it and [redacted] refused to take it back so this poor child and us were in limbo
54	Family contact arrangements. Respite arrangements.
55	Decision making not consistent. One STL/CSO makes a decision & if you get a new STL/CSO decisions are different. Eg reunification process, sleepovers Yes/No
56	Ti e that it takes for things to happen. Apparent red tape hold ups, treatment by CSOs, financial decisions and hoops to Jim through
57	Some managers do not help students with financial help for laptops etc. They always say no money.
58	One centre supplied a laptop the other said we should purchase and may get a refund .
59	New cso. Knowing nothing about the child or if they do they don't like to share it with the carers. Not sure why that is as we are the ones caring and know them the best.
60	Some csos answer email or calls while others do not so takes longer to get permission for one child
61	Lack of relevant input from department due to constant changes to CSO's.
62	Lack of anything from the cso
63	Consistency On emails One visits the other never seen in 5 months
64	Child Safety are out of control and no one holds them to account. They have all the power and they make that known. They are bullies and the foster caters are treated horribly
65	Child safety are completely out of control and no one holds them to account
66	Financial help with some school items and personal things for young person in care.
67	Staff having judgemental views on carers, making decisions based on their 'own personal viewpoint' when looking at how a foster home functions.
68	All Dept never consider if you have other children from multiple depts, no consideration when it

	comes to contact, appointments, functions etc
69	Just poor communication across people and teams, poor recordkeeping
70	Level of interaction of CROSS with children
71	Lack of communication and transparency
72	One of the key differences I have noticed is the inconsistency across different Child Safety Service Centres. Processes, decision-making, and communication can vary widely depending on the team or office, which creates confusion and impacts stability for children and carers. For example, one CSSC may prioritise clear, timely updates and collaborative planning, while another may have frequent staff changes and limited communication, leaving families and carers uncertain about next steps. These inconsistencies can undermine trust in the system and contribute to further instability for children and young people who already face uncertainty in their lives.
73	Different offices have different thresholds for 'safety' to the point that I actually believed some office worked of a bonus for there reunification numbers, given the children they where sending home where not to safe environments.
74	Communication. Information about child's medical needs, Information about child's disabilities. Providing support for carers in Ready Respose and Emergency Placements
75	Lack of information from DOCS.
76	Lack of organisation and being proactive in meeting child's needs for knowing what is happening (case plan) and family contacts being very slow to organise (months before child saw parents after being placed). Lack of communication about case planning and progress of parents with communication.
77	constant staff changes
78	Contact with CSOs Importance of home visits Funding for the children Level of responsibility on the carer, some try and force transportation for contact Advocating for the children to have medication, counselling etc.
79	Experience, knowledge, common sense, respect shown to carers
80	Lack of up to date record keeping
81	level of engagement and communication by different CSO
82	Lack of communication
83	One department doesn't communicate with and department
84	The attitude and decision making of managers in each office vary. One manager in an office can interpret an incident in one way and the other differently.
85	No communication. What parents can and can't do.
86	Financial support - one is super hard to get CRCs paid for. Other support private school when it is important for a child's identity and integration into the family and school is better equipped to support child's needs.
87	I have had NO contact with one of my kids service centre in six months.
88	sometimes it not even different service centres, I can't tell you how many times what a CSO discusses comes from a personal opinion rather than policy or practice. Communication is different from each office, I have emailed several times with the same enquiry since May and not once have I got a reply email, then they don't answer phones either. For the last few months if we try and call we get told we are triaged and if they deem it important enough they will get back (NOT good enough).
89	Carer allowance CSNA payments differ depending on carer when changing placements. Some CSSC will have case planning and placement agreements done in a timely manner others never action it.
90	Cleanliness and presentation of the offices, family contact rooms.
91	General decisionmaking differs
92	Some service centre managers act like the money is coming out of their own pocket and not the government purse. Lack of information about progress of decision making. Lack of prioritisation of all matters requiring decisions. Lack of consultation with key parties.
93	Communication in general, no home visits for months

94	No communication period
95	What is carers decisions vs CS decisions. Some CSSC allow you to make decisions for certain things whilst other dont and you end up in trouble.
96	Face to face contact or even contact between cs and carer and child
97	One service centre will make the decision on placements and won't converse witn the other centres even when it means keeping siblings together.
98	Amount, if sometimes any communication. A willingness to help carers in an emergency. Some will move heaven and earth and others won't even respond to emails or calls
99	Failing to include carer in any planning and keeping carer informed of court dates etc
100	Attitude to Carers, capacity to attend care team meetings, capacity to support the care needs of the child.
101	Management have different opinions. Or some go straight to suspension of contact asap where other Management give parents too many chances.
102	Treating carers with respect and listening to them, it needs to be child. Entered and in the best interest of the children.
103	Poor to no communication
104	CSO availability and willingness to actually assist when asked for help
105	Communication differences
106	Some put in a lot of effort others you never hear from at all
107	With the change of CSO there is marked inconsistency, standard of care reviews when a placement breaks down.
108	Decisions made around kin contact and move to kin differed from one office to the other.
109	Understanding of placement policies and procedures. Consistances from CSO to CSO
110	Parents not coming to contact and it causing disruptions to the children, children being forced to see parents when they aren't wanting too
111	Confirming family contact dome cso's do some dont
112	Young CSO with no idea and very big chips on their shoulders
113	The management team can have a very negative or positive influence on the way the service centre is managed and how the staff then interact with and treat carers.
114	Attitude, flexibility, decision making
115	Adhoc child related supports eg supporting child/carer during school suspensions etc
116	Lack of communication between centres, no home visits from one CSO and other cover but not able to discussed needs with their actual CSO
117	CSSC's differ. My local office makes connections with Carers where they feel valued and an important part of team. Encouraged to have a voice, bringing about better outcomes for all.
118	Quality of staff
119	Capability of case workers
120	Level of support provided for exam0le some will assist with transport other not
121	Burnout of case workers across all departments
122	The way CSO's engage and talk with you.
123	Children and carers treated differently by different service centres
124	Financial , visitation , no child is heard , the CSO'S, treatment of carers the list goes on
125	Thuringowa office - very easy to get supports needed for child's developmental delay City office - nearly impossible to get supports for a child with multiple severe impairments - took over 3 years to arrange
126	The don't communicate with each other, one centres CSO says one thing and new CSO says another
127	Wether I am contacted in a reasonable amount of time or not contacted at all
128	Communication

129	determining outcomes and the quality of relationships with the carers

Attachment E: QFKC Passport Chat Sheet Resource

Carer Guide to Passport Application for Children Subject to Child Protection Orders

Step 1: Email the Child Safety Officer (CSO)

Email the CSO regarding the request for passport application, with date for travel recorded in this request. Ideally, this should be 6 months prior to your planned travel.

The best advice is to make this request as soon as you are looking at travelling. The proposed travel date to be included in the passport application can be an estimate. There is no need to provide an itinerary to Child Safety at this stage to confirm your travel plans.

Please note: Sometimes, this can be when discrepancies in the spelling of children's names—such as on their ID and child protection order — are first noticed. This needs to be resolved before a passport application can proceed.

For international travel, the approval guidelines are as follows:

Following information is extracted from the Child Safety Practice Manual.

Custody Type	Decision Maker
Chief Executive has Custody	Parent * Regional Director
* The parent, as guardian of the child is the decision maker for these decisions. Where the parent is not able to be located, is not willing to make decisions for the child, or is not able to make decisions due to health or mental health issues, the Child Safety officer indicated is able to make the decision. Where there is conflict about these decisions between a parent and Child Safety, a carer or a family member, that impacts on a parent's decision making, work with the parents to achieve an outcome that is in the child's best interest.	
Chief Executive has guardianship	Regional Director

The documents that the CSO requires to make a passport application on behalf of the child are:

- Child Protection Order
- Child's birth certificate
- Mother **OR** father's birth certificate – note: this parent must be recorded on the child's birth certificate as a parent.

It is the responsibility of the **Child Safety Officer to locate and collate these documents**; this is not the carer's responsibility.

These documents are required as **"Evidence of Citizenship."**

As per the Australian Government – Department of Foreign Affairs and Trade – Child Welfare or Protective Agencies: A guide to lodging child passport applications[1], evidence of Australian citizenship can be:

- The child's Australian passport (issued on/after 1 January 2000 and valid for two years), or
- Either parent's full Australian birth certificate (where the parent was born in Australia before 20 August 1986), or
- Either parent's Australian passport (issued on or after 20 August 1986, valid for at least two years and issued before the child's birth), or
- A Citizenship Certificate issues to either parent (before the child's birth) or to the child.

Note: If the child's parent was born in Australia on or after 20 August 1986, evidence of one of their parent's (the child's grandparent) Australian citizenship will need to be presented.

Step 2: CSO needs to apply for a passport

Once the CSO has the above documents, they will visit the www.passports.gov.au website and make an application for a passport. CSOs do this online and create their own login for an AusPassport account with their work email address. This needs to be completed by the CSO.

Once they have completed this form, they are able to print it off and have the child's parent/s – those with parental responsibility for the child - sign the 'Declaration and consent' – Q15 of the application. **The parent/s recorded on the child's birth certificate must sign this section.**

Note: Please see table below to advise who can provide parental consent, based on the child's child protection order.

Following information is extracted from the Child Safety Practice Manual.

Type of child protection order	Forms	Type of consent required
Guardianship to the chief executive	Australian Passport Child Application Form[2] Application for an Australian Travel Document B-10[3]	Regional director Note: parental consent is not required
Guardianship to a suitable person	Australian Passport Child Application Form Application for an Australian Travel Document B-10	Suitable person Note: parental consent is not required
Custody to the chief executive, including an interim order	Australian Passport Child Application Form	Regional director and parents

[1] https://www.passports.gov.au/sites/default/files/2021-04/annex23.pdf
[2] https://www.passports.gov.au/passports-explained/child-quick-guide-applying-passport
[3] https://www.passports.gov.au/sites/default/files/2021-04/b10.pdf

Custody to a suitable person	Australian Passport Child Application Form	Suitable person and parents

When a child is subject to a child protection order, the Child Safety Officer must complete an additional form: Child Subject to an Order Made Under State or Territory Child Welfare Law – B10. This form requires the signature of the person or people with parental responsibility.

Note: The B10 form can also be used in a situation where the parents are unable to be located to provide consent or where a parent may have refused to provide consent. There is a section on the B10 form which allows Child Safety to explain why parental consent was not able to be obtained. The B10 form is also signed by the Regional Director.

It is **important that the CSO's details are recorded on the B10 form under both 'Q6. Details of the person authorised by the delegate to lodge application' and 'Q7. Details of the person authorised by the delegate to provide information or make enquiries in relation to the child's passport application'.**

It is also **advisable to include the Senior Team Leader's name or a second CSO**, in case the current CSO resigns or takes leave during this process. While this is the responsibility of the CSO, it is something carers or support workers can check to help avoid delays in the passport process.

Step 3: Carer arranges passport photos

Once the appropriate consent is obtained, the carer is tasked with arranging a passport photo for the child. If you discuss this with your CSO, this cost can often be added to the case plan and/or reimbursed via a CRC (Child-Related Cost). The fee is around $20.

As per the Child Safety Practice Manual:

Foster and Kinship Carers will be reimbursed for the purchase of a passport for a child, including the cost of the application and the child's photograph.[4]

It is best to wait until this stage in the application process to have the passport photo taken, as they are only valid for 6 months. This can be completed at any post office and does not usually require an appointment.

Once completed, provide the CSO with two copies of the photo. The CSO needs to include both copies as part of the application.

Note: If the child is between 10 and 18 years of age, they must also sign the passport application. This is Q16 on the application form. Their **signature must be drawn inside the white box**, *strictly*, or the application will be rejected.

[4] https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/decision-making-for-a-child#Passports

Step 4: CSO prepares passport application

The CSO is responsible for preparing the passport application, inclusive of the supporting documentation from Step 1 and the passport photos and providing to the Regional Director. If the Regional Director is visiting the Child Safety Service Centre, this process can be completed quite quickly. Otherwise, the documents are sent via express post to the Regional Director's office for signing and then express posted back to the Child Safety Service Centre.

Step 5: CSO arranges time with carer and child to submit application

Once the signed application is returned, the CSO will arrange a time for the child, carer, and an administration officer to attend the local post office to lodge the application.

Please allow up to one hour for this appointment, as it can be a lengthy process.

It is important the child brings identification, ideally with their photo and name – such as a school ID card or Drivers' Licence. Other supporting identification may include a Medicare card, health care card or bank card. Ensure the child has sufficient documentation to meet the standard 100 points of identification.

The administration officer attends to pay the lodgement and application fee. **A carer should not be out of pocket for any costs associated with this application.**

The post office employee completes a very thorough check of the documents and application prior to lodgement so any errors or missing information are usually picked up here. If for any reason something has been missed, the CSO will need to reschedule the meeting with the carer, child and administration officer.

Step 6: All that is left to do now is wait!

The passport office will contact the authorised person recorded on the B10 form with any final questions. They will also contact the authorised person once the application is approved. The passport will usually be sent to the CSSC – which is listed on the passport application form. Child Safety like to take a photocopy of the passport for the child's file and usually store the passport in a safe until the travel date.

Prior to your travel, make sure to arrange with the CSO to collect the passport from the CSSC. They will usually ask for you to sign a one-page document with your name, signature and date of when you collected the passport. It is usually requested that you return the passport after the trip to be placed in the CSSC safe again for future use.

Note: When you travel, ensure you have a copy of the current Authority to Care to accompany the passport. Some carers also opt for the CSO to write a letter on Departmental letterhead advising the child has approval to travel interstate or internationally. The CSSC Manager often signs this document.

Attachment F: Lived Experience Survey Question 17

Questions: Has there been times you are aware of where information has been known to Child Safety about a child that was not shared with you that would have impacted on you accepting the placement?

Answered: 563 Skipped: 110

#	Responses
1	Yes. in this case , at the time we had an ethical agency support worker who finally got our PA months after long term (probable) placement began. When we read it there were warnings that the previous carer had carefully made sure got included about the child and very high risk behaviours that had began following the department placing the child in unsafe situations.
2	One child has a huge issue with theft (perhaps kleptomania?), taking nappy pins, jewel, other people's underwear, and Child Safety told me (after the fact) that " she has some difficulties identifying her own belongings" , sexual abuse with acting out, child from a home with huge DV problems and nothing said to carers.
3	Information required not known by child safety
4	The mother was emailed information about visitation from The Child Safety officer but I,the Carer wasnt
5	More information needs to be given for ALL children that come into care.
6	This particular family have 12 children so long history. Due to "privacy " we have been given no information. Current cso of our children didnt think she needed to talk to cso of other children when trying to change visitations that have been in place for 8 years. Previously with another child cso thought it was a good idea
7	Disabilities and behaviours
8	Behaviour
9	I still would have taken on the child but I would have pursued much greater medical and therapeutic support from the beginning
10	Extreme behaviors
11	Information has been found out by mutual friends and/or pieced parts of stories together or the child has said stuff
12	Finding out by previous carers that the child we accepted into our family has sexualised behaviours
13	Grandchild self placed
14	Though the information shared is always incorrect and not current
15	Transfer from interstate. Qld continually states they don't have the background and information when making decisions
16	Extreme incontinence
17	Child's disabilities
18	Family history of aggression towards carers. Prenatal alcohol exposure resulting in FASD
19	Mostly behaviours.
20	Behaviours
21	We were told the child had no issues but he was diagnosed with FASD, ADHD and ASD level 2.
22	Behavioural, family visits. Sexual behaviour. Autism.
23	They have blatently lied to me and the child
24	Sexual abuse in previous carer household that resulted in legal charges. When we experienced sexualised behaviors we investigated and eventually found out why. It was never disclosed.
25	I took on a temporary placement of 2 young boys who were in the care of their grandmother. The department got tired of the grandmother failing to provide documentation to them and removed the children for a short time to get her to understand that she needed to get things sorted. Both boys were

	ill at the time, which was not divulged to me.
26	The foster agency gave false information
27	Child highly disabled and known as child attended special school
28	limited informations
29	Please note I have only just started general fostering, so my experience is limited, but my calls come from the placement team at Life Without Barriers and she is excellent.
30	No information about my grandchildren would of impacted me taking them
31	the types of abuse have been kept from us
32	Within 24 hours they informed me that the child will be visiting the grandmother three nights week in the Gold coast. I feel that the timing with this was to corner me into doing this drive even though I have other kids in my care
33	I'm only a respite carer not primary carer
34	The behaviours of the child/ren, their family background, and the trauma of the child/ren.
35	There is no information given at the time. We were treated like we should know the procedures .
36	Age of child is often wrong
37	n/a
38	NA
39	I have had my three foster children for nearly 15 years, originally I had very good service from the CSO's, however we were moved to a different office and it all changed. We have had mulitiple CSO's in the past 5.5 years, all who have different ideas of how things should be done, some have been great and others have been less so. Up until the government changed this year, we had very little contact or support from our CSO. This changed and the new CSO was great, but I have just learnt that she won't be back and we will have another CSO again within 6 months, so very frustrating.
40	I was not told about stage 2 autism of our firs placment. I was not told that he had disability. I did not even have their sir names and had to collect them from school. I was not told what time to collect them or what school. I had to ask so many of the really obvious questions. It was a mess. Child safety were not forthcoming at all and i felt forced into a situation out of my control for our first placment.
41	Child placed that had sexual behaviours when I had 4 young girls in placement
42	Although not with current foster child
43	Medical information. Parental drug use.
44	Not experienced this as I am a kinship carer for my 3 grandchildren
45	My support team has been very informative from verbal to written information
46	My foster daughter we raised her brother too. He was diagnosed with asd level 2 ADHD and an intellectual disability. I was unable to work as he was unable to attend school. He would attack physically teachers and kids. I asked if I was able to work because I need to work. They advised they had no place for a child with a disability to be. However I had discovered a place called Pimpama hub. They take kids with extra high needs who struggle to attend school and offer one on one care. I was told I was no able to use this service. I stopped work and study for 4 years while raising him. When I realised I could never work again I had to give him up. If I was told this would have been the outcome and there is a risk of unemployment i would never have committed to having him. I wanted him for the long term. He now lives in Resi care.
47	Child's aggression towards carers was not told to me
48	Absolutely all the time. I was banned from seeing my grandchildren due to a child in our care scaring one of them. She had very bad mental health and we were not informed. I have also had emergency placements for a few days and was nit told about this child's intellectual disability or giventh4 medications he needed.
49	CS and agencies lie to carers to get placements, they truly don't care about other foster kids or bio kids
50	I take in emergency placements, on many occasions information is left out on referral of a child. It is about a week later that I find out Child Safety knew more info but chose to withhold that in the referral.
51	Only one kinship placement so this doesn't really apply
52	N/A
53	We were not told child had complex needs (told she was a cute six year old), Also we haven't been given any information about why children are in care so unaware of what triggers may be etc.

54	We were child that a child was a perfect child however has since been diagnosed with FASD, ADHD and ASD Level 2.
55	Withheld the extent of trauma and that there was sexualised behaviours.
56	Animal cruelty was a known behaviour, not shared until after our dog was killed
57	Information has not been disclosed then issues have arrived with other children in my care & the placement has to end but no carer's available
58	Violent behaviours, sexualised behaviour, harm that has occurred in kinship placements prior.
59	Also with our agencies. But everyone lues just to get kids into a bed.
60	N/A
61	Aggressive and sexualised behaviours hidden no about me form provided
62	Behaviours were with held so we would make an offer
63	Child was not placed with me as I could not facilitate them based off of what I was told. Child has multiple behaviours and medical diagnoses.
64	Taking placements on for agreed dates only for child safety to not follow through
65	Extreme trauma behaviours. Sexual behaviours... or just that child safety might label a major behaviour as a minor if they've been desensitised by their time working at child safety
66	A child diagnosis was ignored.
67	A child with serious medical needs was placed with me, child safety was fully aware, however I wasn't told of the severity and I have it in my carers agreement that I'm not ok with having children with medical needs placed with me.
68	Medical FAS
69	nearly all the time
70	Child placed for respite with a house full of children that it was recommended not to be placed with other children in a placement
71	Behaviours, travel distance to school or daycare.
72	[redacted] needs often underplayed to promote acceptance of the placement
73	Often carers get told what the bare minimum and often whitewashed in order to get carers to accept placements
74	Probably not about whether I would have accepted the placement, but it would have been appropriate to be aware in order to plan and consider
75	Child history of sexualised bahviourn with pet not disclosed but placed with carer with pets
76	Child turned up with broken pelvis, we were not told of any injury
77	Father was a convicted peadaphile and I found out via a fb article that was shared.
78	Family Medical History
79	Undiagnosed (& unfunded) child conditions and behaviours.
80	Yes, we were told a child had no behaviours. Actually they were suspended from school when we accepted the placement and didnt find out until the child told us the next day. Child actually had FASD.
81	Child born with features alcohol and not told

Attachment G: Lived Experience Survey – Question 18

Question: If yes, what was the impact on your family and the child/young person in not sharing the information?

Answered: 355 Skipped: 318

#	Responses
1	Possible placement breakdown
2	Causes family breakdowns with contact with next of kin (ie sisters) as other family members get involved with no explanation to carers.
3	Wasn't told about sexualised behaviours
4	Stress and exhaustion because of physical violence not being disclosed. Food issues where child would only eat fast food and it became a financial burden.
5	Lack of knowledge to provide appropriate support to the child based on their needs
6	Violence and fear
7	You are only told what they want you to know to ensure you will take the placement, then left with no suport
8	Our family, the placement and the lovely support worker were all affected severely. Because after stating concern about what we read in the agreement, we were all targeted and threatened in some subtle and very well practiced means of emotional control, and some very overt ways.
9	A child behavioural issues can impact on other children in the house. Parents attitude towards careers
10	Delays in supports for the child
11	Grandson suffered a serious concussion on a supervised visit four months ago . No transparency by the department and when grandchildren told school, counselling, paediatrician, physiologist and family members that he did not want anymore visits due to feeling unsafe with siblings and bring hurt . Child Saftey team leader [redacted] came to our house and interviewed our 7year old grandson him for 20 minutes alone with another case worker in his bedroom. The team leader had not even meet our grandson and then said ' he wishes to continue visits . ' It appeared to all involved he had been coerced and manipulated to change his mind .
12	A safe situation for his siblings and my partner and myself.
13	The Carer is generally the one that the child confides in if trust is established with the placement. On many occasions Child Safety are already aware of the the level of trauma the child has been through. Passing some of this information to Carers would be very helpful for the Carers
14	Placement breakdown, heartache, burnout,
15	Potentially not the right fit
16	It delayed the access visit between the mother& Carer
17	Wasted time preparing and quitting work as was told child had high care needs and being messed around with CS having lack of experience and separation of indigenous siblings then being told, you can go work now
18	Safety concerns
19	The settling in process, how to approach said child, what triggers affect the child etc. More information is needed always
20	child being removed from placement because of hostile behaviour.
21	Expectation changes instantly so trying to juggle and rearrange plans. Our family not considered at all. You are expected to do whatever they want otherwise you are written up for not encouraging the child's life
22	Trauma care for kin child should have been spoken about
23	Sudden behaviours and symptoms of disability and adjusting to complex needs and finances

24	Child is shocked when CSO delivers the information in a unfriendly way and environment. CSO is a stranger to child and not aware of emotional needs
25	Child has made sexual abuse allegations against previous carers and standards of care allegations but this was not shared by child safety but by others who knew the child. This left us feeling vulnerable. As the child lies constantly in our home and we couldn't work out what was truth or fiction.
26	Behaviours were not discussed and impacted the safety and wellbeing of the other children in the home
27	Taking longer to build relationships by not having the full picture
28	The significance of neglect and trauma the children had experienced and the lack of support in place for them.
29	Children with mental health issues, self harm, BPD, drug use.
30	The level of trauma and neglect not being shared which prevented us from being able to be fully prepared and to have strategies in place. Immunisation status was not disclosed at the time of placement which meant we didnt know the child needed a catch up schedule. The CSO advised us child was due for needles, doctors then advised how far behind the child was. Not having information disclosed as new carers meant we couldnt have plans in place.
31	Child safety told me they had "very little information" about the children coming into my care. 3 year old was still in a pull up and the baby needed surgery on his penis. After we said yes, it was VERY clear, just by physically looking at the children, that they were very disabled. After a while in our care, we got told the CS had been working with this family for over a year and removed the children based on medical neglect and their significant needs not being met.
32	Trauma response is not well supported or understood
33	Heightened risk And stress
34	We weren't told that the children coming into our care had older siblings that had also been taken into care and that reunification had been unsuccessful/determined to be impossible. We were under the impression that our kiddos only required short-term care, whilst the reality of the situation was that there was a pattern of DV, alcohol and substance misuse/abuse, and neglect that would make reunification highly unlikely.
35	Parents in neighbourhood and running into each other Sexualised behaviour and house of girls
36	High risk of placement breakdown, pressure on carers/carer fatigue
37	Disruption of placement due to severe behaviours and lack of access to timely therapeutic support
38	For our family it opened old memories and sent 2 family members into deep emotional stress and physical harm. The young person now has another broken placement on file and a police report due to behaviour while in our home.
39	Many years of exhausting advocacy to try to work out best supports/get better diagnosis. Carer fatigue when issues are not transparently shared from the beginning and, as a result, adequate support can not be put in place. I think this is one of the greatest causes of placement disruption.
40	Set everyone up to fail
41	Risk of harm to other children in the household
42	A very hard 12 months of the department not listening or recording information that was provided to them. The cso pushed for reunification when the bio parents were doing the wrong thing and didn't think they'd get caught out, which they later did. Caused a lot of unnecessary stress if what I had told the CSO was taken seriously. Also team leaders were not listening to information provided and I was told to stop reporting such minor things (like animal scratches, night terrors in baby etc)
43	We could have gotten he child the help straight away and not nearly a year down the track. This put my own children and other children in my care in an unsafe environment
44	Placement breakdown and trauma on out entire family bio children also
45	Having to end placements.
46	The not knowing all information on the child and the possible problems that would be faced especially drug related
47	Higher needs child placed in home taking up most of parent time and not fitting in with family needed to be placed with older children not younger due to behaviours. Medical needs not transferred to carers of child resulting in child needing extra time that left other children with less time with carer, complex cares not discussed prior to placement.

48	Physical assaults. Property damage. Domestic violence towards household members. Multiple disability diagnoses withheld. Loss of income. Loss of social network and isolation.
49	We were not aware of some of the health issues and behaviours from utiro drug use..
50	Receiving false information has seen my family circumstances changed to try and meet the needs not advised of
51	Significant impact - the lack of record keeping within the department is shocking. Our foster child has been with them since birth (12 years) and they do not have a record of her schooling prior to the current school they are placed at, were not aware of a very serious incident with a previous carer and their biological sister which involved the police, didn't disclose a lot of information but I again dare say that is due to poor record keeping throughout the past decade.
52	understanding the traumer so we are better prepared
53	Financial burden
54	The depth and breadth of the trauma is kept from us. It negates timely support to support children and yp.
55	We had to terminate the placement as child safety was unwilling to work with us on the information that was not originally shared.
56	The placement was terminated
57	Not able to provide or source the therapies and supports child needed
58	We were not advised of court mentions or their outcomes. This made planning of day to day more difficult as ready information was confusing or opposite to previous directions.
59	We were under prepared and the child could only stay the weekend and had to be placed with another carer
60	The dangers of the mother and not sharing appropriate information about how dangerous she was.
61	Extensive stress on our family, placement instability, placement breakdown, lack of trust. Extensive lifelong difficulties for child with undiagnosed FASD.
62	Young person tried to commit suicide in our house
63	Okay when medicated, but the times around that are very hectic with no support.
64	We were not told about siblings or grandparents that require us to organise weekend contact twice a month.
65	A lot
66	Behaviours. Information with child safety regarding contact I feel the kids are kept in dark.
67	Left in the dark to work it out for our selves
68	Secual abuse was not known needed to better protect all YPs in the household
69	Breakdown of placement, putting other children at risk
70	No as we just carry on as normal
71	We spent 5 years fighting with Child Safety to get a diagnosis, plus the child was high maintenance.
72	Behaviour such as physical to other children in our care from a new child.
73	NA
74	We accepted a placement with no information regarding the bio parent previously stalking, harassing, and abusing multiple previous carers. It was months before we were made aware of the potential for allegations, stalking, harassing, etc. By that point we did not want to disrupt the child - now we've gone through 5 years of stalking, harassing, bullying, abuse, etc.
75	placement breakdown
76	Our responses to the young persons escalations would have been completely different had we known more details. The emergency placement was not able to be extended past one night as the child's needs were outside of our skill level. Our children also struggled with the behaviours of the young person and felt unsafe.
77	NA
78	It was assumed we knew the information, and the poor overworked CSO was just so busy, they didn't get the info to us.
79	As above.
80	Placement difficulties
81	Impact is that we have a child that's been born and the influence of drug and alcohol and she breastfeed but nobody is aware / not told And the baby comes back to us and screams for two days withdrawing from it

	again then to go back the next week start the round all over again.
82	Disability not told before we took placement
83	Major upsets with personality clashes with carers children Damage to property Too many children for vehicle use
84	Devastating as they were kept from talking to or seeing ne, and their youth worker left the industry!
85	The child was not catered for appropriately
86	Not suitable fit, child has to be moved again
87	Division and disruption among stable family members trying to work together to manage crisis. Decisions made that affect work arrangements, leave arrangements, financial choices to support children. The burden and poorly informed carers are under so much stress as the problems have ripple effect on their employers, friends etc
88	Untreated trauma relating to sexualised behaviors that not only impacted the child in care but other children in the house who were targeted and witnessed it.
89	setting up the house for someone else being hurt
90	Behaviours of children were not identified prior to placement
91	Placement breakdown
92	Yes, my very first placement. The child destroyed my belongings. This behaviour was known to CS but not communicated
93	Child needing more supports, can't commit to ongoing contact arrangements, medical interventions. Extra strain on the household
94	Broken down placement Psychological strain on carers Financially exhausting not being able to attend job when child is not settling or has medical or behavioral issues not been made aware of and is being sent home from daycare or school
95	Stress, lack of supports needed to ensure successful placement
96	The little one was with us for months instead of 2 days.
97	placement breakdowns
98	Sexual trauma for the child. We had another child in care at the time and would have been more aware of boundaries specifically around sharing rooms and being left alone for both children.
99	One had high temperatures and was miserable. It was very stressful. I also had a 7 month old primary placement and wasn't made aware that the boys were sick prior to saying yes to the placement. It was a miserable time. My 7 month old got sick with RSV from one of the boys and was in hospital for 4 nights. It wasnt even necessary to remove the boys at that time and they were returned to their grandmother 4 days later. It could have waited until they were both well.
100	Struggle to care for as multiple other needs in home- ended placement
101	Stress and uncertainty
102	Everyone sick. They don’t share new placement info especially if child is unwell.
103	Behaviors
104	Confusion and additional stress
105	withdrew from placement
106	We were unable to keep the placement
107	sometimes the information maybe obtained after the placement but carers are not told
108	The placement impacted my ability to keep all children in care safe.
109	n/a
110	Children have been move from different deportment every few years and information not past on and then you get blamed for there problems.
111	Not aware of all the trauma that the children had experienced
112	The reasons the children have been taken into care have sometimes been kept from us. Which can cause concerns for other children in the home. The mental state of the parents has not been taken into account when doing face to face contact putt careers in danger
113	Child safety give you no information or don't regularly contact myself. When you ask for help it never gets

	followed threw.
114	Placement break down
115	We have to relinquish care as young persons needs were far more complex than we were informed .
116	An injury and or not appropriately planning and being emotionally available for that child based on their needs
117	Not being able to work due to intense behavior causing financial stress. Change of plans and routine Behavior causing immense disruption and safety concerns
118	Placement breakdown
119	Child came into my care very sick needing a lot of hospital appointments due to heart and lungs collapse and special support to learn how to feed (new born baby). The information was available as child had been in induced coma for a month and was fed via tube, medical staff was surprised I hadn't been informed of that). It was really hard to juggle all that with my personal circumstances at the time. My own child (1yo at the time still breastfeeding) became so stressed he starting hitting his head in walls and windows. Child safety was pushing on top of that to take foster child to contact 3 times per week. I considered ending the placement then.
120	One of my boys fell in love with that child but became extremely anxious whenever she left to her grandmothers As I was unable to provide so much driving to accommodate for this I was often accused of throwing up road blocks by the grandmother and this made the grandmother dislike us this affected our relationship with the child as she was being groomed to hate us to, although none of this was our fault due to the fact that no information on such arrangements for giving to us prior only 24 hours after.
121	New placements behaviours impacting the stability of current placements
122	n/a
123	Behavioural
124	Our safety is a big thing, we have to consider all people in our home this includes the other children in care as well. We have experienced the Parents and their associates doing drive pasts yelling, swearing etc. Out the front of our home, or the threats from the Parents and or the children.
125	The placement broke down and the child did not cope
126	The time it all takes no one tells you it may go on for years. More information at the start. Not to treat carers like criminals like we were. We should be allowed to ask questions, and treat with respect.
127	The unknown. Not knowing possible risks etc
128	Other children already in care don't give the new child a fair go.
129	Unprepared for their arrival and the upheaval it can cause in a home
130	The child became frustrated and explosive ending in placement breakdown
131	Continued distress and frustration to the entire family!
132	Unknown behaviours, trauma
133	NA
134	That the children's parents and grandmother are so over the top overbearing. Hence why these children have been in care since March and we are their 6th placement.
135	Placement breakdown due to complex needs
136	Behaviours impacting other children in our care. Prolonged uncertainty and trauma for the subject child
137	Harassment from child's family, challenges with child's behaviours that were difficult to manage
138	Impact on family was the department lying again. We tried but ended in a breakdown of placement.. And if you find out something, pass it on to the department, you get told "Yes we are aware of that" Nice of them to tell us..
139	A placement breakdown. It was the child's 16th placement. This child put his defences up, rejecting us first. It was heartbreaking. With young children, I try to keep routines on a schedule and this particular day upset everyone. The after effects is the children asking for the child and their fears of moving on.
140	The child could not stay. Other children in our care were hit by the child.
141	When information isn't shared about a child's background, it can be hard to understand the difference between a regular tantrum or defiance or a trauma-based response. Ie. Not wanting a nappy change - it's a hygiene issue and it has to be done but is the tantrum or their defiance just because they don't want it done or is there a genuine fear that the carer should receive support and help mitigating with the child.

142	Placement breakdown and SOCR
143	Child's health issues meant many doctor/hospital visits impacting on time spent with other children; child stayed longer than initially accepted (8 months instead of 5 days)
144	Huge impact. Child Safety knew that the child was banned from the OSHC at her school at the time. I informed them I would need OSHC care and they failed to inform me. This caused massive stress on the placement despite me telling them if OSHC was unavailable the child would need to change schools
145	We were flustered when we collected them due to such limited informtaion so our first interactions with the ckids werent calm and wouldnt have felt safe. They had 3 days to organise the paperwork or inform us of the situation and didnt.
146	Children were at risk and young boy would find anyway to get into girls bedroom
147	It becomes a journey of discovery which can take some months to years to unveil. The child doesn't realise why you don't know and you can - without knowing it - reactivate some of the child's trauma.
148	Financial burden, emotional disruption from behaviours from child. Lack of support from Child Safety and concerns raised being ignored
149	We were not told the young person had previously stabbed someone and burnt down a home. When our support agency found out this info they didn't tell us but just removed the child from our property and took all her belongings. We were distressed and so was the child. She was not provided another placement and so had to stay with friends. We couldn't provide her any reason but she didn't believe us as her former case worker was told we said we wouldn't keep her. Finally we found out the info but when we asked for more details context and timeframes they couldn't tell us as her file notes were all jumbled and inconsistent. The child never trusted us again. She never returned to home care and was in resi care.
150	Behavioural issues. Stealing, aggression.
151	Placement caused undue stress on the family not knowing the relevant information.
152	The child was actually found to be profoundly deaf but CS wouldn't give extra supports to help keep child safe as they were always trying to escape from their cot, pram, high hair, climbing locked screen doors to get out as child was a runner.
153	The child's needs were not being met and resulted in me as the foster carer having to fight for adequate medical care and paediatric specialists
154	Not told of the high needs and disability the child has
155	Not having full disclosures about behaviour is devastating in placements..for everyone
156	We were unable to continue caring for the child. His needs were much more complex than we were told.
157	Sexualised behaviours
158	YP is left confused and misplaced. I was concerned about a particular YP but felt I had no voice. I felt shut down after reaching out to case managers.
159	Allegations
160	The child did not stay in the placement and certain needs not met.
161	Incidents happen that would not have if all info was provided and precautions were able to be put in place.
162	Aggressive behaviour to other children
163	To maintain the placement I had to change my entire schedule & much of my way of life to meet a very full schedule for the child and to accommodate complex needs. This included 7am before school program that wasn't mentioned and a history of constant absconding that I was blindsided by when it started happening.
164	Caused trauma to the children as they were moved on and to the family as the violence was scarey.
165	Child's extra needs were not addressed. Child Safety witheld reports about the needs of the child. Funding was not provided for medical treatment.
166	The child didn't like to be around other children . Continue crying. The children in our care didn't want us to take on any more children then.
167	Being a runner would have made a difference as has other children
168	Sexual abuse history. There was an incident in another carers house which I wasn't told about until there was an incident in mine. The emotional impact of this resulted in me ending the child's placement and her siblings. If I had known, I would have had a safety plan in place.
169	Devistasting
170	Foetal Alcohol Syndrome is the biggest problem. It is almost never diagnosed, discussed or revealed.

171	Placement breakdown as behaviours were more complex that we were told
172	Placements break down when challenging behaviours surface and these were not disclosed prior and endanger other children in placement.
173	child's previous behaviours in other placments such as fire lighting
174	Abuse
175	My foster daughter had to no longer live with her little brother and my biological son. He lost the only Mum and Dad he knew as his disability did not allow funding for disability support so a carer is able to work.
176	Death of an animal Triggers for child's behaviour
177	The child had aggressive behaviour and it scared my foster daughter
178	My sin stopped us from seeing our grandchildren until the young person found alternate placement. The 3nd child the s hool would not allow him to stay until medicated. His medication left him in a zombie state. I reported back to his cso as his meds were new. It was pretty horrendous. I was never told of the outcone sadly
179	Not being aware of a diagnosis
180	1. Child had no vaccinations and could not attend child care without me paying the full amount as not covered by govt funds. 2. Child arrived into care with Giardia, severe poo distribution problems and passed on to myself, causing EVERY DAY room and child clean up.
181	I was not told the child had asthma and the child had an asthma attack needing the ambulance and if I was not trained to notice the signs she could of died Several children I have received serious medical information has not been shared putting children at risk
182	The child almost died because I was not told they had asthma and the child had a full asthma attack needing ambulance
183	After 6.5years the placement is now ending, I've tried, no support, and the impacts on me personally, im traumatised, I've been a carer for 27years and I'm trying to get out, im tired or being abused by the system that I've given so much too, I'm never going to heal and I'm sad bc I love being a foster carer but I hate the abuse from agencies and CS
184	1) Placement ends sooner than later...the child moves onto another placement 2) Stress overload in the placement. 3) No match to existing family members in the foster home. 4) Unrealistic expectations put on a carer if they cannot meet what is required to care for the child. 5) Work-place & career disruption causing increased stress and problems for carers in their employment.
185	Safety for our family and the ability to look after that child properly. We had to end up that placement before the expected time.
186	Knowing about infectious diseases are extremely important as they can affect everyone who has contact with the child
187	Sexual behaviours not disclosed. Developmental delays not disclosed. Pre term baby was a big one, lucky I had experience and picked this up on day one as could have lead to complications for baby, this brought on lots of hospital appointments which in turn took time away from other children. Babies on Oxygen, The Dept really need to have this streamlined as I found I do most of the leg work as it gets done and no one in the dept know what it is they need to order to bring baby home on oxygen.
188	Placement broke down and I broke down.
189	The child was known to have confabulation issues but was not told to me. This child made statements that were horrible and untrue and this affected mine and my child's relationships with people in our community (especially school)
190	Physical violence towards myself and my family fr the child. Resulting in a placement breakdown after 2.5 years
191	N/A
192	Suspected genetic issues (Multiple personality disorders) Known effects from parents behaviours (FASD, withdrawal effects)
193	Potential impact to safety of others in care
194	More needs to be addressed.
195	The impact on our family and the child when important information has not been shared has been significant. Without knowing the child's history, emotional health, mental health, or past trauma, we have had to manage issues as they surfaced, often with little preparation. For example, one child had experienced major trauma

	in a previous placement and was unable to sleep at night because she was frightened, but we were not made aware of this until much later. Another child in our current care had 14 teeth removed before placement, and because we were not told, it took us some time to understand that many of her behaviours and discomfort were linked to pain and difficulty eating. In most cases, children have come without any formal diagnosis despite clear needs, leaving us as carers to carry the responsibility of pursuing assessments and referrals. This has been emotionally exhausting for our family, and it has delayed the children receiving the support and treatment they urgently require. The lack of upfront information undermines stability, makes it harder to build trust, and can compound the trauma the child is already carrying.
196	The word "Moderate Behaviours" used in a placement referral, is used alot. We have found that in most cases the children can be a handful to manage with little or no support in place for months. Childcare, Councilling, Therapies, Damaged Property, etc. Carers have to fight for support and funding alot of the time.
197	The child had a lot of violent tendencies that where not disclosed to us. It made keeping a calm environment difficult and concerns for the small children in our care safety.
198	Significant impact in not knowing that there were two pending criminal cases in which our child was the victim.
199	We have 3 children in care, children came with limited clothing. One child has Spastic Diplegic Cerebral Palsy with no hand over. I had to learn study to understand the young man's disability
200	ongoing behavioural issues including violence and meltdowns. Now diagnosed and medicated for several medical conditions
201	Additional stress we were not equipped to manage.
202	Infant potentially being harmed severely
203	Carer being able to fully meet the needs of the child.
204	Unsure if they knew the issues in all honesty however they do know now and don’t include all the diagnosis on paperwork
205	Dealing with high/complex needs kids when not expecting to, other children missing out on out time and attention and being exposed to acting out/violent behaviour.
206	Sibling separated
207	the method in which the care for the child is given
208	Extreme stress and sadness for the child
209	Family disruption
210	Having challenges arise that would have been easier to deal with had we known earlier and been able to prepare for.
211	Placement breakdown. Trauma to the other children in my care due to behaviours
212	A lot of hard work arguing with child safety about getting a diagnosis and speech therapy then numerous medical related visits. When I also work full time.
213	The placement was much harder and stressful at the start. We have three bio children and I’m so scared that the kids in our care will sexually abuse our children.
214	Ending up having to end placement as FASD was not disclosed
215	Child was much higher needs than was told, didnt sleep, moaned constantly, was very aggressive. My other children were scared of him, I was exhausted from not getting sleep. If he didnt have a good CSO he'd never have been moved on to a more suitable placement.
216	Risk of child's safety
217	Mistrust, difficulty with placement, family issues
218	I usually find out through the primary carer or resi worker
219	Enormous impact of death of much loved pet, the grief and stress was like a child of ours had passed away.
220	know development conditions and health issues
221	Placement went ahead and broke down due to behaviours that were not disclosed to us.
222	Person accused of something that didn't happen
223	Yes
224	In one instance the placement did not work out.

225	Outbursts of behaviours due to not having triggering information which results in physical altercations
226	Resulted in placement breakdown.
227	Placement breakdown
228	Child had sexualised behaviours. We could have prepared better.
229	It's impossible to work as a team to ensure continuity of care when we're not all on the same page.
230	We agree to take two little ones on for 3 months. A condition was they will need to attend day care. After we got them we were informed there is no birth certificates or medicare cards. Child Safety wouldn't even pay for medical visits
231	Exposing children already in placement to new violent tendencies from new placement. Not being prepared to put measures in place for the safety of all household members. Triggering a child accidentally.
232	Placement breakdown for a teen due to my inability to meet the higher needs of the child. Inappropriate feeding and routines of a baby who was much older than we were told. Incorrect treatment being followed for a child with serious burns.
233	Physical injury
234	1. Child had multiple injuries, I could not be told as it could prejudice criminal proceedings. Problems seeking respite or letting anyone handle bub. Without telling of any injuries I suspected. Unreal position! 2. Baby with suspected C.P. plus myriad of conditions. I wasn't told of C.P. the implications of which may have altered my acceptance of his placement.
235	My house hold & other children in my care were put in danger. The child did not sleep the whole night, which impacted him & his behaviours. It compromised my ability to keep everyone safe.
236	Having a child with high needs or severe trauma with no earning.
237	n/a - we are kinship carers, there was never a question that we would say no to providing care for a family member in out of home care
238	A highly traumatised child was placed in our care and we were not sufficiently prepared or trained to cope with their behaviours
239	Near an at risk person Last minute cancellation of acceptance when we found out the info from previous carer
240	not knowing trauma tiggers, not knowing behaviours,
241	Trauma responses so serious,that it ended our placement,information about the trauma would have helped tremendously
242	Placement breakdown. Inability to provide the extra necessities the children needed. On occasion putting children already in my care at risk of sexual abuse, where sexualising behaviours towards others had not been disclosed leaving others at risk.
243	We were not given the information required to prepare for the trauma induced behaviour we had to deal with. It is like pulling teeth getting information at times. Unanswered emails and no one returning calls in common and frustrating.
244	Behaviours which lead to placement breakdown
245	The young child did not receive the actual care she needed and my birth children lived in fear of this child as she was harmful to herself and others.
246	Breakdown of placement
247	Child made my (ltgo) child feel very uncomfortable and was putting him in very difficult situations, requiring an extremely high level of supervision. Child bonded with me and I with her, but she was moved to 1:1 resi where she could be better supported. No additional support was offered to my child to help him cope with her inappropriate behaviours.
248	Physical injuries to child
249	Seafood allergy. Guess what happened when the young person had seafood
250	Constantly keeping an eye out when we were out locally. Reports of harm from another carer.
251	Child has been placed with us who needed specialist care for behavioural problems which greatly impacted the home.
252	A toddler who had severe trauma from mum and was violent towards woman. We accept
253	Increased risk of safety

254	Young person was known to obscond. We were not aware until this person started over a 48 hour period. Resulting in us ending placement due to not having support from the department. Now we are under review for a suitability assessment because we didn't support this young person 🙄
255	We had to relinquish care of the child as the child's behaviours and needs were not suitable for us at the time, mainly due to the other child we had in our care at the time. It was a very difficult decision to make and we shouldn't have been put in that position.
256	I was told when I accepted placement that I would receive monthly respite and 2 weeks annually and have not received a single day of respite from child safety in over 3 years. If I knew that fact at the beginning, I would not have accepted the placement.
257	Risk of harm to other xhuldren
258	Incidents occur and lack of preparation when escalations occur to adequately support.
259	Placement breakdown and PTSD to our biological children and us.
260	Our biological children and other foster children were harmed by the child's behaviour.
261	The impact of having child in my home? Jn
262	Sexual behaviours made one of my biological children very uncomfortable and we new this but weren't told about it even though CS knew and that's why previous placement broke down.
263	Placement breakdown
264	It made it hard to know that we could 100% meet the child's needs and keep the other children safe.
265	Strained emotions, kids left not knowing what was happening, reluctance to take on other placements.
266	You feel like your family is not valued and when you struggle as you don't upstanding placement full history
267	Disrupted placement from not enough guardrails against burn out.
268	The young person in our care needs were not described with his day to day living and the help need with basic activities
269	My daughter (mother of child in my care) was not supported or informed of the reasons her child was removed from foster carer. I was assured my daughter would be provided with the appropriate support should I evict her from the home in order for me to provide care for my grandchild. The department and multiple other agencies/services referred her elsewhere. My daughter was vulnerable and ultimately seriously harmed as a result. All this took place while reunification within 12 months was the goal.
270	That the consistent disregard to the carer as the child is aboriginal and the barriers child safety impose on daily living.
271	Intense stress, severely reduced resources, relationship fractures or breakdowns, financial and housing vulnerability, exposure to violence, delayed/halted healthcare, isolation
272	We could not accept placement , as work coi
273	House under pressure. Other placements and bio kids hurt or scared. Possibly creating long term issues for these permanent children where they may never of experienced lived trauma before.
274	difficulty supporting child to the fullest. We did our best but information would have been better. We get told nearly nothing and allergies aren't always explained which is a big risk to children.
275	Complex needs with disability and trauma, lack of carer skills, lack of capacity to provide intensive care needed by child, and poor training meant that carer household unable to sustain placement, placement breakdown
276	We were not informed a child had a significant disability which then impacted our ability to provide adequate care
277	not truthful about there behaviours
278	Behaviours of children and family members can impact on foster families.
279	We were accredited for long term care and were falsely provided information about a young person who was not on long term orders and unlikely to ever be changed to long term orders. Being falsely informed. Trauma on young person.
280	Taking in placements that are too high needs for a household that already has needs which means child needs to move again - children in house have conflict etc
281	Behaviours where not identified so placed extreme pressure on household

282	They have limited information to put them in a placement that broke down and caused disruption to the child with having to move and the carer being unprepared
283	Placement breakdowns
284	Eventually the placement broke down and support was not given to the child or us as carers or family contact ever reviewed. Reunification plan was with the incorrect parent but not informed until placement was about to breakdown
285	Well the information has still not been shared after 6 years. Both through child safety and the life without barriers.
286	It was not disclosed that the children had siblings and grandparents that wanted regular contact on weekends. The impact was two weekends out of 4 we spent maintaining extended family relationships leaving no time for our own families. Especially when my partner only get two weekends a month off.
287	Lack of preparedness for issues that have arisen due to withheld or incorrect information. Absolute lack of support from child safety when problems do arise
288	Child had to leave my care as it wasn't a match
289	I was extremely anxious, I was forced to break placement as I cannot take on medical children due to my families needs.
290	Having to end placement, for the same behaviours.
291	Took on a placement that I was not able to continue leading to a placement breakdown
292	We could no longer continue the placement as the child's ADHD was that she was unmedicated and we were not told this
293	We were unable to adequately meet their medical needs appropriately which meant that their medical needs intensified when we took them into our care and they were confused as to why they all of a sudden required to be an inpatient at hospital.
294	Placement broke down
295	High. Behaviours, Playing catch up with what he needs for day to day living. He is non verbal and still does not have a communication device. His disability stroller is falling apart.
296	Inappropriate placement for the child, stress on our household, placement breakdown
297	We were not able to care for the children as well as we could have and ended up having to get child safety to cancekbthe respite with us.
298	how can we support a child if we don't have any background.
299	Challenges with bio children, advocating for interventions. Child's needs not met
300	Negative behaviours not disclosed, led to placement breakdown due to the impact on other children.
301	Initially told children had no behavioural or medical issues. Children came from previous carer who explained that had complex needs.
302	Placement was ended and the young person had to go through yet another move in their young life
303	With holding information just leads to poorer care of the kids
304	Standard of care first one in 19 years of caring
305	Children being exposed to sexualised behaviours
306	Diseases that are very easy to be picked up
307	It's gut wrenching when your putting in the effort and you just feel used
308	Absolutely exhausting and not feeling equipped to support young person.
309	The child came into our care with a major birth defect that no one, not even the nurse when we picked up the child, would disclose to us. Even when we asked, as we could see the problem.
310	Unknow medical information
311	Complex medical needs not shared. I had to give up a job and go part time to provide csre
312	On the times this has happened, we were told the child/children had no behavioural issues and that was not true. We are also aware of children leaving our placement to go to other carers where they are told the child is really 'sweet' and I have provided extensive information about behavioural concerns...I have later learned that those placements did not last long.
313	The placement broke down dramatically as the department failed to provide all the information for the family group, did not enrol them is school and therefore impacted carer working responsibilities. This negatively

	impacted the children and carers
314	Another child was harmed
315	Supports needed weren't avail for child/ family and carer
316	Disrupted placement, set up child to fail in feeling secure in placement
317	We had a child with Grp C placed in our house for a month before the child's health practitioner asked how were we going managing the risk of spread. We had 4 other children in our home as well as I have had a compromised liver prior. The stress of having to test myself and my own teenage children was huge. We were at risk as the child had split her lip at the playground and my girls helped me to comfort and control the bleeding.
318	Delays in suitable therapy Funding shortfall. Eg:CSNA WAS PAID TO PREVIOUS CARER, BUT NOT AFTER THAT PLACEMENT BROKE DOWN AND PLACED WITH ME I was unaware he was eligible
319	Child absconding, damage to property, very high level of stress placed on existing family dynamic - this has taken a long time to recover from - and willingness to continue to foster.
320	My child is non verbal and therefore I need to be able to protect my children first. By that time they have dropped off the child and were glad to see the back of the child.
321	Probably not about whether I would have accepted the placement, but it would have been appropriate to be aware in order to plan and consider. I had a time that I had a 19 month old placed with me, we are a swimming family, and we are often in the pool, we have an underwater camera, and I often take photos of the kids enjoying swim time and, at times I'd give these photos to the children's parents. This 19 month old, came to me, and we'd often be in the pool, one day, they were showing me photos of their family members and one of the children had a first name, that was the middle name of the 19 month old. Mum then told me that this child in the photo died about 2 months before this 19month old was born. The child that died, drowned in the sea. I raised this with the department that I had not been advised of this at all. The department's response was that it was not relevant. But had I have already given these parents a photo of their 19month old swimming under water - I don't doubt that it would have been very triggering, distressing and detrimenal to the parents if they had received that without warning. Knowledge is important to all parties.
322	Multiple years trying to get medical diagnosis
323	Greater risk to safety of household members and child in care and higher level of supervision and stress for cater
324	1. I couldn’t let family or others know I suspected due to criminal proceedings. Many broken bones unknown to me meant I had to handle with care and could only leave baby with very select choice for respite. 2. Another child... probable Cerebral Palsy... May have altered my decision to accept... on top of all the other problems which I was given good information.
325	Presenting behaviours and level of cognitive abilities.
326	We couldn’t take him anywhere in a car or pram as he didn’t fit.
327	Sexualising behaviours
328	Financial and emotional
329	Child has had violent behaviours and those behaviours carried into our placement. knives pulled, other children and animals threatened, school behaviours occurred.
330	Placed a 16y male who hated females and had a history of aggression and violance tiwards them puthis former carer in hospitial and I have two biological daughters who were put at risk
331	Child had been victim of sexual abuse. The service centre denied the abuse, later on down the track, the sexual abuse was confirmed & they were aware prior to placement. We would have managed our environment & care differently to accommodate the child who suffered from the abuse. We had no experience, or training of how to care for a child in this circumstance
332	Violent behavioural issues previously known but not shared. Persevered for 5 years, traumatising all of us. Child moved to therapeutic residential at the child’s insistence and when about to advocate was threatened with physical assault with a very sharp knife (not the first time). Still transitioned over a 4 week period as planned. Then discovered management regarded this as my ‘abandonment’ of said child.
333	Behaviours were not a good fit with children already settled with us and it lead to placement breakdown
334	Having to interact with and possibly supervise visits with said parent would impact my decision to take the placement. Also, being aware of the situation with dad would help me know what to look out for re behaviours with said child

335	Complex Behaviours
336	Did not know he could possibly have hepatitisC.
337	Struggled with supplying care as we were unaware of seriousness of behaviours. e.g. one child very clearly autistic, new to care and undiagnosed officially. We struggled through but would have been better prepared had we known.
338	I believe the CHILD - not DOCS.
339	I took a placement of a child with global disabilities, was not told , most children are extremely sick who need hospitalisation, no vaccinations ever,extreme behaviours
340	Not being equiped to deal with the outcome
341	The behaviours that come with the trauma disability etc not explained at placement. No support around this just left to struggle and find out as you go, which makes it very hard to continue with placement.
342	Found ourselves in a position with children with needs we had said we could not manage.
343	Placement breakdown after 1.5 years due to behaviours that could not be managed in the home - child became homeless because at 17yo Child Safety let them "fend for themselves" and child became addicted to substances
344	Violence toward my own children
345	Sexualised behaviour against other children
346	Doesn't get along with other children, has contagious illness such as HFM.
347	I am effectively estranged from the child I am supposed to be guardian for.
348	The child in our care had some fairly serious behaviours and damaged multiple beds and we received complaints from neighbours about the noise of her jumping in her room and throwing herself into the bed. She's 18 now and still does this.
349	Huge behavioural issues that are genetic. We weren't informed of the genetic issues.
350	Not being prepared for behaviours and the lack of medical history given about the child, is hard to then provide appropriate medical care.
351	created more victims and traumatised other wise normal children
352	challenges with placement and access to supports
353	Child was not offered therapies and other services they needed . One placement broke down due to this
354	Not given the right information about child
355	Not being prepared or well equipped to care, and placed other children in carer home at risk

Attachment H: Case Scenario – Carer Experience with Child Safety's Complaint Process

QFKC Note: The following carer is available to submit evidence relevant to the complaints process.

SUBMISSION FOR CHILD SAEFTY REFORM

Dated 5/12/25

I am willing to speak with you personally about anything contained within this document and other issues that I have personally experienced in my interaction with Child Safety. I am willing to take the stand on these matters.

INTRODUCTION (Background and QCAT Context)

1 I am a foster carer of 11 years, I have cared for over 35 children, and the child at the centre of this particular matter was placed with me at two days old. She remained in my full-time care for two years and two months initially. During this period, I met all her daily care needs, managed her complex medical and developmental requirements, and ensured her stability, safety, and attachment.

2 I was undergoing a foster carer re-assessment (my previous one had expired), the assessor had written "Approval recommended" on the assessment and provided it to the manager of the service centre. At this same time in November of 2023, I formally raised concerns with the Manager of said local Child Safety Service Centre about their failure to adhere to the Statement of Commitment to Foster Carers and their own legislative obligations. In my written submissions, I outlined multiple procedural failings and policy breaches by Child Safety, notifying the Manager that her staff had repeatedly failed to uphold the department's responsibilities to me in several key areas, including:

a) **Chronic non-responsiveness**, with emails, requests for clarification, and meeting requests going unanswered for weeks or months at a time.

b) **Failure to progress my long-overdue fostering approval renewal**, despite repeated follow-up by myself, my practitioner, and my agency.

c) **Breakdowns in communication across the care team**, including mixed or contradictory information provided by different staff members.
d) **Failure to provide required information**, such as updates on my renewal, clarification of decisions affecting my household, or responses to practitioner-initiated attempts to resolve concerns.
e) **Failure to work collaboratively**, contrary to Child Safety's own policy requiring respectful, timely engagement with carers as equal members of the care team.

3 These issues reflected clear departures from departmental policy, including obligations under the Statement of Commitment and the requirements for transparent communication, support, and procedural fairness to carers.

4 Once the manager received my written response documenting the service centre's failings, I am of the opinion she acted to protect herself and her staff rather than address the issues raised. Within days, she overturned the assessor's "approval recommended" (which was written on my Fostering Approval application) cancelled my fostering license, and removed my foster child from my care.

5 I immediately filed in QCAT for a stay, QCAT granted the stay, temporarily overturning Child Safety's decision while the underlying issues were investigated.

6 As part of the QCAT proceedings, Child Safety submitted a package of evidence which included documentation stating that a Standards of Care Review (SOCR) had been placed on me. I had not been notified of this in accordance with departmental policy or procedure. Instead, I was advised after hours, the night before the QCAT compulsory conference, which denied me any meaningful opportunity to respond.

7 Given I had not simply allowed my foster child to be rehomed and walked away, Child Safety was then required to justify why my license had been cancelled. It is my belief that, needing "evidence" to support her decision, the department retrospectively trawled through my file and constructed a series of Standard of Care concerns that had never been raised with me at the time, and which the Managers own earlier Statement of Reasons to QCAT confirms did not exist. This sequence of events explains why the SOC allegations suddenly appeared only after QCAT became involved, and why all of the supposed "concerns" were historical, unrecorded, and procedurally non-compliant

8 Following QCAT's stay, the SOCR process then proceeded within Child Safety. The department ultimately concluded that I had not met certain Standards of Care. I disagreed with this outcome from the outset and commenced a complaint process.

My experience of trying to resolve issues at the local service centre level – First attempt at Resolution.

1 Despite these substantial errors, the SOCR outcome letter advised that I had failed several standards. Based on the evidence available, the contradictions in Child Safety's own documentation, and the procedural breaches evident throughout the process, I maintained that the SOCR findings were **incorrect and unfair**.

2 Given this, following my concerns about the accuracy and procedural validity of the Standards of Care Review, I sought to resolve the issues at the earliest opportunity and commenced the **First-Attempt-At-Resolution (FAAR)** process with the local Child Safety service centre. These attempts are clearly documented:

a) On 30 August 2023, a representative from Queensland Foster and Kinship Care (QFKC) lodged a First Attempt at Resolution (FAAR) on my behalf with the local service centre. This FAAR raised multiple procedural concerns, including that Child Safety introduced **new and previously undisclosed information** at the SOCR outcome meeting and then deemed I had failed these new standards without providing me any opportunity to respond. The FAAR also raised concerns about **inappropriate comments regarding the child's clothing**, which were inconsistent with both the

Charter of Rights for a Child in Care and the department's *Gender and Sexual Orientation Policy*.

b) On **4 September 2023**, the local service centre acknowledged the FAAR, stating they needed to obtain a clear outline from senior staff about which standards were said to be "not met" and the rationale behind each finding. This confirmed that as of early September, **even Child Safety did not have a clear rationale documented**.

c) On **5 September 2023**, QFKC informed the service centre that both they and the Child Safety Officer had taken notes during the SOCR outcome meeting, and they were awaiting clarification because there was **still confusion regarding the outcome.**

d) On **19 September 2023**, the local service centre emailed QFKC to say they were *"still progressing the matter"* and would soon *"confirm the specifics of the standards not met and the reasons."* They also indicated they were considering the feedback from QFKC. However, **no such information was ever provided**.

e) From that point onwards, **no further response** was provided by the service centre regarding:

   i. the rationale for each standard alleged to be not met,
   ii. clarification of the SOCR outcome,
   iii. concerns raised about procedural breaches,
   iv. concerns about inappropriate gender-based comments,
   v. or the fact that I was not given the opportunity to respond to the concerns.

f) On **15 November 2023**, during a scheduled home visit, the ASQ practitioner formally requested that Child Safety provide a written explanation of **why each standard was considered not met**, because it was unclear what actual behaviour was believed to have failed each standard.

The Child Safety Officer stated it was "not usual practice" to provide this information.

g) Later that same day, on **15 November 2023**, QFKC sent a further written request seeking clarification about the SOCR findings. No clarification was ever provided.

h) On **16 November 2023**, I received a letter by email stating which standards were allegedly "not met." However:
   i. the letter had been dated **31 August 2023**,
   ii. it was not provided to me until **10 weeks later**,
   iii. and it **did not include any rationale**, only the list of standards.

3 Given that the local service centre never provided any outcome to the FAAR, never provided the promised rationale, and did not respond to repeated requests for clarification, I escalated the matter to the regional complaints team as the next required step.

My experience of escalation to the Complaints Unit.

1 Because the local Child Safety service centre did not respond to the First Attempt at Resolution (FAAR) lodged on 30 August 2023, I escalated the matter to the regional Complaints Unit (South East Region) in early 2024. My experience attempting to resolve the issues through the Complaints Unit reveals further systemic barriers, inconsistency with departmental policy, and a lack of procedural fairness.

2 On **30 April 2024**, I submitted a detailed written complaint about the Standards of Care Review process. The Complaints Unit responded stating they would not accept the complaint because it was "too long" and must be reduced to two pages. This "two-page limit" was presented as if it were an established departmental requirement. I asked the Complaints Unit to provide the policy that required complaints to be restricted to two pages. They were unable to provide any such policy because no such rule exists.

3 After I requested policy evidence, the Complaints Unit changed its justification and stated the two-page restriction was related to the department's **Unreasonable Client Conduct** (UCC) framework. This was inappropriate and incorrect because:

a) I had not engaged in any unreasonable conduct
b) My complaint was factual, structured, and directly related to the SOCR
c) The UCC framework **does not impose a two-page limit**
d) The UCC factsheet does not state that complaints must be shortened or restricted in this way

The insistence on a two-page limit:

e) prevented me from submitting essential evidence
f) minimised critical procedural breaches
g) delayed the acceptance of my complaint
h) created unnecessary administrative burden
i) resulted in a **two-month delay** between initiation and acceptance of my concerns
j) demonstrated that the Complaints Unit was focused on restricting the content rather than addressing it

4 After repeated requests, and in order to progress the matter at all, I created a shortened six-page version of my complaint (still above the arbitrary two-page limit, because it was impossible to condense my concerns further without omitting material facts). On **19 June 2024**, the Complaints Unit finally accepted this shortened version.

5 The refusal to accept the original submission acted as a barrier to fair review This experience illustrated significant systemic barriers within the Complaints Unit, including:

a) **Lack of transparency:** They could not cite any policy supporting the restriction they imposed.
b) **Inconsistency:** The justification shifted when challenged.
c) **Misuse of UCC frameworks:** The UCC factsheet was referenced inappropriately to justify limiting my ability to present evidence.
d) **Procedural obstruction:** The outcome was delayed and the process made considerably more difficult.

e) **Failure to support carers:** Instead of assisting in resolving serious concerns about departmental conduct, the Complaints Unit's actions served to **prevent** the complaint from being heard.

6 My experience demonstrates that the Complaints Unit's process is not an accessible or reliable escalation avenue for carers. Instead of providing clarity, transparency, or fairness, the process created additional barriers and caused significant delay, leaving the original issues unaddressed for an extended period.

7 When I escalated my concerns to the Complaints Unit, I submitted 11 separate and clearly-defined reasons for why the Standards of Care Review (SOCR) outcome and process required review. These 11 reasons are documented in my original complaint and include procedural breaches, factual inaccuracies, human rights concerns, and failures to follow mandatory policy. I also submitted a list of "outcomes sought" as per policy.

8 However when the complaints unit investigated they listed only 2 allegations they would investigate, and sought my response that this covered all my issues. I obviously advised it did not and again I advised of my 11 raised allegations I wanted investigated. Child Safety only agreed to investigate one more

9 No matter how the department framed it, these three "allegations" did not reflect the full scope of the 11 reasons I submitted. Even when I told them that their list of allegations was incomplete and inaccurate , they still only added one additional issue and continued with an investigation based solely on their chosen allegations.

10 In total, the outcome letter addressed only 5 of the 11 points. The remaining six concerns were ignored entirely. All of these concerns were part of my documented request for review, yet **none were responded to at all** in the outcome letter.

11 Of the allegations Child Safety chose to investigate and respond to, a number of their findings were inaccurate and failed to properly consider the information I had supplied. In several instances, the responses appeared written in a way that avoided

acknowledging clear procedural failings and serious wrongdoing. Specifically:

a) The department based its findings solely on the CSO's account regarding the alleged breach of my human rights, while disregarding my version of events. Unsurprisingly, the CSO denied disclosing my personal information to an unauthorised person. However, the only reason I became aware of the disclosure is because that person spoke to me directly to inform me. Had this not happened, I never would have known the breach occurred.

12 This creates an inherent and unavoidable conflict of interest: a Child Safety employee denies wrongdoing, and the same organisation then investigates its own staff member and accepts her account. To acknowledge the truth would require the department to admit it had breached human rights legislation and its own privacy obligations.

13 I alleged that Child Safety failed to adhere to Policy 326-10, Responding to Concerns about the Standards of Care, particularly regarding the requirement to notify me of concerns. In the outcome to SOCR complaint letter dated 5 August 2024, Child Safety stated:

> *"There is insufficient information to indicate that the department did not follow policies and procedures in how you were notified of the SOC-R."*

14 This finding is grossly inaccurate. Pages 5–12 of my original complaint submitted on 29 April 2024 contain clear, detailed and verifiable evidence demonstrating that the department did not follow policy or procedure in notifying me of the SOC issues.

15 Policy 326-10 also requires that carers be afforded the opportunity to respond to all information presented. In the same outcome letter dated 5 August 2024, the department acknowledged:

> *"Records indicate you were not provided with all the concerns pertaining to the decision to raise a SOC-R… and therefore you did not have an opportunity to fully respond to all the concerns."*

Despite this clear admission that procedural fairness was not afforded, Child Safety then advised:

"No further action will be taken in regard to this allegation."

16 This is wholly unjustifiable. Child Safety has acknowledged that it failed to follow policy, failed to provide procedural fairness, failed to notify me of concerns, and failed to give me any opportunity to respond prior to determining that I had 'failed' Standards of Care. Yet despite my reasonable request for the SOCR process to be re-conducted—this time allowing me the opportunity to respond—the department refused.

17 An organisation cannot make findings against a carer while withholding the concerns, denying the carer the right to respond, basing its decision solely on internal staff views rather than facts, and then declare that no corrective action will be taken. This process is neither fair, nor consistent with departmental policy or natural justice.

18 By failing to address all allegations, the Complaints Unit:

b) narrowed the scope of the investigation
c) avoided addressing serious procedural breaches
d) minimised evidence I submitted
e) created a flawed and incomplete investigation outcome

This directly undermined accountability, issues such as contradictory evidence, misuse of information about other children, and policy breaches were simply left unaddressed — allowing systemic problems to remain hidden.

19 Most concerning is what I later discovered through documents released under FOI. In relation to allegations 1.1 and 1.2, the internal practice reviewer explicitly stated:

"I am of the view a standard-not-met outcome is unable to be established for this concern."

"Care team to reassess the concerns raised about (wearing boys' clothing) to

reconsider if it meets threshold for inclusion in the SOC review."

20 Despite these formal findings, the service centre refused to implement the reviewer's recommendations and failed to advise me of them, even though they directly undermined the basis upon which the Standards of Care findings were made.

21 As a result, I continued—without any knowledge of these findings—to fight to demonstrate that the SOC outcomes were inaccurate, unsupported and, in my belief, constructed during the QCAT process. The FOI material confirmed that internal departmental reviewers had already identified the same issues I had been raising, yet nothing was corrected, amended or disclosed to me.

Request for Internal Review

1 Following the outcome letter dated 5 August 2024, I remained dissatisfied with both the process and the substance of the investigation. The decision failed to address the majority of the concerns I raised, and the Complaints Unit provided no meaningful response to the outcomes I reasonably sought. As a result, I lodged a formal Internal Review Request on 9 August 2024, in accordance with departmental procedure.

2 I requested the internal review for the following reasons.

A. *The Complaints Unit addressed only 5 of my 11 concerns*

The outcome letter responded to only **five** of the issues I raised (Points 1, 2, 3, 10, and 11), and completely ignored **Points 4, 5, 6, 7, 8 and 9** — despite these points being core to the procedural failures I identified. This omission alone demonstrated that the investigation had been incomplete, selective, and procedurally unfair.

B. *No response was provided to the recourse I sought*

In my original complaint, I clearly set out the **recourse sought**, as required under the Complaints Management Procedure. **yet I received no response to this at all."** Despite raising specific and reasonable outcomes, such as:

I. requesting a clear explanation for each Standard of Care finding,
II. asking for procedural breaches to be acknowledged and addressed,
III. seeking appropriate corrective action,
IV. and requesting that inaccurate or improperly handled information be reviewed and amended,

None of these were addressed in the 5 August outcome letter. The department simply **ignored** the outcomes I sought, which is contrary to their stated requirements for complaint handling.

C. *The Complaints Unit reframed my concerns into only three allegations*

This created an investigation that only assessed what the department chose to examine, not what I had actually raised. This was a fundamental flaw in the integrity of the process.

D. *The responses they gave were internally inconsistent or contradictory*

For example:

a) They acknowledged I was **not afforded the opportunity to respond** to all concerns — yet they concluded "no further action" was required.
b) They apologised for failing to provide clarity about the SOCR outcome — but again concluded "no further action."
c) They acknowledged the clothing issue was handled incorrectly — yet declined to amend the SOCR outcome or remove incorrect information.
d) The department consistently responded with "there is insufficient information to indicate the department has breached …policy" despite my submission with clear, articulate sufficient evidence.

E. *The Practice Review identified recommendations — but the Complaints Unit told me no further action would be taken*

The Complaints Unit's outcome letter stated that **"no further action will be taken."** However, documentation obtained under FOI shows the Practice Review **did** make recommendations, — contradicting what the Complaints Unit told me.

F. *The Complaints Unit gave incorrect or misleading statements about policy*

compliance

3 For these reasons, I lodged an internal review request stating clearly that the process was inadequate, incomplete, and failed to meet the departmental complaints standards.

4 The internal review of the complaint outcome was undertaken by a Senior Leader in the department, and the outcome was issued on 8 October 2024.

5 The internal review, however, did not remedy the core deficits and in several ways repeated the same mistakes, including: Continuing to investigate only the three allegations the department chose Despite being explicitly informed that six of my original concerns had been ignored, the internal review did not expand the scope to include them. It assessed only the three original allegations created by the Complaints Unit:

a) Rationale not provided
b) Charter of Rights breach
c) Disclosure of private information

This meant that Points **4, 5, 6, 7, 8, and 9** still **received no review at all**.

6 Failure to address recourse sought — again

The internal review outcome letter did **not address** my recourse sought. There was no comment on:

a) acknowledging procedural failures
b) amending the SOCR outcome
c) ensuring compliance with policy for future carers

The review outcome simply stated that "no further action" was required. This was despite the fact that, through FOI, I had obtained documents confirming that:

*"The Practice Review identified (carer de-identified) was **not afforded the right to provide information or an explanation prior to this date** [the SOC outcome meeting],*

*and it appeared departmental staff had **already made their decision on the issue**."*

6 ***Continued inconsistencies with the Practice Review findings***

The internal review affirmed the Complaints Unit's decision, despite: the Practice Review recommending corrective actions

7 ***Failure to examine the procedural breaches under Policy 326-10***

Despite the extensive evidence I provided, the internal review did not address:

a) late reporting (up to 820 days)
b) failure to document concerns at the time
c) failure to notify me of concerns
d) failure to provide me the opportunity to respond
e) improper use of information relating to other children
f) misapplication of developmental considerations under s.122 Child Protection Act

8 ***Failure to recognise the systemic impact***

The internal review failed to acknowledge that procedural errors by Child Safety:

a) influenced the SOCR outcome,
b) influenced QCAT evidence,
c) and contributed to the wrongful removal of a child who had been in my full-time care since two days old.

9 ***FOI documents show that internal reviewers recommended overturning parts of the SOCR findings — but this was withheld from me***

In my submission to the Ombudsman, I noted:

"I sought information through the Freedom of Information Act and found documentation stating that some of the outcomes should be overturned. This was not written into the outcome letter despite Child Safety knowing this information and having a duty to disclose it."

The FOI bundle confirmed recommendations that further action **should** have been taken

a) The internal reviewer noted that **some allegations could not be substantiated**, yet the official findings letter omitted these corrections entirely.

b) The reviewer also noted that **important recommendations from the Practice Review had not been actioned** and should have been communicated to me. Again, the outcome letter failed to disclose this.

c) The FOI brief explicitly acknowledges:

   a. *"…the findings letter advised Charlotte no further action is required, when in fact further action was recommended by the Senior Practitioner…"*

This is direct evidence that Child Safety **withheld substantive review findings from me**.

10 ***The official letter used a generic clause to avoid addressing my specific concerns***

The outcome letter states:

"The complaints process is not one that apportions blame, but seeks ways for ongoing service delivery improvement…"

(8 Oct 2024 Outcome Letter)

This clause was used to avoid answering:

a) My detailed evidence
b) The 11 specific grounds for review
c) My "outcome sought" questions
d) The procedural fairness breaches I identified
e) The introduction of new allegations without right of reply
f) The incorrect application of SOC policy
g) Their misuse of the "two page rule" which FOI confirms has no policy basis

The FOI documents contradict this justification and shows that the reviewer *did* identify blameworthy actions — and then these findings were simply **not disclosed** to me.

The FOI internal complaint brief states:

a) The SOCR was a "point in time assessment" yet was used as a major justification against me.
b) The Practice Review found **significant issues** in the SOCR and complaints handling.

c) These issues were known internally, but the official outcome letter concealed them.

The evidence reveals a pattern:

a) **Errors are acknowledged internally**

b) **But denied externally**

c) **And harmful conclusions are allowed to stand**

13 The Practice Review expressly recommended that the concerns be **reassessed**, noting that the threshold had not been met. However, the Manager of the Child Safety Service Centre informed me that it was "not suitable" to reassess the concerns. This refusal ensured that the original, flawed SOC findings remained in place.

Attempts to Have the Complaint Outcomes Reviewed by the Ombudsman

1 After exhausting all internal Child Safety avenues—including the First Attempt at Resolution, the Complaints Unit investigation, and the Internal Review—I lodged a formal complaint with the Queensland Ombudsman, as advised in the department's own correspondence.

2 This escalation was necessary because:

a) the Complaints Unit failed to address most of my concerns,

b) the internal review outcome did not reflect the reviewer's own findings,

c) FOI material revealed withheld information and contradictions, and

d) the unresolved issues affected the stability and wellbeing of a child with significant disabilities

3 My experience with the Ombudsman revealed further systemic failures in the external oversight pathway.

4 On 4 April 2025 I submitted a detailed complaint to the Ombudsman, supported by FOI documents showing that:

a) Child Safety knew several SOC findings were incorrect,
b) internal reviewers believed some findings could not be substantiated,
c) recommended amendments were omitted from the official outcome letter, and
d) the department told me "no further action" while internally acknowledging further action was required.

5 The Ombudsman relied solely on the department's statements, even where:
a) the internal review letter contradicted the reviewer's verbal comments, and
b) FOI material showed internal reviewers reached different conclusions.

6 The Ombudsman advised they **cannot overturn Child Safety decisions**, amend SOC findings, or compel the department to correct inaccuracies—even when departmental records show the findings are unsustainable. As a result, the Ombudsman could not require Child Safety to rectify a "Standard Not Met" outcome that their own reviewer found could not be established.

7 This means Child Safety can provide incomplete or misleading information to an oversight body without challenge, because there is no mechanism for independent scrutiny of departmental evidence or decision-making.

8 The Ombudsman's outcome confirms that carers have no effective external avenue to resolve serious concerns regarding:
a. SOC processes,
b. procedural fairness,
c. the handling of internal complaints,
d. the integrity of internal review findings, and
e. harm caused by incorrect or unsupported departmental decisions.

Even when FOI documents reveal significant administrative failures, there is no pathway for correction.

9 No correction, no accountability, no resolution

Despite clear procedural breaches, inconsistencies between the SOC outcome and FOI evidence, failures to follow policy 326–10, and denial of procedural fairness, the Ombudsman advised they could not question or overturn Child Safety's decisions. This left me with:

a) inaccurate SOC findings on record,
b) an internal review outcome that did not reflect the reviewer's actual findings,
c) withheld and contradicting information, and
d) no external remedy.

Time Taken from Local Resolution Attempts to the Ombudsman Outcome

1 The full process—from the moment I attempted to resolve the matter at the local Child Safety service centre level to the point where the Ombudsman provided its final position—took **approximately 22 months**.

2 The timeline below demonstrates the extent of the delays, the systemic barriers at each stage, and how each step prolonged the process despite my attempts to resolve the matter promptly and through the correct channels.

30 Aug 2023 – *First Attempt at Resolution submitted to the local Child Safety office* (email from QFKC on your behalf)

30 Aug–19 Sep 2023 – *No response* from the local service centre despite follow-ups.

16 Nov 2023 – SOC outcome letter finally emailed to me (dated incorrectly as 31 Aug)

— 137 days outside policy timeframes.

15 Oct 2023 – 2024 – You submit the SOCR review request

26 June 2024 – You lodge your formal complaint to SER Complaints.

July 2024 – *SER Complaints refuses to accept your complaint,*
5 Aug 2024 – SER issues a flawed "outcome" looking only at 3 of your 11 allegations.

Sept 2024 – You lodge the Internal Review request (11.4).

8 Oct 2024 – Internal review outcome issued (11.5) — fails to address your evidence and contradicts what the reviewer told you verbally.

Nov 2024 – FOI release confirms the internal reviewer wrote:

"I am of the view a 'Standard Not Met' outcome is unable to be established."

Apr 2025 – Ombudsman submission lodge

18 July 2025 – Ombudsman outcome issued:

– Decides **not** to take further action.

– States they "cannot overturn departmental decisions" and can only make suggestions.

– States they are **not qualified** to judge carer performance or Standards of Care findings, so they defer to Child Safety's "beliefs".

– Confirms they cannot compel Child Safety to correct the record, even when the FOI reviewer wrote the SOC should not be substantiated.

This timeline highlights the **extreme length**, **lack of accessibility**, and **absence of meaningful oversight** in Child Safety's complaints pathways.

3. The system is designed to wear carers down. To pursue this matter, I had to:

a) spend hundreds of hours writing multiple detailed submissions,
b) produce timelines,
c) collate evidence,
d) engage in FOI processes,
e) challenge procedural barriers,
f) and persist through 22 months of delays.

The system is clearly designed to exhaust carers, not support them. A carer dealing with trauma, grief, or multiple children—especially children with disabilities—would not have the capacity to sustain this level of effort.

The barriers are so significant that the complaint process is essentially **unusable** for the majority of carers.

4. The process does not resolve anything — it reinforces departmental power. After 22 months, the outcome was:

a) no correction of the SOCR,
b) no acknowledgement of wrongdoing,

c) no action taken on internal reviewer findings,
d) no accountability for policy breaches,
e) no remedy from the Ombudsman,
f) and the original flawed SOCR remaining on record.

CONCLUSION

My experience over nearly two years reveals a Child Safety complaints framework that is structurally incapable of delivering fairness, accuracy, or accountability. At each stage—local resolution, the Complaints Unit, internal review, and external oversight—the system operated not as a mechanism for correcting errors, but as a protective barrier shielding the department from scrutiny. Procedural breaches were left unaddressed, evidence was selectively considered or withheld, and internal findings acknowledging errors were concealed. Even formally documented contradictions within Child Safety's own records resulted in no corrective action.

The Complaints Unit accepted only a fraction of the concerns raised, reframed issues to minimise scrutiny, and issued outcomes that did not reflect the evidence provided or the findings of its own internal reviewer. When escalated, the internal review repeated the same omissions, upheld decisions that internal documentation showed could not be substantiated and failed to address the procedural unfairness that had materially influenced outcomes—including information withheld, concerns introduced without notification, and extensive policy breaches under Procedure 326-10. The review process functioned less as an independent check and more as a mechanism for preserving the department's original position

The external oversight pathway offered no remedy. Despite FOI material confirming that key SOC findings lacked evidentiary basis, that procedural fairness had not been afforded, and that internal reviewers recommended corrective action, the Ombudsman advised that they have no power to amend inaccurate records, overturn departmental findings, or compel Child Safety to take action. As a result, even demonstrably flawed decisions—and the harm they cause to carers, children, and the integrity of the system—remain permanently on record without any avenue for rectification.

What my case ultimately demonstrates is not an individual failure but a systemic one: Child Safety's complaints process does not function as a safeguard, does not uphold natural justice, and does not provide a credible or independent means of reviewing departmental actions. Carers cannot rely on the system to correct errors, ensure transparency, or protect the wellbeing of the children in their care. Without an external body empowered to review and address administrative wrongdoing, flawed decisions remain unchallenged, and those affected are left without remedy.

Meaningful reform requires the establishment of a genuinely independent external review body with the authority to examine evidence, compel departmental action, and correct inaccurate or procedurally unsafe decisions. Without such reform, the complaints process will continue to operate as a closed system—opaque, self-protective, and incapable of delivering the integrity and accountability that Queensland's children, families, and carers deserve.

Yours
Sincerely,
Foster Carer

Attachment I: Lived Experience Survey – Question 29 Open Question

Question: Are there other challenges carers face?

Answered: 375 Skipped: 298

#	Responses
1	Child safety not listening to carers and instead listening to family members
2	If we do question decisions, try to advocate for our children, or (heaven forbid) stand up for ourselves - we are treated badly, bullied, ignored, or - threatened to have our children removed from our care. We are belittled and called "carers" when our kids see us as parents, and we are reminded we are just "placements" not homes. So hard for these kids who need to belong. Words matter.
3	CSO, expressing personal preferences as to the care of children in care. CSO, accusations without out background knowledge of the entire situation. CSO, taking on the children's parents views and statements as the truth without speaking to the carers or the children involved.
4	That privacy is breached and my safety is put at risk
5	Yes. In Far North QLD as carers we have collectively been put through what most would consider absolute hell if we care deeply enough for our kids to fight for their rights. It's sad that it became overpowered by such cold blooded people who it's clear are not even basic good human beings if they put kids and carers through hell, just to keep the upper hand or to work the funding system. It's common knowledge here, many of us have shared our stories with each other and the community. Yes the system is broken, we all know that but Its more often than not, individual senior staff who create challenges for us, and it dribbles down the crony line. If there's no basis empathy in the human services, human staff there's a big problem.
6	Insufficient respite carers, lack of information regarding the legal progress and orders.
7	Constant changes to what we have been told regarding court, a parent and/or contact with a parent.
8	Departmental barriers, (lack of signed consent), for urgent medical and dental treatments .lack of approval for funding or consent for urgent dental surgery Departmental delays in consenting to school based trips camps(9 months wait) in my case. Not provided with copies of AUTHORITY TO CARE (for several months now) Not provided with what court order the children are currently even under or the duration of. Not being replied to when requesting the above. Emails not responded to. Child safety staff frequently unavailable to respond via phone, always too busy to take your call. Never return your phone calls. Ect
9	For us travel distant for contact visits
10	Lack of Communication and no Mediation with Child Safety. Duty of Care on the Departments side is very slack. There is definitely not enough Mediation with Carers to Advocate for the Child's best interest.
11	Dealing with natural parents who can be upset/ angry, changing holiday plans at the last minute because a natural parents withdraws permission the day before. Working around contact so that you cannot go anywhere for the weekend or a few days if it interferes with contact. Haircuts, trying to maintain culturally appropriate living for the child, having to get forms filled out for camps etc (although this has been better lately)
12	Not having information shared. Behaviour management after contact with parents..
13	Dealing with the behaviour after contact and what parents can get away with during contact with no consequence
14	-Being told one thing then finding out what was really said -lack of experienced CSO -feeling not respected or heard -I don't see a change from the stolen generation as my nephews have been separated and should have been placed together
15	Burnout. No support. Hardly any respite carers to offer respite. Promised everything from CS and all are lies

16	Initial outlay to have child
17	Living in rural areas, the cost of travel with the lack of public transport. We can travel up to 5 hundred kilometres in a week.
18	Trying to juggle life with own family and meet the constant changes cso ask. Getting permission all the time to take child when in their eyes you are their family.
19	difficulty in accessing CSOs to get updates on my foster nephews
20	This is probably slightly different for me as a kinship carer. But I have had incredible support with Uniting Care. Sometimes we've had issues with Child Safety with the change over of CSO's. And they are a little harder to reach but overall I have been so lucky with my teams as they are always available in some shape or form Again, especially Uniting Care.
21	Financial support when a child comes into your care if they are on interim orders which can drag on for months and the child is in your care you are not paid the establishment payment until the order is made of short term etc, you have the child but not entitled to the establishment payment which limits your setting up the child
22	Their own personal lives appointments, special occasions, social lives ect
23	Just no respect to carers by cso or manager or agency
24	Isolation as no one understands what this is like not knowing the future for the child
25	Changing CSO's who do not communicate with carers or show appreciation or respect.
26	Expectations of new CSO's not being met leading to tension - such as 'facilitating family contact'
27	Harrassment from biological parents
28	Too much child safety involvement for kin carers.
29	Long term placements - feeling a constant sense of instability, not knowing what's around the corner. Child safety not sharing information.
30	Not enough focus on reducing carer burnout with respite support easily accessible.
31	Not getting enough information or sometimes any has left me in dangerous situations with a child
32	Having ATC's expire resulting in loss of CCS approval and not being able to organise doctors appointments due to this
33	The lack of communication between CS and carers. CS regularly make plans to visit - visits dont eventuate with no advice/apology or rescheduling via phone/text/email. I have regularly rescheduled appointments to facilitate being available for CS (at their request) only to have them not show and not offer any explanation or provide a courtesy call. Hours wasted. I would lose my job if I treated my customers the way I am treated by the CS department. My obligations and rights regarding contact visit transport and expectations has never been explained to me. We are still waiting for confirmation that our kinship application has been approved by the court despite it being accepted months ago meanwhile this means no financial assistance via kinship payments and no sign of the petrol and fuel vouchers we were promised months ago. This battle for formal recognition has gone on for over 12 months. We have received no financial assistance yet both parents- neither of whom are considered willing nor capable to care for their child are in receipt of full government benefits and the associated benefits. Our Granddaughter was removed from their care due to dependency and DV issues - she lives with the trauma of this DV every day yet the system thinks it is beneficial that she visit with the people who subjected her to this trauma every week leaving us to deal with the fallout. Her bio parents contribute nothing financially, physically or emotionally yet their rights are parents are put ahead of what is actually best for her every single time because the system has to show due respect the parents rights even though they are the root cause of the problem. There is no clear explanation of the "process" in simple English. CS just expect you to know everything just because they do. Imagine having a serious illness and being expected to know everything simply because you've havd a diagnosis. That's what dealing with CS is like. They pigeon hole you and then assume you know the process and legalities. My sister fosters and gets so much financial support with various benefits and entitlements yet we care full-time for our grandchild and get nothing until CS decide we are worthy. We have spent over 20k in the past 12 months providing for our grandchild and that doesn't include the fact we had to update our car to something more appropriate for a family rather than a couple. I consider myself fairly intelligent. I am digitally savvy. I work in a sector that is heavily regulated by the government and various other non government bodies and I cannot make any sense of this system despite hours and hours and hours of doing my best to unravel the mystery.
34	Lack of support program around speaking with others/counsellors/psychologists who are foster/kinship carers. Lack of knowledge of supports that are available - psychological, emotional and financial, including Centrelink and Medicare

35	Home visits are tedious, unnecessary and negative impact our daily lives, especially in regards to extracurricular activities and/or quality family time
36	Lack of support
37	Support for challenging behaviours in the school system, including suspension, and how this impacts sustainability of placement
38	Yes. Inadequate support from their placement support agency
39	Carer Burnout Social Isolation & Relationship Breakdown
40	Needless paperwork and visits. There should be a system where once you have been a proven carer with a good record for so many years, you only need to complete registration renewal every 5 years, and bi-monthly home visits etc. Another significant challenge is when legislation and practices which are designed to minimise the trauma of a child being in the system are not followed - eg repeated short term orders which expose both the child and carer family to ongoing, lengthy placement insecurity and and inability to make long term decisions or plans, instead of following legislated time period caps of two years maximum for short term orders, then a child should be placed on a permanency plan. Its not fair to the child or the carer family to keep them in limbo for years, sometimes indefinitely. The legislation has been changed for a reason.
41	The constant need to fight for the children in our care… for financial assistance to meet their extra needs… to have decisions made that are child focused…for the children on long term orders to be able to live a relatively “normal” childhood with decisions made reflecting this
42	Processes for things are too slow. Like asking for time away. Help with paying expenses when things unexpectedly pop up - like seeking help for behavioural issues or when a child needs glasses and the department takes 12+ weeks to pay the provider
43	Being lied about and having or integrity, loyalty, honesty and everything else questioned
44	Not having the right supports.
45	Yes many , feeling like child safety have no respect for you and your family having a life and making decisions about family contact without consulting me if it's ok , just changing days and times whenever they please with no consideration to the children's life and what they want to do , extra curricular activities are affected.
46	Too many to list. Lack of respite and respect to name 2.
47	Child's care needs are not the centre of the action being taken, it is the perceptions and needs of others that have more influence. Avenues like QCAT create additional complexities and an unwillingness from Child Safety to provide interventions that enable consistency and calm for the child.
48	No one listens, no timely action on issues raised (grandchild sexually assaulted while in residential care) Treated like we as career’s are the problem red tape in access and decisions regarding the welfare of grandchild. Lack of access to supportbseevices
49	The amount of CSO pone has to deal with. Staff constantly leaving/moved to other areas etc
50	child destroys property and there are no consequences allowed by child safety
51	Feeling like a criminal asking for finance and documents for children
52	Just the unknown of any information from child safety, it's been really hard to not get support and told they gonna do something and it dosn't happen then falls back to more on my plate as a carer to follow up on or try to get apps and referrals for myself... Constant emails with no replys
53	Shortage of respite carers
54	Sheer volume of meetings and visits. I really wish some of them could be virtual.
55	total lack 9f communication from docs
56	Inconsistency Inability to get loans eg larger car because payment is not taxable Lack of financial security eg superannuation in retirement due to lost work opportunities due to to
57	Financial assistance difficulties
58	Sometimes there a lack of support for children with special and complex needs
59	No genuine avenues to address SOC's. Etc, disbelieved, considered as volunteer accommodation, an old culture of power imbalance, CSO's TL's backing each other up to the detriment of Care's and extremely so for the children. misunderstanding Best Interests of Child and placing undue weight (when suits their purpose) to "the voice of the child" without being tempered by adult thinking
60	Child safety unwillingness to compromise, work with carers, and never having the ability to take accountability for their short comings. A lot of the workers for Child Safety feel they have power and

	they use that in a non positive and productive way. Each CSO and/or office have their own set of rules and will make it up as they go.
61	Inconsistency, c.so. communication. Lack of support. High needs being ignored
62	Inconsistent CSO/Team Leaders who seem to not bother reading our case file, ignoring previous descions because they weren't there, new team-new broom-new case-start from beginning mentality.
63	CSO and Manager personality resulting in improper communication and record keeping. Also how the child feels about the contact they have with the CSO leading them to feel threatened.
64	The reality is we are last on the consideration list. Parents first, child second and carers last.
65	Meeting all the demands and always doing the right thing, but the mother not doing the right thing and is not punished for it
66	Decisions made without consultation with the carer. Financial costs and how it is difficult to "feel like a family" when there are so many rules.
67	Lack of recognition and adequate supports for the brain injury that occurs due to prenatal drug and alcohol exposure. These are not 'behavioural' challenges. This is lifelong neurological damage which requires intensive LIFELONG support and intervention. These kids do well when given the correct diagnosis and supports. Without recognition they go through multiple placement breakdowns which is devastating for the child and the families who desperately want to help them.
68	Carers are not valued. Also your questions are misguided. Just because a CSO can do things does not mean they do. In my experience the CSO treated me (the carer) as a means to an end. We could take a child, they had one. When we asked for help and support it ws denied. When we took steps to seek professional help for the young person we were told that we were not the legal guardians and had no rights making appointments without the CSO's approval. After 8 months of no meaningful action and support from the CSO, the young child attempted suicide. How this can be allowed to occur is beyond me
69	Exhaustion. Lack of respite care has been a major cause in placement breakdown.
70	No superannuation due to the inability to work, no income constant calls from the school saying pick up the child, weekly therapy appointments, home visits, family time visits etc. it's a full time job just being a foster carer, you can't have a career or social life. Friends and family rarely visit and you are not welcome at their house due to children's behaviours.
71	Communication is poor at times with child safety Not getting answers at times from senior team leader
72	Having children placed full time in your care and then having children pressured to see previous carers
73	When CSO do not share information and act as the carers are the enemy
74	Cultural values, connection and family contact are not often or encouraged by the Department
75	Expectations from Child Safety are beyond the volunteer capacity
76	Family pressure
77	Too many children placed with families who are already at capacity with their biological children. My son and his partner have 6 biological children and live in a 4 bedroom house
78	Na
79	The system is designed for bio parents to have control, which is normally fine - but there is an occassion where bio parents should not have control and use the system to abuse and coerce everyone around them. Our little one was abused because of the system and by the system for years while we advocated for her, all in the name of "evidence". Bio mum continues to use the court system to wield control and power. So, while I usually enjoy building relationships with bio families, there are exceptions where bio family are the main challenge facing carers.
80	Lack of support for mental health and paediatrician services available for children in care. They are most likely to need this care, but it is also really difficult to find quality care in a timely manner.
81	All of the above.
82	Lack of support information and team work
83	Not feeling that our feelings about a situation regarding a child's safety that is in our care. Is really considered, I as a carer put the children's safety and welfare first. But I feel that Child Safety does not do this. It seems sometimes they just want to please the mother and not actually do what is in the best interest of the child. So it seems carer's voices don't get heard or taken into account.
84	A lot
85	Getting burnt out not getting supported communication not being valued. Our voices are not heard. Our children's voices are not heard especially when it comes to children with complex needs trauma

	and family contact.
86	Court times , visitation
87	Inconsistencies from Child Safety on decisions. What one child may assessed as a very similar child will be knocked back on Transport for contact OR payment Carers sitting with empty beds & other carers with 10 children in care Carers not able to take kids on family holidays with them - respite not available so whole family suffers with no holiday
88	Cultural awareness with Torres strait Islander customs and family support networks
89	Lack of communication with child Saftey, always hearing information second hand
90	We are NOT LISTENED TO! WE KNOW THE CHILDREN! Child safety and agencies DO NOT!!
91	probably
92	Fear of personal safety. I had to ask court to not to disclose my address. I felt my input was insignificant and reunification was more important than the welfare of the child. The financial cost and care and support was dismissed - leaves you feeling used. The biggest problem with communication was the big turnover of case workers.
93	Being kept in the loop with things that I need to to know such as ndis plans. My input isn't valued even though I am with the child 24/7 for years
94	Certain CSO's team leaders and managers need to have there standards of care reviewed. Toxic behaviour from managers. Child safety need to be cleansed from corruption and lies
95	Uncertainty of future plans for child. Constant changes of plans.
96	Constant change in staff. Foster carers are expected to love and treat these kids as our own which often happens at the expense of our own children. They are also brought into the situation without consideration and suffer. In many instances the bio oaremrs get more rights than us and the children when they consistently fail their children.
97	Frequent changes of CSO and no sharing of information from previous CSO to current. Pressure from Child Safety to do all transport contacts at times not suitable to the household commitments. No negotiation of this just demands made.
98	Child needs not being prioritized, Children all ages in Resi care,Not being able to have holidays, some contact visits impacting family life and commitments
99	-Referred to as volunteers -lack of financial supports or urgency when a child is displaying aggressive behaviour to other children, carers, school staff ECT. For councilors, behavioural specialist
100	CSO who do not support complex children, who refuse to listen to and follow the advice of medical professionals such as GPs, psychologists and psychiatrists. Who allow placements to break down because they refuse additional support to the child, who don't care or listen to the child. CSO are a law onto themselves, there is no one who you can complain to they all stick together and control the narrative
101	possibility of having counselling services available for carers to access to talk through some issues and help deal with things specifically to do with fostering.
102	All services are quick to tell carers what are unacceptable parenting methods but rarely will anyone actually give practical and useable effective advise as to how to handle a situation with behaviours and provide a parenting program for carers that fits for children in care.
103	My most challenging aspect is having a support agency which is not supportive and more of another person to care for and constantly remind them of things requested
104	Agency's
105	None of the issues in the list above were a problem for us. Constant turnover of CSOs in the department gives rise to instability that can be triggering for children suffering from issues like complex PTSD or Reactive Attachment Disorder.
106	Bio family issues
107	Mainly communication between support and department
108	Being overwhelmed with the amount of day to day responsibilities.
109	High turnover of CSO's. No monthly meeting for 7 months. Not supporting family reunification. Not enough support for workers in residential care.
110	Limited support Lack of personal freedom
111	Incompetent CSOs who are all about ticking boxes rather than best interest of child/ren

112	Bridging the gap between day-to-day care, and meeting the expectation of Child Safety. I find child Safety very disconnected from the reality of day-to-day life of careers.
113	Not being kept in the loop about future of children, slow response with emails, apart from financial, little help offered.
114	Having to deal with parents
115	An independent court appointed report gave clear assessment and Child Safety ignored the report
116	Lack of appropriate supports for complex needs in regional areas. Lack of suitable schooling options for special needs. Lack of understanding of trauma and complex needs. Delays and difficulties in accessing NDIS as foster-carer.
117	the lack of response from child safety if a email is sent & you need support from CSO urgently
118	Continuity of CSO's who are up-to-date with the child in cares history.
119	When other agencies assist the department about your child in care to make decisions without caregivers or the caregivers agency informed.
120	No paid parental leave when accepting a placement for a newborn, long term.
121	Whilst providing kinship care to a child, they moved to the child to her biological grandmother and there was no transition and did not support ongoing contact, they left this to the grandma and she did not faciliate. They did not consider the best interests of the child.
122	Decisions that Child Safety make that are not in the best interest of the child or the placement.Some of these decisions have major impact on the children and the placement.An example is my grandchildren's mother abandoned her children numerous time.Child safety rightfully tried for reunification but the mother never complied with anything over and over.This impacted the children suffering further trauma by reliving the trauma.It has been years now with no contact with the mother, by the mothers choice,Child Safety still ask them if they want to see her and the children have said no but they keep asking and this causes a ricochet which impacts the household significantly.I think the children
123	Lack of support, mot able to take a break, kincarers seem to be taken advantage of as they generally want to look after relatives regardless of how the carer is treated by Child Safety
124	Not noing nothing when it comes to CSO not answering emails when you email them with concerns about the safety of the child that have vists with there biological family and there safety isn't met with having a carer present with a child under 2. CSO don't return calls when you ring and leave messages.
125	CSO have no consequence for their lack of work and poor performance
126	Not agreeing with the departments decision when we know our young people best .
127	Being exposed to a system that places the needs of adults before children and is significantly under resourced that does not acknowledge the burden of care or vicarious trauma and is adopting external management via ngos leaving poor connectivity and csos with workloads that are unhealthy and unmanageable affecting Australian children badly
128	Systemic negative teachings and culture within the teams in the centre. Mostly due to opinions and beliefs implemented by the Team Leader.
129	Decision making a lot of the times changes depending on personal experience, beliefs or political views of child safety officers which should never be like that. Unrealistic expectations from carers like driving to contact 3 times per week for a new born child or set apart half day a week for contact because there are not enough child safety workers to drive children around. Decision making - carers who have been looking after a child for years know the child best and yet do not have a say in serious decisions or participate in meetings to discuss the child's future. Carers struggle being heard that's why I refuse to meet child safety without agency worker so there is an external witness to the conversations and other case notes recorded that can be accessed to verify information.
130	I had a four year old boy reunified with his family but no consideration was given to the fact that the only home he knew or remembered was with me on the last day that he was to go home he had a panic attack because he wanted to stay and threatened to kill himself he was only four years old he must have been so scared. I think about that everyday
131	Abusive or bully CSO's, Incompetence within CS as a whole, or individual CSO's/team leaders. Lack of accountability, lack of professionalism and recollection. (Misinformation passed from one to another, often evident in important documents) Lack of follow through with complaints/outcomes/failing to provide superiors contact information. Risk of harm, cs disclosing personal details ie address (putting carers/bio children/children in care at significant risk)
132	Child saftey are untouchable we have made complaints to the minister child saftey and other

	bureaucracy all failed to help
133	The staff turnover is a major challenge and very frustrating to deal with. In my experience the communication from CSOs has been appalling since I started as a carer in the foster system. In the 10 months that I have been a carer we have had 3 CSOs (and 3 team leaders who took on the CSO role temporarily in between CSOs). We are yet to meet the new CSO who has been in place for a few weeks.
134	Unknown
135	dealing with the negative behaviours of the child's parent/s
136	Yes, as carers we are expected to pick up the pieces and put them back together, however Child Safety are constantly telling the carer too bad when we ask for assistance with the child when it comes to visits. I personally have requested that the amount of oily food is limited for a particular child as this child ends up having bowl and intestiinal issues from it. I was told by Child Safety that I can't do that I dont have the right to ask that. I requested no contact with a parent and Child Safety continued to put me in situations where I had to have physical contact with the parent, eg. Not even 24 hours after the request for no contact was made, I was forced to collect the child from a Child Safety supervised visit with said parent, was verbally abused by the parent infront of the child and the CSO just stood there amd did not do anything.
137	I have had in the past false claims from child safety made about me and the care I provide. The CSO had never been out to visit myself and the child so had no basis of these claims.
138	Not having documents provided sometimes taking weeks like authority to care which means I can't access things like child care subsidy, Centrelink doctors have refused to treat kids in
139	Mainly communication with the CSO and them not respecting us or valuing that we have lives outside of them.
140	Not being supported by Child Safety
141	Secrets that the department keep that affect the child and carers home. The carers own children are damaged when child safety acts without warning
142	We have cared for young person who is Kim almost his entire life, almost 10 years. We have been put through continued distress, invasive questions, having to retell our story every time, absolute lack of note taking and complete reactiveness. Reunification has been pushed almost the entire time despite the impact this has on the child and the compromise room of the child's safety.
143	Yes! A decent percentage of the children in Foster Care have trauma of some kind. Child safety officers are NOT trained in trauma to an acceptable level. They also do not have to have a mandatory psychology qualification
144	Appointments been canceled due to emergencies
145	I am a single carer and have been since I was 48 years of age. This means I have lost 15 years of superanuation payments for my retirement. The cost of living is skyrocketing. Trying to get the department to pay for things can be tiresome and frustrating to say the least. For that reason I have very rarely asked for payment of school photo's, uniforms, camps etc.
146	Biological Parents always nitpicking about nothing. It is extremely stressful and absolutely turns you off wanting to care for these particular children.
147	Inability to access loans No superannuation to fall back on when you retire No stability - for the children or the carer - a child being in care seems to be seen as the last option instead of a permanent solution (ie. adoption) Lack of control of what happens No rights to see the children once they leave your care causing grief and loss for both the carer and the children… you could be the only person a little one know from birth then kinship is found and approved after 2.5 years - transition occurs in a weekend and then no further contact-stories are lost and trauma occurs
148	We live day in day out with these kids but our views and experiences matter little to child safety. When times get hard child safety protect themselves putting carers and kids at risk
149	Yes officer tell you that they own you.. The disbelief of what you are telling them, the child is doing or saying. The lying that from some officers, and the denial that come from some officers "I never said but" that's when I wish we could record them, so we could play it back..
150	- Behaviours at Daycare - Shopping challenges with children - Long waiting lists to see specialists. Some everyday challenges we face.
151	Ensuring connection to country is rightly emphasised in Care plans for children identifying as being of Aboriginal and Torres Strait descent. However without formal support - for example in the form of structured immersive programs being available for the children to participate in - non Indigenous carers are set up to fail in doing a decent job in living up to the expectation. NAIDOC etc are NOT

	sufficient on their own to make a difference.
152	Placement offers. I constantly get called to take primary placements when I have said multiple times I am at my limits. Then feel really guilty when I have to say no repeatedly.
153	Not feeling supported by our agency.
154	No transparency and communication. Do not feel heard
155	Safety issues from teens; damage to homes; isolation from friends/family
156	The lack of communication from Child Safety and them not following up on emails.
157	The BIGGEST chal enge by far is not having any avaialable respite carers. We are supposed to have one weekend a month but our agency have flat out stated that its not availabe in our area. We know of loads of respite carers on the Sunshine Coast that have empty homes and are winuig for placements. Meanwhile 30 minutes south there is no respite and carers are exhausted, not coping, cutting corners and ending placements they wouldnt end if respite was available. Agencies arent allowed to use carers "out of area" which is absolutely ludacris. The knowledge of this to a carer in need is a HUGE kick in the guts. Carers 1 hour south are in our area, but 30 minutes north with houses full of empty beds are out of area.
158	Not being heard. As well as being expected to manage parents as well
159	Likely, but I can't think of them at the minute
160	Cso and team leaders making decisions about children without consulting carer
161	Fear of the complaint process and fear of 'comeback' if you do raise concerns or complain so we just don't!
162	Yes, to many to list here.
163	Those are pretty comprehensive and Definitely all real challenges as a carer. The constant unknown of what might happen next - decisions being made and just enforced on us without consultation is a heavy weight to live day in and day out and the feeling of having no control over decisions like shall we go on a family holiday. And the invasion of privacy is really tiring.
164	Change in staff
165	Child Saftey thinking they know the children better than what carers do who have had these children since birth and for a number of years after.
166	Total disrespect and treated as babysitters expected to not speak or advocate for children in care. Carers are ignored by majority of CSOs they don't return calls they don't respond to emails and they don't respond in a timely manner leaving children suffering and also causing harm to the children through their lack of response .
167	Not being listened to when you speak the truth. I quickly learnt that as a carer we are not part of the decision making of a child and our insight into the Childs needs are not listened to. One of our children was returned to his mother when they knew he would be harmed. We tried to stop this and provided evidence that it would not work but we were ignored. he went back to his mother and was beaten, tied to his bed, locked in his room and abused over a nine week period before he was returned to us. We knew this would happen. We are not listened to or valued. We are the enemy
168	Not dealing with complex kinship arrangements and lack of flexibility to support best interests of the children
169	Child safety not taking accountability for their wrong doings
170	I don't feel I could place those statements but did it This is something I am interested in working around Having respite for careers without the carer feeling like they're pushing the child aside expressly if the child could feel abandoned from this I would like to see specialist camps set up in large numbers for respite that builds a child's confidence and skills so they would look forward to the camps
171	Communication, lack of.
172	Dept Bullying
173	The department's need to make themselves look good and not providing the correct resources or services for the child.
174	Child safety staff have no real training on how to respect carers and there views. Carers know the child in care better than any staff worker and carers should be able to have more decision making in the child's life.
175	Not feeling heard as carers, when we raised significant concerns about decisions child safety made that placed the children in harms way. In this situation, child safety was so desperate to obtain hair follicle evidence due to looming court date/end of STCO, that they made a deal with the parent in

	order to obtain this evidence, without listening to our concerns. We were very clear w our kinship agency that if this deal was made, we felt it placed the children at unacceptable risk, and if this decision was made we would be left no choice but to relinquish, as we couldn't handle the anxiety provoking worry that would follow if these children were placed in harms way, whilst in our care. CS made the decision, and I later discovered that the parent faked the hair follicle test anyway. Making it all in vane. For these three siblings we have loved and cared for for several years now that they are in a new placement. The children are begging to still have contact with our family and spend time with us however the biological mother has withdrawn consent for them to spend time with us And Child Safety are not listening to the children's views and wishes. This has placed our family in a particularly difficult situation when we get heartbreaking messages every night of the children yearning to see us and crying themselves to sleep and experiencing suicidal thoughts because they miss us so much and are not supported to continue these relationships that were so important to them
176	I have none of the above
177	Accessing appropriate NDIS plan , they are significantly affected by the agreement between government departmental responsibility. Ie provision of support worker hours and respite for kids in Childsafety that have an NDIS plan, foster carers are not disability trained and many will not take kids with a disability for respite.
178	Dept workers who don't have any lived experiences of raising children but think they have all the answers and that we should do exactly as they say. They think they know what's best for the child by just reading their file.
179	* expectation to go above and beyond and then having to wait weeks or months for simple requests * Decision made by parents through department that is not in best interest of child but then has to be managed by carer (e.g piercings, school) * CSO turn over, new CSOs making comments, decisions on an assumption they know best, after one visit with carer & child. * Long gaps between CSO's and no contact in between * Needing to work fulltime to keep the house running, when the child placed has complex needs * Being promised or suggested additional supports based on complex needs that never eventuate, and then chased up with expediency for $100 at a placements end because they over paid, regardless of many extra costs including repairs from damage to house. * The public parenting - the constant comments from people thinking they know how to fix the child. * No support after placement ends even though there is huge grief and loss and often significant clean up, long waits to know what to do with belongings, even when transition has been amicable.
180	How different service centres help or just disrespect carers and CSO change frequently and lie to better themselves with no thought about the consequences on the young person they are meant to support
181	Lies by the department. Inability of agencies to offer help or get the department to do their job
182	Being told we get a payment for the child so you can pay for whatever they need eg. school uniforms when they first come into our care. Pay for glasses to be fixed or new ones when a child breaks them every few weeks. Travelling to all appointments and contact. I always have to wait over a month or more to be reimbursed for parent contact . The carers allowance definitely does not cover all living expenses for these children. We are always out of pocket .
183	Burn out and not having the ability to take care of medical appointments for ourselves due to complex children
184	Transitioning from care. As soon as they turn 15, the make assumptions a young person should live in disability housing. The young person and carer have no voice and it causes the young person huge amounts of stress.
185	High level corruption in Cairns
186	There are not enough CSO's, they are overwhelmed so they don't have time to communicate with carer's properly or regularly - this is a HUGE frustration. The issue of secrecy and reunifying the children with parents no matter what harm the children may experience is frightening and frankly neglectful.
187	Inconsistency of csos as they change often and we don't allways know about it and new ones often have their own ideas
188	There is a great deal of pressure to keep accepting more placements as there is always so many children coming into care.
189	Dept only communicate when they want something. They dont care about carers or our bio families. The kids are the easy part the Dept is the hard part of this
190	Child Safety has little understanding of disability. It took us four years to obtain a diagnosis for FASD, and this was a challenging time.

191	Child services block their personal numbers. They view advocacy as extra work and seem to avoid communication. Spoken down to often while voicing needs especially surrounding my foster boy with his disability.
192	Not knowing if the child will go back when you are not confident that they will be looked after properly
193	Yes respite care to be able see elderly parent in another state in their end of life age.
194	We are no longer carers due to the poor treatment we received from child safety staff. We saw children return to parents when the parents weren't ready and know the children suffered because of it. We felt that we were not valued or listened to. We always witnessed parents needs and wants put before the children's safety and needs. Trauma was caused by child safety not the parents
195	Children's voices not always been heard
196	I think our biggest challenges is rarely speaking with cso's most now only respond by email. They never have same mobile number. In my experience fostering an indigenous child. He " aboriginalalty was put before her needs as a child sadly
197	Lies
198	I am not heard, lack of communication and lack of support (this issue has only been with the [redacted] [redacted] office ONLY). Lies told by this office, unable to defend myself in an unsubstantiated SOC after 40 years of being a carer.....[redacted] CSO manager said it was substantiated SCO.....I was just to distressed to fight this decision made by her (CSO Manager at [redacted] Qld)....child now no longer in my care.
199	Social Stigma and isolation from peers with children
200	Child safety threaten to take the children if you dare question them. No one stands up to child safety. They don't follow police's they do what ever they want and no one has any power but them. They treat foster carers horrendously and go out of there way to try to make you quit.
201	Unless agencies that hold all the power, the agencies are the biggest problem, I've liked working with CS but agencies are corrupt, threatening, unsupportive and hold too much power, carers have no rights to choose agencies, we should have the right to say this agency is not supporting me I'll move to someone who will but we have no rights
202	Yes ,ignorance and continuous lies that some CSO will do to manipulate the case in their favour, with no comeback on them but causes the young person they are annoying so suffer mentally which impacts the schooling and social life of the child.
203	1) Far too high an expectation lumped onto carers to do work that CSO should be doing for the child. 2) Carers are told CSO is overloaded with cases...unable to meet the needs of a child in a timely timeframe. 3) Child Safety Managers have put out to their staff that there are 'BUDGET RESTRAINTS' & "CUTTING BACK ON SUPPORT' therefore a carer cannot expect support!!
204	Lots but too many to say and it varies from child to child and ages however I have always had support to handle.
205	* constantly * the roller coaster ride is endless. Birth parents can cancel with no consequences. Birth parents can reject their other children but that is not even considered if they want reunification with another child; decisions are made in court and we are not informed of them; we are never consulted about future directions for the child; birth parents know our address- that is ridiculous, dangerous, not necessary and an invasion of our privacy; court orders are inconsistent and at the whim of the judge
206	Yes many :)
207	Not being able to access regular consistent respite. Becoming burnt out and not supported
208	Not being updated. Limited additional financial and physical assistance at times of major strain.
209	Lack of support, especially through placement breakdown events
210	My answers to q. 15 to 16 should be unknown, as I can't possibly know whether or not Child Safety is or isn't sharing information I should know, if they aren't sharing it, but that wasn't an option in the fields
211	Not being able to live the life before taking on a kind ship child. Not being allowed to take on holidays due to 1 parent declining. Only allowed to be away from child for 48 hours. Respite is not an option - would you leave your child with a stranger. Respite is not the answer - it is a band aid then upon return the behaviours are worse
212	As a kinship carer there are many challenges. The challenges begin at the initial investigation stage, investigations not done correctly, only one side is taken into consideration, pertinent information intentionally left out of affidavit to favour one parent over another, despite the information being relevant. Significant gender bias, mothers are believed even when there is no evidence to back up

	mothers statements, child safety policies refer to protection of the mother; this is very outdated, it is common knowledge that mothers can and are perpetrators. Despite this fathers are treated as the perpetrators (particularly in DV relationships) and even when the father can prove the mother is lying and making false allegations against fathers with evidence to prove this. Fathers are still treated poorly. Child safety lilies are a challenge and must be reviewed.
213	Safety concerns re parents being given excessive amounts of carer information especially when parents have criminal records
214	Lack of respite for carers of teenagers. Lack of assistance from placement services in regards to respite(ie:last minute decisions by placement services), impacting on behaviour especially for children with trauma issues.
215	Could have better integrated processes regarding NDIS, ensure medical and other assessments resolved.
216	Another major challenge is the stress caused by ongoing uncertainty for children, which prevents them from ever being able to properly lay down roots. Carers and children are often left in a kind of limbo, with little communication about what the long-term plan is. This is made worse when trauma bonds with relatives have to be investigated, leaving children feeling conflicted and unsettled. Even when they love their carer and feel safe in the home, these constant shifts mean they are always on the back foot, living with insecurity. This is especially hard for children who need stability and certainty the most, yet end up experiencing the opposite.
217	As a kinship carer who took on care suddenly, it was a lot to get my head around. Suddenly having to open my home to people I didn't know and feeling like every aspect of my life was being judged. I have become more used to opening my home regularly but I still find the burden the constant communication and meetings places on my life is detrimental to me having any sense of self outside of my caring role. I have taken on three children under 6 and have had to take time off without pay and then go back to work part-time. This is a huge financial imposition and I feel that I am not adequately compensated for this. There has been an impact on my health, friendships and career.
218	Staff attitude to carers Staff treatment of carer. Team leaders having their own agenda
219	Our biggest challenge is communication and changes in CSO
220	Corrupt staff members who use their power to try to control or intimidate carers when they stand to advocate for the childrens rights and needs in their care. Even after formal complaints are made they are either ignored, or take months and months and months to have an outcome. Complaints should not be fed back for the service centres to manage as our experience has shown us that they will often defend the actions of staff in their own office. Complaints should be dealt with by an exterior organisation eg QFKC
221	Biological parents being able to go around child safety to attack carers directly with subpoena and harassment to friends and organisations families attend.
222	Getting regular respite
223	Respite for children with specific needs , unable to get respite locally out of home.
224	Being consulted and respected in contact arrangements with parents not just told you have to change your week to accommodate the dept and parents
225	I thing many carers feel isolated within the community and don't have many foster type in person communities to be apart of as regular play groups, sporting clubs or social clubs for both the children and carers there can be unfair judgement from those who don't really understand the position of foster children or carers which can make accessing community social or sporting programs difficult. It would be good to have some foster type community activities to attend, this could be sporting days, teams, fair type days. It would be a place that foster children and carers are not judged as they are with peers and have a chance to connect with the foster community.
226	They put a lot of expectations on us to transport and add extra responsibilities and can add things to our schedule without consulting
227	High staff turnover of good CSO's Long waits for follow up and callbacks, return emails etc Cancellations due to other pressing issues with other children COMMUNICATION - our CSO finished up last week and I do not know who has taken over from her or had a email of who to contact if I require assistance. I woul djust need to ring the service centre and hope someone could help me. I also care for a child with high complex needs. My support agency would be my go to and they would follow up on my behalf
228	Lack of appropriate training. It is not enough to equipment new carers with tools to manage reality of caring for children with trauma history.
229	Full insight into child's behavioural history.

230	No consitency or continuity with workers..cso changes regularly.
231	Being able to access respite when needed (not enough respite carers), currently have 1-3 family contacts each afternoon for five children (not related), instead of child safety planning all of them in the one day so I'm not out every afternoon. Having access to a suitable vehicle to transport all the children. We are experienced carers who can provide care for multiple children but having the finances for a suitable vehicles is causing stress. Having multiple schools/daycare for pick ups and drop offs. Would help if I could change schools for some of the children.
232	Many challenges,
233	All the above are relevant to carers
234	A constant Admin role while maintaining relationships between child/ren and parents
235	Different CSOs giving conflicting information. Lack of follow through by child safety
236	Yes Child Safety force children to continue visits with abusive parents. Too many foster children placed with families who don't have space. My daughter was given 5 high needs siblings when she already has 3 biological sons. when she relinquished care the 5 + a new sibling were placed with my son's partner and there were already 2 adults and 6 biological living in a 3 bedroom house. So there was a total of 2 adults and 12 children then living in that 3 bedroom house. CS then badgered the family to find a bigger house. two of the children self placed with their biological mother however there are still 10 people living in that 3 bedroom house.
237	Lack of respite. They seek to just hand over the kids and it becomes the carers problem. There needs to be some kind of fun weekend camps or something for the kids where they can have fun and careers can have some breaks to prevent burnout and placement breakdowns
238	Feeling like a babysitter to the kids in our care. Not being able to make decisions in their best interests. Not being included in decisions that effect the whole house, each CSO wanting the child they are their for to have priority. Not giving notice for changes in contact and expecting the whole house to move plans around.
239	Bios being given contact details, not being consulted before changes to contact schedules and then having to juggle everything, being told we are too attached when we advocate strongly for the child and what they need. We are living with the child, we know them, CSOs and TLs who dont even meet the child or do the monthly visits they're supposed to do, dont know the child.
240	Hands on support, access to respite.
241	Pressured to take placements
242	Mental health need for paid therapy to keep going
243	Child Safety mandating family contact when clearly not in the best interest of the child. poor decision making by the Dept.
244	Not being listened to about serious concerns relating to young person in our care.
245	Unreasonable expectations placed on Carers to make sure the children attend all contact visits, despite not being consulted at all when the contact days and times are being decided upon. The carer not being involved in the decision of when contacts take place means the child's health and wellbeing are not taken into consideration (as the carer knows the child and their routines and needs best) and the carer then also having to sacrifice their own health and wellbeing (as they miss out on their own family time/vacations/rest and recovery time), this negatively impacts the Carer's mental health and family relationships, and reduces their capacity to care effectively for the children in their care.
246	Inconsistency with case workers
247	A duty of care in keeping multiple children in my care privacy up held when Team Leaders make the decision that I have to transport children to or from a parent contact. I have to bring all my little people with me for transport.
248	Day to day life is not always considered
249	In my case when disagreeing with the conduct or decision of a manager, I was totally black listed, discriminated against, defamed, mistreated in spite of the children doing brilliantly.
250	Loneliness, esp single carers. People who are not foster carers can never really understand what we do and that can be quite isolating.
251	Docs removing children from kinship carer without grounds and interrogating and belittling carer for 7 days. No respite. Refusing to let foster agency have a suitable neighbour PACd and therefore receive an allowance for respite. Insisting they must be used on 48 hr rule. Interrogating Kinship carer over outrageous claims from member of public. Accessing pharmacy and hospital records. Gaslighting

	kinship carer, teasing that there is an issue but saying they can't disclose at this point. Making carer wait a week to discus issues. Carer allowance repeatedly ceased without notice. Initial instance, carer told back payment was not possible in DOCS system. Children removed without cause but no respite carer to take them. DOCS then used previous respite carer who was deemed never to do respite care for any child again (documented). Children's personal belongs never returned from respite carers. Despite constant requests from Carer to have them returned. DOCS constantly disregarding Parent's bail conditions and placing carer in situations every week where she is alone with parent and children. CSOs leaving parent unsupervised with children regularly. Acting Team leading refusing carer support person during last minute meeting. CSO repeatedly refusing having children at park during heatwave at parent contact. Children repeatedly sunburn and heatstroke. Ignored carers request to stop park visits during heatwave. Office of public guardian visitor needed to instruct CSO to cease park visits. DOCS workers putting children in car seats not suitable/legal/safe for children so young. CSO not attending home visits when scheduled and not making any contact to cancel. CSO not attending SH meetings and not making contact to cancel. Severe lack of communication. SH meeting items not being actioned. Children's' information on ATC's incorrect. Official documentation and emails with sections copied and pasted and another child in care(not known to carer) personal information including medical and sensitive information recorded by error on same document.
252	No.one listens to the carers who live it in the real world. Text book solutions are not always the answer. Child safety telling young people and carers what theu believe you want to hear to avoid the difficult conversations.
253	The impact of fostering on bio family
254	Trying to get approval for things. For example it took almost two months to get approval for vision therapy which was a time sensitive matter
255	Dealing with the Biological families - not being believed when reporting situations. Dept giving in to the family when they are threatened with media or legal action.
256	Superannuation, access to loans (ie using allowance as income) respite
257	The ever changing of caseworkers for the children; meaning they don't always have the historical, 'on-the-ground' background information to make poignant decisions that relate directly to the children and the carer's.
258	Policy and legislation not always being followed by child safety. Safety/harm Concerns raised by carer not being taken seriously or recorded in case notes. CSO changes and not having all the information in case notes or handover can disadvantage children for reunification time frame and safety concerns followed up.
259	DCP not following the law.rule of law doesn't apply to them
260	Constant changes to CSO' with poor handover and training resulting in a lack of progress towards permanency, therapies and financial supports and inconsistent or conflicting information being given.
261	Dealing with a Government Department where the workplace culture varies from pockets of excellence, to recalcitrant practices of exerting power and control, with the median experience being one of dealing with a mediocre bureaucracy.
262	Ch'n with complex care needs. Carers need Dept to have an awareness of problems. Acute cases where CSO and T.L. out of touch with the real work and efforts of good carers.
263	Lack of information & support of agency.
264	All these issues are a challenge. Child safety lies to cover their arses.
265	Constantly having to get approval for things a parent would just naturally do
266	Child Safety NOT performing THEIR duties and responsibilities to the child. And refusing financial aid that we are entitled to under legislation
267	Agency saying its child safety issue and child safety saying it an agency issue Limited respite planning ahead of time
268	Not paid superannuation
269	Having a peak body that picks and chooses who and what it will represent and support. Having a peak body that doesn't think outside the square and has no ability to actually represent ALL foster and kinship parents instead they impose their personal values on the foster and kinship parents. If you don't fall within their values then they kick you to the curb. The language often used is by the peak body is inappropriate. The peak body that represents foster and kinship parents needs to be disbanded and set aside with a new body developed that takes on the views of ALL foster and kinship parents. Not just the select chosen few

270	Always feeling like if you ask questions or advocate for the child that there will be repercussions and the child will be removed,its basically like being gagged,amd all you want to do is see that the child has the best outcomes
271	Endless waits for decisions to be made that often impact on the children's wellbeing, sometimes significantly, sometimes just the feeling of frustration and lack of control over their lives, so kids feel like they aren't able to be a "normal" kid.
272	Inconsistent levels of support between different regions and CSO's. It is not clear what will be paid for by the department and what the allowance covers. It changes depending on who you ask.
273	Financial burdens as not able to access loans etc for cars and housing. No superannuation
274	Long waitlists for services Apparently our CSSC has already run out of funds (September) to support contact, therapy, and other services for my children.
275	Csos are fresh from uni making major secisions that break placemnet with out considering childs veiws or asking loaded questions of settled children
276	Ongoing changes to staff, hence different csos means different ideas on how children should be cared for although nothing wrong in carer household.
277	Just the lack of transparency and communication from stakeholders. And being told that we are just babysitters and have no rights or decision making abilities.
278	Lack of respite especially for children with high needs
279	Accessing permanency Accessing passports
280	Red tape around things such as excessive permission for extracurricular activities and holidays.
281	Being a valued stake holder and having decision making powers to help support the child.
282	Lack of truth from cso.
283	Frequent changes in CSO's and the lack of. Lack of communication and passing of of information between CSO's when changing to the new one. Lack of transparency regarding child's health, medical and behaviour challenges.
284	CSO's not having enough life experience and training. CSO's on a power trip, talking down to carers. Kids voices not having enough of a influence on decisions.
285	Contact and not consulting carers as it suits the parents regardless of foster family or child's commitments.
286	Getting help with autism/ ADHD etc assessments- process is unclear and been told Child services with organise then told I'm to do it. Responses to emails, texts not received in a timely manner . Not informed when new CSO takes over. Would help if a new CSO would touch base immediately when taking case.
287	We are treated like baby sitters, we are not told important information about the children which could help us care for them better and we are not seen as a significant person in the child's life when making future decisions for the children. We are expected to love them, raise them in a safe home environment yet also expected to not ask questions or care about the child or advocate for the child or we get labeled difficult to deal with
288	I feeling like Child Safety removes kids places them and just hope for the best. Really doesn't enagage only to tick and flick the boxes but really has no interest in the high need or complexity of the children.
289	There is no emotional support for carers or safety measures in place when biological parents find address . No one checks in to see how the carer is.
290	Having our personal information shared with people who are not safe as a standard. Not having a voice for the child's best interest. Biological parents making false claims. Biological parents having all the power for choices and decisions of children they don't have in their care. Necessary medical decisions left in the hands of people who don't have child in their care.
291	Advocating for safety of children during visits. Children ignored and abused
292	I truly feel the independent support agencies as the middle man are often a waste of time for carers. They suggest supports but don't follow through. When multiple placements from different families their is a lack of support during the adjustment periods which is often the trickiest part of placement.
293	Having multiple staff turnover over and life decision made for your child and they have never meet child in 7 years
294	A lack of support, high burnout role with limited access to supports and DCJ say that you are "heard" however you are left to get by, whatever that looks like. DCJ only check in on you, once a month for

	the mandatory home visit.
295	Yes, agendas and policies that are not necessarily legislation but personal preferences.
296	As a kin carer I received no information about my rights or processes ahead of time. My communications are misinterpreted or not effectively being documented and ultimately being viewed negatively or assessments made on 3rd 4th hand information often lacking context. Agency support has been falsely reported as provided or requested. Not being heard in general
297	The parents have to many rights they need to be more responsible
298	Child safety not being able to provide request from school, careers etc. our young person starts high school next year and have been waiting 3 months for a laptop to keep having road block put in the way (the young person can't start his transition plan to high school until he has a laptop)
299	Impact on the ability to sustain employment due to high needs of children in care. No superannuation. Visitation expectations with biological parents.
300	The consistent feeling like you're a bad person for advocating for the child's basic needs and rights. We consistently feel like we're in trouble for speaking up. It's awful.
301	Volunteering to support vulnerable children being case managed by an Agency that appears to have limited capacity to support the care needs of the child. And often has never even met the child.
302	Child safety saying one thing and doing another.
303	Perosnal challenges of unprofessional matters with csos
304	The high turn over in team members from the department makes it difficult to work with as there is no continuity in decision making or understanding and affects the well being of the children in care as a individual case.
305	Agencies also carry all of these same concerns and risks. The whole system, whether we have a good or bad experience... comes down to a popularity game.. and if agency or child safety like us or agree with us. Policies can be interpreted differently depending on who reads them... some agency and dept workers will let concerns slide if they like a carer.. but some will slam a carer if they don't like them
306	the amount of visitations gets weary and not being able to have a break or time off with the children
307	Personality clashes with cs staff impacting on treatment and decisions
308	when you have one cso who is great and one who does the below bare minimum… constantly justifying HSA and CSNA there disabilities/behavious/high needs do not magically disappear overnight these are life long disabilities. No Respite? CSO's expecting carers friends and family to do respite.
309	Housing, financial stress, children's families expectations, CSO and agency staff turnover, CSO and agency staff capabilities, CSO and agency staff expectations for home visits, Standards of care and harm reports, cancellations of support services and lack of allied health and therapeutic services
310	Carers are required to understand process of child safety and the children's welfare without education or explanations when court orders change or parents rights are put ahead of the child's ability in life. Some carers report stand over /threats from CSOs when parent contact is changed without consulting with care family whether it works for them and the children in our care. We have family to care for and are not pawns to do the bidding of CS or bio families
311	Being treated like a criminal everytime something happens. Believing a child clearly when they are lying.
312	Ndis funding for children with disabilities is difficult for children in care. There is no oversight or advocacy
313	Constantly being taken advantage of by child safety. Constantly being dictated to by child safety around where to be and when in relation to contact visits. Lack of follow up by child safety. Lack of acknowledgement to emails and text messages sent. Constant contradictory advice and actions. Lack of trust and faith in the system. Expectation that carers self educate about the child safety process with no direction provided by the department
314	Carers want permanency just as much as their kids - I don't feel the system is child oriented anymore (pre carmody inquiry it was more so) now it is parent oriented and what the kids need isn't as important is what the parents need/want
315	Lack of information CSO changing and limited notes and information on the system CSO making their own interpretation of the legislation
316	Unable to work due to therapy appointments, schools wanting early pick ups due to behaviour problems. No income or superannuation. Impacts ability to borrow money for housing and cars.

	Isolation from own family due to children's behaviour Accessing community events limited due to children's behaviour
317	Complaints that are placed against them that are not true, and child safety not following up on it when it was raised initially and takes them at least 6 weeks to do something about it. We have advised that the situation will go downhill but they don't follow up on it. And leave it to family to place the complaint which is not fair. They don't take it seriously from carers
318	Child Safety not communicating and when going through complaints process child safety brush you off and don't hold themselves accountable
319	Getting access to ATCs in a timely manner. This affects finances with ACCS and causes problems with daycare enrolment and accessing medical care.
320	Yes, new CSO thinking they know better then the carer. Not seeing CSO'S for months at a time Not being able to help the child because of poor management of CSO's
321	When you are a new carer- trying to understand how everything works, and not knowing any experienced carers who can answer your questions.
322	Bullying, lack of clear understanding and expectations, lack of action from CS, ANYTHING being completed timely
323	Challenges arise when child safety think they know the right thing to do without even considering the child and carer
324	Lack of power in decisions impacting the child and family
325	I'm tried of begging for management for sit down meetings to discuss my FC medical and disability issues and the damage to my car.
326	Lack of access to supervision or therapy, lack of information provision, lack of any consultation
327	Everything seems to fall on the carer to be responsible for, it's like the department relies on the guilt, that stands by the side of care and love, and they exploit that, at the carers expense and risk the carer burning out and potentially leading to re traumatising already vulnerable children.
328	So many. Friendships lost because can't get assistance from child safety. In small communities where child safety are based with siblings wtc: you are treated unfairly if children are out of their home area. Guidelines and agreements are changed without anyconsultation. Especially with placement agreements/visitations They tell you you need to establish relationships with family in community and yet they take away flights with kids, accomodation, and a vehicle when in the comminuities consultation. Especially with placement agreements/visitations They tell you you need to establish relationships with family in community and yet they take away flights with kids, accomodation, and a vehicle when in the comminuities
329	knowing children are not going to a safe environment when you have helped repair the damage that was caused only for them to be sent back to same situation
330	Not being able to work due to complex needs of children and amount of meetings, appointments, therapies etc involved.
331	The uncertainty of not knowing and never being kept in the loop.
332	Interacting with biological family.
333	Abuse from biological parents. I feel like I'm under coercive control with one bio parent and child safety has no recourse to stop it, except removing the child, which is what the bio parent ultimately wants.
334	The system is part of the problem in that carers get great support from service centres at times because they are working 'outside' the box, and they shouldn't have to.
335	Most of the above do not apply to my situation.. Information around how parent is going and likeliness of reunification needs to be transparent to carer. More information about court and hearings and what reasons it keeps getting adjourned for Short term kinship.
336	Yes! The blurred lines with biological family and the department placing too much responsibility on the carers for the maintenance of family contact relationships
337	As a carer in [redacted] with children on LTG at 3 different service centres I can say the CSO at [redacted] was great however almost all the other CSO from [redacted] and [redacted] and [redacted] service centres were horrendous. The constant disrespect from not only CSO'S but the Team Leaders and Managers was at times bullying. I'm not the only carer that has experienced this. Many of my friends have been under doctors for stress because of it. I have had team leader lie to my face on more than 1 occasion
338	Child Safety not actioning items in timely manner Child Safety always pushing for children to be

	reunified or Family contact Child Safety always pumping carers and children to obtain information to relay back to the biological parents against the children's wishes Child Safety blaming carers for Children not wanting to have Family Contact Child Safety always needing biological parents onboard for decisions that CE can make on LTG CE orders Child Safety lose focus of what is best for children and always push what biological parents want and then question children every visit as to why if they don't agree to what parents want.
339	Never knowing what is actually happening with CS and their decision making The amount of time it takes for decisions to be made CS not following through on recommendations for children in care Stress of trying to manage work with children's challenging behaviors Not being supported enough as a carer
340	The isolation of not being able to discuss the issues you are facing as a "parent" As a carer rarely you can go to "general" people's places as the children under your care often don't behave as "expected." Going to another foster carers place maybe the only outlet carers may find but we are restricted with what we can discuss while many of us would have already experienced a lot of the same things already. Friends disappear and loneliness is real.
341	Financial challenges
342	Lack of consent, failure to provide consent, delays in obtaining consent for necessary medical and dental procedures which delays treatment and contributes to poorer outcomes . Eg: children losing adult teeth as a result of non consent to urgent dental treatment
343	Owing to lack of volunteer carers, frequent calls requesting placements when you are at capacity or not able to do more at this time. There is no pressure to say yes. However, its hard to say no, and most of the time I have to, however it makes me feel sad for the kids and the workers. Enough researcxh exits for paid Foster Carers e.g.(https://pic.care/) We don't need to create this in Qld we need to make this a national organisation and leverage the existing model and infrastructure. We don't have to rebuild what other states and countries have been doing for years. Our kids need us and residentials at $400k per year are expensive to say $100k per year to ultimately gain better outcomes for our children. Why is this so hard? Please do not build new and different infrastructure - lets leverage and expand what exists.
344	Fear of child safety taking the child/ren off them.
345	Expectations exceeding reality.
346	There is a severe lack of genuine, ongoing cultural education for Indigenous children. In our experience, five different cultural contacts within six months were very insistent on meeting the child, but after the first visit, there was no follow-up or meaningful relationship established.
347	Receiving respite is almost impossible
348	Of the challenges listed above, there is no way to place them in any particular order, they are just as equal as each other and they the department is completely dysfunctional in relation to all those categories. The department's use of the SOC process is vindictive.
349	Burnout
350	Base rate allowances are slave labour 24/7. Wake up Qld... look at the endless listing Carers are supposed to supply from a very unrealistic Allowance .....while putting up with many unrealistic demands. CSO's and T.L's too often saying "but your Allowance covers that!" .....Bunkum
351	Department & agency's don't communicate to share information
352	Not being updated about decisions being made, not being treated fairly, having CSO & STL extremely bias against you but does everything for bio family, transport for contact if unable to change your work/scheduled appointments to suit, not being respected, not being able to fight or complain to someone higher than child safety themselves, child safety telling you they don't have to listen to lawyers because they are above the law!
353	Major inconsistencies of carer supports both financially and therapeutically
354	Confused why they cannot live full time with their parent/s. Not being listened to of how they are feeling in relation to this.
355	poor Child Safety employee work performance no accountability, frequently changes to CSO's with no notification to carers, The balance of probability that is used during SOCR and there is no burden of proof sort, lack of accountability from Child Safety employee's when they do not undertake processes and procedures, no external agencies (eg Churches of Christ) supporting Carer's in [redacted]
356	No consistency with csos changing and not always knowing when and who the new one is
357	Lack of respite available Required to facilitate contact Overcrowding Out of pocket expenses not always covered Access to information like Medicare nos. etc

358	Constant changes in staff, the power others (ie former friends who have a beef with you) have to cause issues by 'making reports'! The frivolous reports that are made at times - ie child's hair not perfect for daycare. This only causes stress. During the socr process, the lack of information given to the carer re the accusations or concerns!
359	Yes, but these types of surveys are completely ignored. They're never followed up, so waste of time.
360	We just aren't valued, we are nobody in there eye
361	Legal challenges to fight for your grandchildren The kids in cares views and wishes is not heard or respected The children's independent lawyers never have met the children they're representing in court . The pressure you are put under by doing the departments job for them Medical appointments Visitation
362	Decisions they make without consultation with carer like they have no worth when they are living with the child 24/7 They lord it over with their own agendas of power.
363	Feeling isolated by not being able to talk about situations
364	Lack of skilled support from NGO
365	By much in the way of a support network. As we are often mums who are older while our peers have children that have grown up and left home and they are at a different stage in life.
366	Medical and mental health support for children
367	no respite options decisions made that impact child and carer family without any consultation or consideration eg family time on weekends for 1 child that impacts on rest households commitmrnts
368	Being male.
369	Yes our opinions and insights are not given adequate weight when considering changes that impact the child in our care.
370	Bullying within the dept. Discretional accountability for decisions being made. Children knowing how what they have to do or say to trigger the Dept- without just cause or investigation being carried out by independent bodies
371	We were constantly frowned upon for having full time jobs.
372	The complaints process is flawed . It's not independent . The agency's are not independent - they are loyal to the Dept as that's where their money comes from ie the children the dept will allow to be placed through each agencies carers . Even QFKC is loyal to the dept and not independent . If carers are 'not cooperative ' with the dept they are black listed, have children removed from their care or not renewed as carers
373	Feeling of isolation
374	Lack of respite and breaks for carers with complex kids
375	Due to significant stress relating to the child's behaviour, respite is an option, however, it is not

Attachment J: Lived Experience Survey – Question 32 (Other Option Responses)

Question: What do you feel were the main factor that contributed to the placement breakdown?

Answered: 106

#	Responses
1	No emergency support when needed
2	Placement not receiving supports
3	That placement agreement was carefully written omitting certain information
4	Lack of communication
5	I had informed of funeral and unable to plan a home visit, kinship still showed up while family was very busy, CSO informed that CS has requirements to follow..felt disrespected and that my family was not important
6	Marriage breakdown
7	Cso placing pressure to make us do things that they should be doing like visitations, lying about conversation had, writing things in documents that were not said or discussed then refusing to change it
8	My nephew's placement with another carer broke down.
9	Failure of EVERYBODY, ourselves included, to recognise CARER BURNOUT. We were cooked, but didn't realise why. If we had been offered respite for 3-4 weeks, the placement would likely have not broken down.
10	Child safety failing to address concerns
11	Child safety and lack of information ad communication
12	A young CSO out to save these poor children. She even raised her hands to foster the child, without her sibling.
13	Everyone bending over for the junkie mother and the mother doing nothing
14	All of the above. These are not 'behavioural' issues.. prenatal drug and alcohol exposure requires proper diagnosis, intervention and NDIS support to manage. We are setting children and families up for failure by ignoring the facts and continually treating this as 'behavioural challenges'. Lifelong brain injury is not behavioural issues.
15	Lack of respite
16	assaulted by child
17	The behaviour would trigger her younger sister causing additional trauma. Two younger sisters had been placed with us two years before we took in the older sister and it just didn't work for the entire family.
18	Most of the above
19	All of the above
20	Behaviours of biological parent
21	Lack of genuine cultural support. We had many come visit that were just there to tick a box and not have a genuine connection of culture with the child
22	Family contact pressure on the children to misbehave so that Child Safety can send them home
23	Agency support was great
24	Top two equally
25	Our inexperience at the time was a factor. We did have good support from the department at the time.

26	Care team was not able to offer any support, despite face-to-face meeting stating we would be supported. 7 Days later when we called again for help , no help provided, and 3 children were taken from a stable long-term placement to emergency care, without any further communication. Removed from school kindy with a bag to go on holidays, while we were investigated. This is a bigger story then i can fit , happy to have the files opened as it shows of the shortcoming of the current system.
27	Biological family ringing child, pressure to leave, unprofessional support from Centre Manager & Mother at the time.
28	CSO's Team Leader making poor decisions , not respecting us as carers , not listening to our concerns regarding lack of standards of care in kinship placement , the push to have young people placed with kinship despite lack of standards of care , no replies from multiple calls and emails to cso etc etc . The young people are not the problem , the department itself is
29	Lack of communication from the department was the major contributor
30	Respite only in my case - I refuse to put up with high levels of manipulation and disrespectfulness that are ongoing despite strategies to manage it.
31	Suicidal behaviours of child
32	The child had access to persons from past that caused harm and child safety did not listen and implement adequate plans to prevent harm from person
33	Officer telling the child they could go to a person she knew, these people were not approved carers. When officer was approached about this matter. Officer made out didn't know what child was talking about, a week later child was removed and placed with that person..
34	Parent
35	All of the above!!!!!
36	Parent begaviour
37	Child saftey taking children away based on false alligations
38	My own family had to deal with a very difficult time
39	A combination - very complex behavior (which I knew about prior, having cared for the YP before) but also supports promised never came to fruition, including regular respite.
40	Culmination of problems
41	As detailed in my previous response, Child Safety needed evidence for the upcoming expiry of the short-term custody order and they traded a hair follicle test from the children's Mom in exchange for making a deal with her that in our minds place the children in unacceptable harms way two weeks after this happened and we were forced to relinquish The same Child Safety officer who did not even have the courage to call me back when I was begging her to not make this deal and she had received contact from the children's school guidance officer saying they were crying and missing us and wanting us to be respite carers. We were happy to do that to keep the relationship with the children going because we love them and care for them so much and a meeting was supposed to be set and then we never heard anything further. The children still contact us every night begging to see us.
42	Mainly my husband not coping with the behaviour
43	Department forced the child to move with other carers even though she didn't want to go. My CSNA for my other child was going to be cut if I didn't agree to convince her to move.
44	many things above not just one thing
45	3 children involved, my daughter had 2 of them. All taken as oldest child at 12 was told by Mermaid CSO she could place where ever she wanted. As FD 12 did not like her siblings she wanted to leave care where her sister was so dept took both siblings from my daughter to stay together even though FD 5 wanted to stay at her placement as did my FS 3. This was also relayed to the CV but the CSO did not listen to what the children wanted and destroyed a whole sibling group who are now no longer together.....
46	Change of Policy making the household routine management unmaneagable
47	Zero support, heavy advocacy by me for some very traumatised children and CS being too busy to care, CS only have time to put band aids on things, no care team, no stakeholder meetings, now the placements are breaking down, and a useless agency, QFKC are supporting me, they see to care
48	We manage complex children with increased diagnosis and very challenging behaviours. very little respite for most children. We get told that there is definitely NO RESPITE available for heightened difficult teenagers. Carers feel like only the focus is mostly on the child's needs, the foster carer

	matters even less.
49	While the placement ultimately broke down due to behaviours that became unsafe and unmanageable, I believe this outcome was heavily influenced by the lack of transparency and support from the beginning. We were not made aware of the extent of the behaviours, nor given the tools or resources to respond effectively. With better upfront information and consistent support for both the child and ourselves as carers, I feel the placement may have had a very different outcome. The absence of this information left us unprepared and made the experience more difficult for everyone involved, especially the child.
50	Attitude of child safety
51	very little support for myself
52	New CSO who decided that one of the sisters could be removed and placed back with a parent that still isn't capable and placing trauma now on the siblings.
53	Toxic behaviour from another carer trying to get the child back and NO support from child safety from the bullying. We ended the placement to stop the harassment. The other carer took her back, then ended the placement again less than a year later.
54	First placement broke down due to decisions made against our wishes
55	My disagreeing with a manager resulted in the breakdown.
56	I ticked one, but the other 3 also applied
57	Didn't have one, poorly designed survey
58	All the above.
59	Not being listened to regarding the children's trauma & need for further therapy.
60	So many issues no one would listen to.
61	Carer not receiving effective respite
62	no breakdown because we would never consider not caring for our great nephew
63	Not being listened to and supported in relation to these behaviours. They did not have my back
64	Communication from cso and damaging the relationship between carers and birth mother
65	No transparency, when we knew the kinship person the child ended up with and could have made a lovely transition for the child
66	Mental health. Both the inadequacy of child safety grasping the complexities of mental and also the lack of quality and long wait times to access mental health services, specifically the challenges between disability and mental health and how each service would hand off the responsibilities to the other, including child safety, mental health and NDIS. To the point of fighting harder for needs to be met and residential care was the answer and child went downhill further and further and the disconnection, loss and grief for all parties continues to be significant.
67	2 siblings that needed to be separated at the time due to abuse by one of the siblings to the other.
68	really all the above
69	Agency told me after child was gone, that they suspected he had RAD but I was new (first placement) and nobody suggested this to me, suggested training, or suggested diagnosis/support.
70	Cso specifically telling settled complex child if they are not happy here she can find a new placement - child suspended - child ran away to child safety on a sunday looking for this nee place
71	Not given enough info on behaviors, not enough support to us as carers
72	The placement has not broken down, however I know I will not be continuing to the child reaches adulthood
73	And no support for said behaviours
74	Child safety allowing biologicals to emotionally abuse the child because they felt safe with their carers
75	The first one was due to no cso and then when placement agreement meeting happened finally cs played down behaviours as just adjustments and not that child needed some help. The only offer was to give melatonin at bedtime.
76	Child safety refused to allow mental health support and treatment and supports for young person
77	All of the above
78	all of the above… promises of help and support broken
79	Our capacity to cope with stress of being carer household

80	Huge behaviours from teenager, lying, violence.
81	Child's behaviour and family dynamics and family contact
82	NA
83	I was not told of child's medical needs
84	Care team not working together, child safety not taking concerns seriously, poor transitional planning from residential care to family base placement, child safety officer speaking negatively to carers
85	N/a
86	could not afford to stay home for meeting and appointments
87	Supports needed From external or allied health agencies
88	Case manager having a personal vendetta against my placement support worker
89	Inexperience as a first time care, training really didn't prepare you for reality
90	The lack of consistency with CSO'S changing and behaviours "being new" to each new CSO.
91	I have had a breakdown many years ago. Survey should have timeframes. The breakdown was a result of behaviours which my collective family could not manage.
92	N/a
93	Child's use of substances whilst in a household with younger foster children
94	The time to access paediatrician was 18 months and child psychologist was 6 months. If we have access to this earlier, our placement may not have broken down.
95	The child's behaviour and the lack of support from the department. The department attempted to refuse financial support for the child.
96	Accurate info not provided about child
97	Was no told of the behaviour which put other placement in danger
98	Sexual abuse allegations (not founded)
99	Age appropriate behaviours from children leading to SOCR, then not feeling respected, or believed by the investigation team, not being told about the process, feeling judged despite our success as carers
100	Behaviours were extreme and unsafe for child, carer and family members. Carer got to point of breakdown that led to letting child go. This then led to the carers never seeing child again. This impacted everyone, including another child in placement who had grown up with said child. Very little was done to help with child's behaviours that were difficult even for professionals to manage.
101	I clicked NO, but I'm being asked for a 'reason'? Who's designing these survey questions?
102	Harm report
103	Plus financial burden, didn't receive full communication about teh child's behaviour
104	And financial burden
105	A passive aggressive absence of communication designed to bring about an outcome consistent with corporate values exclusively.
106	At 18 [redacted] believed that she was now allowed to do whatever she felt like. She no longer

Attachment K: Lived Experience Survey – Question 7 (Other Option Responses)

Question: What are the major consequences in your experience of not having a Placement Agreement

Answered: 86

#	OTHER (PLEASE SPECIFY) RESPONSES
1	UNSURE
2	I'm from Cairns and it meant that long term interconnected Department and Agency staff were able to hide details about harm they themselves caused our foster children before they came into our care. Harm such as putting fucking opportunities above Childrens safety. eg: allowing unsupervised family contact where the kids were abused. Or unsafe reunifucations or kinship placements that held high funding deals
3	Nil at the moment that I am aware of
4	Lack of planning, myself and my grandkids weren't able to plan anything. When something was planned we needed to drop it and meet CS request.
5	N/a
6	Was soC reviewed over something I had no idea about. Then saw the case plan that I was unaware of and didnt sign and CSO at Logan lea made up. Even supervisors where shocked about what I had apparently agreed to. But they never got in trouble but now its on my record as a soc reviewed
7	This isn't relevant for me, I have my granddaughter and I have just been supported the whole journey with Uniting Care
8	I have not had any issues not having one in place
9	Child safety not having an accurate idea of where kids are at
10	Child Safety have not written the plan
11	There is a placement agreement and a case plan, but we don't have a copy
12	Feel left out of the process despite the Department having policy of inclusion.
13	Always had a placement agreement
14	It really does not effect us as we just do what children need
15	Not sure
16	Clearly you as the carer try to do what you think is the right thing but that's not how it always pans out because the department have completely different expectations that they haven't made you aware of!
17	Cultural placement principles
18	Might get a placement agreement but it is always evolving but not being updated. Child came into care via investigation and assessment but when actually received placement agreement it was 3 months later with old cso information and nothing updated
19	These plans are not updated regularly and not referred to very often.
20	No support
21	Unknown duration
22	Have not experienced any consequences
23	There hav been times when we didn't even have a CSO because of the turnover and chaos in the department. We just carried on.
24	I have only had one placement agreement
25	Early access not given

26	n/a
27	The child is unsure of what will happen
28	Csna stopped due to paperwork
29	I am a respite carer only and so I imagine these this you are asking about don't apply to me as I'm not a primary carer.
30	We dont even have an updated safe contact plan so we cannot ensure contact or safety plans
31	n/a
32	Up until the change of government we hadn't seen our CSO in person or rarely heard from her for 2 years.
33	Child safety say you have agreed to things but you have never signed off
34	No consequences that I am aware of
35	False accusations by CSO
36	I have not experienced any problems or concerns around this before
37	I am kinship Caring my grandchild
38	Dept. does not listen to carers when it comes to what is best for the child
39	Always had a placement agreement
40	No real effort goes into creating the placement agreement. They just update it and ask you to look through it. I don't understand it's purpose.
41	Controlling department staff and agency cohorts get to meet their own agendas often funding based, not child's needs
42	We discussed this by phone but I have recieved nothing in writing
43	I have never had a problem. When issues have arisen the plans have acted as guide, but if there is a deviation then it is acted upon.
44	Repeating process with new people.
45	Even with it in place some young children's wishes are still completely ignored . are compl
46	CS do not care about placement agreements, many cso's claim that a carer has no right to be involved in a placement agreement, I've fought hard to be involved however they still don't care. And when I get to see a PA it doesn't contain any info about me or my foster children it is a cut n paste from case plans about the children's parents, absolutely ridiculous!, CS needs re-training in PA urgently
47	We as carers are not thought of or valued
48	Lack of knowledge for carer
49	Due to not having things set out case workers seem to fall behind in processing things and nothing is being actioned or done in a timely manner
50	Unsure
51	NA not required for respite
52	Communication break down between CSO & Carer
53	Leave carer feeling unsupported and needs of child not listened to
54	We haven't had any yet - plans are always done but often late
55	Neglect
56	N/A
57	Kept in the dark and told what to do
58	All of the above responses
59	I feel all the above
60	Changes nothing
61	Agency is struggling to negotiate supports
62	Cso negligence should be held to the same standards as carers
63	Conflicting Visitations
64	N/A
65	Normally placement agreements are done on time but we have had so many CSO and they are over worked this has not been done. Doesn’t affect us in the time being as we have been constant

66	Emotions and mental state of children and carers are heightened.
67	Haven't seen any consequences
68	Children removed due to personal vendettas and against children's wishes causing more trauma and more harm to the children but also the foster/caring family
69	CSO jot doing
70	Problems arise with ambiguity on what will happen, not just who will do it
71	We are flying blind with no plan and no direction. We assume the child is staying and behave accordingly. We continue to seek practical assistance and therapy for the che, advocate and hold the department accountable.
72	Child Safety have no accountability
73	Information in plan is not accurate
74	It doesn't really matter. A placement agreement makes no difference to the care that is provided to the children or their needs being met. As their carer, they are provided with everything that they need from me. The department has largely disengaged from the children that I have in my care.
75	Team are forced to operated reactively instead of proactively
76	Respite carer (monthly)
77	Left in the dark
78	CSO's are not honest with the children in our care
79	All or most of the above
80	Medical and mental health care plan require a NEW LIST OF STANDARDS IMPLEMENTED
81	A carer has to fly by the seat of their pants with nothing to guide their decisions and you rarely have any communication with the CSOs or team leaders because they don't communicate very readily or promptly.
82	Key points essential for childs care are never worked on
83	They're just cookie-cutter Placement Agreements anyway - only the 'names' listed change.
84	nA
85	Na
86	No clear boundaries

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Understanding the **Needs of Kinship Carers** in Australia

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with cultural knowledge, practice wisdom and the voices of children and young people in care to produce research summaries, practice resources, tools and training to support the provision of high quality, evidence informed therapeutic care. The CETC works in collaboration with children and young people, therapeutic care agencies, governments, peak bodies and other important stakeholders seeking to ensure the delivery of high quality therapeutic care and positive outcomes for the children and young people who require it.

Suggested citation: Macpherson, L., Mitchell, J., Macnamara, N. and Gatwiri, K. (2022). Research Brief: Understanding the Needs of Kinship Carers in Australia, Centre for Excellence in Therapeutic Care: Sydney.

Background

Kinship care placements in Australia are now more prevalent than foster care. They are the fastest growing form of out-of-home care in this country (AIHW, 2021). On 30 June 2019, 93% of Australian children in out-of-home care were in home based care, with 37% in foster care and 54% in relative/kinship care (AIHW, 2021). This figure compares to 53% in foster care and 34% in kinship care in 1999 (AIHW, 2000). Data pertaining to the previous decade is not available. What is known, however, is that State and Territory child welfare policy and practice was previously geared towards placing children in foster care arrangements rather than with family or kin in Australia (Scott & Swain 2002). This practice is reported to have taken place across state and territory child protection systems; however, it was particularly evident in the case of First Nations children, where removal from family, community and culture became known as the creation of a 'stolen generation' (Human Rights and Equal Opportunity Commission, 1997).

The legacy of this policy orientation continues to challenge Australian child welfare systems today, with First Nations children currently reported to be 11 times more likely than non-indigenous children to be placed in out-of-home care (AIHW, 2020). This alarming figure continues to rise despite a policy shift in favour of kinship care placements throughout Australia. A trend toward favouring kinship care is evident in other Western Nations. In England, for example, there has been a large increase in the number of children being placed with 'grandparent special guardians', increasing annually from 5% in 2010 to 12% in 2017. Similarly, in the USA, 'more children are being raised by their grandparents today than at any time in recent US history' (Dueer Berrick & Hernadez, 2016, p.24).

Kinship care has been defined as the 'full-time protecting and nurturing of children by grandparents, aunts, uncles, godparents, older siblings, non-related extended family members, and anyone to whom children and parents ascribe a family relationship' (Child Welfare League of America, 2013, p.1). Carers may be relative carers – typically grandparents, aunts, uncles and older cousins – or non-relative carers, including family friends or those who may have had, at best, a tenuous link with the child prior to assuming the role of caregiver (Kiraly & Humphries, 2013).

Kinship care may be formal care, where children are placed as a result of statutory involvement, or informal care, where there may be an absence of agency assessment or involvement (Gordon, 2016).

The rise of kinship care in Australia represents a paradigm shift in social policy underpinning the provision of out-of-home care. Some argue that the motivation for the shift is primarily economic insofar as kinship care costs less. This is due to carers being provided with less training and given lower allowances and fewer supports (Boetto, 2010). Others suggest that irrespective of the political motivation to bring kinship care into favour, policy makers need to understand the critical differences between the previous system, which was founded on the work of volunteers (foster carers) who were connected to and supported by charitable organisations, and the emerging model of kinship care by relatives. An understanding of the context within which kinship care has evolved is seen as central to understanding current issues, including the identified needs of kinship carers.

THIS RESEARCH BRIEF WILL:

- Summarise the historical context for kinship care in Australia
- Present contemporary research findings that examine how kinship carers are faring
- Provide an overview of kinship care within a First Nations context
- Examine what is known about children in kinship care
- Apply a trauma lens to kinship carers' trajectory
- Identify kinship carers needs and key messages from the research

The historical context for kinship care in Australia

The unprecedented growth in the use of kinship care as a care option in recent years has, in many respects, not only preceded the development of a comprehensive social policy framework but has done so in spite of the previous 'practice wisdom' that kinship care should be a last resort rather than the first option for vulnerable children assessed as needing placement away from their birth families (Scott et al. 2002). In former decades, 'kin' – in particular grandparent carers – were seen as part of the 'problem' for the child being brought into care, with their own parenting of the child's parents being assumed to have been deficient. These attitudes and beliefs on the part of child protection agencies served to perpetuate the removing of children – including, in Australia, First Nations children – from their families and communities to be placed with 'more appropriate' foster families, who were overwhelmingly white and middle class (Scott & Swain 2002).

What do we know about how kinship carers are faring?

A recent Australian study involving 116 kinship carers and 210 foster carers examined their perceptions of well being as carers, with a view to noting differences between the two groups (Harding et al., 2020). Whilst findings found that overall wellbeing measures produced similar results between the two groups, some critical distinctions between kinship carers and foster carers were noted. Kinship carers as a cohort were older and more likely to experience stress and mental health concerns compared to their foster care counterparts, yet also reported greater satisfaction in their carer role than foster carers (Harding et al., 2020). In addition, this study confirmed earlier findings (Kiraly, 2015) that **kinship carers have less access to training and support services and far less contact with service providers than do foster carers** (Harding et al., 2020). This includes service providers who might offer support to them in their kinship carer role, as well as services designed to support children in their care. Importantly, more than half of the kinship carer respondents reported that they had not had an opportunity to participate in any formal training to support them in their carer role (Harding et al., 2020). These findings are not new. Earlier Australian studies have found that kinship carers reported less life satisfaction than foster carers and experienced greater health concerns (Delfabbro, 2017; Que et al., 2018). Carers recognised that they needed services to support them in their role and to address the needs of their kin child (Delfabbro, 2017).

In a major study of kinship carers in New Zealand, approximately 1100 grandparents described their experiences of raising their grandchildren – including the 'joys and challenges' of becoming a kinship carer (Gordon, 2016, p.3). This study has been described as the 'largest study of social, emotional wellbeing and economic issues affecting grandparent caregivers in the world to date' (Bundle, 2017, p.10). Research participants indicated that they loved having the children in their care but also reported **emotional, financial, health and housing difficulties** (Gordon, 2016). In a review of surveys involving kinship carers, Kiraly (2015) noted that a major concern associated with taking on the care of kin children was its impact on **personal finances**. Most costs were associated with day-to-day living expenses, but some related to expensive specialist assessment and treatment of children's special needs. For some, the costs of protracted legal proceedings had been particularly burdensome. This review concluded that carers had a myriad of unmet needs, ranging from meeting legal expenses to support for helping with their grandchildren's homework (Kiraly, 2015).

Kinship care of First Nations children and young people

It is now well evidenced that First Nations children and young people are overrepresented in child protection systems across Australia, with many of those children being raised by foster carers or in residential care (Gatwiri et al., 2019). Considering the colonial history of dispossession and attempted erasure of cultural identity, Butler (1993) argues that First Nations children's welfare is underpinned by five key principles, namely: spiritual identity, caring for the environment, extended family, cultural transmission, and self-determination. The Secretariat of National Aboriginal and Islander Child Care (SNAICC) (2005, p.2) also states that 'maintaining contact or involvement with family or returning to family will always be in the First Nations child's best interests if safety issues can be addressed'. Despite the demonstrated importance of cultural connection for First Nations children, Kiraly and Humphreys' (2015) study showed that 'children in non-Indigenous kinship care in Victoria may be growing up without an active connection to their Indigenous family and culture' (pg.30).

Given that culture is a particularly salient component for the wellbeing of First Nations children and young people, the Aboriginal Child Placement Principle places preference on kinship care over non-relative foster care. This policy has been ratified within all Australian states and territories (Australia Institute of Family Studies, 2007). According to the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), "Aboriginal Kinship is a diverse and complex system [and] refers to the biological bloodlines that have been passed on from generation to generation" (QATSICPP & Smith, p. 7). In First Nations contexts, family and community underpin the development of a child. Simply stated, "stability for Aboriginal children and families exists in relationships and connections to community, culture and country and conceptualisations of family and caregiving are embedded within the culture. Therefore, 'being with family, being raised by family in culture is at the heart of an Aboriginal child's perception of permanence, identity development" (QATSICPP & Smith, p. 7). This is why DiGiacomo and colleagues (2017, p.2) suggest, "the term 'carer' may not resonate with First Nations carers who perceive it as reflecting formal care workers; thus, First Nations carers may not identify as carers despite significant care responsibilities". This may consequently inform the underpinning challenges for First Nations carers accessing formalised external supports.

Due to historical issues of colonisation and implications for the stolen generation, there exists significant mistrust between child welfare services and First Nations carers and communities. Ongoing gaps in culturally sensitive and safe practices can also increase mistrust and fractured relationships between child welfare services and institutions and First Nations carers. This means that First Nations carers may only seek support when there is a crisis or not at all. This historical context has acute implications for First Nations carers and their communities due to the high levels of structural and social economic disadvantage (DiGiacomo et al., 2017). Despite this ongoing disadvantage, recent research has showed that First Nations kinship carers take on the carer role because of a "strong attachment," a deep sense of "family and cultural responsibility", mistrust of foster care experiences of First Nations children placed "with strangers" and to "look after" their own children in a culturally informed way (Irizarry, Miller, & Bowden 2016, p.206).

Given the continued dearth of research on the experiences of First Nations carers, Kiraly, James and Humphreys (2015, p.30) suggest that "an active partnership between child protection and Indigenous services is needed" if First Nations children are to remain "connected with family and culture" as per the requirements of the Aboriginal Child Placement Principle. If this is not addressed, they argue, First Nations children in kinship care will "remain at risk until all assessments are thorough and culturally aware, and robust support is available to caregiving families" (Kiraly, James & Humphreys, 2015, p.31).

Outcomes for children in kinship care versus foster care

Kinship carers are the primary point of focus within this Research Brief. That said, it is noteworthy that internationally, there has been considerable research interest in the kin children who are cared for (Akin, 2011; Harnett et al., 2012; Koh, 2010; Koh & Testa, 2008; Stene et al., 2020; Winokur, Crawford, Longobardi &Valentine, 2008; Winokur, Holton & Batchelder, 2018). There is some evidence, primarily emerging from the USA, **that children in kinship care are faring better than their counterparts in foster care** (Harnett et al., 2012; Winokur, Holton & Batchelder, 2018). A systematic review of 62 studies involving outcomes for children in care, for example, found that children placed with kinship carers had fewer behaviour problems and stronger adaptive behaviours compared with children placed in foster care (Harnett et al., 2012). More recently, a systematic review of 102 international studies examining the "kinship care effects on safety, permanency and well being" (Winokur, Holton & Batchelder, 2018 p.19) presents compelling evidence that children benefit from placement in kinship care. This review found that, when compared to children placed in foster care, children in kinship care demonstrate a lower rate of behavioural and emotional difficulties, are more stable in their placements and experience lower levels of depression and higher levels of overall well being (Winokur, Holton & Batchelder, 2018 p.19).

In summary, existing research indicates that **children in kinship care fare better** than those in foster care: they stay in placement longer, have greater educational continuity, better health and mental health outcomes (Winokur, Holden & Batchelder, 2018). Further research to explore the 'essential ingredients' contributing to successful outcomes for children in kinship care placements may be helpful.

WE SUGGEST THAT THEY MAY INCLUDE:

- **depth and continuity of relationship with an extended family member or friend offering unconditional love and support to the child,**
- **connection to culture and community. This is particularly critical for First Nations children who may otherwise have been removed from community.**

Applying Life Course theory to the lived experience of kinship carers

A 'life course' approach may offer some additional opportunities to reflect on the experiences and needs of kinship carers (Connolly et al., 2017). A life course approach offers an interdisciplinary perspective focusing on five basic concepts: cohorts, transitions, trajectories, life events, and turning points. These points of focus enable close examination of the interplay of human lives and time, interdependent lives, human agency and diverse trajectories (Hutchison, 2005). Drawing on this approach, we recognise that kinship carers are not a homogenous group and feature young and mid-life carers, which may be siblings, cousins, aunts and uncles or family friends, known as kith. The approach has particular relevance for grandparent carers who have reached 'late adulthood', defined as sixty-five years onward (Connolly et al., 2017).

This is the life stage when many adults enter a period of retirement from the workforce. For some, it is a stage of new life opportunities, having separated from the paid workforce. Having additional time to take up new interests and hobbies and to strengthen existing or create new friendship networks is a long-awaited possibility for some in this stage of life.

For others, it may be a time of increased financial distress, particularly where there is housing instability. This stress is likely to be exacerbated by the unanticipated (and therefore unplanned for) requirement to become a full-time carer. In addition, whilst their peers may be enjoying newfound opportunities to socialise, grandparent carers may experience isolation and loneliness in their lack of 'fit' in friendship or support networks.

Whilst many adults in this cohort remain healthy and active, it is also a normative expectation of this life stage that physical and cognitive health will decline. Some will experience mobility concerns and frailty. For them, the physicality of caring for children, in particular infants and younger children, may present particular challenges.

These are but some of the 'normative' considerations for grandparent kinship carers from a life course perspective. Challenges faced by kinship carers in late adulthood, however, may be **compounded by their historical and current experiences of trauma** (McPherson & MacNamara, 2014).

Applying a trauma lens to kinship carers' trajectory

The international evidence concludes that **kinship carers, as a cohort, are older, in poorer health and experience more stress** than foster carers (Harding, Murray, Shakespeare-Finch & Frey, 2020). Kinship carers who are grandparents also often come into the role in an emergency placement situation, following years of difficulty with their own (adult) child's mental health, violence or substance abuse issues (McPherson & Macnamara, 2014).

Children who are the subject of statutory child protection may initially be placed with kinship carers in a crisis situation. The legislative framework governing practice in each state and territory in Australia requires effort to be reasonably made to enable children to live at home if at all possible, based on the overarching 'best interests of the child' principle. For example, Section 10.3 (i) of the

Chidren Youth and Families Act (2005) in Victoria, Australia requires that consideration must be given to:

> *(i) the desirability, when a child is removed from the care of his or her parent, to plan the reunification of the child with his or her parent.*

Similarly, where a child is removed from home in New South Wales, Australia and the Children's Court is involved, a 'restoration plan' must be developed to enable parents to work toward the restoration of their child into their care (FACS, NSW, 2021).

These legislative provisions endeavour to ensure that children can live with their parents if at all possible and if it is safe to do so. What this may also mean, for example where birth parents are struggling with substance use addiction, is that a series of crises may result in multiple requests for placements to be provided by kinship carers, following the 'breakdown' of reconciliation with parents. **It could be theorised that these placements made in crisis may not be 'one off' events. In fact, kinship carers may find themselves in situations of perpetual crisis as they take on the role of carer, only to later relinquish care to a potentially unsafe caregiver before being again requested to offer care, and so on.** Further research is needed to investigate this issue.

In addition to the issues of placement crises that kinship carers may need to manage, the implications of **previous traumatic life experiences** involving the parents of their kin child, in terms of carers taking on a role that may trigger unresolved, complicated grief and trauma (Machin, 2014), does not appear to have been addressed in the prevailing research. It is also recognised, however, that kinship carers often have limited access to social capital, rendering them less able to access formal and informal networks of support (Taylor et al., 2020).

Consistent with these findings, a small Australian study seeking to better understand the experiences of grandparent carers identified the paradox for carers whose experiences were: **"simultaneously made up of pain/pleasure, myth/reality, inclusion/exclusion, being deserving/underserving, visible, invisible and voiced/silenced"** (Backhouse & Graham, 2010 p.306). **Experiences of 'deep pain'** were recounted by grandparent carers where the key issues surrounding placement included parental mental health, substance abuse, violence, imprisonment, HIV/AIDS and parent apathy or apparent indifference toward their child (Backhouse & Graham, 2010). This study identified the complexity and ambiguity of changing role identity for grandparent kinship carers, who moved between the role of parent and grandparent, in situations that were compounded by loss and grief. In another study involving 303 grandparent carers in the USA, reports of **feelings of guilt** about the inability of their adult child to parent were a major source of stress (Duerr Berrick et al., 2016).

A study in the United Kingdom recently explored the trajectory of grandparent kinship carers from initial assessment through to placement and beyond (Hingley-Jones, Allain, Gleeson, & Twimasi 2019). Participants in this study indicated that initial assessments and decision making with respect to their grandchildren was often made at a time of family crisis. For some, these unplanned placements led to major impacts on grandparent carers' capacity to work, plan for their retirement and manage what had become difficult family relationships. These authors critique social policy and social work practice, concluding that grandparent carers are often left on their own to address the complex emotional needs of their grandchildren who had experienced early trauma (Hingley-Jones, Allain, Gleeson, & Twimasi 2019). In another small qualitative study conducted in the USA, grandparent carers expressed dissatisfaction with a welfare system that appeared to exclude them from critical decisions, highlighting service gaps and unmet support needs. The authors concluded that the **voices of grandparent carers needed to be included in the development of policies and programs designed to support them** (Gentles-Gibbs & Zema 2020).

FROM A 'TRAUMA INFORMED' PERSPECTIVE (MITCHELL ET AL. 2020), THE COMBINATION OF A 'PERFECT STORM' OF RISKS TO PLACEMENTS EMERGE FROM THE LITERATURE FOR KINSHIP CARERS, WHO, WHEN COMPARED TO FOSTER CARERS, HAVE;

- **poorer health,**
- **greater financial and housing difficulties**
- **limited social networks and support,**
- **lack of preparation for the role prior to placement**
- **lack of training and support post placement**
- **limited access to services**
- **crises and ambiguity in relation to their role as parent and grandparent and**
- **feelings of guilt in relation to their adult child's inability to parent safely**
- **experience of trauma and loss, triggered by caring for the kin child (for grandparent carers).**

Despite these identified risks, children in kinship care stay in placement and school longer, with stronger health and mental health outcomes than their foster care counterparts (Winokur, Holden & Batchelder, 2018). Clearly, kinship care is a promising out-of-home care model worthy of investing in.

What are kinship carers needs? Some tentative conclusions

Overwhelmingly, the messages from the literature in respect to kinship carers are that they experience a unique journey in terms of becoming and remaining a carer of a child/children who have experienced harm. This is a journey that (for grandparent carers) may have involved **grief, loss and trauma** as parents of a now adult child. For some, this child may have died. For many involved in the statutory child protection system, that child may have a history of substance abuse, violence, incarceration and /or mental health concerns.

A service system that was built historically to address the training and support needs of foster carers is unlikely to address the needs emerging from this unique journey. Foster carers are adults who have identified an interest in becoming a carer, made plans within their lives to pursue that interest and have commonly undertaken pre-placement training to become accredited carers for a child who will be 'matched' to their family (McPherson & Macnamara 2014).

Based on what is known about the unique trajectory of kinship carers and the available literature, what follows are a series of six key messages proposing kinship carers needs and implications for policy programs and practice.

1. **Policies** designed to support kinship carers must include the 'voices' of carers in their development, implementation and evaluation, ideally using models of participatory co-design (Gentles-Gibbs et al., 2020).

2. **Policy and program frameworks** need to reflect both the dominance of kinship care as a preferred form of placement and the unique characteristics of kinship care placements. Based on an array of studies suggesting that kinship placements may be unplanned and occur in the midst of a family crisis (Connolly et al., 2017) impacting on the child and kinship carer, tailored responses are required to address emergency practical and emotional support needs.

3. **Models of Training** and ongoing support for kinship carers should be available and include explicit attention to the needs of children who have experienced trauma and the needs of kinship carers who may be experiencing the 'pleasure and pain' of caring.

4. Being cognisant of past policies that excluded kinship carers as a viable placement option (Scott et al., 2012), **practice frameworks** should ensure an outreach, proactive approach to supporting kinship carers that is non-judgemental, respectful and relationship based (Conolly et al., 2017). Practices should be holistic and mindful of normative life course issues as well as the potential triggers, pain and distress that may be associated with the kinship placement and family relationships.

5. **The therapeutic care team approach** (Macnamara, 2020) is one that may address many of the concerns emerging in the prevailing research regarding kinship carers' needs. Therapeutic care teams offer a trauma informed, therapeutic response to a child in a kinship care placement. As core team members, kinship carers are respected, listened to and heard. Their observations and experiences of the child in their care are valued. A network of professionals and other adults using this approach to work with the child develop a "relationship in which all parties feel equal and share responsibility for the success of their common purpose: the best interests of the child and the well being of the carer" (Macnamara, 2020, p.228).

6. In light of identified experiences of **isolation and loneliness,** kinship carer peer support groups may be an invaluable form of support, offering new networks, emotional support and social connection. These groups might also create a space for carers to consider their well being and their personal processes of "meaning-making" (Cavanagh et al., 2020).

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