



**Commission of Inquiry into Queensland's Child Safety System
(2025)**

National Organisation for FASD (NOFASD) Australia

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NOFASD AUSTRALIA SUBMISSION COMMISSION OF INQUIRY INTO QUEENSLAND'S CHILD SAFETY SYSTEM (2025)

1. EXECUTIVE SUMMARY

NOFASD Australia, the national peak body for Fetal Alcohol Spectrum Disorder (FASD), welcomes this Commission's comprehensive examination of systemic issues in Queensland's child safety system. Our submission focuses on the urgent and under-recognised intersection between FASD and the child protection system. FASD is a neurodevelopmental disability caused by prenatal alcohol exposure (PAE). Its prevalence among children in out-of-home care (OOHC) is alarmingly high, yet systemic responses remain inadequate.

We call for reforms that embed early screening, diagnosis, and evidence-based supports for children with FASD, as well as mandatory workforce education, legislative recognition, and integration of FASD into all facets of policy, planning, and service delivery.

2. ABOUT NOFASD AUSTRALIA

Founded in 1999, NOFASD Australia is the national organisation representing individuals, families and carers affected by Fetal Alcohol Spectrum Disorder. We are dedicated to providing an effective link between those with lived and living experience of FASD and professionals whose work intersects on this topic. We provide a free, confidential helpline service, available 7 days a week, national advocacy, training, and evidence-based resources. Our work is informed by lived experience, professional partnerships, and a commitment to improving outcomes across education, health, justice, and child protection systems.

3. KEY ISSUES RELEVANT TO THE INQUIRY

3.1. THE SCALE AND IMPACT OF FASD

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe the brain-and body-based impacts caused by prenatal alcohol exposure (PAE). It is a lifelong, non-genetic neurodevelopmental disability that affects learning, memory, attention, communication, emotional regulation, and behaviour. Individuals with

FASD often require support across all areas of daily life. Each individual is unique and is likely to have areas that pose significant difficulties for them as well as strengths that may sometimes ‘mask’ their challenges. FASD is therefore often referred to as a ‘hidden’ or ‘invisible’ disability. Emerging evidence reinforces that FASD is not only a brain-based disability but a whole-body condition, with recent research identifying increased risks across metabolic, cardiovascular, renal, immune, sensory, reproductive, and sleep systems throughout the lifespan (Vanderpeet et al., 2025).

One of the challenges in understanding FASD is the issue of dysmaturity where the individual’s behaviour and abilities do not match their chronological age. Older children and teenagers may exhibit age dysmaturity and show poor impulse control. They may not distinguish between appropriate public and private behaviours, and may not comprehend or follow rules. Teenagers with FASD are at higher risk of mixing with ‘unsafe’ individuals and groups, criminal behaviours, abuse of alcohol and other substances, and separation from family support

The severity of FASD-related impairments varies widely and is influenced by multiple factors, including the amount and timing of alcohol use during pregnancy, maternal health (including nutrition, stress, and mental health), and broader environmental conditions. FASD is the leading preventable cause of developmental disability in Australia and the Western world.

A landmark 2025 national prevalence study by Tsang et al. found that 1 in 28 Australians may be affected by FASD, equivalent to one child in every classroom. This rate is based on national-level modelling, estimating a 3.64% prevalence rate in the general population of Australia although it is likely that certain vulnerable populations have significantly higher FASD prevalence. (Tsang et al., 2025).

Children with FASD experience lifelong cognitive, behavioural, and emotional challenges and are at increased risk of disrupted schooling, mental health concerns, out-of-home care involvement, and justice system contact. These challenges are often compounded by comorbid conditions, including ADHD, autism, and trauma exposure (Elliott et al., 2025).

In Queensland, the scale of impact is particularly evident in the child protection population. The 2024 Queensland Children in Care Census found that:

- 41% of children in care have a disability.
- 1 in 5 of these have diagnosed or suspected FASD.
- 1 in 5 children with a diagnosed or suspected disability have unmet support needs in relation their disability (Department of Families, Seniors, Disability Services and Child Safety, 2024a).

Despite its prevalence, FASD remains underdiagnosed and poorly recognised within the child safety system. Many children with FASD are misidentified as having behavioural disorders, leading to punitive responses instead of therapeutic support. The scale and complexity of FASD requires specialised, coordinated, and disability-informed responses, none of which are systematically embedded in Queensland's current child protection framework.

3.2. SYSTEMIC FAILURES IN RESPONDING TO FASD

Despite its high prevalence in the out-of-home care population, Fetal Alcohol Spectrum Disorder (FASD) is not systematically recognised, screened for, or diagnosed within Queensland's child protection system. The 2024 Census shows a substantial number of children in care with suspected disabilities, including FASD, have unmet support needs, even when disability has been identified (Department of Families, Seniors, Disability Services and Child Safety, 2024a).

“Significant barriers remain, particularly for young people diagnosed and undiagnosed with FASD.” – Anonymous (NOFASD Stakeholder Feedback, 2025)

While children with FASD may enter the child protection system due to parental alcohol use, neglect, or exposure to harm, these situations often reflect broader failures in early support and prevention. Once in care, the system continues to fail these children through a lack of coordinated, disability-informed responses. These children are routinely denied timely diagnosis, appropriate assessment, and therapeutic support planning.

The *Child Safety Practice Manual – Disability (2025)* acknowledges FASD as a co-occurring condition and promotes a neurodevelopmental lens. It also references NOFASD's "Parent Toolkit" as a resource for families and professionals. Yet despite these acknowledgements, there are currently no mandatory or system-wide screening procedures for FASD, nor any embedded diagnostic referral pathways or

neurodevelopmentally informed case planning processes outlined in formal practice frameworks. These gaps have been consistently highlighted by caregivers, practitioners, and advocacy organisations.

The *Australian Guidelines for the Assessment and Diagnosis of FASD (2025)* confirm that insufficient or missing documentation of prenatal alcohol exposure remains a major barrier to diagnosis. This issue is particularly problematic in contexts where caregivers with relevant knowledge are unavailable or records are incomplete, a common reality for many children in out-of-home care. Stakeholder feedback further highlights this concern: carers report being dismissed even after presenting formal diagnoses, and frontline workers describe a lack of training and systemic obstacles to securing assessments.

“We had trouble getting our diagnosis through Child Safety paediatrician, so we went private and got it through them.”
– Anonymous (NOFASD Stakeholder Feedback, 2025)

These experiences reflect a system-wide disconnect between policy and practice, wherein children with FASD are routinely excluded from developmentally appropriate placements, therapeutic supports, and stable care environments.

Without cross-sector coordination, neurodevelopmental disability screening, workforce capability building, and early intervention pathways, children with FASD continue to cycle through multiple placements and systems ill-equipped to meet their needs. This gap undermines placement stability, casework effectiveness, and long-term outcomes, reinforcing trauma rather than interrupting it.

3.3. RESIDENTIAL AND OUT-OF-HOME CARE CHALLENGES

Children with Fetal Alcohol Spectrum Disorder (FASD) are disproportionately represented in Queensland’s residential care system, which is frequently ill-equipped to meet their complex neurodevelopmental needs.

- Residential care use in Queensland increased by 85% over five years, a rate of growth not seen in any other Australian jurisdiction. Queensland now accounts for 40% of all residential care placements nationally, despite having just 21% of the country’s children in care (QFCC, 2024).

- Almost one in three children in Queensland residential care are under 12, including a concerning number under the age of five. This raises significant concerns about age-appropriateness and developmental harm (QFCC, 2024).
- More than 40% of children in care have a diagnosed disability, yet current models often lack trauma-informed, developmentally appropriate, and neurodisability-informed practices (Department of Child Safety, Seniors and Disability Services, 2024a).

Despite reform efforts, residential care environments frequently fail to deliver tailored responses for children with disabilities, particularly those with FASD. Children with neurodevelopmental disabilities often experience multiple placement breakdowns, inconsistent caregiving, and escalating behavioural challenges. These experiences compound trauma, increase emotional dysregulation, and elevate the risk of criminalisation and youth justice involvement (NOFASD, 2022).

The 2024 Children in Care Census revealed that 73% of children in care had experienced four or more placements. This level of instability disrupts attachment, undermines therapeutic progress, and disproportionately affects children with disabilities like FASD. Alarming, 44% of children in care had self-harmed, and 22% had attempted suicide - figures that reflect the system's inability to provide safe, consistent, and neurodevelopmentally informed care (Department of Families, Seniors, Disability Services and Child Safety, 2024a).

Stakeholder reports consistently describe residential care staff as under-trained in FASD, lacking the skills to differentiate between disability-related behaviours and intentional defiance. This often results in punitive responses, rather than therapeutic support.

“Having worked within the disability, child protection and youth justice system as a social worker, significant barriers remain, particularly for young people diagnosed and undiagnosed with FASD. There is limited wider understanding of the impact of FASD.”
– Anonymous (NOFASD Stakeholder Feedback, 2025)

The 2025 *Australian Guidelines for the Assessment and Diagnosis of FASD* emphasise the importance of building FASD capability across care systems. Key recommendations include:

- Strengthening documentation and inquiry processes related to prenatal alcohol exposure,
- Supporting cross-sector workforce training, including for child protection and care staff, to improve identification, referral, and understanding of FASD
- Ensuring diagnostic outcomes inform therapeutic care planning (Australian FASD Guidelines Development Group, 2025).

Until these practices are systematically implemented, children with FASD will continue to be mismatched to unsuitable placements, re-traumatised by unstable care arrangements, and funnelled into systems not equipped to support their long-term wellbeing. Repeated placement failures and behavioural escalation also significantly increase the likelihood of children with FASD entering the youth justice system, often under dual Child Protection and Youth Justice Orders.

AIHW (2024) data demonstrates that approximately 65% of young people under youth justice supervision in 2022–23 had previously been involved with child protection, 25% of whom had been in out-of-home care. Individuals with FASD also experience significantly elevated mental health vulnerabilities. Research indicates 91% face mental ill health, with death by suicide accounting for around 13% of deaths compared to 2.4% in the general population (Lange et al., 2022). These risks are compounded in residential care, where high Adverse Childhood Experience (ACE) scores and ongoing placement disruptions intensify emotional and behavioural challenges. Without therapeutic support, the behavioural symptoms displayed due to a neurodevelopmental disability are too often misclassified as delinquency, rather than being met with appropriate disability-informed interventions.

3.4. WORKFORCE TRAINING AND CAPABILITY GAPS

Despite growing awareness of Fetal Alcohol Spectrum Disorder (FASD), workforce capability across Queensland’s child protection, education, youth justice, and health sectors remains critically low. Professionals often lack the training needed to recognise and respond to neurodevelopmental disability, resulting in systemic misidentification, missed diagnoses, and inappropriate interventions.

There are no mandatory FASD-specific training requirements for child safety officers, residential care workers, or youth justice staff in Queensland. For example, the Certificate IV in Youth Justice, the nationally recommended minimum qualification for

youth justice workers, contains no explicit reference to working with neurodevelopmental conditions such as FASD (Howell, 2024). Likewise, FASD is not routinely included in induction or professional development across child protection practice settings.

This widespread gap contributes to the misinterpretation of FASD-related characteristics, including impulsivity, poor memory, emotional dysregulation, or social naivety, as intentional misbehaviour or non-compliance. As noted in NOFASD's Out-of-Home Care Literature Review, these misunderstandings often lead to punitive, rather than therapeutic, responses and may escalate distress or crisis behaviours (NOFASD, 2022).

In a 2025 national survey conducted by NOFASD, over 75% of respondents indicated that professionals in child protection, education, justice, and health lacked a functional understanding of FASD and its impacts. Families and frontline workers reported repeated experiences of being dismissed, unsupported, or forced to pursue private diagnoses.

“Refusal to be acknowledged by Child Protection even after diagnosis” – Social worker, NOFASD Stakeholder Feedback (2025)

“I work in Child Protection where FASD is frowned upon.” – Carer, NOFASD Stakeholder Feedback (2025)

Although some progress has been made, such as the inclusion of FASD training by the Australian Childhood Foundation and the Centre of Excellence in Therapeutic Care, these initiatives remain voluntary and limited in reach, falling well short of a system-wide workforce development response (Howell, 2024).

Training is urgently needed to:

- Build awareness of FASD and its implications for behaviour, regulation, and learning
- Equip child safety and care professionals with practical tools to identify, respond to, and appropriately support individuals with FASD
- Reduce stigma and shift practice toward compassionate, developmentally appropriate support

Without this capability, the system will continue to cycle children with FASD through inappropriate placements, crisis interventions, and escalation to the youth justice system, reinforcing disadvantage rather than interrupting it.

The human and economic cost of undiagnosed FASD is substantial and directly tied to a workforce that is not trained to recognise or respond to early signs. A 2025 media report highlighted that missed diagnoses of FASD are costing Queensland millions of dollars each year, with long-term financial impacts spread across health, education, justice, and disability systems (Little, 2025). These costs are avoidable. As Professor Elizabeth Elliott emphasised in the same article, *“early recognition has benefits for savings across the health, education and justice system.”*

Cairns-based advocate Anne Russell described travelling overseas to obtain a diagnosis for her children after being repeatedly dismissed by professionals:

“It was too late ... our parenting style hadn’t changed in the most formative years.” (Little, 2025)

Her story reflects a broader pattern reported by families across Queensland, one of stigma, disbelief, and professional systems ill-equipped to recognise or respond to FASD. Without meaningful investment in training, early diagnosis, and workforce capability, these outcomes will continue to be replicated at great cost to both individuals and public systems.

3.5. LEGAL AND DIAGNOSTIC BARRIERS

Children with Fetal Alcohol Spectrum Disorder (FASD) face significant diagnostic and legal barriers that compound their disadvantage and delay access to support. These challenges are especially pronounced for children involved in the child protection or youth justice systems.

Despite the release of updated national diagnostic guidelines, access to FASD assessments remains limited in Queensland. Carers report lengthy waitlists, lack of services outside metropolitan areas, and the need to self-fund private diagnoses due to fragmented or absent referral pathways. The *Cairns Post* “Cause and Effect” campaign (2025) has drawn public attention to these gaps, reporting year-long delays in public FASD assessments in Far North Queensland and a critical lack of diagnostic services. The campaign underscores early identification as a vital strategy for preventing youth justice involvement and improving long-term outcomes

(NOFASD, 2025). These delays directly impact a child's access to therapeutic supports, disability-informed case planning, and systems such as the NDIS. Even with a formal diagnosis, access to the National Disability Insurance Scheme (NDIS) remains inconsistent due to variable interpretation of eligibility criteria and a lack of recognition of the functional impacts of FASD (FARE, 2023)

The 2025 Australian Guidelines for the Assessment and Diagnosis of FASD acknowledge that children in out-of-home care often lack complete prenatal histories, creating a barrier to diagnosis. They recommend that:

- Prenatal alcohol exposure be recorded alongside other prenatal factors;
- Child protection workers receive training in accurately collecting and documenting this information;
- Diagnostic outcomes be incorporated into children's Health Management Plans (Australian FASD Guidelines Development Group, 2025).

However, these recommendations are not yet embedded in Queensland's child safety procedures. Without formal requirements or training, caseworkers remain ill equipped to pursue FASD assessments, and many children with complex needs remain unidentified or unsupported. Even when a diagnosis is secured, stakeholders report that it is often ignored or minimised in planning processes.

Diagnostic barriers are mirrored by legal misunderstandings. Young people with FASD frequently appear in court without their impairments being identified or understood. Characteristics such as suggestibility, impulsivity, and difficulty understanding consequences are often misread as intentional defiance or criminality.

"Police, lawyers, judges, psychologists etc. do not understand the effects of FASD on a person... I have been ignored when trying to explain FASD." – NOFASD Stakeholder Feedback (2025)

This lack of recognition fuels a cycle of unmet need, missed opportunities for diversion, and ongoing criminalisation. A landmark WA study found that 89% of young people in youth detention had at least one severe neurodevelopmental impairment, and 36% were diagnosed with FASD (Bower et al., 2018). This study continues to be cited as a wake-up call to improve early screening, support planning, and trauma-informed justice responses (Howell, 2024).

Until diagnostic systems and legal processes are formally updated to reflect the realities of FASD, children and families will continue to be failed—punished for behaviours rooted in a brain-based disability and denied access to the disability-informed support they urgently need.

3.6. UNFULFILLED RECOMMENDATIONS AND SYSTEMIC ACCOUNTABILITY

The 2013 Queensland Child Protection Commission of Inquiry (Carmody Inquiry) issued over 100 recommendations aimed at reforming the child protection system. Over a decade later, many of these remain only partially implemented, particularly those relating to disability access, transition planning, and neurodevelopmental needs. This includes children and young people with intellectual disability, autism, ADHD, and conditions like FASD.

The Inquiry found that young people with cognitive and developmental conditions were at elevated risk of homelessness, exploitation, criminalisation, and untreated mental illness. It called for extended post-care support, improved developmental screening, and tailored placement options, reforms that remain critically needed today.

Key recommendations still requiring full implementation include:

- Recommendation 4.12: Ending the forced relinquishment of children due to disability.
- Recommendation 7.7: Mandating comprehensive developmental assessments for all children entering out-of-home care.
- Recommendations 7.8 & 8.7: Expanding early intervention and trauma-informed services.
- Recommendations 8.6 & 8.10: Delivering specialist training and professional carer pathways.
- Recommendations 9.1–9.3: Supporting transitions from care to age 21 with continued access to disability services (Queensland Child Protection Commission of Inquiry, 2013).

The continued failure to implement these reforms perpetuates the same systemic neglect identified over a decade ago—now carried by a new generation of children and caregivers affected by FASD.

Importantly, these failures are not only policy oversights but may also constitute breaches of state and international human rights obligations. A rights-based approach to reform must underpin any serious effort to address the needs of children with neurodevelopmental disabilities.

- Article 3 and Article 37 of the UN Convention on the Rights of the Child (UNCRC, 1989) require that the best interests of the child be a primary consideration in all decisions and prohibit cruel, inhuman, or degrading treatment.
- Sections 17, 26, and 33 of the Queensland Human Rights Act (2019) protect against cruel treatment, affirm children’s rights to special protection, and uphold the right to a fair hearing.

Current practices, such as punitive responses to disability-related behaviours, chronic placement instability, or proposals to expand adult sentencing of neurodivergent young people, may be inconsistent with these legal protections. These issues demand urgent attention and underscore the importance of revisiting the Carmody Inquiry’s recommendations through a disability and human rights lens.

3.7. CULTURAL SAFETY AND PREVENTION GAPS

Fetal Alcohol Spectrum Disorder (FASD) disproportionately affects Aboriginal and Torres Strait Islander children, yet culturally informed prevention, diagnostic, and support pathways remain limited in Queensland. A high prevalence of FASD has been documented in some remote communities, with one study identifying rates as high as 19%, although this is not representative of all Aboriginal populations (Fitzpatrick et al., 2015). While other jurisdictions have begun embedding culturally informed approaches, Queensland’s child protection and youth justice systems lack formal mechanisms to ensure prevention, identification, and intervention are culturally appropriate and community-led. The absence of culturally-grounded FASD pathways increases the risk of misdiagnosis, disengagement from services, and continued intergenerational harm.

Aboriginal and Torres Strait Islander children remain significantly overrepresented in out-of-home care. National data shows they are 11 times more likely to be in care than non-Indigenous children (AIHW, 2024). They are also overrepresented in youth detention and neurodevelopmental disability cohorts. For example, a landmark

Western Australian study found that 47% of young people diagnosed with FASD in detention identified as Aboriginal (Bower et al., 2018). These figures highlight the urgent need for early identification, culturally responsive care, and community-based prevention.

The 2025 Australian Guidelines for the Assessment and Diagnosis of FASD emphasise the ongoing impact of intergenerational trauma, colonisation, systemic racism, and inequity on Aboriginal and Torres Strait Islander communities. These systemic factors have contributed to deeply entrenched mistrust of government systems, particularly in child protection and health. The Guidelines also acknowledge that this mistrust, combined with shame and stigma, can significantly hinder families' willingness to disclose prenatal alcohol exposure, a critical component of accurate diagnosis (Australian FASD Guidelines Development Group, 2025).

To meaningfully reduce the overrepresentation of Aboriginal and Torres Strait Islander children in care and the justice system, prevention and response strategies must be culturally led, trauma-aware, and strengths-based.

4. STAKEHOLDER PERSPECTIVES AND LIVED EXPERIENCE

Lived experience narratives and stakeholder feedback illustrate deep systemic barriers surrounding FASD diagnosis, recognition, and support across Queensland's child protection and youth justice systems. NOFASD's 2025 "FASD, Stigma and Diagnosis" survey revealed widespread stigma and systemic access barriers, with carers and professionals describing the emotional and financial toll of navigating fragmented systems. One respondent shared:

"Having had (too much) involvement in the justice system with my young man it is abundantly clear police, lawyers, judges, psychologists etc do not understand the effects of FASD on a person and their behaviours and ability to make wise decisions. I have been ignored when trying to explain FASD"

Others reported being blamed for poor parenting or dismissed due to the child's outward presentation:

"Denial from DCP. Ignorance of behavioural effects in larger community. Parent blamed for behaviours."

"We have experienced challenges and barriers with understanding in multiple systems - education, child protection, justice, physical"

health, mental health, dental, community access e.g. sports, alcohol services, Centrelink/welfare services, NDIS, family and friends. Our child looks 'normal', with an average IQ, yet functions as a small child."

These experiences are echoed in the case of [REDACTED] a 14-year-old First Nations girl from [REDACTED] with FASD and significant intellectual disability. Despite being assessed as having the cognitive capacity of a five-year-old and found unfit to stand trial, [REDACTED] has been detained in adult watch houses more than ten times. Footage published by SBS and *The Guardian* shows her naked, distressed, and isolated, banging her head against a wall and crying, "It's too cold in here." Her grandmother explained: "People who don't know her will think she is a normal teenager, but she's not... She doesn't understand cause and effect." [REDACTED] repeated incarceration, despite clinical advice to the contrary, exemplifies the systemic failure to identify and respond appropriately to neurodisability, especially among Aboriginal and Torres Strait Islander children (Luu & Elias, 2024; Smee, 2024).

Concerns about the lack of recognition and support for FASD are also being raised by clinicians in youth detention. At Cleveland Youth Detention Centre, more than 15% of young people are diagnosed or suspected to have FASD. A recent pilot screening program by Townsville University Hospital assessed over 100 children, with approximately one-third referred for neurodevelopmental assessment. Clinical nurse Jason Laverack emphasised the importance of early intervention: "Once out of care, they will be able to access services like the NDIS to get the help and support they need" (Hill, 2025).

Similar issues persist in the broader out-of-home care system. The 2024 Residential Care Roadmap Progress Report, informed by consultations with 70 young people in care, found no reported improvement in safety, placement stability, or support. One consultant noted: "Not one young person that I spoke to could say that they had seen a difference in the quality, or safety of their residential care over the last 12 months." The report identified "limited progress" across core reform areas, including the delivery of trauma-informed, therapeutic, and Aboriginal-led care models (Department of Child Safety, Seniors and Disability Services, 2024b).

These accounts underscore the urgent need for system-wide change. Families, carers, clinicians, and young people are calling not only for the recognition of FASD,

but for compassionate, culturally informed, and neurodevelopmentally informed responses. Responses that uphold the dignity and rights of children and break cycles of harm.

5. RECOMMENDATIONS FOR REFORM

To improve outcomes for children with FASD and address systemic gaps across Queensland's child protection system, the following reforms are recommended:

PREVENTION AND EARLY INTERVENTION

- **Embed FASD prevention in departmental strategy**, with a focus on culturally safe, strengths-based messaging tailored to caregivers and communities at risk.
- **Leverage existing resources** co-designed through [Every Moment Matters](#) campaign, led by the [Foundation for Alcohol Research and Education](#), [NOFASD](#) and [NACCHO](#) to include materials for child protection workers and Aboriginal communities (e.g., [Strong Born](#)).
- **Support community-led education and prevention initiatives**, including those co-designed with Aboriginal health services and lived experience advocates.
- **Embed the FASD Indigenous Framework** into Departmental practice guidance and staff development programs to ensure culturally safe, community-informed approaches to prevention and early support.

EARLY IDENTIFICATION AND DIAGNOSIS

- **Introduce FASD screening** at key entry points, including child protection intake, case planning reviews, and youth justice referrals.
- **Require comprehensive developmental screening** for all children entering out-of-home care, as recommended by the Carmody Inquiry (Rec. 7.7).
- **Expand access to fully staffed, multidisciplinary Child Development Services**, with prioritised investment in regions of high need (e.g. Far North Queensland).
- **Fund culturally safe diagnostic services** that align with the 2025 Australian Guide to the Diagnosis of FASD, including trauma-informed assessment pathways and Aboriginal-led delivery models.

- **Ensure diagnostic outcomes are integrated** into Health Management Plans and used to inform NDIS applications, placement decisions, and case planning.

WORKFORCE DEVELOPMENT AND TRAINING

- **Fund mandatory FASD training for frontline child safety staff**, residential care providers, health professionals, legal practitioners, and justice sector workers.
- **Engage established providers** such as NOFASD Australia to deliver tailored online and face-to-face training, with lived experience input and evidence-informed content.
- **Mandate inclusion of FASD and neurodevelopmental disability content** in all accredited training programs for practitioners working with children in care.

DISABILITY-INFORMED CARE AND SUPPORT

- **Prohibit the use of short-term, crisis-driven Individualised Placement and Support (IPS) arrangements** for children with diagnosed or suspected FASD.
- **Align placement decisions with neurodevelopmental needs**, ensuring stability, therapeutic care models, and access to NDIS and allied health services.
- **Provide specialist carer training** for foster and kinship carers supporting children with FASD, as outlined in the Carmody Inquiry recommendations (Rec. 8.6, 8.10).
- **Support transitions from care** for young people with FASD through sustained case management and disability support pathways.

ACCOUNTABILITY AND GOVERNANCE

- **Report annually on FASD and neurodevelopmental disability outcomes** within the care population, including rates of identification, access to diagnosis, placement stability, and service access.
- **Mandate inclusion of FASD indicators in departmental KPIs**, monitoring progress on training, diagnosis, and outcomes for children with disability.

- **Establish an independent oversight mechanism** to receive and investigate complaints relating to disability-informed care, service access, and system navigation barriers.

LEGISLATIVE ALIGNMENT

- **Amend the Child Protection Act 1999** to formally recognise neurodevelopmental disability, including obligations for early identification, culturally safe responses, and long-term support.
- **Implement outstanding recommendations from the Carmody Inquiry**, especially those relating to disability relinquishment, developmental screening, and extended post-care support.
- **Ensure alignment with national frameworks**, including the National FASD Strategic Action Plan 2018–2028, the Closing the Gap Priority Reforms, and the 2025 Australian Guide to the Diagnosis of FASD.

6. CONCLUSION

Queensland's child protection system is at a critical juncture. Despite clear evidence on the prevalence and lifelong impacts of Fetal Alcohol Spectrum Disorder (FASD), systemic recognition, diagnosis, and support for affected children remain deeply inadequate. The consequences of inaction are visible across every level of the system, children cycling through unstable placements, carers navigating fragmented services, professionals without the tools they need, and young people with FASD being criminalised instead of supported.

This submission has drawn on national prevalence data, expert evidence, frontline insights, and lived experience to demonstrate the urgent need for reform. The recommendations provided are practical, evidence-based, and align with existing government commitments under the Closing the Gap framework, the National FASD Strategic Action Plan, and the Queensland Human Rights Act. Many also build directly on unfulfilled reforms first called for in the Carmody Inquiry over a decade ago.

To break cycles of harm, Queensland must act now to embed early identification, trauma-informed care, cultural safety, and disability-inclusive practices at the heart of its child protection responses. The evidence is clear. The voices of families,

professionals, and children must be heard. The time for piecemeal action has passed and an holistic approach must be mandated in order to achieve meaningful positive outcomes

FASD is not rare. It is not new. And it is not going away. With the right systems, training, and leadership in place, Queensland has an opportunity to lead the nation in creating a child safety system that recognises neurodevelopmental disability, upholds human rights, and delivers genuine therapeutic support to those who need it most.

7. Appendix A: Mapping of NOFASD Recommendations to Terms of Reference and Carmody Inquiry Recommendations

NOFASD Recommendation	2025 Inquiry ToR Alignment	Carmody Inquiry Recommendation(s)
Require developmental screening for all children entering OOHC	Fixing a broken system – practices and procedures; Residential care	7.7
Fund culturally safe diagnostic services for FASD	Safer children; Safer communities	7.8, 8.7
Mandatory FASD training for all frontline child protection workers	Fixing a broken system – workforce resourcing and training	8.6, 8.10
Integrate FASD screening at intake and case planning	Fixing a broken system – decision-making frameworks	7.7
Prohibit short-term IPS placements for children with FASD	Reforming the residential care system – quality of care	8.6
Establish independent oversight mechanism for disability-informed care	Fixing a broken system – complaints process and governance	New recommendation (relevant to ToR)
Amend Child Protection Act to recognise neurodevelopmental disability	Legislative reforms	9.1, 9.2

NOFASD Recommendation	2025 Inquiry ToR Alignment	Carmody Inquiry Recommendation(s)
Embed Aboriginal-led prevention and care pathways	Safer children; Safer communities	8.7, 9.3
Track and report annually on FASD outcomes in care population	Accountability and governance	9.1
Ensure NDIS access pathways informed by FASD diagnosis	Fixing a broken system – access to support and disability services	7.8, 9.2

8. REFERENCES

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