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The Trustee for Life Choice T/A Well Life Services
NDIS Provider – 4050080412 | NIISQ Provider - C-100196
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Child Safety Commission of Inquiry

Submitted by: Elspeth Haswell-Smith, Psychologist and Founder, Well Life Services

Date: 29/10/2025

Location: Toowoomba, Queensland

Executive Summary

This submission addresses Well life Services' experience providing care for children with complex disabilities who are under the care of the Department of Child Safety, as well as our experience as an unregistered provider and being in-scope for HSQF licensing. Drawing on 23 years of community sector experience and three years' operating as an unlicensed residential care provider, I highlight the urgent need for disability-informed approaches to child protection, systemic coordination across the NDIS, NIISQ, Child Safety, Youth Justice, Education, and other stakeholder agencies, and clearer licensing pathways for specialist providers.

Key recommendations include:

- Recognition that disability assessment must precede trauma-informed care planning and the need for staff who understand disability – i.e., restoration and expansion of the Quality Practice and Support Team model.
- Development of culturally appropriate, disability-centred, and trauma-informed therapeutic care frameworks.
- Improved information sharing protocols across systems.
- Improved interprofessional collaboration and stakeholder engagement.
- Workforce planning – Mandatory disability competency for Child Safety Officers and Youth Workers.
- Better planning and supports for transition from adolescence to adulthood.
- Clear licensing pathways with dedicated liaison support.

I am a registered psychologist, Non-Executive Director and founder of Well life Services, established in October 2019. My involvement in the community services sector spans over 23 years, beginning at age 17 working in Qld Disability Services. Throughout my career, I have worked across regional Queensland, including Cairns, Mount Isa, and 19 years in Toowoomba. I have worked in disabilities and Domestic and Family Violence before entering private practice.

Well Life services is a registered provider to NDIS and NIISQ. Well Life Services has provided support at the complex intersection of disability and child protection, including:

- Specialist Support Coordination under the Voluntary Out of Home Care (VOC) MOU for children with complex disabilities with no child protection concerns.
- Residential Out of Home Care under Intensive Placement Support (IPS).

- Transition to adulthood support for young people with disabilities exiting the child safety system.
- Support for young adults in NDIS Supported Independent Living (SIL) placements.
- Support for children funded under both NIISQ and NDIS with Youth Justice involvement.

We have supported children and families navigating multiple overlapping systems, including Child Safety, NDIS, NIISQ, Youth Justice, Housing, Education, and Allied Health.

The Critical Gap: Disability-Informed Child Safety Practice

Children with Disabilities Are Being Failed

Throughout our work, we have identified a profound gap in how the Child Safety system understands and responds to children with complex disabilities. The system consistently fails to recognise that:

> ***Developmental understanding and disability diagnosis must come BEFORE trauma-informed responses.***

Without understanding a child's developmental stage, disability, and/or neurological differences, the system cannot:

- Distinguish between disability-related behaviours and trauma responses, including how they can intersect.
- Provide appropriate and effective environmental modifications.
- Meet cultural needs, particularly for First Nations children with disabilities.
- Develop and implement effective risk assessment and mitigation strategies.
- Support the child to use their voice in developmentally appropriate ways.
- Engage experts to ensure adequate diagnosis, support, and training are meeting the needs of the child, resulting in a reduction in long-term costs.
- Ensure that the child's disability-related needs are accurately funded by NDIS and the appropriate stakeholders are engaged under the funding.

Real-World Consequences

We have witnessed the devastating outcomes of this gap, including:

- Children's needs being unmet due to a lack of coordinating between stakeholders.
- Escalating behavioural symptoms misunderstood as behavioural choices rather than unmet disability needs or inaccurate diagnosis.
- Lack of engagement with education.

The Loss of NDIS Service Officers Specialist Support: Part of the South West Region Quality Practice and Support Team

The Child Safety NDIS Service Officers from the Quality Practice and Support Team in the South-West Region represented a model that worked. This team enabled service providers to liaise directly with Child Safety Officers who specialised in disability-related support needs. **This team has been significantly reduced in staff numbers and appears to have been phased out.**

The reduction of this team has resulted in:

- Child Safety Officers without adequate disability knowledge managing complex cases.
- Loss of NDIS funding due to poor communication and planning with NDIS.
- Risk of Support Coordinators in the NDIS landscape not being funded and reverting to navigation models that will place children at further risks.
- Poor or non-existent responses to provider correspondence.
- Lack of collaborative risk assessment and mitigation planning.
- Relationships between Child Safety and specialist providers.

Recommendation 1:

> *Restore and expand the NDIS Service Officers Quality Practice and Support Team model across all regions. Ensure all Child Safety Officers receive mandatory disability competency training, with specialist teams available for complex cases.*

Therapeutic Care Frameworks: The Australian Gap

Lack of Holistic Frameworks

There are many therapeutic care frameworks worldwide to support children with disability, who have experience trauma, and / or who are in Out of Home Care. However, there is a noticeable gap in these frameworks as they typically focus on either disability ***or*** trauma.

Yet many children engaged with Child Safety have disability and / or developmental delay ***and*** have experienced trauma.

Therapeutic care frameworks used in Queensland do not address both the young person's developmental and disability needs, and their trauma history. This can significantly impact the quality, relevance, and responsiveness of care provided to children and young people involved with Child Safety.

> ***Children and young people can not receive truly holistic care if the approaches to their care do not recognise, consider, and address ALL of their needs***.

International Models Don't Fit

Current therapeutic care frameworks adopted in Queensland predominantly originate from the USA or Canada. As such, these frameworks fail to address:

- The needs of First Nations children, who represent 50% of children in our care.
- The intersection of disability and trauma – approximately 42% of children in residential care have limited to severely limited intellectual functioning / developmental delay.
- Australian cultural contexts and service delivery systems – for example, we do not promote the use of restrictive practices.
- The unique developmental needs of children with complex disabilities.

Developing an Australian, Disability-Centred, and Trauma-Informed Model

Well Life Services has invested significant resources in:

- Research on therapeutic care frameworks appropriate for the Australian context, and the relevant elements of therapeutic care frameworks and models that could be incorporated into Well Life Service's current delivery of care and support.
- Consultation with Allied Health professionals and stakeholders who specialise in Children with Complex Disabilities living in Out of Home Care arrangements.
- Partnership with the University of Queensland to ensure ongoing research and development.
- Establishing a framework centred on disability assessment that informs developmental-stage, trauma-responsive, and culturally appropriate care.

Key Principles of Our Approach

1. **Disability assessment first:** Understanding the child or young person's developmental stage, diagnosis, and neurological differences, as well as their trauma history, to enable an appropriate trauma-informed care model.
2. **Cultural integration:** Embedding First Nations cultural practices and knowledge, recognising that 50% of children with disabilities in care are First Nations.
3. **Developmental staging:** Tailoring interventions to the child's developmental age, not chronological age which may not be truly reflective of their functioning and support needs.
4. **Environmental design:** Creating inclusive and accessible spaces and routines that meet sensory, communication, and mobility needs.
5. **Stakeholder coordination:** Ensuring all systems understand and respond to the child's disability alongside their trauma history.

The Risk of Investment Without System Support

We face significant uncertainty:

- Will Child Safety value and support disability-centred therapeutic frameworks?

- Are we investing in approaches that won't be recognised, funded, or supported by the guardian?
- Without system-wide adoption, will our children transition into services that don't understand their needs?

Recommendation 2:

> *Child Safety should commission the development of Australian therapeutic care frameworks that centre on disability and First Nations perspectives, with particular focus on the intersection of complex disability and trauma.*

System Coordination Failures

The Multi-System Challenge

Children with complex disabilities in care navigate an overwhelming array of systems, including:

- Child Safety
- National Disability Insurance Scheme (NDIS)
- National Inquiry Insurance Scheme Queensland (NIISQ)
- Education
- Youth Justice
- Allied Health
- Housing

These systems do not communicate effectively, do not share information appropriately, and frequently lack a shared vision for the child's outcomes.

Poor Information Sharing

Critical information is routinely unavailable or withheld, for example:

- Previous Allied Health assessments
- Medication histories and current prescriptions
- Behaviour support plans and incident reports
- Risk assessments from previous placements
- Restrictive practice implementation plans and methodologies
- Educational assessments and Individual Education Plans

This information vacuum forces providers to:

- Start assessments from scratch, delaying appropriate support
- Repeat traumatic assessment processes for children
- Operate without full understanding of risks

- Duplicate services and waste resources

Recommendation 3:

Establish mandatory information sharing protocols that ensure providers receive:

- *Complete allied Health assessment histories*
- *Current and historical medication information*
- *All behaviour support plans and restrictive practice documentation*
- *Risk assessments and mitigation strategies from previous placements*
- *Educational and developmental assessments*
- *Clear authorisation for providers to access and share this information across systems*

Stakeholder Engagement and Shared Vision

The lack of coordinated stakeholder engagement results in:

- Conflicting approaches to the same child
- Services working at cross-purposes
- No shared understanding of goals or success
- Fragmented support that confuses and destabilises children

Recommendation 4:

Require coordinated support planning meetings with all stakeholders before placement, and regular review meetings throughout. Child Safety should facilitate these meetings, not just participate.

Workforce Capability Crisis

Youth Workers Unprepared for Complexity

The residential care workforce, predominantly Youth Workers, face:

- Minimal disability-specific training requirements
- High costs to access specialised training independently
- Limited understanding of developmental approaches to disability
- Insufficient supervision and clinical support
- High burnout and turnover rates
- Workplace Health and Safety risks

The gap between workforce capability and the complexity of children’s needs is growing.

The Need for Clinical Oversight

Children with complex disabilities in residential care require:

- Regular clinical oversight
- Disability-informed behaviour support planning
- Trauma-informed practice embedded in disability understanding
- Cultural supervision for First Nations children
- Ongoing professional development for direct care staff

Recommendation 5:

Establish minimum clinical oversight requirements for residential care for children with complex disabilities, including:

- *Access to appropriate Allied Health consultation and diagnosis*
- *Regular clinical supervision for direct care staff*
- *Mandatory disability competency training for all Youth Workers*
- *Cultural supervision requirements for First Nations children*

Transition to Adulthood: The System's Greatest Failure

Unprepared for Independence

We have supported young adults transitioning from Child Safety care to NDIS-funded independence, and the outcomes are frequently devastating, such as:

- Inadequate life skills preparation during care – for example, some young people:
  - Have never used proper knives, forks, plates, cups, etc.
  - Have never lived in 'home-like environments'.
- Inappropriate matching in NDIS SIL placements can lead to placement breakdown and result in homelessness at the ages of 18 to 25 years.
- After exiting child safety and entering into inappropriate SIL matching, young adults have experienced addiction, homelessness, and incarceration – crises that stemmed directly from inadequate preparation for transition, poor SIL matching, and property damage.
- Young people do not always receive adequate diagnosis and support in place leading up to transitions.
- Experienced a lack of collaboration from NDIS on funding to ensure a smooth transition to adulthood.
- Experienced the Department of Housing missing the significant housing needs for children with disabilities transitioning to adulthood.
- Exit care to face immediate financial crisis. The Disability Support Pension on $822.60 per fortnight is insufficient to cover marker rent, let alone repay property damage costs

incurred during placement. These young people require priority access to Department of Housing, which must be engaged as a key stakeholder in transition planning from age 15 onwards.
- Vulnerability to exploitation, addiction, and involvement with the justice system.
- Loss of all stability and support networks.

The 18th Birthday Cliff

The transition at age 18 from Child Safety to NDIS represents an abrupt change when these young people need continuity most. We have witnessed:

- Young people placed in SIL arrangements with strangers.
- Loss of relationships with caregivers who understand their needs.
- Providers selected based on vacancy rather than suitability.
- Inadequate information transfer about the young person's disability, trauma, and support needs.

Recommendation 6:

Develop supported transition pathways that:

- *Begin planning at age 16, not 17, to enable adequate time and preparation for a well-supported transition.*
- *Prioritise continuity of relationships and placement where appropriate.*
- *Require disability-informed matching to adult services.*
- *Ensure comprehensive information transfer.*
- *Provide bridging support across the 18th birthday transition.*
- *Include life skills development throughout placement, not just before exit.*
- *Ensure adequate housing that is affordable and appropriate.*

The Unlicensed Provider Experience: A Three-Year Journey

Well Life Services brought our first child into care in October 2022, operating as an unlicensed provider. The pathway from NDIS Practice Standards to HSQF compliance was unclear, and Child Safety provided no indication of whether we would be invited to become licensed. We relied on the goodwill of other service providers who supported us to rapidly uplift our compliance standards. In addition, auditors provided support to oversee mock audits and ensure we were working towards HSQF standards.

It took three (3) years before we received correspondence indicating we were "in scope" to complete our licensing audit, with 18 months to engage an auditor.

This extended period of uncertainty created significant challenges:

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- **Safety concerns:** Operating without the full regulatory framework while providing complex disability care. Also experiencing directives from stakeholders that would place the child at risk and lacking in collaborative risk assessments.
- **Operational ambiguity:** No dedicated Child Safety liaison to guide the licensing journey.
- **Financial risk:** Unclear whether investment in enhanced infrastructure and frameworks would be valued or required.
- **Professional isolation:** Limited guidance on meeting the unique needs of children with disabilities in the child safety context. Refusal to pay for consultation from disability experts to assist with the management of complexity to reduce risk, address safety, and reduce models of care.

The Need for Clear Licensing Pathways

Recommendation 7:

Child Safety should establish clear, transparent licensing pathways for providers, including:

- *Early communication about intention to license a provider*
- *Collaborating on risk and mitigation while unlicensed*
- *Access to a dedicated liaison officer throughout the in-scope journey*
- *Clear timelines and milestone expectations*

Summary of Key Recommendations

1. **Disability Competency for Child Safety Officers:** Restore and expand the Quality Practice and Support Team model; mandate disability training for all CSOs.
2. **Australian Therapeutic Frameworks:** Commission development of disability-centred, culturally-appropriate therapeutic care models for Australian contexts.
3. **Information Sharing Protocols:** Implement mandatory sharing of Allied Health assessments, behaviour plans, risk assessments, and restrictive practice documentation.
4. **Coordinated Stakeholder Planning:** Require facilitated multi-agency planning, risk assessing, and review meetings for all children with complex disabilities.
5. **Clinical Oversight Requirements:** Establish minimum standards for Allied Health support and supervision in residential care of children with disabilities.
6. **Supported Transition Pathways:** Develop comprehensive transition planning beginning at age 16, with continuing of support across the 18th birthday.
7. **Clear Licensing Pathways:** Establish transparent processes with dedicated liaison support for disability-specialist providers seeking licensing.

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Conclusion

The Child Safety system is failing children with complex disabilities. This failure stems not from lack of caring, but from fundamental gaps in understanding disability, poor coordination across systems, unclear pathways for specialist providers, and therapeutic frameworks that don't fit our context.

Children with disabilities deserve a system that:

- Understands their disability before attempting to address their trauma.
- Coordinates effectively across all support systems.
- Values and supports specialist disability providers.
- Prepares them thoroughly for adulthood.
- Centres on First Nations culture and knowledge.
- Providers clinical oversight appropriate to complexity.

Well Life Services has invested three years and significant resources developing approaches to bridge these gaps. We have done so without clarity about whether we would be licensed, whether our frameworks would be valued, or whether the system would support the model of care these children desperately need.

The question before this Inquiry is not whether the current system is adequate. Our experience demonstrates clearly that it is not. The question is whether Queensland is willing to transform its Child Safety approach to genuinely meet the needs of children with disabilities.

I thank the Commission for the opportunity to contribute and remain available to provide further information or clarification as required.

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Case Example

17-year-old Indigenous Female (referred to here as Ms YP).

Diagnoses

Fetal Alcohol Spectrum Disorder (FASD), Autism Spectrum Disorder (ASD), Moderate Intellectual Disability (ID), Separation Anxiety, Reactive Attachment Disorder (RAD), Hearing Impairment (bone conduction hearing aid), Speech-Language Disorder, Motor tics, Migraines, Congenital Heart Disease (CHD).

Out of Home Care History

Ms YP was in foster care since birth; however, the long-term foster care placement eventually broke down, requiring Ms YP to move to an alternative care arrangement.

Ms YP then experienced 5 placement breakdowns with service providers in a space of 6 weeks.

Transition to Well Life Services

Ms YP arrived at Well Life Services with plastic bags of clothes that were size 10, yet she was a size 16. She, therefore, did not have access to appropriately-fitting clothes, which impacted on her comfort, dignity, self-identity, and sense of safety.

In addition, the medication our staff were provided for Ms YP was incorrect and not labelled adequately. This was a serious safety risk.

No risk assessments or transition planning had been conducted prior to Ms YP being placed in our care.

Within 15 minutes of arriving at the Well Life Services Office, Ms YP went into the toilet and consumed shampoo. She then removed her clothes and lay in the foyer reporting that she was experiencing heart pain. An ambulance arrived and she was transported to Toowoomba Base Hospital.

This was a known presentation of Ms YP's, a repetitive cycle of which we were eventually advised; however, Well Life Services was not informed of these risks on initial handover.

Initial Placement Period at Well Life Services

During the initial weeks in care, Ms YP often became escalated when accessing the community and demonstrated unsafe behavioural symptoms, such as walking in front of traffic and assaulting community members and staff. She also frequently disposed of all her belongings and broke furniture in the house.

The home in which Ms YP was placed was on the corner of a busy road and it was not suitable to her living requirements. For example, a service station was located adjacent to the home and, when dysregulated, Ms YP attended the service station and attempted to drink fuel from the petrol bowser. This was a significant risk to her health and safety.

The Toowoomba Police and Ambulance services were in attendance daily.

Although Ms YP was transported to Toowoomba Base Hospital frequently for support due to significant concerns for her mental ill health and physical safety, the hospital declined to admit her for assessment or medication review.

Example Crisis Situation

In one situation, Toowoomba Base Hospital directed us to take Ms YP home even though the risk of harm to herself, carers, and community was assessed by our staff as *high*.

Two security guards from the hospital physically placed Ms YP into a Toyota Prado against her will and consent. This impacted on Ms YP's dignity and sense of safety, and created further risks of harm to herself, the security guards, Well Life Services staff, and other members of the hospital and community.

When in the car, Ms YP, in a highly dysregulated state and without her needs being acknowledged or addressed, removed her clothes and urinated through the car in an effort to communicate her distress.

I was present throughout this situation and drove the car approximately 200 metres; however, I was unable to continue driving as Ms YP released her seatbelt and climbed through the car. At this stage, it was unsafe to drive.

Ms YP subsequently left the car and threw a shopping trolley at community members.

Queensland Police arrived and provided an escort home.

Ongoing Support Provided by Well Life Services

Following risk assessments and safety planning, Well Life Services found a home that was environmentally suitable for Ms YP, with a large garden and adequate fencing. We also made home modifications to ensure the safety of Ms YP and her Youth Workers.

Well Life Services engaged Dr Vanessa Spiller, a clinical psychologist, who specialises in FASD. With her support and a dedicated team, we created a low-stimulating environment and implemented activities to begin regulating Ms YP's nervous system. Addressing her disability-related needs through care and environmental modifications

enabled Ms YP to calm and settle. Once in a more regulated state, she was then able to begin engaging with and responding to trauma-informed interventions.

Further to this, Well Life Services advocated for Ms YP to receive much needed medical support from the Specialist Mental Health Intellectual Disability Service (SMHIDS), as well as an MRI to support a deeper understanding of Ms YP's brain-based injuries and impairments relating to FASD.

Well Life Services experienced a lack of collaborative and coordinated response and support from Queensland Health, Department of Housing, Specialist Support Intervention. With the level of complexity of Ms YP's presentation and needs, Well Life Services were required to strongly advocate around the risks the service faced, while also navigating systems where the doors closed rather than opened.

For example, during a meeting with Ms YP's stakeholders, Well Life Services were requested to stop calling emergency services. We, of course, understood this request as engagement with emergency services, such as Queensland Police and Ambulance, can be highly distressing and more traumatising to Ms YP. However, we were required to contact emergency services for safety support as there was a lack of risk management prior to Ms YP transitioning to our care. We were not advised of her safety needs, potential risks, or support and mitigation strategies. In addition, there were many instances where we would be failing in our duty of care to Ms YP if we did not contact emergency services. For example, when Ms YP reported heart pain, we were required in our duty of care to seek immediate medical assistance. If we had *not* called for an ambulance and the heart pain led to a significant medical episode, Ms YP may not have received the required care in an appropriate and necessary timeframe. This was not a risk we were willing to take.

Summary

This example is only one of many.

It highlights (1) the lack of information we frequently receive from other services when children and young people enter our care, (2) the level of risk our young people, staff, and community can face, (3) the poor understanding of disability-related needs, and (4) the difficulties we experience in effectively engaging and collaborating with external stakeholders to receive better outcomes sooner.