CHILD SAFETY COMMISSION OF INQUIRY

Court 1, First Floor, Toowoomba Courthouse
159 Hume Street, Toowoomba

On Tuesday, 24 February 2026 at 10.34 am

Before: Mr Paul Anastassiou KC, Commissioner

Counsel Assisting:	Ms Robyn Sweet KC
	Mr Nathan Boyd
	Ms Bianca Mendelson

COMMISSIONER: Yes.

MS McMILLAN: Yes, good morning, Commissioner.

COMMISSIONER: Good morning.

MS McMILLAN: I just raise two issues, if I could. The first one is - it's perhaps my overlooking it - is there a hearing still scheduled for March and one for April?

COMMISSIONER: That's a very good question. We're planning to have a further hearing in April, particularly focused on the resi care model of care and the financial aspects of that model. There might be, and this is still under review, a further hearing focusing upon, broadly speaking, the question of accountability of the department's senior officials, of the department and the like. That is not settled at present, but as soon as it is we'll let you know, obviously.

MS McMILLAN: Yes.

COMMISSIONER: But I can say confidently I think that the hearing in relation to the resi care model will proceed in April.

MS McMILLAN: Thank you.

COMMISSIONER: And I think we have some tentative dates for that already.

MS McMILLAN: I think we've certainly got something in our diaries. Whether that's the --

COMMISSIONER: So that's the plan.

MS McMILLAN: The second issue, if I could raise, is I understand that submissions from parties and perhaps others, I don't know, are due on 20 March.

COMMISSIONER: Due in the sense that there's no time to waste.

MS McMILLAN: Yes. No, no, no, I wasn't being --

COMMISSIONER: No, I know that. That's what we have asked for because of the accelerated timeframe and to allow some

opportunity to digest the material and take it into account in relation to the drafting of the report. Much later than that might end up - it may not be possible to digest it if it's much later than that.

MS McMILLAN: I understand. The other related question is will we have some indication from the Commission as to what it will find helpful from various parties?

COMMISSIONER: Let me give some thought to that.

MS McMILLAN: I am putting you on the spot, Mr Commissioner.

COMMISSIONER: No, no, it's a fair enough question. What would be helpful, as a general proposition, would be submissions directed to the subject matter of the terms of reference and in particular matters that can be properly characterised as having an impact on the way the system operates, so the systemic issues. Now, I had this discussion previously, I think, in particular with Mr Hastie. There's always a question about the degree to which one can extrapolate from individual's evidence to the generic.

MS McMILLAN: Yes.

COMMISSIONER: But it is possible to extrapolate, particularly when themes are repeated, problems identified by one person seem to be similar to those experienced by others in different places, and therefore I will to the degree I think it is reasonable extrapolate from the individual to the general because, given the scope of the terms of reference and given that I'm directed to look at matters at a systemic level, and also where possible to use a sort of case study methodology, that is the course that I think is mandated. So there will be, I suppose, room for debate about the extent to which extrapolations of general propositions can be advanced or inferred.

MS McMILLAN: Yes.

COMMISSIONER: It might be, for example, that survey evidence could have been obtained. It's not presently and now a possibility from the perspective of the Commission to undertake a survey, but I was thinking about that just recently and it occurs to me that the department may have

undertaken its own surveys, and I think there is some evidence about surveys as to satisfaction by relevant groups with its performance, and I'm going to expand my request for the production of any such reports. Indeed, I would say as a general proposition that it's commonplace in commerce for satisfaction surveys, exit surveys --

MS McMILLAN: Yes.

COMMISSIONER: -- such as when an employee leaves --

MS McMILLAN: Yes.

COMMISSIONER: -- and here relevantly let's say when the child leaves resi care or foster care. I'm not aware that the department approaches the evaluation of its own performance in such an orthodox manner, and perhaps it ought to, and I think I might have something to say about that. But I'm going to ask for more of that material because there are limitations to the extent to which one can extrapolate from specific evidence --

MS McMILLAN: Yes.

COMMISSIONER: -- although we have had a body of evidence on various topics --

MS McMILLAN: Yes.

COMMISSIONER: -- from which I think confidently inferences can be drawn and will be drawn, and of course we've had the proactive statements from the department focusing on their systems and processes, which are also of course relevant. Now, that's not a very straightforward or short answer to your question. If I think of particular matters as the analysis progresses that I could be assisted with, I'll let you know.

MS McMILLAN: Thank you.

COMMISSIONER: But as a general proposition I would invite any interested parties to focus on the terms of reference and their relevant interest in the system, and identify systemic issues as they perceive them.

MS McMILLAN: All right. Thank you, Mr Commissioner.

COMMISSIONER: Thank you very much.

MR BOYD: Commissioner, there's just two matters I wish to raise before we commence Dr Griffiths' evidence. Dr Griffiths has provided a number of statements. The second statement contains a case study in relation to a particular young person. That young person, as I understand it, would be easily identifiable if there was reference to dates, locations and things of that nature in an open hearing. If that matter can be discussed, if necessary, however, on the basis that it is done at a level of generality such that things such as dates, place names and those matters that might be able to identify the individual are not referred to in the open court hearing?

COMMISSIONER: That's in the second outline, is it?

MR BOYD: Yes.

COMMISSIONER: Yes. We will I think follow what has become the settled practice of de-identifying the material that might lead to the identification of the identity of a child - it's usually a child --

MR BOYD: Yes.

COMMISSIONER: -- so that if we all proceed on the basis that we have been, not identifying the name, where the location is something that might reasonably identify the individual there's no need to refer to the location --

MR BOYD: Yes.

COMMISSIONER: -- or any other identifying factors. We've proceeded in that way thus far I think generally without hiccup, and I propose we continue with that course.

MR BOYD: Yes, thank you, Commissioner. Thank you. The second matter I wish to raise is in Dr Griffiths' third outline of evidence it refers to her providing a fourth outline of evidence.

COMMISSIONER: Yes.

MR BOYD: This appears at paragraphs 11 to 14 of that outline.

COMMISSIONER: A fourth outline, did you say?

MR BOYD: So the third outline --

COMMISSIONER: Yes, third outline; thank you.

MR BOYD: -- refers to the existence of a fourth outline of evidence. As it says in that outline, the fourth outline was provided in confidence to the Commission. The reason for that is that it relates to a model of care that is being proposed by OzChild presently, which is the subject of an ongoing tender, so it contains commercially sensitive information.

COMMISSIONER: Well, it contains presumably price-sensitive information if they're presently involved in a competitive tender process.

MR BOYD: I don't know if I could say it goes to that level of detail. However, Dr Griffiths has raised - it was provided to the Commission on the basis that it was in confidence because it related to an ongoing tender process.

COMMISSIONER: The fourth outline?

MR BOYD: Yes.

COMMISSIONER: I don't seem to have the fourth outline.

MR BOYD: It wasn't proposed to be tendered during this morning's hearing, Commissioner.

COMMISSIONER: I see. So the Commission has it --

MR BOYD: It's in the possession of the Commission, but because of the basis on which it was provided it was not to be both tendered today nor the subject of evidence.

COMMISSIONER: It could be tendered as a confidential exhibit for reference only by the Commission.

MR BOYD: Yes, I'm happy --

COMMISSIONER: I mean, we have it.

MR BOYD: We have it, yes.

COMMISSIONER: Is there objection to the government parties having - I suppose there might be because they're likely to be the counterparty in the tender process.

MR HASTIE: We will get the tender, the tender to my child services client. But my learned friend and his - and, sorry, Dr Griffiths would be concerned that competing tenders, presumably - concerned that competing tenders wouldn't wish to know not only price but maybe even the content.

COMMISSIONER: Of course. But there aren't any competitors present. Of course if it was tendered openly then that would be a different matter.

MR HASTIE: Yes.

COMMISSIONER: Your client will get the tender in due course.

MR HASTIE: Or we might have it. I don't know.

COMMISSIONER: It may be presently subject to amendment by the tendering party. This might be where they're at thus far, so to speak.

MR HASTIE: Usually there's mutual confidentiality agreements that protect my client and also the tenderer. I don't know whether or not the other parties might, Commissioner, act for competing tenders. But, Commissioner, as you say, if the Commission has the document and if you wish to mark it as a confidential tender and keep it to the Commission, there could be no objection to that.

COMMISSIONER: I think that's the course I will take just so that the record's clear, and by the sound of it, Mr Hastie, you don't need it for present purposes?

MR HASTIE: No, Commissioner.

COMMISSIONER: Yes. Thank you. All right.

MR BOYD: And I should say, Commissioner, I will be exploring through this witness that type of model at a higher level and how that might be implemented, just not to the level of detail that's provided in that fourth outline.

COMMISSIONER: Yes. But that detail may be of assistance at least in understanding what is being proposed, from my perspective.

MR BOYD: Certainly.

COMMISSIONER: Yes. All right. Well, why don't we proceed on that basis.

MR BOYD: Thank you, Commissioner.

COMMISSIONER: Is there any objection from anybody to that course?

MS McMILLAN: No.

COMMISSIONER: No? Good. All right.

MR BOYD: I call Dr Lisa Jane Griffiths.

COMMISSIONER: Thank you.

<LISA JANE GRIFFITHS, SWORN [10.48 am]

<EXAMINATION BY MR BOYD

MR BOYD: Good morning, Dr Griffiths.
A. Good morning.

Q. I'll just firstly confirm the material that you've provided to the Commission. You have provided four outlines of evidence; is that correct?
A. Correct.

Q. And, as you would've heard a moment ago, discussion going to the fourth outline of evidence, which is to be provided confidentially to the Commission?
A. That's correct.

Q. And there are a number of annexures attached to each of those outlines of evidence?
A. There are.

MR BOYD: Commissioner, you should have a copy of the relevant material, save for that fourth outline, which we'll make available.

COMMISSIONER: I do. So do you wish to tender them separately or as a single exhibit?

MR BOYD: The first three outlines perhaps could be tendered jointly --

COMMISSIONER: Yes.

MR BOYD: -- and then the fourth outline separately because it is confidential.

COMMISSIONER: The three outlines of Dr Griffiths will be exhibit CA-65.

EXHIBIT #CA-65 - FIRST THREE OUTLINES OF DR GRIFFITHS

COMMISSIONER: And I'll treat as tendered the fourth outline, which will be confidential exhibit CA-66.

EXHIBIT #CA-66 (CONFIDENTIAL) - FOURTH OUTLINE OF DR GRIFFITHS

MR BOYD: Thank you, Commissioner.

Dr Griffiths, could you please just start by telling us the various roles and positions that you currently hold?
A. Of course. I'm currently the chief executive officer with OzChild, which is a community service organisation that's been around for 175 years. We operate in Victoria, New South Wales, the ACT and Queensland, and here in Toowoomba. I've been in that role for 12 years. I also hold a number of appointments. I'm on the board of directors as the chairperson of Families Australia, which is the national peak body for children and families. I'm also on the board of the peak body for children and families in New South Wales and also on the board of PeakCare, which is the peak body here in Queensland. I'm also the chair of the National Foster Care Sustainability Group, and I hold a number of appointments as a professor for the Australian Graduate School of Leadership, and I'm also an adjunct professor for Torrens University Australia.

Q. Thank you. One of the topics which I'll come to in a moment is the Treatment Foster Care Australia program, which is being implemented by OzChild in this region. But before I get to that I just want to take it back a little

bit to talk about the genesis of the program and the types of programs that can be implemented in the child protection space. Now, one thing that you've referred to in your first outline of evidence is the concept of an evidence-based program?
A. Yes.

Q. Yes. And that's an expression that gets thrown around a fair bit in the child protection space, would you agree?
A. I do agree.

Q. And would you accept that the term can be applied fairly loosely in that some programs that claim to be evidence based are perhaps not evidence based?
A. It's definitely a term that is used loosely, and the rigour of the underpinning evidence of certain programs or practices is markedly different.

Q. Okay.

COMMISSIONER: What do you mean by an evidence-based program?
A. Commissioner, what I mean is that evidence-based programs use - have an underpinning research base and they're rigorously evaluated. But if you look at the hierarchy of evidence, because evidence based actually comes from - you know, evidence-based medicine - if you imagine a triangle and at the top of the evidence hierarchy you would have meta analyses or systematic literature reviews, which would be studies of studies. Underneath that you would have what people would be familiar with as randomised control trials, which are known as sort of gold standard, where you are studying an intervention in a population group where there is a control group and an intervention group and you sort of want to understand what the success of that intervention is. Coming below that you would have what's known as quasi-experimental randomised control, which --

COMMISSIONER: I understand those methodologies, both academic and in the I suppose broader social science context.
A. Yes.

COMMISSIONER: But when you talk about evidence-based programs do you mean that you have a program and then you evaluate the program by one of the methodologies that

you've just described, or one or more of those methodologies? The methodologies themselves are not controversial, like a random double blind study of, say some medical drug, for example. That's a standard methodology, isn't it?
A. Correct.

COMMISSIONER: Right. Now, in relation to foster caring, what is the program or programs to which the evidence-based evaluation that you speak of is to be applied or has been applied?
A. In the realm of foster care, Commissioner, there's only one gold standard program that has undergone multiple randomised control trials, and that's the subject of my evidence today, which is Treatment Foster Care Oregon, and we've adapted it to the Australian context, or Treatment Foster Care Australia. In regards to evaluations of foster care, what's probably worthwhile understanding is foster care itself is a service between a volunteer carer providing support for a child. What I'm referring to in terms of evidence-based programs, they have core components. They're an intervention. When you're at the level of an intervention, such as Treatment Foster Care Australia, then you are trying to create some sort of change, behaviour change, and have a causal effect. That's not what typically occurs in a foster care placement. You know, the placements setting is somewhat of a crisis response service or child removed from a family, they need a placement which is safe and secure. But the level of supports to that care vary in practice and vary in evidence as to how successful a carer can be in working with the individual needs of that child.

COMMISSIONER: See if you can explain to me, please, the differences between what I'll call traditional foster care - a voluntary model with a degree of financial support provided by the department, with a degree of practical support provided by the department, but essentially, as I would understand it, the model involves volunteers taking on the role of being the day-to-day carers, if you like de facto parents, of the child and all that that entails. Now, that's the traditional model. What are you proposing that is different from that?
A. With the model of Treatment Foster Care Australia specifically, that is designed, and it's intentional, to be a short-term model to either step a child out of a residential care setting because there may be behaviours

that they are displaying that are preventing them being successful in being able to be safe in a foster care placement or a kinship care placement, or actually to be reunified back to family.

COMMISSIONER: All right. Look, let's see if we can step through or if you could assist me by explaining to me the elements which are different. You've identified one already, namely that your model, the Treatment Foster Care model, is not proposed as a long-term residential placement for the child but some short-term arrangement intended to provide the child, I assume from what you've said, with some therapeutic assistance; is that a correct characterisation?

A. Yes, Commissioner. So the model itself has been around for over 30 years. So it has 30 years of evidence in its application to different cohorts of children - so children would have characteristics such as they might have offending behaviours, they're not able to attend school, they're hypervigilant, high arousal, they're unable to control their emotions, low self-control - and it is intentionally designed with a clinical team, of which the carer is part of that clinical team, to set specific behaviour change goals so that if a child is in residential care and has had what's known in the out-of-home care system as multiple placement breakdowns, so they're not being successful in placement with their kinship carer or with their foster carer, so they're put into a residential care setting, they're co-mingled with other children that have experienced significant trauma, significant abuse and neglect, and they are acting out, they are being disruptive, destructive, then this model, if the child matches those criteria, they're broad, then it's an intentional model to work to take that child into the program, a carer is matched to the child and the child matched to the carer, and the clinical team supports the foster carer in an average 11-month intervention to reunify that child either back to family or to step down to a long-term foster care placement or back to kin.

COMMISSIONER: So it is not a model which substitutes for a long-term foster care?

A. No, it does not.

COMMISSIONER: It's a transition to either - a model aimed at transition to either reunification?

A. Yes.

COMMISSIONER: Or, if that's not available, to long-term, what I'll call for the sake of distinction, traditional foster care model?
A. Yeah, a family-based placement.

COMMISSIONER: Or residential care?
A. No, the model is intentionally designed to keep children out of residential care.

COMMISSIONER: What if in the application of the model to a particular child reunification proves to be unavailable and a long-term foster carer cannot be found and the child still needs care, what then?
A. Well, during the course of the model we - so I guess the eligibility criteria for children to come into the model, it's a - you know, a team work between the department as is the provider in - and the provider takes on the onus of finding the carer, the therapeutic carer that will be part of the clinical team. They know it's a short-term intervention.

We also take care of providing the respite carer so that carer can have respite as required. But one of the criteria is that there is an after-care placement identified for the child, and that could be reunification, so it would be part of the case plan goals, or it could be a kinship carer, so someone in the family network, or it could be a long-term carer that says, "I want to care for a child." So that's all part of the model. So it's successful by having all of those components in place.

COMMISSIONER: So at the outset you've identified what the end point will be, and it will be one of those three outcomes?
A. Correct, and --

COMMISSIONER: What if those three outcomes are not available? I mean, are you saying to me that in all cases of a child entering into this model or being cared for therapeutically within this model it is, as it were, guaranteed that one of those three outcomes will be available?
A. Well, the guaranteed success rate I can give you is off of the evidence. So the international literature would say that 60 per cent of the children will be successful in completing the program.

COMMISSIONER: What about the decision-making in relation to reunification, because I've heard a good deal of evidence that causes me to be concerned about the soundness of decisions in relation to the reunification of children where factors objectively would suggest they shouldn't have been placed with kin or family; and I could tell you I'm troubled by the I think almost ex-ante and predetermined objective of reunification without an objective evaluation at the time the decision is being made as to whether the child's best interests, properly evaluated, would be served by reunification, all of which is undertaken under the cover of placement powers. So how does your model address decision-making in relation to reunification?
A. As I referred to, Commissioner, in that case plan or the goal setting for that individual child we will work collaboratively with the department in understanding whether reunification is a viable option.

COMMISSIONER: But you might be collaborating in the pursuit of a goal that is a shared goal but one not suitable for the particular child in question. So you have a great deal of unanimity as to the intended outcome, which I would suggest presents a risk that objective evaluation of whether or not the child should be reunified is, on the several cases I've heard, not properly evaluated. So what I'm asking you is whether there is in this model, which seeks these worthy outcomes, an embedded bias to an outcome that may in fact in the individual case not be congruent with the child's best interests?
A. Well, in our professional practice and certainly in my organisation and from an ethical perspective, you know, we're very child centred in our work, so we would certainly never - if we felt at any time that there was reunification to the wrong party - and in the case study that we might run through shortly that the reunification initially for the young person was to dad, but subsequently safety assessments determined that that was not going to be in the best interests of the child, so the plan was changed and reunification then was made to grandparents. And three years on from that successful intervention, which lasted longer in this young person's case, they're still safely living with their grandparents.

COMMISSIONER: Are you aware in your various roles in connection with foster caring of a pretty wide body of complaint on the part of foster carers --

A. I am.

COMMISSIONER: -- who are confronted with a situation where they are, in my hypothetical example, prepared to provide permanency for the child, are attached to the child, the child is attached to them, and somebody makes a decision, often contrary to the wishes of the child, that the child should be reunified and oftentimes the attempted reunification fails and the child ends up back with the foster carer, and the foster carer isn't permitted or certainly not facilitated in becoming a long-term guardian because of the prospect, sometimes I would suggest a vain hope, that the child will be reunified, so the child ends up in a state of limbo rather than in a state of comfortable permanency with his or her foster carer.

Now, that tension has emerged in the course of evidence I've heard before this Commission - in this Commission and indeed a number of stories I was told by participants in the youth engagement session that I participated in yesterday, and it is a repeated - it's a theme that keeps getting repeated. So it leaves me wondering on what basis evaluative decisions are being made as to the best interests of the child when it comes to these questions as to reunification. So how does your model address that question; that is, the proper evaluation of the best interests of the child when it comes to reunification?
A. So I want to acknowledge, Commissioner, that I completely empathise and understand and honour and have great respect for the work of our foster carers across the nation, and work tirelessly in many roles to promote - to make their work and their altruistic nature acknowledged and much, much easier.

COMMISSIONER: Well, explain this to me then: why is it that their views are not sought by the department, as far as you understand it, or other relevant decision-makers and advisers when the critical question of whether the child's circumstances should be altered arises? As I understand the evidence - I don't believe it's disputed by the department - they disdain the input of foster carers in relation to the question of whether the child should be reunified or not.

MR HASTIE: Commissioner, that might be - I might have led you into error. That would be putting it too highly to say my client disdains the opinion. It's not unreasonable, as,

Commissioner, I think you're advancing, the proposition that there are a number of considerations involved in reunification and that foster parents would be one of them but not the controlling one.

COMMISSIONER: I'll choose a different word other than "disdain" --

MR HASTIE: Thank you.

COMMISSIONER: -- but the basis of my inference that the department is not interested in the views of foster carers on these critical questions - and you can correct me if I'm wrong - is that there is nothing in their process, procedures, policies, manuals, standard operating practices, et cetera, that even goes so far as encourages consultation with foster carers in relation to this important matter. It's a decision, as I would understand the evidence, and there's been quite a lot of it, that is made entirely intra-department.

MR HASTIE: Well, ultimately it is, Commissioner, so there's no dispute about that, and I think what some of the evidence from the foster parents who dealt with this subject was that they felt that the attempts to have reunification were taking - were preventing the child from permanency with the foster parent --

COMMISSIONER: Well, that's one aspect of it, I agree.

MR HASTIE: Yes, and that they were frustrated by that, and I think one of the witnesses in Cairns used the expression there has to be limits to the attempts to obtain reunification. But I didn't understand even her to say that the emails on the subject were ignored by my client.

COMMISSIONER: Well, there have been a number of witnesses who have spoken about this. There was a witness last week who gave up being a foster carer as a result of certain interactions with the department.

MR HASTIE: Yes.

COMMISSIONER: But what I was focusing on is the absence of evidence from the department of its affirmative interest in consultation with foster carers on this important matter. As I've said, there's nothing - and you can point

out to me if I'm wrong because it's either there or it's not - in the written material, and there is from the department witnesses that I've heard no suggestion that foster carers are an important group to consult with when making an evaluation of what's in the best interest of the child. So I'm asking this witness these questions because of her role in various ways in relation to the foster care model, including the traditional model.

MR HASTIE: Commissioner, I have no objection to that and it's, with the greatest of respect, a very sensible question to ask. It was just that the one word was putting it too highly, respectfully.

COMMISSIONER: All right. So --

MR HASTIE: But I think the witness probably understands what, Commissioner, you're getting at.

COMMISSIONER: Yes. Because - all right. Thank you.
A. Yes.

COMMISSIONER: So do you --
A. May I answer, Commissioner --

COMMISSIONER: Please.
A. -- in two ways. So can I distinguish first of all general foster care as we're discussing and most - I understand most of the carers that you have been engaging with are in the general foster care realm and --

COMMISSIONER: Yes, they are.
A. Yes, and those are the carers that we have at OzChild all across Australia and here as well in Queensland. Treatment Foster Care Australia is a small, discrete program that has small numbers of children in it, up to seven, and therefore the carers in that model know joining the model that they are part of a clinical team that's a short-term intervention. So they're probably not atypical of the carers that you're referring to in whether they have any decision-making rights or party to whether it is suitable for that child to be reunified.

The other distinguishing feature about this model is that, if reunification is a suitable option, that's decided by the department with input from the service providers, but also with the child themselves, and often their motivation

for coming into the program is that that is an option. Most children - and I know that, Commissioner, you've spoken with many - do not want to remain in residential care and would prefer to be in a family-based environment. So this is a pathway, and the pathway that's best suited to their needs is determined by various risk assessments that are undertaken by the department with our support.

But, to go to your broader point about carers in general foster carers, what you are hearing is common amongst carer voices across Australia. They aren't often involved or party to conversations about the child, yet the child lives with them every day.

COMMISSIONER: Doesn't that strike you as somebody involved in this system as passing strange?
A. Absolutely. I mean, there - and if you look at, you know, the model I'm describing over here, they are part of the clinical team, which means they are part of the dealing-making of what's happening to that child every day, how the strategies are deployed to best support that child, if the child isn't going to school they have a teacher that works with them to ensure that that care - that the child does attend school. So lots of the challenges that carers face day to day - and there's a myriad of them, you know, cost challenges, accessing health care, workplace entitlements. The list is very, very long, Commissioner, and we certainly do not accommodate the great needs of carers so that they can be set up for success to care for children.

COMMISSIONER: Dr Griffiths, I understand that you've come here, and I'm very grateful, to talk about a different model of foster caring, a therapeutic model --
A. Just one particular --

COMMISSIONER: -- and one that is a short-term model with certain end objectives that you've identified.
A. Yes.

COMMISSIONER: And in a moment we'll come back to that model, but since you're here, opportunistically, as it were, I'm interested in your views about the general foster care model, the sort of matters that I've raised with you, because it seems to me presently that the treatment of foster carers by the department and the diminishing of their relevant knowledge and input to important decisions

is a very significant disincentive to well-intended people becoming and remaining foster carers, and if we think that foster care is a better model than resi care as a general proposition, then we shouldn't be disincentivising foster carers, should we?
A. I couldn't agree more, Commissioner.

COMMISSIONER: Okay. I'll return the questioning to counsel and he can ask you questions about this new model that you're here to talk about. Thank you.

MR BOYD: Thank you, Commissioner.

Coming back to the Treatment Foster Care Australia model, that's been implemented in Queensland since 2018; is that right?
A. Correct.

Q. And it's being utilised in this region?
A. Yes, here in Toowoomba.

Q. How long has it been in Toowoomba?
A. Since 2018.

Q. Okay. Was this the first location in which it was deployed?
A. It was, yes.

Q. Okay. Now, I'd just like to - sorry, I take that back. The goal of this program is to get children out of residential care into home-based care; is that right?
A. Or it can be used - it 's used predominantly for that reason, but also - for a myriad of reasons children have multiple placement breakdowns, and if a child is bouncing around foster care placements, general foster care as the Commissioner referred to, then this model can also be used to prevent placement breakdowns and stabilise the child so that they can go back to foster care and be settled.

Q. Okay. So that's a child that might be at risk of ending up in residential care --
A. Absolutely.

Q. -- and avoiding that occurring?
A. Avoidance, yes.

COMMISSIONER: And does it apply to self-placing children

as well?
A. It could, Commissioner, yes. If the - I mean, one of the important components is we want to ensure that - I mean, you know, to use the term, we would say consent. We don't actually use the term "consent" with the child, but it's a voluntary program, so we want the child to want to be in the program, and we get that sort of imprimatur from the child through various means, including, you know, spending time with them, playing basketball, and then explaining the program, showing them photos of where they're going to live, what it's going to feel like but, ultimately what the goal is, where they're going to end up, and that's very motivating for many children.

MR BOYD: And this particular program is targeted at children between the ages of seven and 12 years old; is that right?
A. The model we run here, yes.

Q. Yes. Okay. I think you've already mentioned the eligibility requirements. Can you give an overview then of what the program looks like? A child that's working its way through the program, what does that look like for the child?
A. So it's probably valuable for me to explain the sort of structure of the program.

Q. Yes.
A. So I've mentioned that we target and recruit specially - well, foster carers that want to be in a shorter term program. Not everybody is available for long periods of time. So they know that they're going to have a break. So our - you know, in any foster care world you have to go out to recruit carers much like you're recruiting any type of volunteer. They are a voluntary carer, but they do receive a much higher carer allowance because we expect that they don't work because the needs of children that are referred to this program have deep complexity, often are in residential care or have had multiple placement breakdowns --

COMMISSIONER: So if it's a couple would that be both members of the --
A. No, only one person doesn't have to work. But often they are a couple and they're both accredited carers, but we have a primary carer that is part of the clinical team.

MR BOYD: And as part of that they receive a higher carer allowance?
A. They do, yes.

Q. Which is, as I've - $75,000 a year pro rata tax free?
A. Correct.

Q. Okay.
A. Yes.

Q. And, sorry, go on.
A. Yes. There's a program supervisor that is kind of the ruler of the program. So they work with the department in tandem to identify the children that are suitable for the model.

COMMISSIONER: Did you say tax free or grossed up for tax?

MR BOYD: It's tax free.

WITNESS: Tax free.

COMMISSIONER: That's some special arrangement with the Treasurer, is it?

MR BOYD: It's not assessable income as it's an allowance.

MR HASTIE: There's a tax ruling referred to in the witness's evidence.

MR BOYD: Yes, Commissioner.

COMMISSIONER: Yes, okay. Good.

WITNESS: Just for clarity too, there is a special tax determination for Treatment Foster Care Australia. The tax determination that I included in the evidence is the general ruling for all foster carers, but OzChild had to seek a special tax determination for this particular model of care. I can provide that to you.

COMMISSIONER: So it's just excluded from assessable income?
A. That's correct.

COMMISSIONER: It makes a big difference in terms of the financial incentive?

A. Yes. Yes. If we're expecting that carer to be at home full time and not have an income and to partake in a whole range of activities, then we recognise that we don't want to disadvantage a carer in any way, so that higher tax-free income is applicable for the complexity of the children that they are working with.

MR BOYD: Because these carers have particular obligations under this program, is that correct?
A. They do, yes.

Q. Can you just explain what those are?
A. Well, they are the carers for the period of time that the child's in care. So it's an average length of stay of about 11 months, but it can go anywhere from nine to - in the case study today, that was 16 months. They have to attend weekly carer meetings. They participate in what's known as a parent daily report. So we collect data every single day - it might seem like a lot - on carer stress levels and trying to understand the behaviours that are presenting. So that is analysed by the clinical team so that we can then deploy strategies very, very quickly to support the carer if some of those behaviours, such as, say, argumentative, bedwetting, spitting, not making their bed - these things often can stress carers on a daily basis. So our parent recruiter rings the carer in the morning, asks 41 questions. It takes about five to 10 minutes, gives them a picture of what's going on, and then that is used to then inform what strategies and goals are needed to work with the child and the carer during that week.

The carer has to attend a weekly team meeting as well as a peer support group. So there's obviously other carers that deliver the program. So they get a lot of enjoyment out of that because they are able to bounce off of one another. You know, there's lots of evidence outside of this program in general carer support that, when you bring carers together to problem solve and troubleshoot and you facilitate that, you're going to get a much better success of their - and reduce their carer stress over time.

Supporting the carer themselves is the program supervisor, but also the child has a child therapist, and that child therapist will be progressively working through the goals that are set for that child. It's a behaviour change program. So we're looking to see significant change. By

way of example, if a child is struggling with self-regulation, then the child therapist would work with that child on how they would deploy strategies to improve their breathing, reduce anxiety.

We also have attached to the program a teacher and, unlike the original model which was developed in the US, it's mandatory for kids to be in school in the US for the full timetable, whereas here in Australia schools can actually reduce timetables depending on the child's behaviour, and most children that are referred to this program either aren't going to school at all or they're on managed attendance arrangements. They can be, you know, as little as two hours a day. So the carer would in fact have that child at home for most of the day bar the two hours that they're allowed to attend school. So it's critically important that the carer then, you know, is available to work with the child.

But in support of that as part of the clinical team we have a teacher that supports the carer in that educational progress and attainment, and we're obviously looking for a return full time to school. The teacher as well will work on a whole range of assessments with the child, and when the child comes into the program we undertake a range of standardised tests, such as our child behaviour checklist. We also have a strengths and difficulties questionnaire --

Q. If I could just interrupt you there because I want to ask you about those tests in a little bit more detail?
A. Yep, okay.

Q. There is I think three assessments that are deployed. The first is a strengths and difficulties questionnaire?
A. Correct.

Q. And that's completed by a parent or a carer?
A. Pre coming into the program, yes, so we've got baseline measures.

Q. Okay. And what does that identify?
A. It looks - if I can just - refer me to it I can give you the exact answer. You might need to point me to where I've got it in the evidence. Going into - that's the case study. So the strength and difficulty questionnaire, just so, you know - it's used to assess emotional and social behaviour and wellbeing, and to monitor that progress over

time.

COMMISSIONER: Is there a particular page you're referring to?
A. It's actually, Commissioner, in the second outline of evidence, "Baseline assessments on entry into TFC Queensland", which is at paragraph 45 on page 6.

COMMISSIONER: Isn't that an assessment that all children in care should have available to them?
A. Absolutely.

MR BOYD: That's where I'm going with this line of questioning, Commissioner, because there's a few more tests which I think the same could apply.

COMMISSIONER: Well, we've got there.

MR BOYD: The information that's obtained from that, how is that able to be used or what does that enable?
A. Well, when you - most of the children that would present from, you know, a residential care placement would be in the clinical range, so the higher range. So they would have high anxiety, you know, would not be coping well with - so the child therapist will develop a range of strategies of how they plan to reduce that over time. Equally, that information is shared with the carer so they have all knowledge of - you know, sometimes carers, you know, often raise concerns that they don't have enough information of the child. They get all of this rich information so they are really well set up to be able to work with the child in a therapeutic manner. And the same for the other standardised tests as well, are used intentionally to set that child up for success and to plan the behaviour change in accordance with the needs of --

Q. The other ones that you've mentioned there are the child behaviour checklist and progressive achievement tests?
A. Yes.

Q. These again are tests that - sorry, the child behaviour checklist is undertaken by a parent or a carer, so you don't need to be a professional to perform these tests; is that right?
A. That's correct, yes.

Q. And child behaviour checklist will identify things such as their problematic behaviours, emotional functioning, potential areas of mental health concerns; is that correct?
A. Correct.

Q. And that is information that would be useful for a carer or the department when a child is coming into care; do you accept that?
A. Absolutely, yes.

Q. And is there any reason why that particular test couldn't be administered to all children when they come into the care of the department?
A. There isn't a reason why they can't be administered. The more important question probably is how then - what's the effect of that. So you have the results of the tests. What's the sort of strategies you're going to put into place to address that. So if you know that, you know, a child is - has high anxiety, by way of example, what practice or intervention do you want to use matched to that child's needs so that they can --

COMMISSIONER: But isn't that a second question? A lot of the criticisms from carers is that they're not given any or any adequate information about the child, including their child protection history, including their mental and physical health issues, and so they're on a journey of discovery of their own to find out what's wrong with the child or what the child's needs are. And that's the starting point, isn't it, to any kind of intervention that would be of assistance to the child? So the question is why wouldn't that sort of test be undertaken routinely or why shouldn't it be in relation to any child coming into care of any kind; and the next question is, well, what do you do with that information; but you need that information first, don't you?
A. Correct, Commissioner. I think one of the challenges and the very nature of the child protection system is it's a crisis response, it's statutory intervention. So the work of child safety officers or child protection officers is very challenging when they go out to assess whether a child is safe to remain at home, and if they make the decision to remove I would imagine at that time, you know, they don't have the time available to conduct such tests. But, once that child is placed, I absolutely agree that if you want to set any professional up for success, but

particularly the carer, who often isn't the professional in the relationship, then to have access to as much information as possible and particularly to the support of, "Well, if I see that behaviour presenting, how do I deal with it," and have that is essential for the carer to feel highly effective.

COMMISSIONER: I've heard a lot of evidence about the difficulties encountered by carers in being able to make arrangements for medical appointments, to have specialists evaluate the child, to get specialist treatment, and the endless back and forth by email and otherwise to make arrangements for investigations, medical and - both physical and psychological/emotional investigations in relation to the child. That is the recurrent complaint by carers about what they are left to deal with. Now, you are involved with PeakCare?
A. Correct.

COMMISSIONER: And PeakCare is a peak body that represents various care providers, is it not?
A. It does.

COMMISSIONER: But not foster carers? Or does it represent - I thought it represented resi care providers?
A. It represents community service organisations, yes, and there is a peak body for foster and kinship carers here in Queensland as well, QFKC.

COMMISSIONER: Yes. The foster carers that you are looking for for this program, are you looking for carers with particular skills, particular expertise?
A. We would never discount anybody that puts their hand up to care in this model or a general foster care model. It's more about, in this particular program, whether they have the capacity to give up work, want to make a difference in the child's life, particularly want to work in a very therapeutic and individualised way with that child who has particular needs that we will be working to transform through the course of the program.

COMMISSIONER: Tell me this. Have you given thought to the matter of equity as between foster carers having regard to this program compared with the day-to-day tasks that I've heard evidence about that foster carers in the general foster caring community also have to undertake? There's been a lot of evidence about the sacrifices that foster

carers make. They give up their leave, sometimes they leave their jobs, they spend hours advocating for the child, arranging contact visits with the child's family; it's a huge undertaking.

Now, what do you say to the foster carers out there in the general system who are perhaps not formally but informally providing much of the support that this program requires of these particular carers and they're doing so on the basis of an ongoing commitment? So what do we say or what do you say we should say as a matter of fairness to those foster carers about their position and reward for their position vis-à-vis those who participate in this scheme?
A. So, Commissioner, if I answer it this way. In my work as chair of the National Foster Care Sustainability Group my organisation contributed significant funds to establish that group as well as rallied the sector leaders that represent both carers - we have foster carers as well as peak bodies and community service organisations around Australia to deal with the one of the issues you raise that is very problematic for carers - or three of the issues you raise that are problematic for carers, because every jurisdiction that offers foster care does not treat the foster carers in a way that should be respectful of all the things - challenges you've raised. So in the --

COMMISSIONER: All right. But do you agree with me that the comparative benefits in terms of appropriate financial recompense for foster carers in your model compared with foster carers under the general model - we have a common understanding of what I mean about that, the general foster carers - that that disparity is a matter of relevance in terms of government policy at least because if there's a desire to encourage ongoing foster carers to participate then disparities of reward for broadly speaking the same effort is likely to be a disincentive to foster carers volunteering under the general model?
A. Well, it would be fair to say, Commissioner, that if you sat with a group of Treatment Foster Care Australia carers you might get a very different response from your general carers in terms of, you know, the - you know, the model is short term but the carers do get significant support because of the challenges presented. But I take your point and I do not disagree that the general foster care population deserves absolutely to get compensated and never should be out of pocket for any of the costs associated with raising children that are part of, you

know, the State's remit. And the types of support those carers should have access to, could they be improved? You raised the point about accessing medical appointments. This is, you know, a huge challenge in every child protection jurisdiction, timely access to medical appointments. There is - and of course who pays for the medical appointments and whether the carer - because carers, depending on their work status, might not be eligible, by way of example, to the Commonwealth dental scheme. So if they are employed and they are looking after a child in foster care - and I had a foster carer the other day who took a child in on an emergency placement, had terrible problems, dental problems, went to the dentist and was charged $1,000. The department said to her, you know, that should be reimbursed through the Commonwealth dental program, and when she tried she was told she was ineligible because her income was too high. So she was out of pocket, so --

COMMISSIONER: So means test the foster carer?
A. So she was means tested because of her income and she didn't meet the Commonwealth program. So those matters, you know, it's not the State's issue, that is a Commonwealth issue, and those are the sort of things we are prosecuting with the Commonwealth government about and we are requesting a health access card for all children that are in out-of-home care so that no carer would ever then be out of pocket or no child would never have access to a professional appointment such as an OT, dentist. It's ridiculous that it falls outside of so many schemes.

COMMISSIONER: And Centrelink for - Centrelink benefits that are available for some children, after I think 16 years of age, I believe on the basis of evidence I heard last week that that is not means tested according to the foster carers' income any longer but was?
A. Yeah --

COMMISSIONER: And I have asked Mr Hastie to clarify that, but --
A. Yeah, I think that might be a reference to the activity test. They've removed the - but there are some - numerous Commonwealth barriers, and you mentioned also about workplace entitlements. So foster carers are often disadvantaged. So, for example, in the National Employment Standards, foster caring is not recognised in the National Employment Standards, so even though they're performing a

parenting role. So, again, we are putting pressure on the Commonwealth to ensure that foster carers get recognised as performing a parenting role so that they can --

COMMISSIONER: For what purpose?
A. So that if they are employed they could access either paid or unpaid leave.

COMMISSIONER: Paid or?
A. Unpaid leave. So if they wanted to take leave for any reason because of foster care. So they're not - they don't have - they're not recognised as - parents have various types of leave under the National Employment Standards.

COMMISSIONER: If they're employed they'd have access to certain leave?
A. Yes. So compassionate leave. So they're not recognised like adoptive parents are recognised.

COMMISSIONER: But, just to descend into the detail a bit, the tax-free income is not subject also to the payment of superannuation?
A. That's correct. That's correct. The current tax determination, which is 20 years old, it's meant to cover the costs of raising children, and I'm sure the Commissioner might agree that the costs of raising children in out-of-home care might be substantially higher than the cost of raising children that are at home with their families. So carers have increased costs because of the complexity of children in out-of-home care. They have lots of out-of-pocket expenses but none of those they can claim for under tax because they - so it's a very complex arrangement.

COMMISSIONER: Well, I don't think you can have it both ways. If the payment is not deemed to be assessable income, then --
A. But it's not adequate either to cover the carers.

COMMISSIONER: That's a different question. If it's $75,000 not subject to tax, it's being treated not as assessable income, so I don't think you can also claim deductions --
A. No. No, no, no, but in the case of general foster carers part of the arguments we're making to the Commonwealth are if you have carers - long-term foster carers, they're often disadvantaged by the fact that they

don't attract superannuation if they're staying home looking after the child, the carer payments are inadequate, and those expenses are not reimbursible in any way and often fall short of meeting the needs of that child.

COMMISSIONER: Sure. And the payments that are made to general foster carers aren't subject to tax either, are they?
A. No.

COMMISSIONER: No. All right. Thank you.

MR BOYD: Just before I come back to what we were talking about a moment ago, just to round off on this topic while we're here, you mentioned the leave entitlements. Were you referring to general foster carers when you just mentioned that?
A. Correct. Yes.

Q. And is that to place them effectively in the position of a natural parent where they might be able to take paid parental leave or compassionate leave or unpaid leave; is that what you're referring to?
A. Yes, that, and we also wanted to recognise - foster carers are volunteers, so there are provisions for emergency services leave - emergency leave, and the very nature of a foster carer is such that they take on emergency work in that they have to stop what they're doing. They get a call at 2 o'clock in the morning, "There's a child coming into care. Can they be placed with you?" So it's probably highly unlikely they're going to work in the morning when that's occurred. So we are asking the Commonwealth to explore the option of including them in that emergency leave provision.

COMMISSIONER: So you mean that if the foster carer - we're talking about general foster carers?
A. Yeah, general foster care, yes.

COMMISSIONER: If they are required to do something that falls within some category and they're employed, they would be entitled to leave, supported by the Commonwealth presumably, in order to attend to those duties; is that what you're saying?
A. Well, currently they're not, so if - yeah.

COMMISSIONER: No, but - yes.

A. But what we're saying is, is we'd like the National Employment Standards to reflect the importance of foster and kinship carers, might I add, who often are placed in the situation where they might be asked to take care of a young baby in the middle of the night, and if they receive a young baby and it might have foetal alcohol syndrome, then they might not be able to go to work for two weeks, and what carers currently will do is they'll take time off as in their own annual leave and it will eat away their annual leave provisions. So they're disadvantaged by the current arrangements, so we're asking for those to be updated and we're making a submission to the current parliamentary inquiry.

MR BOYD: Okay. And the effect of that isn't to put them in a better position; that's to avoid them suffering a financial detriment?
A. Absolutely, yes.

Q. I come back to the Treatment Foster Care program. There was one other test I wanted to ask quickly about, which is what you referred to as progressive achievement tests, which are, as I understand it, effectively standardised literacy and numeracy type tests; is that right?
A. Yes, that's correct.

Q. And that's not a complicated test to administer, I expect?
A. No.

Q. Does it need to be administered by anyone in particular?
A. No. When we get the test done they're done by the residential care staff or the foster carers themselves.

Q. Okay. And that would give a picture as to where the child's at as far as their academic development?
A. Absolutely.

Q. And, again, what we were saying before, that would be very relevant information for any child entering care?
A. Yes, and, given that the majority of children that come into this model are several years behind their peers and it's very challenging for them to be successful in school, this is a critical one.

Q. Okay. And that would be information relevant both to carers and to Child Safety to be able to identify any extra academic assistance that child may need?
A. Absolutely, yes.

Q. Okay. To your knowledge, is that being done in Queensland?
A. I can't speak for broader than the TFCO program, but I can take it on notice and see if they do that.

Q. No, no, if you don't know the answer, that's okay.
A. Yeah.

Q. And I take it those tests are very valuable then for the employment of the TFCA program to then be able to identify needs and to track progress; is that right?
A. Absolutely, because if you don't have a baseline measure across all those domains, which are the fundamental domains to support a child to be successful in life, then what are you working with.

Q. Are those tests administered later in the program as well to track development?

A. Yeah.

Q. Or how do you identify success?
A. So they're taken by two points of entry. So the residential care worker, if they are coming from residential care, will do them, as well as the foster carer on entry to the program, and then they are administered again at conclusion of the program to see the difference.

Q. Okay. And what types of differences have been observed from the program?
A. Remarkable. So, by way of example, if - you know, if we look in the case study, I can give you the exact changes. So in outline 2, on page 20 of 20, you will see that the case study refers to the scores of the child in question that came into the TFCA program, and he was assessed by both the residential care worker - by the residential care worker on entering the program and all of the scores around - under the SDQ, behavioural difficulties, hyperactivity, concentration, peer relationships, emotional distress were all assessed as very high, in the red range, clinically significant; pro-social, kind, helpful behaviour was very low, which means that, you

know, that child was not very helpful. As you can see, the carer assessed the change of the child throughout the program and were all in the green scores or close to average, and what's remarkable in those scores is that the behavioural difficulties had completely ceased and their helpful behaviour was at 100 per cent.

In terms of the teacher, she actually undertook the same tests at the beginning, so you got two vantage points, so you've got a comparison group between the teacher undertaking those tests pre and post, and again we go from very clinically high scores, and that lens would be that the teacher's looking at how that child is performing in a school-based environment as opposed to the residential care setting. The only one there that is still concerning is the hyperactivity and concentration difficulties, but everything has gone to close to average or has improved remarkably.

And if you look at school attendance, before entering TFCA school attendance was 56 per cent, comprehension skills were that this young person was in the bottom 2 per cent of the population of the same age and was in the bottom 10 percentile of peer relationship and also mathematical comprehension. Post TFCA, school attendance was at 98 per cent, and not only had they moved up several reading grades, so going from, you know, the bottom 2 per cent to being an average student, which is pretty remarkable, also received outstanding work across all subjects.

Q. Okay. And this has come as a product of both identifying needs at the outset and then working as a team through the program to get these outcomes?
A. Absolutely, yes. All of the team members - the teacher, the child therapist, the family therapist - and the family therapist works with the destination placements, so in the case study that's grandparents, because, to go to one of the Commissioner's earlier points about reunification and what are my thoughts of that in this program, we spent three months - well, we spent the whole program working lockstep with the destination placement. So, if that was back to mum and dad or if that was to grandparents or a foster carer, they are working with our family therapist throughout the whole program, and once the - if it was a reunification and the child had gone back to live with mum and dad, we would continue to work there for a further three months; so in terms of assurance that

that placement is the correct placement, then having eyes on that child and working with that child, and they consent to wanting that to occur, I would have a high degree of confidence.

Q. And the results that we've just seen there, which are quite impressive, is that the type of results that are typical for the program?
A. It is, yes, and that --

COMMISSIONER: Who evaluates it? Who does the evaluation?
A. Of the --

COMMISSIONER: Of these - well, these results that you've just been speaking about?
A. Well, they're standardised tests, Commissioner. So they're, you know, a standard - and you would be familiar with standard valid, reliable tests. So they're designed by others, not by us. So we are just using somebody else's tool, and we are measuring the before and after on those standardised and reliable tests. So very strong evidence base behind them.

COMMISSIONER: But the person applying the test, the residential care worker, is that a description of the foster carer?
A. That's the person - so - because this is a pre test, before entry, so that was undertaken by the residential care worker. But, as Mr Boyd's asked me, is this test hard to administer. No, they're designed to be used by professionals, and in this case the foster carer as well.

COMMISSIONER: Yes. So it's the before and after. In the case of the residential care worker in the first instance, the child was presumably in residential care?
A. Correct.

COMMISSIONER: And then an evaluation or application of the test by the foster carer in the program?
A. Correct.

MR BOYD: And the matters that are identified in that data we've just looked at, that all tends to suggest that the child has been stabilised and will not require as much support going forward when placed in a placement after the completion of the program; is that correct?
A. That's correct. And to add that placements break down

because of behaviours like this.

Q. Yes.
A. So the presentations you see here of having really high behavioural difficulties, high anxiety, a lack of emotional regulation, puts pressure on the placement and on the carer, it breaks down, they go into residential care. So they present, and what this model does is work to of course identify the strategies to help that child be successful through a therapeutic program.

Q. Okay.

COMMISSIONER: I take it, Doctor, that you regard foster caring as a preferable model of care to residential care?
A. Absolutely.

COMMISSIONER: Right. How would you extrapolate this model and adapt it to apply to foster caring generally, because your model is constrained by being of short duration, and I assume you would concede that elements of the model could be adapted for application to support young people - children and young people who are in the general foster caring realm as well as foster carers in the general realm?
A. Yes. This model is not for all children. This model is for a percentage of the population and particularly to step kids out of residential care, and in Queensland we have a large residential care population; so a highly effective model that can help step kids out of resi.

But to go to your point, Commissioner, I - and our own experience of implementing this model across Australia was in fact the same where we knew that our general foster carers were kind of getting a bit of a raw deal in terms of the support that carers get in this model - what could we learn from this model that we could apply with the evidence underpinnings to be equally successful. So last year we undertook a - sorry for the language - quasi-experimental design study, which was like an RCT except we didn't have - we had a control group and an intervention group but it wasn't randomised.

So we took the general foster care population in Victoria, we selected 10 carers that were general foster carers that had business as usual, and we selected another 10 carers that had one of the tools in this model called the parent

daily report, which is another standardised tool. The carer - and I do believe as well these tests we just referred to were also utilised. But the parent daily report I mentioned earlier is where the carer is called every day, there's a series of questions they are asked, and that's to elicit, "Did you observe this behaviour and did it cause you stress?" They may have observed the behaviour but it didn't cause them stress, because what we find in the research is that if a carer observes behaviours in children that cause six or more points of stress then the likelihood of a placement breakdown is extremely high.

So when we administered the PDR to that intervention group of carers in the general population last year we did it for six months. Now, it's not just as simple as calling them up and asking them what's causing them stress because you find out what is causing them stress and you have to do something about it. So we then - we had a therapeutic specialist that worked then on those same sort of strategies with carers of how they could manage those challenges --

COMMISSIONER: All right. Well --
A. -- and at the end the conclusion, and the evaluation is attached to my evidence, was that carers - there was no placement breakdowns in the intervention group and carers were far more satisfied with that, having the PDR, than not.

COMMISSIONER: Is that evaluation in your report "Evaluation of the parent daily report trial"?
A. Yes.

COMMISSIONER: Okay.

MR BOYD: Yes, that's the document.

WITNESS: Yes.

COMMISSIONER: Your new model is constrained as to time and applies, as I understood you, but please correct me if I'm wrong about this, to young people with high needs of one kind or another; is that right?
A. Correct, yes.

COMMISSIONER: So could your model be adapted, perhaps with some minimalism where it's appropriate, to support

foster carers generally? Whether the child has been identified as having high needs or not, you might accept the proposition that looking after any child, any individual child, presents challenges for any parent or foster parent, and are there ways in which your model could be adapted for the more general care of children and young people with the usual range of needs and demands rather than the particularly high needs that I think your program is directed to?
A. Yes, and in outline 3 we talk about a professional care model, not professional foster care, just to distinguish a difference, and there are multiple components which - within the evidence base, Commissioner, around what works for children's unique individual needs. There are - evidence-based programs kind of pinpoint common characteristics and are targeted strategically to work with that cohort or population. In the general foster care arena what you're - I think you're asking me is all the - you know, there's a multitude of characteristics that children present, how can you ensure that the carer is set up for success with the right level of supports to meet the needs of the child.

COMMISSIONER: That's essentially what I am asking.
A. Yes.

COMMISSIONER: And how would you adapt the processes and practices that you've developed for this more high needs targeted program --
A. So we would extract what we call the common elements, which are practices that - or techniques, strategies that help the carer in addressing whatever the presenting factors are in the child. So, by way of example, if a child has offending behaviour, then the type of support that the carer might need is markedly different from a carer that's supporting a child that has a disability. So how you would adapt the model is to identify all of those common elements - so you have your baseline scores. They would be standardised assessment tools that would be for all children, you would have your parent daily report where you would be checking levels of carer stress, but in your case plan goals you would be looking at the unique characteristics of that child and what goals you wanted to achieve, and then applying the best available evidence to meet that need.

COMMISSIONER: Have you made a submission to the

Queensland government or to the Victorian government or any other government to the effect that this model could be adapted for application more widely to the provision of better services to foster carers and consequently to the care of children in the foster care realm?
A. I've been - so a submission --

COMMISSIONER: Has your organisation made any such submission, is what I'm asking?
A. So submissions tend to be part of active tender processes. So it's hard to make a submission unless one is sort of live. Have we met with different departmental officials in various jurisdictions about a care model that takes the learnings from TFCA and can be adapted to the general care population? We've had numerous conversations and various governments have taken bits of that. In New South Wales, by way of example, they're going through a reform process now. They've met with us multiple times about what works, how did this work, why did that work. We've given them and shared our knowledge, and we are waiting to see whether they want to do anything with that.

COMMISSIONER: Would you make a submission to this Inquiry to the effect that this model could be adapted beneficially and be applied more generally to the foster caring community --
A. Yeah.

COMMISSIONER: -- or model of care - if you thought that adapting this model would be beneficial, then I'd be interested in a submission from you as to how this model could be adapted to apply more widely, not to the exclusion of this model where appropriate for high needs children, but to understand characteristics of it that may be beneficial more widely?
A. Yep, we would be more than happy to take that on notice and provide the Commission with a model that would take the learnings out of TFCA and how they could be applied in a general foster care context.

COMMISSIONER: Only if that is a model you would support?
A. Yes. Yes. And I couldn't sit here today, Commissioner, having implemented it for nearly a decade in Australia, without having great confidence that we know how to adapt it to specific needs.

COMMISSIONER: Yes. All right. Thank you.

A. Thank you.

MR BOYD: Commissioner, were you intending to having a mid-morning break - I know we've been going for a while - or wish to push through till lunch?

COMMISSIONER: We might carry on, I think, because I started a bit late, unfortunately.

MR BOYD: Certainly. Thank you.

Just to come back to the Treatment Foster Care model and to round that out, as you've set out in your third outline, there is an overrepresentation of or a high number of children in residential care in Queensland? Sorry, you just need to answer for the purposes of the transcript.
A. Yes, there are.

Q. And that's unique within Australia; we don't see those numbers in other states in Australia?
A. Not to the proportion in Queensland, we do not.

Q. Separate to the benefits to the child that would come from this program, there are considerable cost savings that can come if a child successfully passes through this program; is that right?
A. That's correct.

Q. Could you just identify or step us through how this is a cost-effective program as far as the treatment of children in care?
A. Sure.

Q. It commences at about paragraph 100 in your first outline.
A. So we have undertaken significant cost benefit analysis of this model. The cost of residential care varies from jurisdiction to jurisdiction. Here in Queensland it is the least expensive on average compared to the ROGS data. The average cost of a residential care placement across Australia is close to 900,000, the cost in Victoria is 1.2 million, the cost here is 420,000, but that speaks obviously to the limitations of the current residential care model. But that in and of itself is expensive because the average length of stay of a child in residential care here in Queensland is 4.8 years, according to the data from the Family and Children's Commissioner.

This model is a time --

COMMISSIONER: Have you done any projections of the likely future cost of residential care in Queensland? You might be familiar with the projections done by the Family and Child Commission --
A. I am, yes.

COMMISSIONER: -- "Buyer beware", which projects an increase to about 7 billion by 2030, which is not far off. Have you done any - has your body done any projections of your own?
A. Yeah, we've done projection modelling based on - obviously, if my chief financial officer was sitting here, he would say, you know, projections are a little bit of guesswork. But based on the current trends in Queensland and the rising number of kids then I believe that the work done by the Family and Children's Commissioner is pretty accurate in the linear sense of how many children will be in care and what that will do to the cost base, which --

COMMISSIONER: I think PeakCare proffered a different projection based on some analysis done by The Demographics Group in a report that they provided late last year --
A. Yes.

COMMISSIONER: -- and I can't now remember the difference, but it was a significant difference compared to the projection by the Queensland Family and Child Commission. I was wondering whether - well, you indicated just then that that $7 billion projection for resi care which was forecast by the "Buyer beware" report is a forecast you wouldn't dispute?
A. No, I wouldn't dispute, and, to go to your point about the demographic data, so I am familiar with that work, The Demographics Group, and that work was replicated in several jurisdictions in Australia because of the crisis that is, you know, a decline in foster care because there are demographic factors that contribute to that decline. So no matter how much we think we might be able to attract new foster carers, even if we made it a perfect system and we had higher incentives, the changing demographics don't make it possible.

COMMISSIONER: Yes, I understand that point, that there are demographic constraints that have been taken into account and may be immutable. But the PeakCare submission

had within it projections by The Demographics Group that, nevertheless and despite those demographic constraints, have forecast a lower increase in the likely cost of residential care to 2030 than was forecast by the Queensland Family and Child Commission.

So, accepting the demographic constraints which were the subject of the - included in the report by PeakCare, they nevertheless came up with a much lower number in terms of the forecast cost of residential care. I'm yet to understand but will in due course the key variables in those forecasts. But I think one of them might be an assumption about the rate of reunification in the lower forecast in the PeakCare submission?
A. Yeah, I would imagine, Commissioner, and, again, I would have to have the reports side by side, and I'm happy to take on notice and analyse those assumptions because often that could be the key variable. But I think with the Family and Children's Commissioner's report "Buyer beware" that the trajectory was based on if nothing changes, as in if all things stay the same, then that's the likely cost, and that's - you know, that's the modelling you can only do, is based on if you put the assumptions in, if we keep going the way we're going, know what's going to be the result in four years, well, this is going to be the result. So if carers keep declining and children - the preferred option for children is on track to continue to be residential care, then those costs will escalate.

Now, any mitigations to change that trajectory would be around where you put children. So if you're not putting them in residential care and you want them to go into kinship placements or you want them to go into foster care you need foster carers, and you also need a means of getting them out of residential care. But critically you need to slow down demand, which is a whole body of work that needs to occur too.

COMMISSIONER: That's another topic, isn't it?
A. It is.

COMMISSIONER: Early intervention and prevention?
A. It all works in a systems lens, though --

COMMISSIONER: Yes, of course.
A. -- if you're going to change that trajectory, and the current trajectory - and we haven't seen the latest data,

but my understanding is, is that foster care - residential care numbers are not declining, they're still increasing. So that would, you know, obviously --

COMMISSIONER: So, your understanding, the cost of residential care in Queensland is about, what, $450,000 per child per year on average?
A. On average, about 420 is what I am told. But it would vary per placement.

COMMISSIONER: What did you say the figure was in Victoria?
A. Victoria, 1.2 million.

COMMISSIONER: Why such a nearly threefold difference in --
A. It's a very different model of care that they run in Victoria, and they are very small numbers. So less than 500 children are in residential care in Victoria. There's 1.2 million children in Victoria and the same is in Queensland, so they are comparable jurisdictions in that regard. But they have a much smaller residential care population.

COMMISSIONER: Why is that?
A. That's a big question, Commissioner.

COMMISSIONER: But 1.2 million children in care --
A. No, 1.2 million population of children in Victoria, and it's the same size in Queensland. So they are very comparable. Same numbers, roughly, in out-of-home care. There's about 12,500 in Queensland, there's about 10 and a half, 11,000 in Victoria, so very comparable. But where children are is very different.

COMMISSIONER: So where are the children in Victoria cared for then?
A. Eighty per cent of the children in Victoria are in kinship care. There's a much smaller number of foster carers. There's about 1,800 foster carers in Victoria, so that's where the next proportion of children go. As compared to here, where we have much higher numbers of foster carers. But those numbers are - based on the demographic analysis, will rapidly decline. And in residential care there's less than 500 children in Victoria, and my understanding, you know, the last count was about 2,200.

COMMISSIONER: And in Victoria what is the incidence, if you know, of the representation of Aboriginal children in the child protection system?
A. Actually higher overrepresentation in Victoria than Queensland. So 17 times more likely to be removed in Victoria if you're Aboriginal or Torres Strait Islander child, whereas in Queensland I think that number's closer to about 10 or 12 times more likely.

COMMISSIONER: Yes. And the kinship care figure in Victoria of about 80 per cent --
A. Yes.

COMMISSIONER: -- are you able to say whether the kinship care is largely in the Aboriginal community, or does the kinship care data that you've mentioned apply to both Aboriginal and non-Aboriginal children?
A. It applies to both, and - but, you know, with my colleagues that work in the Aboriginal sector and the wonderful Aboriginal community-controlled organisations, and it's always the preference of those organisations to place children with mob, with kin, and not in foster care and not in residential care. So they will work day and night to make sure that they find family that the child can be placed with. So you have a higher percentage of Aboriginal children overall in kinship care compared to non-Aboriginal children.

COMMISSIONER: Yes. Thank you.

MR BOYD: Thank you, Commissioner.

Just to round out on the - or come back to the cost benefits, I think we were about to embark on what you've put in your first outline there. But, in short, what are the cost savings that we see through a child coming from residential care transitioning through this program and then into a family-based placement?
A. So in my evidence we took a snapshot in time and it was - so we did an estimation that --

COMMISSIONER: Where do I find that?
A. Sorry, Commissioner.

COMMISSIONER: That's all right.
A. Outline 1, paragraph 101.

COMMISSIONER: In your first outline?
A. Yes.

COMMISSIONER: I have page numbers but not paragraph numbers.

MR BOYD: It's page 18 in the bundle.

COMMISSIONER: I see.

MR BOYD: Under the heading "TFCA Queensland cost effectiveness".

COMMISSIONER: I think I might be looking at the wrong document. Outline of evidence or - is that what I should be looking at?

MR BOYD: Yes.

COMMISSIONER: There's two page numbering. Okay. Yes, I have it now, thank you.

MR BOYD: Thank you.

Yes, sorry, Dr Griffiths?
A. So since TFCA Queensland commenced in 2018 through to 30 June 2025 there's been direct savings of approximately 23 million to the Queensland care system. That's based on 17 children were in residential care on commencement of the program and since they have completed the program none of those have returned to residential care. All 17 children were either reunited with birth families or transitioned to home-based kinship or foster care placement. The average completion time was 10.8 months. The average age of that child would have been 9.2 years. And we've looked at the annual cost of residential care in 2024 of 420,000, but we index that for future years. There's a typo here saying assumed cost comparison post TFCA Vic - that's meant to say TFCA Queensland - compared to just three years of residential care. So we haven't looked at the life of the child. So we've just looked at what the cost savings are over a three-year period, and if --

COMMISSIONER: What is the cost per child on a monthly or yearly basis under your program?
A. So the cost of the program on an annual basis,

annualised - bear in mind that children tend to go through it/complete it earlier than that - is about $299,000.

COMMISSIONER: So it's 299 against?
A. Four hundred and twenty. But the length of stay is only 11 months as opposed to the average length of stay in residential care is 4.8 years. So you've got 420,000 times 4.8 versus 299,000 divided by 12 times 11.

COMMISSIONER: So are you saying that on your data there isn't a single child who was taken into your program who was not either reunified or placed with kin?
A. Those that have completed the program, correct. There hasn't been one child returned to resi that's gone through the program here in Queensland.

COMMISSIONER: Do we need to be careful to make sure - and this comes back to my earlier point and it does cause me some concern, I'll be frank - that the decision to return a child by way of reunification or to place a child with kin or any person has to be properly evaluated in the interests of that child?
A. Yes.

COMMISSIONER: And I am concerned by the evidence I've heard of poor decisions being made in that regard affirmatively reunifying the child in circumstances which, on the objective face of it, are unsupportable, and there have been a number of instances of that. Now, you combine that with the constant complaint that I've heard, including from many carers who I spoke to last night at the engagement session, that they are being actively obstructed from having a permanent relationship with the child because, to use my own language, foolhardy decisions are made to attempt to reunify, which fail and impinge adversely on the permanency interest of the child. Now, it would be a worrying thing, wouldn't it, if in pursuit of good data outcomes the proper evaluation of the best interests of the child were to be subordinated?
A. So, Commissioner, just to answer again so we're comparing apples with apples, the general foster care population - and I have many of those carers that are with us at OzChild who have got long-term care of the child - would absolutely in many circumstances want to have permanency of that child. I'm not disagreeing with that. With this model, it's not part of general foster care. So the children themselves are either at risk of having their

fifth, sixth or seventh placement breakdown and they're referred to the program or they're in residential care, and the decision-making around where that child goes is made with that child before entry to the program. We gain consent from the child. We do not take a child into the program unless they agree that it's what they want to do.

COMMISSIONER: You're right. But that's an element that is relevant to the question I asked you earlier, namely the extent to which this program might be adapted to apply more generally, because here you are targeting children in residential care for whom a foster caring placement is not presumably available or the placement has failed, perhaps failed several times?
A. Correct.

COMMISSIONER: So you're not comparing the outcome of remaining with the foster carer as against reunification or kinship care?
A. No, we're not.

COMMISSIONER: So the counterfactual is different in your model?
A. Correct.

COMMISSIONER: But even in your model I assume you would agree that a careful evaluative decision has to be made about whether the child should be reunified or placed with kin in the best interests of that child in the circumstances of that child?
A. Absolutely, Commissioner. As I emphasised, as part of the clinical team we have a family therapist that works with the after-care placement. So if it was identified as part of the case goal plans that a child was suitable for reunification, so, you know, lots of checks and balances from our experience in working with the department (indistinct), so we haven't experienced that they've not done well --

COMMISSIONER: But surely it's not a matter only of the suitability of the child, but the suitability of the place to which they will be returned?
A. Yes, absolutely. Absolutely.

COMMISSIONER: The availability of an environment from which they were removed, we'll have to assume, for good cause?

A. Yes. Yes, Commissioner, absolutely. So there is a significant risk assessment undertaken on the suitability of the destination placement.

COMMISSIONER: Who undertakes that?
A. Both Child Safety and we're part of that process, too. So they determine whether they agree that a placement will be safe for a child to be reunified to.

COMMISSIONER: Would you have any objection to an evaluation of that decision being subject to court oversight and approval?
A. Other than - I mean, I think, Commissioner, the --

COMMISSIONER: Let me put it in context for you. It's the court order that removes the child?
A. Correct, yes.

COMMISSIONER: And Child Safety has to go to the court and persuade the court on material that there's a sound basis --
A. Yes.

COMMISSIONER: -- for exercising a very significant State power. Why shouldn't the court have oversight of the reverse? Because I haven't heard that advocated by any interest groups in this area and certainly not by the department. But I am wondering why it shouldn't. So I'd be interested in your view.
A. I'm just trying to look for a comparison, Commissioner, because I do believe - and I can take this on notice - that it is that way in some other jurisdictions in Australia. So it might be more useful to sort of see if the court has powers to determine. I know certainly in Victoria that, you know, there is - they've just actually changed the legislation, but there was - the court would grant an order that the child protection department needed to come back and make a permanency application within a defined time period, so not to have children drifting in care. But the challenge often with putting timelines on that is that the right services and supports - so if it is a reunification order and we need to - mum and dad need to have met all of these particular criteria to receive that child back in a required timeframe, if the services aren't available, then it's hard for those family members to make --

COMMISSIONER: Well, I understand that. But court timeframes are often aspirational, they're always subject to variation, and they do provide impetus because if a timeframe is imposed on some step, as commonplace in court processes generally, then the relevant parties have to either comply or say why they couldn't. So, yes, I understand it would impose sometimes unachievable timeframes, but there's no reason, and, as I say, it's commonplace, why timeframes cannot be extended if there's good reason. Good reason wouldn't include failing to give attention to what needs to be done, such as developing a case plan or whatever it might be. So that's one factor. Any other reason you can think of why it wouldn't be a good idea to have judicial oversight of the permanency decisions?
A. I think that, you know, I would defer to my colleagues that work in Child Safety because that's their domain. We don't have --

COMMISSIONER: Isn't that where you work?
A. No, I don't work for Child Safety. I'm --

COMMISSIONER: Not for Child Safety, but this is your area of expertise, isn't it, the care of children in State care?
A. Yes. So my answer would be in terms of - if you want to be assured that reunification is successful, then a lot of work - so set aside who determines whether it's the right placement or not, whether it's the court or subject to the court, the work that needs to be done with - because, as you rightly pointed out, Commissioner, if a family has had children removed, there was extreme circumstances for that removal. Children aren't removed lightly.

COMMISSIONER: Well, one would hope so.
A. Yeah, children aren't - well, children shouldn't be removed lightly. There's a whole myriad of complexity involved. But there's lots of work that can be done with families to overcome that complexity if they - to go to your point about early intervention and prevention, and where we see huge successes in stabilising families so that children can safely return home. But the investment must be put in that area. If that investment is not there, then it's really difficult for families to be successful. So I'm not answering in a way that may be --

COMMISSIONER: No, I hear - you're not answering my

question, but that's all right. But you're saying what has been said to me by many witnesses in the course of this Inquiry - early intervention, all of the proactive work towards reunification, all of that kind of thing - and it's all doubtless correct and sensible. But at the end of the day there are critical decision-making points. One is at the point of removal and one is at the point of return, and in between those two points there's lots of other little decisions that get made that have a significant bearing on the life of the child, and really my question is allowing for all of the good work that you've suggested needs to be done - and there's a chorus of agreement about all of those issues. Notwithstanding that chorus of agreement, there appears to be a very high level of dissatisfaction with decisions particularly in relation to reunification but also in relation to removal.

Now, when it comes to removal, the department can point to the court and say, "Well, that was a court order and we persuaded a court." But when it comes to returning a child, with the attendant risks that that involves if a bad decision is made, that decision is made, notwithstanding all of that good work that's occurred in the meantime, without any person being able to scrutinise the veracity of that decision. So I'm wondering why, if we are all interested in the safety of children and if we acknowledge that it's a very serious thing to remove a child but equally serious to remove a child against that background - sorry, to return a child against that background, why the court shouldn't be involved in scrutinising such decisions?
A. I would answer by saying that what I'm looking for I guess is what would be problematic with that. So to take it on, you know, face value, that - and there's no problem with the court scrutinising the decision as was that the right decision to be made, but what you wouldn't want to have occur is that then it creates sort of a perverse disincentive to not want to reunify children, because if there was another hurdle to overcome that might change practice. So it's too hard to get reunification, so --

COMMISSIONER: But, let's assume you're right about that, whose interest would that affect? It wouldn't affect the child, would it?
A. No, and --

COMMISSIONER: Because if what you're looking at is what's in the best interests of the child --

A. Yes.

COMMISSIONER: -- yes, it's a hurdle --
A. Yes

COMMISSIONER: -- but it's also a protection, isn't it?
A. Yes. Yeah, I wouldn't disagree with that, Commissioner. Systems tend to behave in weird ways when we introduce new things, so careful consideration of the consequences of all of those needs to be attended to. But I absolutely agree that everything should be done with the best interests of the child.

COMMISSIONER: There's no systematic evaluation by the department, as I understand it, of the success of its reunification decisions. There's no feedback loops that verify and evaluate or measure the success of those decisions. Now, why is that?
A. Well, there's data, of course, which tells you how many children bounce in and out of care. So you would have that information. But the evaluation of the decision-making, I can't speak to that because I --

COMMISSIONER: You say there's data. There's some data about the fact of reunification defined by the return of the child for a number of months or something. I'm not sure that the data reveals clearly enough the failures, where the reunification fails and the child ends up back in resi care, usually. But for somebody involved in the study of the way this system operates and how better it might operate, isn't the evaluation of the success of the decision or decisions to reunify or place with kin critical to understand whether or not good decisions are being made in the interests of the child?
A. I would always agree that in any decision-making it should be evidence-based decision-making and that you're looking at multiple sources of evidence to increase the likelihood of a better outcome, and in particular in this case for children. So, yes, I would agree. So this --

COMMISSIONER: But here we need to evaluate the quality of the opinion that's formed at the time the decision is made. You see, the removal of a child and the return of a child is based on somebody's opinion as to the risks associated with the child's circumstances in the case of removal and as to the risks associated with the return of the child. That evaluation is a prediction as well at the time it's

made. Sometimes you can be more certain about the prediction because there's already been some manifest harm to the child. But when you're making a decision to return a child you have to make a prediction about whether that's going to be in the best interests of the child moving forward, and that's based on somebody's opinion, and hopefully the opinion turns out to be sound mostly. But, if you don't evaluate it in terms of measuring whether it has a beneficial outcome for the child, how do you know? Whether the decision is made by a court or whether it's made by the department, doesn't it need to be evaluated? A. In the case study attached to my evidence, Commissioner, this was not a reunification but a return to kin. Initially it was a reunification to dad. But in the decision-making around whether dad was suitable to be reunified to - and that was the child's preference - the decision was taken by the Child Safety Department that dad was not deemed suitable based on a range of evidence presented. So I believe that was made in the best interests of the child.

But with the grandparents we had a more challenging scenario. They were interstate and needed to be subject to the blue card assessment that is here in Queensland, and because the grandparents had a prior criminal activity or criminal record, which was driving without a licence, that doesn't necessarily present a safety risk to a child --

COMMISSIONER: But you're giving me an example of really the reasons for the decision in that particular case? A. Of how the process would work in assessing the safety and suitability of where the child is going to return to, because the same could be applied to a foster carer.

COMMISSIONER: Of course. But let's assume all of those factors have been taken into account, a decision has been made which is on its face a sound decision based on the material available to the decision-makers at the time. But it turns out, despite the best opinion of the decision-makers, that it doesn't work for the child or, God forbid, the child comes to some harm. Now, if you don't have some measure available by which to retrospectively assess the incidence of decision-making that turns out to be good as opposed to decision-making that turns out not to be so good, though it was at the time it was made based on some apparently sound bases, how do you know, and why wouldn't you evaluate by some socially

scientific method whether or not you're achieving good outcomes?
A. I would not object to that at all. It's good practice.

COMMISSIONER: Yes. And it's good practice, isn't it, even if you have the laudable objective of reunification, which you presume or make an assumption is in the best interest of children generally?
A. Yes.

COMMISSIONER: Because it might not always be the decision that's in the best interest of the particular child in question?
A. Well, one would hope it would be because that's what the legislation requires, but I understand your point --

COMMISSIONER: Well, it doesn't require that. The legislation requires, the paramount principle requires that the best interest of the child is paramount. That's what it says. I won't bother taking you to the section, but that is the paramount principle in the legislation, as one would expect?
A. Yes. So that should be what - yeah, so the evaluation should be --

COMMISSIONER: That requires an evaluation?
A. Yes.

COMMISSIONER: All right. Thank you.

MR BOYD: Thank you, Commissioner.

I believe where I was at a little while ago was just rounding out the potential cost savings from this program, and I think, just to summarise it, it's about $420,000 a year for residential care?
A. Yes.

Q. And it was $299,000 a year annualised for a child to go through this program?
A. Correct.

COMMISSIONER: 490 I think the --

MR BOYD: It was 299.

COMMISSIONER: No, 299 as against 490, I think was the figure.

MR BOYD: I think it was 420.

WITNESS: Yes, 420.

COMMISSIONER: Oh, 420; okay.

WITNESS: But with the caveat that this program only goes for 11 months, so --

MR BOYD: Yes.
A. Yes, and residential care average length of stay is much longer.

Q. So it could be $260,000; if it runs a bit over a year it could be a little bit more --
A. Correct.

Q. -- than the 299?
A. Yeah.

Q. But on a yearly basis it's 299?
A. Yes.

Q. So as a starting point it's actually cheaper than residential care?
A. Correct.

Q. Okay. So you're saving money just by going into the program?
A. Correct.

Q. And then the outcomes are you have the savings of family-based care as opposed to residential care?
A. Ongoing, yes.

Q. Yes. Can you just identify what those savings are?
A. So the cost savings which I mentioned, you know, for the children that have been through this program from 2018 to 2025 were 23 million.

Q. And that's just in relation to 17 children?
A. Yes.

Q. So that's a substantial saving to the Queensland

taxpayer?
A. Substantial saving, yes.

Q. How many children - or what's the capacity of this program in Queensland at the moment?
A. There are three teams, one fairly new team in - there's a team here in Toowoomba, a team in Ipswich and a new team in Eimeo. Teams take about four months to set up. They're intentional. In their first year of operation obviously you're establishing the program, and they kind of - we describe it as building the cadence. We don't sort of open the door and have seven children in on the first day of operation. We bring in one child per month. So during the first year you scale up to when you're fully operational.

We've replicated this model in multiple jurisdictions in Australia - New South Wales, we've been in South Australia, Victoria - and sometimes we do a time-limited program. So an example of that is we were asked to - there was five particular adolescents that were in residential care in Victoria that were suitable for the model. So they asked us to stand up a team so we could get those children out. So we set up a team --

COMMISSIONER: What do you mean by suitable for the model? How do you get to be suitable if you're a child?
A. I guess, Commissioner, that meets the eligibility criteria because it's not suitable for all children.

COMMISSIONER: What does that mean, though? Does it mean that the child has to have certain high needs, because that's what you're trying to address? Does it mean that the child must have available ex-ante a potential family to be reunified to so that, if the child doesn't, then the child doesn't qualify because you're outcome is directed towards reunification or kinship care? So what do you do with the children who at the start you assess as not being likely to be reunified or placed with kin? You see, you're excluding, if that is the criteria --
A. Well, I can give - so if I give you the exclusion criteria. So based on the international evidence, Commissioner, not all children presenting issues are suitable for the model. The model's an evidenced based program, lots of research underpinning it, clinically driven. So some presenting issues would not be successful. By way of --

COMMISSIONER: I'm trying to understand what the constraints as to the application of this model are.
A. Yes. So by way of example - so we don't exclude - there's not many exclusionary criteria, but a child that would have a severe developmental or cognitive disability, because that would limit their ability in consequential thinking or self-regulation. So they might have very limited verbal skills. So they're not going to be able to take up the intervention which is about behaviour change; so not suitable for children with profound disabilities.

If a child has, you know - is at current real - at high risk of self-harm to themselves or others or a danger, because this is a child that will be placed with a voluntary foster carer, and they might have active suicidal or homicidal intent, so they will not be suitable until that - it doesn't mean to say that they couldn't become suitable. So if that child was identified then we would work with the residential care provider in how --

COMMISSIONER: So it's not available for the hard cases, by the sound of it.
A. No, it absolutely is available for the hard cases.

COMMISSIONER: Well, not if they've got cognitive impairment, some profound disability, or have a propensities to self-harm.
A. Current high level risks. So if you look at the population of residential care in Queensland, and there is a high population, the percentages that would be self-harming and/or with active cognitive disability will be high. But there's a large proportion that don't.

COMMISSIONER: How many children, do you know, who have been considered for this program have been excluded as not suitable?
A. So we looked at the sample data of 123 children that were referred to the program last year. Forty per cent were accepted by the program and 60 per cent weren't. Of that, about 20 per cent were because they didn't meet the program criteria. Some 20 per cent were withdrawn for other reasons. And about 20 per cent --

COMMISSIONER: What would the other reasons be?
A. I'll grab that and give you the --

COMMISSIONER: It's a very selective program, isn't it?
A. Well, I don't think it's very selective, Commissioner. I think that would be an unfair assessment.

COMMISSIONER: All right. So ignore the adjective. It's selective?
A. Based on the evidence, yes, because it's been studied numerous times and if you want to get a predictable outcome then there's eligibility, much like if you're going to - by the very nature an evidence based program has been tested numerous times so that you can get confidence in the outcome.

COMMISSIONER: Sure. So you're really saying, "It works for the kids it works for. We know it works for kids with certain characteristics"?
A. Correct.

COMMISSIONER: "And they're the ones that we're going to take for this program."
A. Yes.

COMMISSIONER: Right.
A. Which is a large proportion, but in that - so of the 126 children and young people that were referred to the program, those that were not accepted, 31.6 - so there was 24 that didn't meet the eligibility criteria; 23 which had no suitable aftercare option; 18 were withdrawn by the referrer; four children declined wanting to come into the program, which is their choice; a sibling group couldn't be separated; a school change wasn't approved; no parental consent; no service capacity. So --

COMMISSIONER: So of that sample did you say 60 per cent were accepted or was it 40 per cent that were accepted?
A. So of that sample 40 per cent entered the program and 60 per cent weren't accepted for those range of reasons.

COMMISSIONER: All right. So here you've got the State faces this problem. It doesn't get to select the characteristics of the children that sadly have to be taken into the care of the State. So I'm not saying that to suggest that your program doesn't have utility, but it seems to have utility for those categories of children for whom you have an evidence basis for concluding it will be successful.
A. Correct.

COMMISSIONER: Right. But it's also important, given that the objective of your program is effectively reunification or placement with kinship care --
A. Or foster care.

COMMISSIONER: Or foster care. What's the breakdown there? How many in terms of the children who have been taken into this program have been eventually placed with by the kinship care, reunified with their parents, or placed in long-term foster care? Do you have that data?
A. Yes. It tends to be about a third of each. A third are reunified, a third in kinship care and a third in foster care.

MR BOYD: If I can direct, Commissioner, your attention, it's at paragraph 98 of the first outline. There's a graph there which has that specific data.

COMMISSIONER: All right. Okay. I'm just trying to get an overall feel for it. So when I come back to the question of how this program might be extrapolated to apply more widely to foster caring maybe it can't because it's based on criteria that exclude, just on those figures, 60 per cent of kids.
A. Well --

COMMISSIONER: So how do you extrapolate it to more generally? There might be elements of it that will be of assistance, but its key characteristic is that it's selective, isn't it?
A. Well, it's selective based - it's matched intentionally based on the research evidence, and this --

COMMISSIONER: Well, I get that. But the research --
A. Yes. But, to go to your point about the other characteristics of children, I don't disagree. This is not a silver bullet, Commissioner. This is for a certain group of children and is very beneficial for children that have these characteristics in having a predictable outcome and being stepped out of residential care to a family based environment, be that back home, with kin or into a foster care placement.

COMMISSIONER: And when you accept a child into your program do you investigate at the outset the availability of a suitable kinship carer or the potential or likelihood

of reunification, and do you also identify in advance a foster carer who, if the first two alternatives fail, will be the long-term foster carer; is that how it works?
A. We work in conjunction with the department on - so we absolutely recruit and train the carers. The department, who has case management of the children, will look for and is part of the criteria, so we request that the department identify a suitable aftercare placement so that we can successfully transition the children to that placement.

COMMISSIONER: The department decides at the outset that the child meets the criteria --
A. Well, we --

COMMISSIONER: -- and as part of that has to identify either a kinship carer, or a potential reunification with the parents, or have identified a foster carer; is that how it works?
A. Ideally. It doesn't work like that all of the time. Sometimes the department will make referrals, you know, not understanding the criteria because there's been a change in staff and sometimes they will make referrals where there isn't an aftercare placement identified. But the child might be in extreme need of a placement and we have often taken a child that doesn't have an aftercare placement identified, and then we will work proactively with the department to identify that aftercare placement.

COMMISSIONER: So what does that mean? In the course of the process you identify a foster carer, do you, as part of your other sort of network of foster carers?
A. Yes. So an ideal situation would be those children eligible for the program would be referred. But if they're not entirely eligible, by way of example not having an identified aftercare placement, they're not discounted. We will proactively work with the department to try and (a) source a carer, a foster carer as an aftercare placement if that's preferred, or help with family finding.

COMMISSIONER: Where does the child's voice come into all of this?
A. Well, that's part of the process.

COMMISSIONER: I would like to understand when you have a child recruited, as it were, for this program is the child - and the child is coming from the pool of children in residential care, as I understand it; right?

A. Majority, yes.

COMMISSIONER: Okay. Well, where is the minority coming from?
A. As I mentioned earlier, they might have had multiple placement breakdowns in foster care or kinship care.

COMMISSIONER: And for the time being they are in residential care or are there any self-placing children that are considered?
A. Of the referral data I have here, Commissioner, 96 of the children came from residential care.

COMMISSIONER: Right. Okay. So let's assume that's the main sort of pool, and what you're trying to do is get children out of residential care into family-based care?
A. Correct.

COMMISSIONER: Right. So it's voluntary from the child's perspective?
A. It is.

COMMISSIONER: And what are the ages of the children?
A. In this model in Toowoomba the children are aged between seven and 11, though we have accepted children --

COMMISSIONER: Between?
A. Seven and 11.

COMMISSIONER: And 11.
A. But we have accepted children at the age of six.

COMMISSIONER: And how do children at that age get to, in your view, express a meaningful opinion about what they want?
A. We do it through therapeutic techniques. By way of example, in the case study our program supervisor visited the residential care service to meet with the young person. They were displaying very, you know, aggravated behaviours. They weren't happy. They were hitting and kicking and punching things. So she took the view that that was not the best place to try and engage the child around whether they were suitable for the program and whether they would consent to joining it.

So we discovered that that child was interested in basketball. So we arranged with Child Safety and the

residential care provider to meet that young person at the basketball court. Part of the program we have skills coaches. They are peer mentors to the children in the program. So one of our skills coaches, who's a really cool basketball player, took the child to play basketball, started talking about what they would like to achieve; you know, would they like to be a basketball player, you know, what goals did they have, what were they thinking --

COMMISSIONER: But how does any of that tell you whether or not the child can meaningfully express an opinion to you about where he or she wants to be placed? You're talking about an age range of between six and 11.
A. Yes.

COMMISSIONER: Perhaps at the upper end.
A. Yes, so --

COMMISSIONER: But how do you get a six-year-old to do it?
A. Well, it's developmentally appropriate, Commissioner, and --

COMMISSIONER: Certainly.
A. So obviously the way you would engage a child at six years of age is quite different to an 11-year-old.

COMMISSIONER: I think I can understand that.
A. Yes. So in engaging this young person in the case study by way of example at the basketball court we raised the - well, what we first want to do is sort of share with the child, you know, what does this program look like. We try and demystify it so it's not a kind of - you know, "You go on a placement. It's not a residential care service. You're going to live with a foster carer that's got - that you get to meet. You'll get to have a look at the house. You get to have a look at what the bedroom's like. And what we're going to try and do is help you with some of the things that kind of create difficulty for you in this program to try and make it fun and engaging," and then the child kind of starts to learn during that engagement about what the program looks like, what it feels like.

COMMISSIONER: All right. So you do the best you can to --
A. Yeah, yeah, so that they want to be part of the program.

COMMISSIONER: -- encourage the child --
A. Yes.

COMMISSIONER: -- and to make the child comfortable when confronted with the news that, well, he or she is to be moved.
A. Moved from residential care, yes.

COMMISSIONER: So it's not strictly voluntary, is it, for a six-year-old?
A. Well, it's as voluntary as - it's very important as part of the model to ensure that the child agrees because they're signing up to something where they have to commit to it because they've got --

COMMISSIONER: Well, the six-year-old is not signing up to anything, is --
A. Well, yes, but I'm using --

COMMISSIONER: I mean, surely.
A. I'm using adult language, Commissioner.

COMMISSIONER: Yes.
A. A six-year-old, you know, as I say, that's at the very bottom of the age range. But with a six or a seven-year-old you're basically saying, "This is an opportunity for you to live at home with a foster carer. The foster carer is going to look after you. You're going to have some fun people who are going to work with you."

COMMISSIONER: Look, all I'm trying to get to and ask you to concede is that it's not appropriately described in the context of a six- to 11-year-old age group as voluntary.
A. No.

COMMISSIONER: I mean, maybe if it was a 15- or 16-year-old.
A. Yes.

COMMISSIONER: I mean, don't you accept that?
A. Yes, I do accept that.

COMMISSIONER: I mean, it's guided, isn't it? And I'm not saying there's anything wrong with that, but let's not call it voluntary, I mean, unless you want to --
A. Yes. No, I absolutely accept that, Commissioner; yes.

COMMISSIONER: Right. Now, why isn't this program available for children in resi care who are older, say between 12 and 17?
A. It is available, it's just not being commissioned here in Queensland currently.

COMMISSIONER: All right. We might leave it there for the moment. We'll adjourn to 2.15.

LUNCHEON ADJOURNMENT

COMMISSIONER: Mr Boyd.

MR BOYD: Thank you, Commissioner.

Dr Griffiths, I just want to come back to what we were talking about before lunch regarding the costings of this program and some of the savings that you identified in your material over the longer term. At paragraph 102 of your first outline and going over the page you've set out a graph there which models the cumulative cost of children in residential care versus the TFC program we're discussing. Can you just explain I guess the figures that are represented there and how they were arrived at?
A. Yes, I can. So when we've had a look at a child that's graduated from the program, so if they were aged eight, we've looked at the cumulative cost of care in this particular graph through to age 18. That's separate to the 23 million which I just said was modelled on three years only. So if that child remained from age eight to age 13, which, you know, is the 4.8 years, then the blue numbers describe the cost of residential care. If the child removed - if the child returned to foster or kinship care, then the cost is in orange, and the cumulative cost assuming that they remain in that placement. And if the child goes back to parents then the small box is the cost of being at home.

Q. Okay. And, just dealing with the parents then, what comprises those costs? So, looking at the number 8 there, that's the $270,300 figure; is that right?
A. Correct.

Q. What are those costs? What do they comprise?
A. Well, typically for parents, if the child's still on orders, there will still be some costs associated with

providing support to that child.

Q. And what types of supports would they be?
A. They would predominantly be case management support from the department. So we didn't want to exclude - so, you know, I could say the number zero from exit from the program. But we would make the assumption that the Child Safety Department would continue to be involved.

Q. Okay. And is that a continued involvement to the age of 18 or over a shorter period of time?
A. Well, it would depend on how the orders might change and whether there's, you know --

Q. Sorry, that estimate you've got there.
A. Yes, we've just made the assumption that if they continue to be involved that would be the cost if they went back home versus if the child's in foster or kinship care, there's still costs associated with providing support to foster and kinship carers versus the child remaining in residential care.

COMMISSIONER: Just let me understand this graph. Are they cumulative numbers or individual based on I think a year by year basis?
A. So the cumulative number. So year by year. So the cumulated costs to age 18 of remaining in residential care versus exiting from residential care. So if the child remained from age eight through to age 18 then the cost would be 4.960 million, and every year the child reduces in age the cost of course reduces because less time until they turn 18.

COMMISSIONER: Yes. So just explain to me what the - say, taking the example of the eight-year-old child, the green graph, returning to parents 270,300 for a 10-year period until the child attains the age of 18; is that the assumption?
A. We're trying to, you know, in best cases make a fair comparison. So if the child - the average length of stay of a child in residential care in Queensland is 4.8 years. I don't have the data to state, if a child is reunified back to family, how long that - if it is in fact until 18. That data isn't available. So, rather than not give a fair comparison, we make the assumption if they're at home with parents, they're still on orders, they're still going to be receiving some type of support. So there is still a cost

of sorts.

COMMISSIONER: That data is not available because the department doesn't keep the data about the effectiveness of reunification; isn't that the case?
A. I'm not aware, Commissioner, and that might be something for consideration about undertaking some sort of longitudinal study. They certainly have done that in other jurisdictions. In fact in New South Wales they have the longitudinal study of the pathways of children in out-of-home care and all types of care. So we can make that available to the Commission so you can --

COMMISSIONER: But not in relation to Queensland, the Queensland experience?
A. No. There's no longitudinal studies that I'm aware of in Queensland.

COMMISSIONER: Yes. Well, unless I'm told something to the contrary by the State parties, I'll assume you're right about that. Now, how do you arrive at this figure of $270,000 in the scenario that the child returns to parents? I think you said something about a department involvement?
A. Yes. So when there is a reunification to family the department still maintains case management of that child on that reunification order. The length of that order - I can't predict how long the child will be on the order. So rather than, say, the child's gone back home, there's zero costs, we're making the assumption to say there will be some costs when they go back to family just to make --

COMMISSIONER: But whose costs? I mean, are you talking about departmental?
A. Yes.

COMMISSIONER: Some attributed cost?
A. Yes, there will be some cost to the State of Queensland still incurred.

COMMISSIONER: But are you sure you're right about that in the sense that, if there is a reunification and if, let's say, a long-term guardianship order in favour of the Chief Executive has been revoked as a result of the reunification or assume that no long-term guardianship order had yet been made, how is the department still involved to the tune of the figures that you've identified here?
A. So I'm making the assumption here, Commissioner, that

there will still be some costs that the department would remain involved for a period of time. Now, if they're not involved, if the order is permanency back to mum and dad, then clearly that bar will be removed. But rather - to be reasonable, we've taken an acceptable cost that they may still be removed. So we know the costs of remaining in residential care. We know the costs of continuing to provide foster care or kinship care support, because they're costs that are borne, you know, to use the services of a community service organisation. There's an assumption that Child Safety would remain involved. If they don't, then that cost would be zero.

COMMISSIONER: Do you take account in those figures in the green bar of benefits that are provided or could be provided to the family, notwithstanding the reunification; that is to say, ongoing support for the family? Does it include any component of that or is it just some attribution of estimated costs per child to the department post reunification?
A. Yeah, in this example, Commissioner, it's the latter.

COMMISSIONER: So there's no - the cost could in fact be higher if the family concerned is in receipt of benefits and financial support of some kind or another to support the family in relation to the care of the child? So that's not included in those figures at all?
A. No. And I'm not aware of - yeah, so my answer would be no, and that would be a question for the department as to ongoing costs in relation to providing support to families that have had children reunified.

COMMISSIONER: I think I know, based on evidence that has been given, that in the case of reunification to the parents, in the case of placement with kin carers - I suppose the kin care placement would fall within the --
A. The orange.

COMMISSIONER: -- the orange. But, even so, let's just stick to the green bar. There are available ongoing supports to the family?
A. Foster and kinship carers.

COMMISSIONER: No, even to the family if there's a reunification, what I've called strictly speaking. There is a discretion and there are available financial supports that can be provided by the department?

A. Yes. And so the assumption there is accounted for by that number. It's much less than, from my understanding, to what it is. But I'm happy to come back and qualify that.

COMMISSIONER: Sorry, your number you've just explained is an assumption about the department's costs and doesn't include an allowance for benefits that might be paid by the department post reunification to the parents?
A. Yeah, the assumption is that there are costs that are borne by the department because somebody has to pay the cost. So the assumption is that - so the department in all instances would either pay the residential care provider, the foster or kinship care provider, and if there are supports or payments to the family in reunification the assumption is that there are costs.

COMMISSIONER: You've just confused me.
A. Sorry. Sorry, Commissioner.

COMMISSIONER: You can attribute a cost to the department by reason of its ongoing involvement in whatever way the department might continue to be involved?
A. Yes. So --

COMMISSIONER: Now, that's one thing. It's another thing to include costs by way of, if you like, disbursements by the department for the financial support of the family post reunification. They are two different categories of costs, aren't they? And I'm just trying to get clear that the latter is not included in your figures in the green bar.
A. If you wouldn't mind, Commissioner, I'll take that one on notice and get confirmation of exactly how we made that assumption so we're clear.

COMMISSIONER: Certainly.

MR BOYD: Thank you, Commissioner.

Okay. So we've just discussed in relation to reunification to the natural parents, and there's levels of assumptions I think you've just made clear that need to be made in relation to coming up with the figure that you've got there.
A. Yes.

Q. But that doesn't apply to foster and kin care; is that

right?
A. Yes. So the ongoing costs for a child that would be supported, the cumulative cost at age 18, so the 570,000 if they were age eight it would cost - if they stayed in care to 18 the cumulative cost would be 570,300 compared to 4.96 million if they remained in residential care.

Q. And that data there, the 570, using that one as an example, is there any assumptions that underpin that or is that based on average costs as provided by the department?
A. Average costs for providing a general foster or kinship care placement; yes.

Q. Okay. And that's data that's been made available by the department?
A. Well, and also we know because we get paid that amount.

COMMISSIONER: I'm just trying to be careful about this. The cost of providing the placement. Now, you're not providing a placement or the department isn't if the child has been reunified by definition; isn't that right?
A. Sorry, Commissioner, Mr Boyd asked what the costs were providing a foster or kinship care placement.

COMMISSIONER: I see. Okay. Thank you.

MR BOYD: So I'm just confirming that there's a level of assumption involved in the reunification, but the figures are known in relation to foster and kinship care.
A. And kinship care; correct.

Q. And obviously the figures are known in relation to residential care?
A. Yes, publically available data as well as what --

Q. And allowing for in relation to reunification, that there may be some variance there, with respect to both reunification and foster and kin care there are substantial savings with the child returning to either the family home or a care placement as opposed to residential care; is that right?
A. Substantial, yes.

Q. Okay. And you go on to identify some other work that's been done in relation to cost analysis in Victoria. I guess fairly briefly is what we're seeing here as far as

potential savings per child, is that what's also been identified in other states, in Victoria?
A. Yes, it's been identified by different parties at different times in both New South Wales and Victoria. The savings in those jurisdictions are greater and the reason for that is simply that the cost of residential care in those jurisdictions is much higher.

Q. And I think you said earlier it was 1.2 million or thereabouts in Victoria.
A. Yes.

Q. Okay. And, with respect to the program being delivered in other jurisdictions, can you comment on the efficacy of the program there?
A. Yes. The program produces higher results in regards to the number I gave earlier. About 72 per cent of children are successful. The international evidence would say 66 per cent. In Queensland it's 72 per cent. In other jurisdictions it's as high as sometimes 90 per cent. So there could be a range of reasons as to why it's greater efficacy.

Probably the program with the strongest efficacy would be Victoria. The reason for that would be is the referring party, being the department there, they're called the placement coordination unit, they are very - they understand the model well, they know where it fits, they know who it's for. Their referrals are matched. So there's the eligibility that we discussed earlier. It's never - so there's nobody ever, I guess, not eligible because they understand how it best works with the population of children in Victoria.

COMMISSIONER: Sorry, what did you; nobody is not eligible?
A. No, sorry, "they know", I said. Sorry, I'm originally from Wales, Commissioner. They know. So, the team that does the referrals to the program in Victoria, they're the same team that's been doing the referrals the whole length of the program. So there's not been any changeover in staff. So they're very familiar with who the program best suits. So nobody's not eligible in that because they refer all the children that are best suited for the model.

COMMISSIONER: In other words, they don't refer children who are not eligible according to the terms of the program?

A. According to the research won't get the best outcomes. So this model is not for all children, but it works for a lot of children and it's very effective for those that it works for.

COMMISSIONER: Tell me, does the research tell you that this program works for the children who meet certain criteria or characteristics but not others?
A. Yes. So the research studied multiple cohorts of children that have very similar characteristics and tested it in different contexts with different samples. So, by way of example, they did a randomised controlled trial around delinquent youth. They've done randomised controlled trials with teen pregnancies. So there's lots of different ways they tested whether the model is suitable for those cohorts.

COMMISSIONER: But the model doesn't ask the question, does it, "What is in the best interests of this particular child?" Isn't it more, "If the child has the following characteristics - whatever they are - the chances of successful reunification or successful placement with kin or successful placement with long-term foster carers is more likely"? Isn't that what the research tells you?
A. Sorry, could you repeat that again? I lost my train of thought. Apologies, Commissioner.

COMMISSIONER: That's all right. I'm trying to understand what you say the research verifies. Does the research tell you this, in substance? If the child has the following characteristics, those that correspond to your selection criteria, then if you apply this program it is likely, or more likely or even probable that the child will be successfully reunified with the family, or successfully placed with kin, or successfully placed with a long-term carer; is that what the research tells you?
A. Yes.

COMMISSIONER: Right. What I'm suggesting to you is it doesn't tell you in the case of any individual child that that outcome or any one of those outcomes is necessarily in the best interests of the child, that particular child in that particular child's circumstances, because that, I suggest, depends on an evaluation of all of the circumstances that pertain to that child, that child's family, that child's potential kinship carers, and the circumstances that contextualise the best interests of that

particular child.
A. And I would say, Commissioner, that I agree with you on the evidence on the research base - so the evidence is trying to say that from our testing of this model across different cohorts we understand that these characteristics are going to increase the likelihood of success for these children. But, to go to your point about individualisation, it's a very individualised program. So when the child --

COMMISSIONER: But where is the individual evaluation - that's what I want to understand - of the child's interests?
A. Of the child's interests?

COMMISSIONER: What is in the best interests of the child? The two are not inconsistent propositions. You can say this program has proven to be - by whatever measures you have - successful in achieving one of these three outcomes, provided it's applied to a particular cohort that meet certain characteristics reflected in your selection criteria; right? Now, that is a valid and consistent - a valid conclusion to draw to support the application of the model.

But what I'm suggesting to you is that it does not, because of that empirical data, avoid the necessity to make an individualised evaluation of what is in the best interests of the particular child in question. And so the model, by your description of it or the evidence as you've described it to me, does not seem to provide a definite certainty that in all cases it will be in the best interests of the particular child to end up in one of those three options.
A. What I'd say, Commissioner, is that I partly agree that there is no definite certainty that any intervention or program with the child is going to in definite certainty produce the outcome that's in the best interests of the child. You know, you've heard throughout your hearings that children in residential care are being harmed every day. What this model seeks to achieve is in a very thorough and planned intentional way to meet - to use your terminology, to meet the child's needs. We do incredible depths of assessments to understand what they are. We have a clinical team that works with that child to achieve the goals that are going to help with the child's ability to function more optimally in society, and that is not happening for children in a residential care setting.

COMMISSIONER: I get that. I understand your argument that these outcomes are preferable to the child staying in residential care. I don't think there is anyone who is going to argue with that proposition, or at least I haven't heard anybody put a contention - perhaps there was one - that residential care maybe is better. But it might be for a particular child. And it depends very much on a qualitative evaluation of the suitability of the proposed reunification, of the kinship carer or the foster carer. You still have to make a judgment, don't you, in order to make a decision that one of those three outcomes is in the best interests of the particular child in question, otherwise you're just applying some sort of formula?
A. Well, I'm not disagreeing that there isn't a judgment made about what the best - because the way that the out-of-home care system works is children are removed from families and placed into a placement option. It's a horrible way to describe it, but they're either placed with kin, with a foster care or into residential care, and that's it, those are the options.

And what this model seeks to do is improve the options available to the child at the more complex end of that system. The individual needs of the child or to go to the best interests of the child, I think, Commissioner, what you're - if I'm understanding correctly, you want to understand that there needs to be some sort of qualitative analysis of whether we met the best interests of the child, was the kinship carer the best decision or was the reunification the best decision, or was the foster carer the best decision --

COMMISSIONER: That's partly what I'm getting at. But my point - and perhaps I'm explaining it badly - is that, notwithstanding the evidentiary support for this model, when it comes to making a decision - and somebody has to because we're talking about children who are between the ages of six and 11 years old - an evaluation has to be made about that child's best interests in the context of what is proposed as the outcome for that child amongst one of those three options.
A. Yeah, I completely agree with that, Commissioner.

COMMISSIONER: Right. So, notwithstanding the retrospective evaluation based on the data of the model being successful, its success assumes that one of those

three options was the best option for the child in question. And, to my mind, that begs the question of whether an evaluation of that particular child's interests has been undertaken and found to be consistent with the data that generally supports those outcomes for children applying this model. And troubling to me is that the model suggests a pre-ordained conclusion, supported by the empirical evidence on your evidence, that one of those three outcomes is the best outcome; thereby running the risk, I would suggest, of avoiding a genuine judgment bespoke to that child's needs and interests as to what the best outcome for that child is.

A. In response, Commissioner, I think again I partly agree that to - the model does not - the model itself does not pre-ordain whether a child goes to foster, kinship or reunification. That is nothing --

COMMISSIONER: Thank you. It's the selection criteria.

A. No, the selection criteria doesn't either. That decision that you are talking about is the decision made by the department; not by the model; not by me --

COMMISSIONER: Sorry, I'm perhaps being imprecise in the use of language. Model is a general description of the program that you implement.

A. Yes, and the program does not prescribe where the destination placement should be. The department determines that, and that's part of the eligibility criteria. So --

COMMISSIONER: Well, that's the problem, potentially, because you're only eligible for the program if somebody's made an ex-ante decision that you're likely to be best served or the child's interests are best served if they are placed in one of those three options.

A. Well --

COMMISSIONER: So it's the constraint embedded in the selection criteria that has the potential, I'm suggesting to you, of leading to unevaluated decisions because the model - and by that I mean - sorry, the evidence suggests that this program will in all likelihood lead to one of those three outcomes.

A. Well, the model is designed to prevent children placements breaking - you know, placements breaking down and children ending up in residential care or to step children out of residential care. The destination placement - and I agree with you, Commissioner. Your

proposing that who makes the decision of where that child goes needs to be evaluated. I don't disagree with that. But it's not a dysfunctional of the model or it's not a limitation. The eligibility criteria is not wrong. In fact, if anything, it reinforces the argument for the eligibility criteria because if it was open-ended then you'd get what you get in the system now. So, without this program, you have kids that are put in incorrect placement options every day.

COMMISSIONER: I accept that. I suppose the point I've been trying to explore with you is that the program/model, as well based in the empirical evidence as it may be, does not in the end avoid the need for a judgment based on the individual child's needs to be made by somebody.

A. And those child - that decision about those child's needs may well change, as is described in the case study. The decision by the department in the analysis of where the after-care placement should be for that child, it was determined a reunification to dad. But, upon work with dad, he was deemed unsuitable and it was not going to be an appropriate placement, in the best interests of that child. So professionals within the system have to make those judgment calls every day, and that judgment call was made. And then another after-care placement was determined, yes, in a judgment call, but with a range of risk assessment to satisfy that it would be in the best interests of the child.

COMMISSIONER: It troubles me that the professionals in this system make judgments without being subject to scrutiny.

A. I understand that and I would welcome scrutiny over this. So the decision-making is not on our part; it's on the department's part. But where we have - and in Queensland case management sits with the department. But in different jurisdictions it works differently. But if you're asking should there be greater scrutiny of those decisions, yes, I don't disagree with that and I would welcome that for the decisions made --

COMMISSIONER: Well, what I've been trying to tease out in part is just because there's a body of empirical data and I'm going to assume sound empirically based evaluation of this program does not mean that the evaluative task can be avoided. It has to be undertaken in relation to each child. That's the first proposition. And the second

proposition is that that evaluation is presently undertaken at critical points not at the outset, not at the intake stage, but at the exit stage without scrutiny.
A. Yes.

COMMISSIONER: And allied to that there is a deep and vociferous feeling that's been expressed to me by many, many carers that the decision-making is poor, often wrong, often unsupported and often contrary to the best interests of the child, and those involved with the child who have those views have no avenue in which to be heard; not at the point of decision-making and not later. Now, coming back to the more general restriction of the general foster carers, having been heavily involved in this area, what are you told by foster carers about their experiences with department decisions here in Queensland concerning the removal of children from their care or the placement of children for reunification purposes or with kinship carers?
A. So if we're separating from this model where the model is not --

COMMISSIONER: Yes, we've moved on from the model.
A. Okay. So with general foster and kinship carers, yes, carers often feel that they're not included in decision-making and that --

COMMISSIONER: Is that a view that's been often expressed to you by foster carers?
A. Here and everywhere. So it's not exclusive to Queensland.

COMMISSIONER: So one complaint is, "I wasn't consulted"; they're not included in the decision-making?
A. Yes.

COMMISSIONER: And what about complaints as to the soundness, as they see it, of the decision made by the department?
A. Well, carers often, for the obvious reason, are very emotionally invested in the relationship and the attachment that they have with children. And when, I guess, case plan goals are set by any department members, be it here or in other jurisdictions, that may be contrary to what the carer is observing in how the child might be thriving in their care is very, very challenging. It's a very contested area.

COMMISSIONER: Implicit in what you've said, I think, is an assumption that the carer is expressing views based on self-interest, is that what you're really saying; that they are invested with the child, therefore they're hurt by the removal of the child, something of that nature?
A. Of course, and there's been studies undertaken where there is immense grief and loss when carers have children removed from them.

COMMISSIONER: Yes. But in the course of this Inquiry I've heard evidence from quite a number of foster carers and I've spoken to a number as well, including last night, and the grievance is not that that connection is being severed with them but that it's been severed for no good purpose and not in the best interests of the child, often confirmed by failed reunification efforts and the child ends up back with the foster carer, having been, you know, further traumatised by the detachment from the foster carer and then returning to the foster carer, and it just is plainly disruptive to the child. So are you suggesting to me that you would discount the complaints voiced by foster carers because of a sort of self-interest - not an unworthy self-interest - due to their having become attached to the child in question?
A. No. I'm sorry if that's what I inferred.

COMMISSIONER: No.
A. I'm basically coming from the carer's lens. Their dedication to children is incredible. And they are volunteers, but they're never off the clock. They're not like emergency services, firefighters. They go and fight the fire, they put the fire out, and they put the uniform away. These guys are wearing an invisible uniform every day.

COMMISSIONER: Well, quite.
A. And they're closest to the child. So they actually know more about that child than any of us can actually - in the professional sense can really, you know, be critical of. So I have deep, deep admiration for carers, which is why I head up the National Foster Care Sustainability Group. So I completely agree that the way the system - and I want to say the system as opposed to individuals in departments - ends up treating carers is - and this is very uniform in child protection systems, they don't work very well. Carers end up feeling - you know, they're not consulted, they're disenfranchised, they don't get a

decision about the child. There are families also that get disenfranchised. So it's a very complex system. And the outworkings that you're describing that carers would like to be consulted, it should be their right to be consulted --

COMMISSIONER: Yes.
A. -- but inevitably the system ends up kind of getting so busy in crisis that it doesn't attend to those matters very well or in a way that it should be deeply respectful.

COMMISSIONER: I'd like to come back to some of the things you've just said. But, in relation to the assumed motivation of a carer, which one could readily infer - I'm not suggesting you're saying it, but they do develop an interest in the child because they've lived with them, they've cared for them, they've nurtured them, they've loved them, and they are all the things you want in a carer, presumably.
A. Of course

COMMISSIONER: Right. Notwithstanding that, the evidence I've heard from quite a few carers is they will yield to the better interest of the child if the better interest is served by reunification or placement with kin or whatever the case may be. What they don't want is to see the child not have a good outcome when reunified when decisions as to reunification or placement with kin ignore the plain objective facts which any casual observer would notice and question, and yet decisions continue to be made removing the children from a loving, stable, nurturing environment, leading me to question whether there is some intractable ideology driving the decision-making rather than the aforementioned or discussed true evaluation of the child's best interests. I'm interested in your view about that.
A. As I mentioned earlier, Commissioner, we'll provide to the Commission the longitudinal study of children that have been in out-of-home care that's been tracked over time in New South Wales to give evaluative outcomes of where those children went. So I think that might be useful for the Commission to sort of, you know, tease that out. But in regards to --

COMMISSIONER: It's not going to help us with Queensland, though, is it, because we don't have any study?
A. But we are all in Australia and I guess it can give some degree of understanding as to whether - those child's

outcomes and whether they thrived better at home, better in kinship, better in foster care, and it would be of interest for you to see that, and I don't have it at hand to discuss. But in regards to foster carers being - I have got many examples of foster carers at OzChild who absolutely will always do everything they can. If the case plan is to reunify that child, they go above and beyond to make it work. And I've --

COMMISSIONER: Yes, that's broadly the evidence I've heard.

A. Yes, it is. But they get incredibly disappointed when - if then that's not successful. And often what's kind of missed a little bit in this conversation is, well, when that child was reunified what was going on to support the family, because there's lots of evidence that sometimes the goals that are set for the - that you want that family to achieve, if they're not getting the support to achieve that then they will fail in being able to successfully parent that child again. So if --

COMMISSIONER: And if you make a precipitous decision without proper planning and return - as I had heard in one of the engagements I had a few weeks ago, return 11 children at about the same time to a woman who had not had any children for four years and suddenly had to cope with 11 children of a variety of ages and with various challenging behaviours, it's certain that that decision is going to come to grief. I mean, it's highly predictable, isn't it, that, assuming those facts, it's unlikely to be successful?

A. Unless, you know, there was a full-time nanny, a house --

COMMISSIONER: Assume there was none of that.

A. Well, you know - but I think we need to broaden our minds to sort of think about the supports that are necessary. We've been talking about the supports that are necessary for carers to be successful. But we also need to bear in mind that, equally, that families need to have those supports too.

COMMISSIONER: Yes.

A. And without - in the absence of that, yes, I completely agree if you're just sending 11 children home to somebody that hasn't parented for four years, that would seem on the surface to be ludicrous. But --

COMMISSIONER: The particular example doesn't matter. I mean, there is on the record in this Inquiry a number of quite obvious examples of very poor decision-making in this area for which I've had no good explanation as all. Now, I do want to come back to something you said a minute ago, which is that the carer is 24/7. And the carer is the parent and all that is entailed in being a parent. But the legal parent is the State.
A. Correct.

COMMISSIONER: And I can't think of any area of government, the provision of government services, that is more difficult and granular than the State as the parent. You can look at healthcare, the range of professionals that provide healthcare; you can look at education, range of professionals who provide education; ambulance services, so on and so forth. But what you have the State as the parent is the mystery of being a parent and all of the judgment and nuance that comes with being a parent. Do you agree with that?
A. Yes.

COMMISSIONER: But the State's a legal entity. It can only act through human beings. Therefore, how does the State act as a proxy for the parent? Clearly the answer is through human beings hopefully in a family based setting where natural relationships can develop; do you agree with that?
A. I do agree with that.

COMMISSIONER: If the function of the State as the parent becomes brittle and bureaucratised insofar as processes and decision-making is concerned then the nuanced job of being a parent that can only be undertaken by individuals is impeded, not enhanced. So, if you agree with those propositions, how do we make the child safety system, the tertiary system, more nuanced, more focused on the individual evaluation of the child, more bespoke, and less brittle and bureaucratic?
A. That's a big question.

COMMISSIONER: I know. I've been attempting to grapple with that, and I'm looking for your assistance.
A. Well, there is a kind of common saying in child welfare circles that try and place the decision-making as close to the child as possible.

COMMISSIONER: Yes, but all of these platitudes about being child-centric and wraparound care and blah, blah, blah, they don't actually tell you anything when you try and work out what they're intended to convey. There's a lot of labelling, and the labelling is often inconsistent or ill-defined. Labelling is a sort of lazy excuse for actually thinking about what the real question is and I find it, frankly, distraction from understanding what it's really about.
A. So I might give an example from another jurisdiction, if that's helpful, Commissioner.

COMMISSIONER: Please do.
A. So you asked earlier about the number of Aboriginal children in care in Victoria; was it a higher percentage in kinship care. And Victoria has recognised that because it has the highest removal rate of Aboriginal children and young people in Australia that it needs to attack the problem of child protection differently.

COMMISSIONER: Rate not number, I assume?
A. Yes, rate. So the removal rate is higher. The overall total - it's still over 50 per cent of children are Aboriginal. So it's comparable to Queensland. But in Victoria about a decade ago they started to trial what they call section 18, which is a section under the Act in Victoria where the parenting authority, which resides with the secretary in that jurisdiction, can be delegated to the CEO of the Aboriginal community-controlled organisation.

COMMISSIONER: For what purpose? For removal?
A. Initially, no. But today, yes.

COMMISSIONER: Isn't it still a court decision in Victoria?
A. No. The Aboriginal community-controlled organisations - and there's four - have got delegated - and it's different from Queensland's delegated authority; so I just want to be clear. So the CEO of four different Aboriginal community-controlled organisations have the same powers that the State has to remove a child.

COMMISSIONER: But here the State exercises the power through the judicial arm of government. Are you telling me that in Victoria the removal of a child doesn't require a court order?

A. It would require - sorry, Commissioner, it would require going to court. But it's not the department that goes to determine whether a child should be removed. So the approach that ACCOs take in Victoria is markedly different from the approach that - so to go to your point about, well, how do we get decision-making closer, so typically, you know, Aboriginal community-controlled organisations are very in touch with their community. They know everyone in their community, they know mob, they know what works for their families and they've --

COMMISSIONER: Well, I've heard that said but I would like to test that because it's almost put as a sacred proposition that's not open to scrutiny.
A. Well --

COMMISSIONER: Let me put this to you on that point. If you make a decision - presently the department makes a decision - that the child should not be removed, there's no oversight of that. It's final. And it could be a false negative decision with horrible consequences. And indeed some of the evidence given at this Inquiry, including from a young man whom I spoke to again yesterday who gave evidence in Cairns, he was left - and he was an Aboriginal child, he was left at home for 10 years longer than he should have been and, as a consequence, suffered greatly. He was eventually taken into care.

Here's your problem. If the decision is not one that is open to scrutiny, not tested, then you run the risk of making decisions affirmatively in terms of removal but at least in the context of a removal it's an open court process and material is put before the court. If you make a bad decision which is a false negative it's like getting a false negative pathology test. A cancer that could have been detected three years earlier and you may not have died from it is not detected.
A. Yes.

COMMISSIONER: Now, if you repose that decision-making in a group with an interest in not having the child removed - and I'm going to assume there is a good and legitimate interests that Aboriginal groups have in not having their children removed, but their proper interest is not having their children removed unnecessarily or without good cause - how do you on the delegated authority you've suggested occurs in Victoria, how do you have public confidence in a

system of decision-making that could and would represent a gate to getting to the court if that decision-making is made by a group with an interest in not removing the child even though, on a proper evaluation, the child should be removed?
A. Well, to sort of continue with the example, Commissioner, so just to be more fulsome in my response, with the delegated authority the Aboriginal organisations, they will get notified that there are, you know, harm reports, you know, risk of significant harm, child protection notifications about the family members. They know who the family members are. They send their workers out, their version of Child Protection. And in their model, as I understand it - and I've been to sit in some of the court hearings - if the child is at imminent risk they will always remove the child.

COMMISSIONER: But that's somebody's judgment; okay? Somebody has to make a judgment about that. Now, what is the imminent risk? And reasonable opinions may differ, which is why a negative decision, that is not to act to remove the child, might still be a reasonable decision on the facts known at the time. If there are facts known that objectively suggested that the child should have been removed, as has been the case in a number of instances I've been made aware of, then it's not a reasonable decision.
A. No, I don't think --

COMMISSIONER: And it is worse because it is not uncovered until often many years later or until unnecessary harm has been done to the child. So the negative decision is harder to scrutinise than an affirmative decision. And by affirmative decision I mean an affirmative decision by the department at present here in Queensland to make an application for an emergent order. So one of the factors, I think you would agree, that provides public confidence in the removal of the child is the court process.
A. Yes.

COMMISSIONER: Right. So in Victoria the Aboriginal community-controlled organisation has a say, as I understand what you're saying, in the decision whether to apply to the court for an order. Is that --
A. Yes. They're a party to the court. And the court is managed differently. So it's, I guess, you know, made culturally safe. It's a round table. The magistrate sits at that round table, an equal playing field with all

parties present. There's possum skins. There's obviously an acknowledgment to Country. But before - in my observation, and I've sat in a couple of hearings, is that there's never a contest because if the child is - because what, I guess - in this case the organisation is VACCA, and they do have an evaluation of this model which we can provide to the Commission. If they know the child is not safe with whoever the family members are then they would have worked with those family members to agree before the court that they should relinquish them. And they also at the same time put into place the necessary interventions to help mum or dad get to the level that the safety can be maintained.

COMMISSIONER: So is the process in Victoria that you've described one that doesn't involve the Child Safety Department or whatever the equivalent is?
A. Correct.

COMMISSIONER: So it's entirely delegated?
A. It is. So you asked about how the decisions could be made differently. So that's why I wanted to give you that example.

COMMISSIONER: Yes. Do you not accept that there is in that model potentially a greater risk of false negative decisions being made?
A. In the evaluation that they've conducted so far they have a greater success rate at reunification --

COMMISSIONER: No, that's not what I'm talking about. We're talking about the decision to remove or not remove.
A. I don't know whether the evaluation - I would have to take that on notice, but I'm not sure - this distinguishment, Commissioner, you make about the evaluation of a decision - and I completely understand what you're saying. I mean, you know, I teach evidence based decision-making. So I, you know, am always emphasising you can't just put a finger in the sky and say, "Well, that's the decision for today." You've got to use multiple sources of evidence before - you know, to increase the likelihood of making a better decision.

Now, would I prefer that all professionals in my sector where we're dealing with very vulnerable children use evidence-based decision-making in everything they do? Absolutely. So you have no dispute with me about the

qualitative evaluation of how effective decisions are made. I completely agree with that.

The practicality of how you get the best decision-maker, which I think was your emphasis, you know, we're in a bureaucratic system, how do we get decision-making where, you know, it's in the best interests of the child and who evaluates that decision, it is something I'd be more than happy to take on notice and think through because it's slightly outside of - it's a very - I mean, I know, Commissioner, you're aware that the system is - it's a crisis response system. It's a statutory system. We remove kids. We place them into care. And at that point of time the decision's made is it right, is it wrong, was it in the best interests? And if it's wrong I completely agree with you it can be very damaging. And it works both ways. It's damaging if a child is not removed and it's also damaging if a child is removed.

And in the work that Professor Leah Bromfield has been conducting - and she's the Director of the Australian National Child Protection Centre in Australia based in the University of Adelaide - her research would say that most of the time we do more harm to children by removing them. And I have recommended to the Commission that you meet with Professor Bromfield so she can share with you many of the studies she's undertaken in that regard. So it's assisted --

COMMISSIONER: It's not hard to accept a proposition that harm is unavoidable, some degree of harm, removing a child from the family. The test in the Act here is the child is a child in need of protection, meaning the child has suffered harm or is at unacceptable risk of harm, and doesn't have a parent willing and able to care for the child. That's the test, and it's a rational test.

Probably embedded within it is an assessment of the harm that is involved in removal, but it's not explicit. It's assumed because it's a sort of self-fulfilling test. If the child is in need of protection, as defined, the child should be removed. Well, the question answers itself once you establish that the child is a child in need of protection. So it doesn't explicitly call for a balance of harm analysis, but it's probably implicit within it.

And I know there's academic articles about the balance of

harm, and the balance of harm analysis is what courts do all the time in other contexts such as granting injunctive orders and the like. I think at the core of it the critical decision-making points are removal of the child and return of the child. Now, there's lots of decisions in between, and the care of the child in between, and the placement of the child, and whether the child can go on a holiday with the foster parents, all a myriad of granular stuff. That's also important.
A. It's very important for carers; yes.

COMMISSIONER: Very important for the child.
A. Yes.

COMMISSIONER: The child wants to be able to play sport or whatever it is.
A. Yes, they want to go off on holiday.

COMMISSIONER: They all matter.
A. Passports

COMMISSIONER: But at the beginning and at the end of the process --
A. Yes

COMMISSIONER: -- some adults have to make a decision for this child, and it's unavoidably patronising because you're dealing with children.
A. Yes.

COMMISSIONER: And that makes it even more consequential because they often don't relevantly have a say because they can't because they're too young.
A. Agreed.

COMMISSIONER: And so the court process exposes decision-making to the light and oxygen of scrutiny, which is why I think there isn't an exception in Australia when it comes to the exercise of that power to remove. And it can be invoked in different ways. And what you've described as the Victorian model is really the decision-making anterior to the court application. And I can't see a good reason why any relevant interest group, Aboriginal controlled organisation, shouldn't be involved in that evaluation; that is, whether the court should be approached to make an order for removal.
A. M'hmm.

COMMISSIONER: And potentially the more inputs to that decision the less likely it is for a false negative decision to be made. But at present that's not the way it works, at least in relation to what are called emergent orders in Queensland. Are you aware in Queensland there's a sort of bifurcated system where emergent orders are made on application by the department, on advice from internal lawyers, but once what's called a child protection order comes into play then there's an independent statutory office that decides whether there's adequate material to make an application? Are you aware of that model here in Queensland?
A. I'm not.

COMMISSIONER: No. All right. But, anyhow, coming back to what I would like your assistance with, it really is concerning how best to make the critical decisions at the beginning and at the end, and anything else you wish to assist me with in terms of decision-making along the way; and how to make those decisions as true proxies for parents, bearing in mind that the service, if you like, has to be delivered by a bureaucratic structure.
A. I'd like, Commissioner, to give some dedicated thought to that question. I understand the depth of the question and I feel that I would not do it adequate justice.

COMMISSIONER: That's fine.
A. But now I have that question and I can certainly - and given one of my areas of expertise is around decision-making, then I certainly will turn my mind to what would be in the best interests for children overall if that was to look differently and draw down on examples that are in place here and potentially internationally that we might be able to look to to see if they could be suitable.

COMMISSIONER: And also if I could ask you to draw upon your knowledge and experience of foster caring, kinship caring, the residential care model, because once the State has taken the child legally the State's got no arms with which to hold the child. It has to make all sorts of decisions about the care of the child. And how does the State best enable nuanced judgments to be made by those human beings who have to hold the child 24 hours a day? And that brings up another set of problems in terms of guidelines about behaviour and rights, so-called rights --
A. Of carers or children?

COMMISSIONER: Of both.
A. Both.

COMMISSIONER: Because you'll hear - and I'm sure you're aware of this - this artifical world that foster carers are often required to live within as well as youth workers at residential homes, when the ordinary practices that are intuitively used by parents to deal with their children and the variety of behaviours that children may have at different ages and stages of development have somehow become sort of brittle rules. And the rules have a good reason, a lot of them, but they're not really the answer because they set up a contest between rights and obligations that is not reflective of the reality of a relationship between the parent and a child.
A. I understand.

COMMISSIONER: So the parent says, "Well, I'm going to take the laptop away because you've been behaving badly" or something, and in the resi care context or the foster care context that leads to a complaint from the child that in turn leads to an inquiry about standards of care or even a harm report. That drives off the foster carer. How do we make this system of looking after children by this unnatural entity called the State --
A. Yes.

COMMISSIONER: -- more intuitive and less brittle?
A. I'm very happy to take that one on notice, and also to reflect back to your earlier comment this morning or request about some of the lessons that come out of the model that we were talking about, being Treatment Foster Care Australia, and its application. By way of example, the carers feel very - the rules in that, there is rules in that program that are held by the program supervisor, and the carer is the champion of the child, and the child knows that if the behaviour is unacceptable that there are consequences. But the catchcry is, "We want to catch them being good." So the carer is constantly trying to reinforce those positive pro-social behaviours, and it works very well. But I'd love to take on notice and come back to the Commissioner with deep thought and reflection on how that nuanced decision-making closest to the child as well as of course at the system level could be potentially improved for Queensland children; yes.

COMMISSIONER: Please. And while you're at it, if I may ask, give me some help about how that sort of more natural nuanced relationship between a carer, whether it be a residential carer or a foster carer, should properly be scrutinised by the department, because the other side of all of this is the risk to children from abuse --
A. Of course.

COMMISSIONER: -- sexual abuse --
A. Yes.

COMMISSIONER: -- physical abuse, the whole panoply of abuse.
A. Yes.

COMMISSIONER: And they're vulnerable --
A. Very much so.

COMMISSIONER: -- in a foster caring home. They're even more vulnerable, I believe, in a residential care setting because they're children and they are vulnerable to the adult.
A. Absolutely. And to members in the community as well who exploit children in residential care.

COMMISSIONER: Yes. So, plainly, conduct which is criminal is not allowed. That's not the hard case, is it? I mean, the hard thing about that is detecting it and having mechanisms in place for reporting in a timely way and so forth. It's not hard to say that conduct's not allowed when it's criminal. What's difficult is the sort of negotiation that parents inevitably have with their children about what can be done, what's allowed, what isn't yet allowed, what they'll have to wait to get a bit older for, all of those sorts of things that any parent is familiar with. So how do we craft a relationship between the department and the foster carers and the residential carers that fosters real good parenting and doesn't sacrifice good for perfect?
A. Yes, I'd be very happy to work on that and provide it through to the Commission.

COMMISSIONER: As soon as you can, if you don't mind.
A. As soon as you can. My homework for tonight.

COMMISSIONER: Thank you very much. They're all the questions.

MR BOYD: I have no further questions, Commissioner. For the benefit of Dr Griffiths, though, there's been a number of matters which she's taken on notice today and the Commission has made requests of Dr Griffiths. Commission staff will go through the transcript and identify what those matters were and provide that to Dr Griffiths.

COMMISSIONER: Just for the sake of confirmation, if there are any matters - I don't think there are, but if there are that require production of documents that would be subject to some constraint, privacy or otherwise, please let us know and I'll provide you with a notice.
A. Yes, of course.

COMMISSIONER: And we will of course respect the confidentiality of it. But I think the subjects we've been debating - and thank you very much for engaging in the debate, by the way - are not matters that fall within that more sensitive category.
A. Yes, I think if it's for the better outcomes for children of Queensland then nothing's off the record. So I would be put to work and do whatever I can in support.

COMMISSIONER: Very grateful. All right. Now, Mr Hastie.

MR HASTIE: Thank you, Commissioner.

<EXAMINATION BY MR HASTIE [3.30 pm]

MR HASTIE: Doctor, the program or model you recommend is one as a number of interventions that might be made to protect children in Queensland; is that how we should understand it?
A. Yes, correct; yes.

Q. All right. And part of the model is limited in a sense to a restricted number of children; that's what you're proposing, isn't it?
A. Well, when I say "restricted" that's probably not the terminology I would use. The capacity of the program is seven children.

Q. All right. And partly that reflects the investment of money required for the program?
A. No. So what's best for the outcomes for the child; so the time that's required to work with those children to get

to the goals that we want to achieve.

Q. And the people who are available to be either foster carers or other social workers and the like who might be able to assist the child?
A. Yes, correct.

Q. All right. Now, in relation to that, on page 13 of your first statement you refer to a number of people who are required as part of the program to participate in the program.
A. Yeah.

Q. And do we take it that each of those people - paragraph 81, Commissioner --

COMMISSIONER: Yes.

MR HASTIE: -- might have a number of children that they're responsible for or is it the case that they would be responsible for only one of them?
A. Yes, yes. So all of the team members that makes up the clinical team, they're responsible for all children in the program. It's not for one individual child. So if there's seven children in the program then each - the program supervisor, the family therapist, the child therapist, they have those caseloads of the seven children; yes.

Q. All right. And can we take it that, in effect, the program for an individual child would be bespoke in the sense that maybe the Commissioner is talking about? An identification of the strengths and weaknesses of the child would occur at the start, and then you would work out, well, what behavioural challenges lay ahead and the best way of dealing with them?
A. Yes. The standardised measurements that we mentioned at the beginning of the program give us an understanding of the complexity of the child and help us assess what - the case plan goals, how they will be achieved and how we best move through that.

Q. And can I just ask you about the position F, teacher; would that be a qualified teacher?
A. It is, yes.

Q. And the aim of that person, reading your case study,

would seem to be to liaise with the school and assist in the educational opportunities for the child?
A. Yes. And also, as I mentioned in evidence, in the case study that particular child was on managed attendance arrangements, so only going to school two hours a day; so would also provide tutoring to that child to help play catch-up footy, for want of a better term, for that young person so that they could get in line with what they needed to be in their year level with their peers, because it's very difficult for a child to be five year levels behind their peers and going to school.

Q. All right. But the aim would be to at the end have them in a position where they could go to school?
A. Yes. And at the end of the program, you know, children are often fully in school. And, in the case study, this child went from a 56 per cent attendance rate to 98 per cent.

Q. With a bit of presumably encouragement?
A. Obviously the benefit of the program having that clinical support, they've got a teacher that's there working with them and giving them tasks to set them up for success or learning becomes fun, and that's part of the teacher's role. So they've got dedicated time. And it would be wonderful for all children in out-of-home care to receive that. But the children that come into this model, yeah, it's a wonderful addition.

Q. And you spoke about consent. But I take it from what you were talking about you're really saying that it was a program designed for children who wanted or had the capacity for change and were encouraged to change and, with that encouragement, the ability to change?
A. Yeah, we want to make sure that - you know, this is the child model. If we were talking about an adolescent model, you know, adolescents - you know, they vote with their feet and they will say, "Yes, we're in" or "we're out". With the younger children, most children, you know, they want to go to a family-based placement and, more often than not, they want to go home. But, in the absence of that, they're pretty encouraged by the opportunity to have support to get them to that family based environment.

Q. All right. And looking at page 12 or paragraph 75 you, in your evidence-in-chief, mentioned the sorts of children who the program wasn't suitable for. And in this

paragraph you refer to in particular, it would seem, that the program aims to work directly - well, that you with Children Services or Child Safety aim to work directly with respect to children who have behavioural issues.
A. Correct.

Q. All right. Can I just confirm with you, if you go to page 15 and paragraph 87, you identify why your model - or the model prefers or requires foster carers to have at least one of the foster carers full-time availability to work in that position as a foster carer as opposed to working because of the work required of a foster carer?
A. Yeah, the model is very intensive. So the foster carer is a volunteer, but the undertaking is that for being part of the program then it will require them not to work because, yeah, they're required to attend so many team meetings and they have daily check-ins and lots of clinical work to do.

Q. If I can take you then to the next page - paragraph 96, Commissioner - you mention some key findings from children who completed the program, and many of them or all of them - indeed all of them were from children and they were with respect to how they felt, that they felt better after having completed the program.
A. Yes. So as part of the Queensland renewal assessment, so it's an activity that Child Safety requires us to undertake, then that is qualitative findings. So we ask the children a range of questions and we ask the carers a range of questions, and then we provided that qualitative assessment to the department as part of our renewal assessment.

Q. And I take it your evidence is to the effect that if the children felt better having participated in the program they were more likely to - that suggests, anyway, that some of the behavioural issues would have settled down?
A. Well, as per the use of the standardised assessment tools, yeah, their clinical scores come down into the normal range of children that, you know, in everyday life. So it's exceptional, the change in behaviour. They're very settled.

Q. And that's why at the end of the case study you've got, I think, some of the feelings and the behavioural issues were average, which was a good sign?
A. That's a great sign. When you're in the clinical

range and, you know, you're pulling cupboards off of doors in residential care to attending school full time, winning awards, and in the case study the young person three years on is now representing the school in AFL and has also won an award for academic achievement, and still settled.

Q. Now, can I just ask you back that question of completion, and you refer to in paragraph 97 - page 17, Commissioner - to children having successfully completed the program. What does successfully completed mean?
A. Basically they went through and graduated. So we have an actual graduation, not dissimilar to graduating school. You graduate the program. So it's part of the incentive for the child to sort of keep - you know, keep on being good. And so those that have successfully completed have graduated. They get a graduation certificate. They have a party. It's a big day. We make it a very significant day. And then they are no longer in TFC or they've graduated on in life to live back at home in a family-based environment.

Q. Now, I take it that means that there's some people who - or some children who don't make it to the end?
A. Yes. So, as I referred to earlier, it's a 72 - so for all those program that enter the program and the Commissioner led me to what are the reasons why they maybe drop out, 72 per cent of them go through. So there was about 60-odd and 43, you know, successfully completed.

Q. All right. So if we go then to - which leads me to the next question. Paragraph 99 on page 18, Commissioner.

COMMISSIONER: Thank you.

MR HASTIE: You mention that there was a study done and the key insights, which had 27 of the 36 children remain in after-care placement either with a birth family or a home-based carer, and you're able to say that the period of time, I assume given when the study was taken, ranged - you're able to say, "Okay, they've been there either three months or three years, depending on when the exit was"?
A. Yes. So we relied on the department to help us with that information because obviously they know where the children are post, you know, discharge from our - because once they're out of the program we don't have line of sight of them. In the case study example the particular - the grandparents of that child still keep in contact with us. So we kind of know where that child's at. But the

department provided the data to say this is where all those children are and they're still remaining in those placements.

Q. All right. So I wanted to ask you about subparagraph (b), there's 25 per cent or nine children, the placement hadn't been sustained for various reasons. Does that mean that they went into residential care?
A. No. None of the children in Queensland have gone back to residential care. But the department would have made a decision there where it's either broken down for another reason but they've been able to move them to another placement and they're still in that low level placement.

Q. I see. So the placement had changed but the figure that you mentioned at paragraph 98 hadn't varied.
A. No.

Q. In other words, none had gone back to residential.
A. No.

Q. All right. Now, can I ask you next about what's said to be cost-benefit analysis. On page 19, Commissioner.

COMMISSIONER: Yes.

MR HASTIE: And you refer to a Social Ventures Australia study which you've annexed to your statement. In paragraph 103 that should be 2020, shouldn't it?
A. Yes, sorry. Apologies. Good pick-up.

Q. That's all right. And that was a study that came out of COVID?
A. Yes. So during COVID the Victorian government and community service organisations had concerns about the potential for a large number of children to enter into care. So this study was conducted to analyse what were the best available interventions to help slow down demand and also - because coming out of COVID, as you probably would be aware, Queensland luxuriously didn't have the same restrictions as what Victoria had. So there was no eyes on children in schools. Kids weren't going to school. So there was a concern about the large number of notifications and how we would deal with the subsequent demand. So that study was commissioned to look at the best available evidence and then determine what we needed to do and be invested in, and that was the cost-benefit analysis if

those interventions were taken up.

Q. All right. And can I just briefly take you to page 21, paragraph 111. You summarise the results of the OzCare delivery in the three states you mention, and that's as at 2025. Do we take it that that goes back to, say, 2016 when you started - OzChild, sorry, started in Victoria?
A. Yes, and bearing in mind of course that, as I said, the sort of first year is the establishment year. So it's not that there's seven children in placement on day 1. So it's staggered. So that represents the data back, yeah, at June 2025, and different teams started in different years. So Victoria was the first, but of course we didn't start here until 2018.

Q. And can we take it that the figure of 134 children across three states successfully completed, that means they - when you use that expression I take it you mean they stayed the course in the sense they did the 11 months or whatever was required?
A. Yeah, and they graduated; yes.

Q. And you say that in (c). And in (d) you deal with where they were placed afterwards, and that's some demonstration of the success with respect to that number of children?
A. Yes. Yes. So we followed up to see where they all were, and in the broader sample of all children - of children that have successfully completed the program as of June last year there was one child that went back to residential care of the 134.

COMMISSIONER: Mr Hastie, I just misunderstood the evidence a minute ago. The study goes back to 2018 or '16?

MR HASTIE: Sixteen, Commissioner.

COMMISSIONER: Yes.

MR HASTIE: I think I asked the witness --

COMMISSIONER: Yes, you did.

MR HASTIE: -- when it started in Victoria.

COMMISSIONER: Yes. But Queensland since 2018; is that

right?
A. Yes.

MR HASTIE: Yes.

COMMISSIONER: Thank you.

MR HASTIE: Now, can I take you to appendix 3 to your statement which, Commissioner, starts on page 55 of the court brief.

COMMISSIONER: Thank you.

MR HASTIE: This is a document that you've produced that summarises the evidence that's relied upon for this particular model of care?
A. Some of the evidence. This is just a sample. There's lots more.

Q. All right. But this is presumably the best if it's dated 25 August 2025?
A. 2023, yes.

Q. Is it?
A. You're looking at "Social programs that work"?

Q. No, appendix 3, "Treatment Foster Care Oregon".
A. Sorry.

Q. Appendix 3.

COMMISSIONER: Page 55.
A. Sorry, apologies.

MR HASTIE: You may not have the court brief. So does appendix 3 help you?
A. I'll look up 55. Hang on. Got it. Yes. Sorry, yes, you're correct; 2025. Apologies.

Q. No, that's all right. As long as you've got a document.
A. Yeah.

Q. You've kind of agreed with in the first paragraph the description of the program is for serious behavioural and emotional - sorry, youth - indeed it says youth rather than children with serious behavioural and emotional problems,

particularly those at risk of placement in restrictive settings.
A. Yes.

Q. And indeed one of the studies that's referred to there is a study of adolescent youths.
A. Yes.

Q. All right. Rather than children. To deal with the Commissioner's question just prior to lunch, the program you've suggested and have run in Queensland is for pre-adolescence, but you said that the program's available for post-adolescence?
A. Correct.

Q. And where is that? Where does that occur?
A. The adolescent model is run in New South Wales, and in Victoria there was a request to customise the program to be broader and accept children and adolescents because of the demand for adolescents entering residential care. So it's the only team in the world that accepts children together, I guess, between seven to 17.

Q. And where's that: Victoria or New South Wales?
A. That was in Victoria. And in New South Wales they have a standalone 12- to 17-year-old adolescent model.

Q. And as well as a pre-adolescent model?
A. Yes.

Q. All right. And those figures we mentioned - I took you to before, I think, of 146 children over the period of time, do they include the adolescents as well as --
A. They do.

Q. From New South Wales. All right. Thank you. Can I take you to the third paragraph which refers to - it starts with the words "Meta-analysis and systematic reviews"?
A. Which page are you on?

Q. Sorry, page 55.
A. Yes, yes, yes.

Q. The first page of appendix 3, depending on what copy you've got.
A. Yes. "Meta-analysis and systematic reviews"; yes.

Q. Now, that says:

> *Moderate certainty that the model reduces future criminal activity and days spent in locked settings, with additional though less robust evidence for improvements in peer associations, drug use and depression.*

That's the description from one of these authors. That's the finding. So it only describes itself as having moderate certainty with respect to some things and less evidence in support of other improvements?
A. Yes.

Q. So, as you understand it, that's what those studies show?
A. Yes, I do. And I think it's important to note that, you know, meta-analysis and systematic reviews are studies of studies. So they are looking at multiple studies, of which there is, you know, I think in the realm of about 80 to 90 studies on Treatment Foster Care in its various forms. And moderate - you know, to translate to non-academic language - is actually pretty confident.

Q. All right. I'll leave that. If you go to not the next paragraph but the paragraph after that, beginning with the word:

> *However, the effectiveness of the model is most pronounced among youth with high levels of anti-social behaviour and implementation in different contexts can present challenges.*

A. Yes, and that's always, you know, a challenge of, you know, importing models that have had studies conducted under different settings, under different contexts. So you're somewhat testing the model when you first put it on the ground in a new context. We would note that the model here is referred to as TFCO in the research evidence, and we've since - the model has been customised in Australia because it's been adapted to the local context. So we have modified the model in relation to what that context presents.

By way of example - and you led me there earlier in the

evidence - in the model that is in these studies there is no teacher. In Australia, because of the nature of school principals can say, "You're behaviour is not desirable in my classroom. You're going on a modified timetable," so we customised the model to fit to that context.

Another important customisation that we've made in Australia is to have a senior Aboriginal practice lead because half of the children referred to the model are Aboriginal. And we know it is absolutely critical that children have their connection to culture and that we honour and respect that, and there's cultural safety in the program. That is not - that is absent in the studies that this refers to.

Q. Thank you. Can I ask you is the approach taken in this case study with respect to going to, say, two hours to school and then having a teacher being able to home school or to do it otherwise, is that the way it's done as well in New South Wales and Victoria?
A. Yes. It's an essential component in the customisation because of the - you know, if you look at particularly the residential care population, more often than not they're not going to school or they're on modified timetables. So it's very challenging for those young people or children to meet their attainment scores like their peers. So making that customisation was essential so that kids can catch up. And, you know, there would be an argument made for all children in residential care and in out-of-home care who often fall behind their peers to have access to teachers or tutors that can help support them get in line with their peers nationally.

Q. So I take it the teacher then - you mentioned before about difficulties, sometimes behaviour at school. I take it you meant schools wanting to limit the ability or remove a child from a school?
A. Yes.

Q. So if you have a teacher employed you've been able to - need systems to make an arrangement with the school where they would accept them two hours, say?
A. Well, the school - I mean, the teacher's role is to build the confidence up of the young person to integrate them back with the aim of going full time. So they work very closely with the school, develop a really strong relationship. And, as was in the case study, that was

achieved quite quickly with that child because they actually had a real propensity for learning and, as soon as it was tuned in, you know, they were back to full-time school pretty quickly.

Q. All right. Look, on the next page, Commissioner --

COMMISSIONER: Mr Hastie, sorry, before you move on, have you considered the application of this model to children who are very young? We know that there are many more very young children coming into care and increasing numbers in resi care. Have you given consideration to adapting it for a much younger cohort?
A. There is a younger cohort model. It's called TFC - it has a P on the end for preschool. So three-year-olds to six-year-olds. And, again, if it's matched to the individual child's needs, so if the presenting behaviours are getting in the way of them being successful, then certainly this model would work. I think for that cohort, Commissioner, there's lots of other things that can be done to get them out of residential care, but goes to your earlier questions about the support for carers, the support for - you know, that's necessary, including Mr Hastie's questions about educational support, because that's often a huge barrier. If a child isn't going to school, that puts a lot of stress on a carer.

COMMISSIONER: Yes. And in terms of adapting the model what adaptions or crafting of the model would be required to meet needs in remote areas, bearing in mind Queensland is a vast geographic area, there are lots of remote communities? Do you see this model as readily adaptable to meet the needs of remote communities, of perhaps discrete Aboriginal communities? Can the model be adapted for that?
A. I think a - well, a different model I think. So elements of this model, but not this one. Regional population centres, because if you think, you know - well, we've demonstrated it in Toowoomba and that's, you know, a good example of similar population centres in Queensland. But in very rural and remote areas then we would propose a different model to deal with children in that way, which is subject to one of my --

MR HASTIE: Tasks.
A. -- outlines and tasks, yes. Yes, so we have a model that would be better served to deal with those circumstances.

COMMISSIONER: Thank you.

MR HASTIE: And that's in a sense confirmed over the page, if you go to what would be 58, Commissioner, but under the heading "Conclusion". So it's page 5 of 6.

COMMISSIONER: Yes.

MR HASTIE: The last sentence in the first paragraph:

> *More research is needed on its long-term effectiveness for lower-risk youth and implementation in diverse contexts.*

A. Yes.

MR HASTIE: Thank you, Commissioner.

COMMISSIONER: Thank you.

MS McMILLAN: No, thank you.

MR KIYINGI: No questions.

COMMISSIONER: Ms Greenwood, do you have any questions for this witness? Can you hear me?

MS GREENWOOD: Yes, please, Commissioner.

COMMISSIONER: Thank you,

<EXAMINATION BY MS GREENWOOD [3.59 pm]

MS GREENWOOD: Doctor, what I'm going to do is just pull some summary questions from three of your attachments, LG-3, LG-8 and LG-10. And, for my colleagues, that's bundle 140 to 147, bundle 168 to 171, and bundle 201 to 237. Just starting with the Oregon results, this is at page 220 of the bundle, you identified the outcome from the Oregon model was that for 12- to 17-year-olds already in resi care or foster care and at high risk of entering residential care the outcome was that 70 per cent would move on to long-term home-based care or return to living with their families, and only 30 per cent would remain in resi care or transition into resi care. So can I take it in terms of the ambition to have an off-ramp from resi care

that's a reasonably effective program for doing that?
A. Yes.

Q. We've already heard in evidence in this Commission that there's an issue around adolescents having a breakdown in placements. So basically younger children are more successful in placements but, once we hit the adolescents, placements come under a lot more stress and are likely to break down more often. And, as I understand your program, you try to address those stressors and to prevent the breakdown; is that correct?
A. Correct. Yes.

Q. And also we've heard that for children who have had multiple placements that break down they almost inevitably end up in resi care. So that's one particular cohort that your program looks at; is that correct?
A. Yes.

Q. And also we've heard in evidence often the only way for sibling groups to stay together is for them to be in resi?
A. Yes, that is correct. And we have had referrals to the program of siblings groups, and in fact the case study that I provided we also had one of the siblings of the child who also went through the program simultaneously and successfully graduated and is also living with grandparents successfully three years on.

Q. That's fantastic. What we've already heard in evidence is our residential care model is an accommodation model, not a therapeutic model. If I understand your literature correctly, the key challenge for children or young people in resi care is that they're often living with other children that are typically also survivors of complex trauma; is that a fair characterisation?
A. It is.

Q. And many children in resi display regular high-level anti-social behaviours such as violence, aggression and defiance?
A. Correct.

Q. And children in resi care - and I think you're being polite here - are often exposed to other children who have not learnt these life skills in terms of what you're trying to --

A. Yes.

Q. -- teach the children. So it's extremely difficult for a child to learn positive social skills in resi?
A. Yes, because one of the things we really focus on in the model is that pro-social behaviour; so modelling the behaviour you want to see. So children need to see a role model where they can see, "Oh, that's what that looks like. Okay." But that often doesn't occur in residential care because the modelling is actually of the opposite.

Q. And you've already partially answered this question to my colleague, but a child by acting in an anti-social way is increasingly disadvantaged by engagement with police and the youth justice system, and you've already referred to suspension from school.
A. Correct.

Q. And we've already heard evidence earlier when a child was suspended for school for swearing in school. So children can be disadvantaged quite quickly by behaving in an anti-social way?
A. Very much so. And for the untrained person it is very challenging to come across children that behave in an anti-social way and often, you know, react accordingly.

Q. I am interested, however, in the limits of your model and, you know, how far it can go and how far it can't go. There's a high proportion - I'll just put this proposition to you; tell me whether you agree with it or not and whether your program can deal with it. A high proportion of these children with diagnosed or undiagnosed mental illness such as anxiety, depression, post-traumatic stress disorder, bipolar and schizoaffective disorders, have you seen that and is that something that your model can deal with?
A. When we do the initial work with the Child Safety Department on identifying the children, you know, we mention the sort of clinical assessments and, you know, they're diagnostic assessments and so we try and get an understanding of how well that child is going to be able to deal with the model, because there is some consequential thinking that is necessary to be able to create the behaviour change because you're trying to model the right behaviours, incentivise that child to want to undertake those more socially desirable behaviours, and they have to be able to process that.

So defending on - so there's absolutely all children that present with some of those concerns that you read out. The severity of them and the limitation of them being able to be successful sometimes reveals itself in the scores or in the behaviour that the child safety officer or the residential care team will say presents. So there's a bit of, you know, a balance, I guess, in understanding. In the case study, by way of example, there was lots of aggressive behaviour that was occurring in the residential care facility. There was lots of punching, kicking, fighting going on and, you know, lots of anxiety and depression displayed. The degree of how much obviously was able to be worked through in this model.

Q. But essentially what you're saying is your model is based on positive reinforcement; so the child has to have a capacity for that --
A. Yes.

Q. -- and also not to be continually exposed to a negative spiral?
A. Yeah, they have to have - so a significant intellectual disability, I think, would exclude the child from the model. But we have had children that have had developmental delays that have done very, very well in the model. But it isn't, you know, for all children. It is one model that is highly successful for a range of children, but not all children.

Q. Just switching over to LG-10, which was the Victorian study which identified the particular stressors of COVID, this study was looking at what needed to be done to strengthen the child-care system in the wake of the particular stressors of COVID. I'll just put some propositions and then ask you at the end. There was a recognition that those listed stressors either increased the risk factors or reduced the protective factors that kept families together and children safe. The stressors that they listed included family conflicts or separation, family violence, parental substance misuse, parental unemployment and financial stress, housing stress, ability to meet basic needs, mental health and exposure to stress, and ability to care for children with a disability. And then additionally for Aboriginal people living in Victoria there was a protective factor of thriving within culture, family and community, and the imposed physical distance

seemed to diminish their ability to remain connected and socially supported.

Can I ask you that those stressors, while there was certainly a peak of them in COVID and in Victoria in particular because of those particular lockdown laws, but those are stressors that you would see elsewhere in communities under stress?
A. Absolutely. And, you know, we didn't get to the early intervention/prevention conversation today, but identifying that, I guess, picture of harm in community and the contributions those stressors have on families really sets you up to understand what types of interventions you need to put in place to deal with them adequately so you can slow down the demand into the statutory protection system because unless you are, you know, able to do that, then it's going to be a real struggle to reduce the overall number of children in out-of-home care.

MS GREENWOOD: Probably to the Commissioner's relief, I'm going to skip over the questions I was going to ask you about early intervention and prevention. But --

COMMISSIONER: Well, Ms Greenwood --

MS GREENWOOD: Sorry, Commissioner.

COMMISSIONER: No, that's all right. How long do you think you've got, because I just noticed the time?

MS GREENWOOD: I'm reasonably confident I can finish quickly, and that comment was to assure you I'm very close to the end.

COMMISSIONER: I'm reassured. Thank you.

MS GREENWOOD: So, cutting to the chase on that Victorian court in LG-10, they identified that further work is needed to fully understand and plan for a successful shift towards early intervention and implementation of evidence-based intervention, and this probably piggybacks off an earlier question by the Commissioner. Has there been much progress in what's needed to fully understand what's needed for that shift and actually make the system less reactive and more focused on early intervention?
A. There is varying degrees of progress in different jurisdictions in regards to that matter. At the time of

this study and this proposal was put to the Victorian government they did in fact make a significant investment into early intervention and prevention programs. That has somewhat transformed the level of practice in that arena. What we have seen 2026, if you look at the data, because there was some modelling done there of how the data could go the wrong direction, that investment has paid dividends in that the overall number of children in out-of-home care in Victoria has not increased. But I will preface that by saying that the overrepresentation of Aboriginal children and young people sadly has increased in terms of the number of Aboriginal children in care.

And I can provide for the Commission - if you want to issue me a notice - the data that I have access to. I can show the trajectory of the non-Indigenous population in out-of-home care has declined by about 3 per cent and, from memory, the Indigenous population has increased in out-of-home care by 3 per cent. So the investment has worked in early intervention in terms of reducing demand. So there's less entries to care.

Similarly in New South Wales they made a significant investment in 2018 to two particular evidence based models - one called functional family therapy child welfare; one called multi-systemic therapy child abuse and neglect - that was targeted for particular risk factors that you made mention of earlier; so families that have a multitude of issues around mental health issues, substance abuse issues, family violence issues.

Six teams of multi-systemic therapy child abuse and neglect were put on the ground in New South Wales, and 18 FFTCW teams were put on the ground. Over the five-year period that they were implemented they had a significant reduction in entries to care, and that has continued. So the population of out-of-home care in New South Wales has not increased, but they are struggling - like Queensland is - with the number of foster carers leaving the system and also the residential care population. So they've done a good job of slowing down demand, but still struggling with how you get the population of out-of-home care reduced.

Q. Thank you. You may or may not be able to comment on this, but kinship carers in Queensland have needed blue cards. That has been legislatively amended, but we don't have a different system in place yet. Are you able to

comment on how the equivalent card works in Victoria or how fast kinship carers can get approved?
A. It's a little bit quicker than it is here. And in the case study I talk about the kinship carers as having to obtain blue cards for them, and there were several delays, and delays for the child in the program as a result of that because there was a criminal history for the grandparents which, as I mentioned in evidence, was a driving offence, driving without a licence. But that was not considered a risk factor in obtaining a blue card for the assessment of being suitable to take care of their grandchildren.

But certainly it's very challenging for kinship carers when they have those hurdles. And it's challenging in all jurisdictions with the compliance, but then the other side of the argument is, you know, they're there for the protection of children as well, those compliance measures.

COMMISSIONER: Ms Greenwood, Dr Griffiths has been very generous in volunteering - perhaps "volunteering" is too strong a word - but agreeing to further assist me with some further submissions. And in that spirit, without testing a friendship, as it were, she may be prepared to respond in writing to further questions if you would like some time to reflect on other questions you may wish to ask her.

MS GREENWOOD: Thank you, Commissioner. Really the only other topic was what VACCA has been doing with building new programs that are strongly rooted in cultural therapeutic ways and that there had been others when the Victorian report was written that had offered to build an evidential base. So maybe, Commissioner if I can just leave that as a question for future comment, unless the witness wishes to talk about that now.
A. I'm very happy, Commissioner --

COMMISSIONER: Yes, go.
A. -- to provide as much available evidence on the success of VACCA's programs. And they've also developed a range of cultural practice models, which is the evidence you're referring to, to help train workers in knowledge and understanding of ways of knowing and doing, and I would be more than happy to provide for the Commission what I can source.

COMMISSIONER: Thank you very much.

MS GREENWOOD: Thank you, Commissioner. That concludes all my questions.

COMMISSIONER: Thank you, Ms Greenwood.

Before we rise I just wish to say - well, I want to apologise to Aunty Lizzie Adams and Trent Adams, who have been patiently waiting here all day expecting to give evidence today. I hope it won't be inconvenient for you to return tomorrow, and you'll be first up. I hope you appreciate that there was quite a lot of material to cover with this witness. And so thank you for your patience.

And, Dr Griffiths, thank you for your very thorough work, for engaging in the debate. The discourse is challenging, I think, for a whole lot of reasons. And I've been greatly assisted by being able to - I hope you don't mind - test propositions with you and have your responses. And I'm also very grateful that you're prepared to provide further assistance in the way that you've indicated. So thank you very much for your time and your contribution.
A. Absolutely delighted, Commissioner. Thank you for the work you're doing to serve Queensland's children.

COMMISSIONER: Yes, in advance, as it were. Fingers crossed. All right. We'll adjourn until 10.15.

THE HEARING WAS ADJOURNED AT 4.22PM UNTIL WEDNESDAY, 25 FEBRUARY 2026

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