Submission from [redacted]

Received: 30 September 2025

Background:

- [redacted]

Summary of ‘Access to health services’ attachment:

1. **Health Challenges for Children in Care**: Children in the child safety system face disproportionate rates of physical and mental health issues, either as a cause for entering care or as a result of neglect, abuse, or the care system itself. Foster care is often a better option than residential care, as it provides a consistent adult advocate for the child’s health needs.
2. **Family Care Program**: The submission notes the downgrading of Queensland Health’s Family Care Program due to budget cuts (2014) and the COVID-19 pandemic (2020). This program previously provided early intervention and support for families at risk, including prenatal visits and postnatal home support. The author advocates for its expansion to improve child safety and reduce child protection interventions.
3. **Prevention and Early Support**: Emphasis is placed on the importance of prevention, early parenting education, and intense support to enable families to safely care for their children at home. This includes addressing risk factors like domestic violence, homelessness, and poverty, which are common reasons for child removal.
4. **Challenges in Child Protection Services**: Frequent staff turnover among Child Safety Officers (CSOs) leads to inconsistency and gaps in care. The

submission recommends smaller caseloads, more hands-on support, and continuity of CSOs to build stronger relationships with children and families.

5. **Therapeutic Residential Care**: Residential care should be a last resort and must adopt a therapeutic model, especially for children with extreme behaviours or multiple failed placements. This includes access to psychological expertise, stable staffing, and tailored support to meet individual needs.
6. **Crisis Intervention**: The submission calls for an adequately resourced crisis team within Child Safety to provide immediate and specialised intervention for children whose behaviours threaten placements or school attendance.
7. **Advocacy for Vulnerable Groups**: The submission stresses the need for strong advocacy for women and children experiencing domestic violence and ensuring no child is removed solely due to poverty or homelessness.
8. **Attachment and Emotional Health**: The importance of early attachment for infants' emotional health is highlighted, with concerns about the impact of multiple placements on infants. The submission suggests providing the same level of support to at-risk parents as is offered to parents with disabilities.
9. **Broader Systemic Issues**: The submission critiques systemic priorities, urging the government to fund child protection and health services adequately and recognise the importance of these vulnerable children.

The overarching theme is the need for early intervention, consistent support, and therapeutic care to improve outcomes for children and families in the child protection system.

Summary of 'FASD and neurodysregulation' attachment:

The document discusses the challenges and complexities of diagnosing Fetal Alcohol Spectrum Disorder (FASD) and its overlap with other factors like trauma, developmental issues, and behavioural difficulties in children, particularly those in out-of-home care. Key points include:

1. **Diagnostic Challenges**: Diagnosing FASD is difficult due to reliance on DSM-5 criteria, which focus on neurocognitive and neurobehavioural issues and prenatal alcohol exposure. Other causes, such as trauma, must be excluded. Physical features like facial characteristics are not scientifically validated and may not apply across populations, particularly First Nations communities.
2. **Trauma and Neurodevelopment**: Emotional trauma can cause significant structural and functional changes in the brain, such as reduced amygdala volume and prefrontal cortex thinning, leading to issues like emotional dysregulation, memory problems, and hyper-reactivity. These effects can mimic or exacerbate conditions like FASD or ADHD.

3. **Multifactorial Causes**: Children’s developmental and behavioural difficulties often result from multiple factors, including prematurity, congenital conditions, trauma, and environmental influences. Misdiagnosis of FASD can lead to inappropriate treatment and stigma.
4. **Systemic Issues**: Current residential care services are inadequate for children with trauma-related behavioural issues. Therapeutic services like Evolve exist but are underutilised due to limited access and referral mechanisms. Regional areas face shortages of developmental paediatricians and outpatient psychology services.
5. **Cultural Sensitivity**: The diagnosis of FASD carries racial and cultural implications, particularly in First Nations communities. There is concern about its use as a tool to access support under the National Disability Insurance Agency (NDIA) system, potentially leading to stigma and inappropriate interventions.
6. **Support Needs**: Children in care require tailored support, ranging from understanding foster carers to specialised therapeutic facilities for those with severe behavioural challenges.

The document emphasises the importance of a nuanced approach to diagnosis and care, considering the broader context of trauma, systemic limitations, and cultural sensitivity.

Access to health services

It is well recognized that children in the care system have a disproportionate rate of health problems. I use the term health to encompass both physical and mental well being. These problems may be the reason they are in care ; parents may be unable to cope with health needs or behaviour, or the problems may have arisen from neglect or abuse. It is also the case that some issues are caused by or aggravated by being in care.

Physical health

The burden placed on a family by a child with significant health issues can be immense and some families are simply unable to cope. Whilst health and disability services strive to support children to stay at home there are a myriad of reasons why this may not be achievable. Thus children may be placed in foster care or, as a last resort, residential care.

Foster care is often a good option for these children. They have an adult who takes on the role of parent, carer and ,importantly, advocate. Health services have one main point of contact, training and health education can be targeted and hopefully the childs needs can be met.

It is very different for children in residential care. Very simply there is no one in charge. The facility manager may have the health details for the child but these are not passed on to the hands-on carers. The carers work a rotating roster and have varying levels of health literacy, ability and initiative. Our health staff may be asked to train 8-10 staff in simple procedures but the logistics of finding a time to do this will prove impossible. The default position for most residential facilities when there is a problem is to bring the child to ED (often by ambulance) which is distressing for the child and places an added burden on emergency facilities. An example of this situation is a recent problem of constipation with a severely disabled patient in residential care. The child was admitted to hospital, treated and discharged back to her care facility with an ongoing plan. She represented a short time later, same outcome. It became apparent that her management in the home was inconsistent, depending on the individual staff – they seemed to be unable to recognize signs of constipation thus kept failing to follow the set plan. [redacted]

Similarly with health appointments. The child will be brought by the carer rostered on that day (assuming the CSO has informed them of the appointment – this is not always the case); this individual may have very little knowledge of the child's current status – 'Im new, Ive been off for a few days, 'I don't usually look after her" which makes the appointment very frustrating and inefficient. The best instances are when the CSO is also in attendance and we do ask that they attend as well as the immediate care workers.

Improvement would be achieved if residential facilities had access to a consistent GP service. It is important for anyone with chronic health problems to have a primary health provider. There is merit in the idea of a primary health practitioner assigned to children in care either through the Department of Child Safety or Queensland Health(possibly within community child health). As well as physical health needs such a service could also provide primary health checks and determine which children may need more intense assessment and intervention.

Mental and emotional health

This is the health area in which children in care are most neglected. We do not always recognize the strong attachment children may have for even the most abusive parent/home and that their 'bad' behaviour is an expression of their distress. Individual foster carers can struggle in a domestic situation and there is little practical support offered by either Foster Care agencies or the Department of Child Safety. As paediatricians we are frequently asked to prescribe medication for these children -to 'help him sleep', 'calm him down' ,' keep him in school 'etc, when what is needed is behavioural therapy and support. I have had so many foster parents pleading with me to prescribe medication as they feel without it the placement will break down. When this happens residential care is probably going to be the only available option. (I would ask if this is the point at which the Department should be considering if reunification is possible and what support could be provided to the family to make it work given the significant costs of maintaining a residential care placement).

It is at this point that psychological intervention becomes urgent. There are limited available services in our region. [redacted] often refuse to see these children as the issues are behavioural as opposed to' mental illness'. The paediatrician will be at the limit of their expertise. [redacted] has 'no capacity' to take on new referrals. Private psychology services have long wait lists and limited experience in trauma. Foster care support services have limited ability in this area.

One solution would be an adequately resourced crisis team with relevant expertise, based within Child Safety to provide immediate and intense intervention when a childs behaviour is placing a placement or school attendance etc at risk . They could also be used to support residential care facilities manage those children with extreme behaviours and possibly provide education and training across the sector.

Role of the CSO

I will start by acknowledge the extremely difficult and harrowing nature of the work that a CSO does, however …..

One of the most frequent complaints I hear from carers and older children is ‘I don’t know who my CSO is’, ‘my CSO has left’, ‘I don’t have a CSO’ and from the Department, ‘that CSO is ne ,’a new CSO has not yet been allocated’,’ the CSO is on leave’. In such circumstances it is very hard to know who to go to when a need or problem arises and so many things fall through the cracks.

As a result a CSO doesn’t attend the medical appointments, doesn’t know the health problems, care needs or particular circumstances of the child. There are too many children within their case load to get to know them, the changeover of staff is too frequent.

I would like to see a system where, within reason, the CSO remains the same for the duration of the child’s journey through the child protection system. I would like to see a system where the child, the family and the CSO develop a relationship where the needs of the child are acknowledged as of paramount importance and they work together to achieve this. I would like to see the CSOs involvement with the family to be more ‘hands on’ and supportive. I know of a CSO working in Victoria who took a child in care to his after school football training as no one else was available and otherwise the child would have missed out. It is these small ‘normal’ things that matter so much to children in care. For a child in residential care with carers changing daily your CSO may become the most consistent adult in your life.

Such changes would require a smaller workload and more CSOs on the ground; it is up to the government to acknowledge that these children are important and deserving of such support and fund the system appropriately.

The early years

It is always very sad when we see young infants being removed from their families but they are our most vulnerable people and thus require the greatest level of protection. They are also the cohort where prevention is likely to be most effective.

Queensland health previously provided a 'Family Care Program' for families identified with risk factors for protective services involvement. These included domestic violence, drug and alcohol misuse, mental health problems, and socioeconomic disadvantage. Women were screened at antenatal clinic visits, referred, with consent, to the Family care team and, if accepted, offered a prenatal 'get to know' home visit. Following the birth families would be visited at home at least weekly in the first month and then as needed for the first year of life. The home visiting team included child health nurses, social worker, psychologist, and health workers as appropriate. Parents were supported as needed- feeding, sleep and settling, developmental milestones, budgeting etc. A monthly case discussion was held, including a Paediatrician to discuss issues, decide need for further intervention or assessment, discharge a family etc. My experience with this service was that it was very effective in supporting at risk families through that potentially difficult time of a new baby in the home.

In 2014 Queensland Health was subject to budget cuts and staff including child health nurses and health workers were lost. The Family Care Program was downgraded. There was a further erosion of services in 2020 with the Covid pandemic and cessation of home visiting.

I believe expansion of this service would be very helpful in making very young children safer at home, provide parents with support and confidence to look after their children and keep some children at home with their families and out of the child protection system.

I would like to comment on questions asked by the Commission around the harm associated with removal of infants shortly after birth. The Child safety guidelines around this suggest that the department should work with identified families prior to birth so that they may have an opportunity to change or at least will be informed as to what the outcome is likely to be. In my experience this rarely happens. Hospital staff are frequently aware of the impending removal of a child before the parents . I have even known of an instance where it was requested that a [redacted] was asked to break the news (this request was refused). Health staff need to maintain a therapeutic relationship with all our patients if we want to provide good health care and such negative experiences for patients can make this very difficult. The emotional distress for the parents (usually mothers) can be extreme and may result in self harm, renewed drug and alcohol use and self destructive behaviours. It also reinforces the belief of being inadequate, unable to parent.

For the infant there is the risk of poor attachment (I cannot emphasize enough how important attachment in the early months of life is to the ongoing emotional health of an person) as many infants will change placement multiple times in the early months.

For this cohort I would like to see more resources put into prevention, early parenting education and intense support, in the aim of enabling families to keep their babies safe at home. I am aware of the intense support that can be provided to mothers with disabilities to enable them to parent, why can we not provide the same level of support to this group of parents?

I would briefly like to mention the issues of domestic violence and homelessness. These frequent causes of a child being taken into care. Regarding homelessness no parent should have a child removed because of poverty. Again it is dependant on government to consider the priorities, what does our society really think is important? Domestic violence is a major cause of children being removed. Women are rarely the perpetrators but often are blamed for not leaving and considered therefore to be 'not willing' to protect their children. This is obviously a broader issue but has significant impact in the world of child protection and child services should continue to be strong advocates for women and children experiencing family violence.

Therapeutic Residential Care.

Residential care should be a last resort option for children needing out of home care. It is usually children with the most difficult behaviour, the greatest needs, for whom multiple placements have failed and need this form of care. Therefore it should be therapeutic .

There are many models around the world, we don't need to reinvent the wheel.

Children and staff should have ready access to psychological and behavioural expertise. There should be stability of staff with institutional knowledge of each resident.There should be consistency in practices and procedures, children should be made to feel safe, important and heard.

I would envisage a two tier level of therapeutic models – the most intense for those extremely dysregulated children who need intensive ie daily support, with 1: 1 care and psychological therapy.

There should be a second tier for children with less extreme behaviours, who may be able to attend school, participate in community activities but remain quite volatile and needing significant support.

I provided the paediatric outreach service to [redacted] for many years and had many of the young men from [redacted] as my patients. These boys would arrive in clinic with multiple diagnoses of [redacted] and frequently were on multiple medications., including [redacted] Over time, for many, I was able to wean their medications , review their diagnoses and discharge them in their late teens as likeable young men looking to the future. This is the benefit of a therapeutic care placement.

FASD and neurodysregulation

During the three weeks of the Commission in Cairns there has been considerable discussion around FASD , suggesting it is thought to be a common disability in children in out of home care or who otherwise come in contact with the child safety system. As an experienced [redacted] I have great difficulty in making a diagnosis of FASD using the current criteria and even greater difficulty in determining if FASD is the cause of a child's developmental and behavioural issues.

DSM 5 criteria for FASD are based on 'significant' neurocognitive and neurobehavioural problems and pre-natal alcohol exposure. It also stresses the need to exclude other potential causes for the neurological problems, such as social and emotional trauma. It does not focus on the facial and growth features. I would like to point out the latter have not been scientifically validated. For example the standard values for eye features are based on a Scandinavian population if you are under 6 and a Canadian population if you are over 6. Extrapolation to our First Nations population would appear to be a very long bow.

Alcohol intake can be very difficult to prove. Consumers frequently under estimate their intake and observers will often overestimate others consumption. I was recently asked to provide a diagnosis of FASD in a patient who was in kinship care. Her elderly carer was finding her behaviour at 11 years of age becoming increasingly difficult to manage. Prior to this the child had been managing at school with no major behavioural concerns. There were no growth or dysmorphic features. This child was born prematurely at 29 weeks gestation and had congenital hypothyroidism, both conditions being associated with neurocognitive and neurobehavioral difficulties.

To be thorough I asked the [redacted] to review the antenatal records for the mother. [redacted]

[redacted]

Whilst I believe alcohol is an important public health problem it is not the only drug than acts as a teratogen. The diagnosis of FASD has significant racial and cultural overtones. In our current NDIA system it seems to be used as an easy means of getting access to support/therapy, which may be needed, but inaccurate diagnosis is likely to result in inappropriate treatment and perhaps more importantly stigma. I strongly believe that as a diagnosis it is used to distract from the effect that social and emotional trauma has on a child's development. It is easier to believe that a child has been damaged by its parent in utero, rather than by our misguided attempts to help or the effects of colonization.

[redacted]

I would recommend reading a paper by Eliason et al, The Lancet Vol 8 November 2024 who articulate this position better than I can.

I would also like to expand a little on the neurological effects of emotional trauma [redacted] and the role of the medical profession [redacted] in this area.

It is now well recognized that emotional trauma has a significant AND PHYSICAL effect on the brain, both in adults and more especially in the developing brain of children. Exposure to trauma results in changes in an individual's hormonal response to stress, changes in neurogenesis and altered neural connections and can cause structural and functional changes in the brain such as decreased volume of the amygdala and thinning of the pre frontal cortex. These changes can result in problems of emotional regulation, concentration, memory and hyper-reactivity to stressors. ADHD, FASD or trauma?

Understanding some of the factors that influence a childs behaviour is vitally important in how they are cared for. Individual children in the care system will have different abilities to cope but on some level they all will be traumatized. For some an understanding and supportive kinship or foster carer may be all they need but others may require a high level of professional expertise to manage their behaviour. It is this latter group that need the intensive and comprehensive support of a therapeutic facility. In my opinion the current residential care services are completely inadequate for pre adolescent children or children with problematic behaviour arising out of trauma, yet for this latter group they are more likely to end up in 'resicare' as most foster carers struggle to cope. As [redacted] I have very little specialist training in [redacted]. Our local health service does not employ a [redacted] Private practitioners also have long waiting lists and often have little expertise in the degree of trauma this cohort has experienced.

[redacted] is a [redacted] that was set up specifically to provide interventions for children in care but focussing on attachment. Referrals to this service can only be made by a child safety officer [redacted] In my experience very few children are seen by this service I our region, for a variety of reasons. But the mechanism is there to provide psychological and behavioural therapy for children in the care system.