Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ANDREW JACKOMOS

I, Andrew Jackomos, Executive Director, Aboriginal Economic Development, Department of Jobs, Precincts and Regions, of 1 Spring Street, Melbourne, say as follows:

1 This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Victoria's Mental Health System ('**the Royal Commission**').

2 This statement is true and correct to the best of my knowledge and belief.

3 The views that I express in this statement are my personal views and are also from my previous roles and experiences.

Background

1. Please detail you background and experience

4 I appear before the Royal Commission at the request of Commissioners. I am honoured to have been asked and I hope I can be of value to your work.

5 As I write this statement and then give evidence I am reminded of a young Aboriginal man rotting in a Florida prison serving for what is a direct outcome from failed government policies that saw the removal of Aboriginal children from their families, from community and from country.

6 Of course, I am talking of Russell Moore. Russell's removal as a baby from his mother's breast, which not only impacted terribly on his mother, his siblings and himself, but has impacted on future generations of his family, his clan and the broader Aboriginal community. And of course, the victim's family. My personal regret from twenty years working in Justice and as Commissioner for Aboriginal Children and Young People (**Commissioner**) was that we could not get Russell home to serve the balance of his sentence.

7 My father appeared at the Florida court hearing for Russell's defence and spoke of the failed government policies that separated Aboriginal children from family and community and the impact on the mental health of the community. The mental anguish is certainly cumulative particularly when, as individual Aboriginal

people, we experience and share the pain and sorrow of the collective community.

8 I am a Yorta Yorta man from north central Victoria and have direct bloodlines on my mother's side to the fighting Gunditjmara of south west Victoria and on my father's side the Greek Island of Kastellorizo.

9 I was raised in both the Yorta Yorta community and the Melbourne Koori community. I am one with these communities and know of no existence outside of them.

10 As an Aboriginal person, you feel and suffer the consequences of the many, as you also celebrate our collective successes. Mental health and related illnesses, along with suicide and self-harm, imprisonment and child protection intervention has impacted significantly on my family, my children and extended family, and myself.

11 For much of my working life, I have worked in an environment that is driven by the outcomes of unresolved mental health issues and socio-economic disadvantage that drives the connection between the Aboriginal population and the child protection system and the criminal justice system. For the past twenty years these factors have dominated my working life, but on a personal basis they have dominated the majority of my life's journey.

12 From the start of this year, I have been the Executive Director, Aboriginal Economic Development, in the Department of Jobs, Precincts and Regions (**DJPR**) where the theme for my work is economic prosperity, led by jobs and business growth. We are about to commence work with Youth Justice around increasing work opportunities for Koori youth leaving incarceration.

13 I do not believe we can achieve economic prosperity for the collective Aboriginal community until we have successfully addressed intergenerational trauma, disempowerment and exclusion along with the consequences of mental health that's omnipresent with our children, young people and our vulnerable families. Yes, we do have very successful entrepreneurs, but we have some way to go where the mass can enjoy these outcomes.

14 Unresolved intergenerational trauma, along with social exclusion and economic disadvantage are factors that are contributing to the over-representation of Aboriginal people in the criminal justice, prison, family violence, child protection and mental health systems.

15 From 1999 to 2013, I was an Executive Officer in the Victorian Department of Justice and led the development of the Victorian Aboriginal Justice Agreement and oversaw two of its later iterations. During this time, I am most proud of the relationship developed between the Koori community and the justice system, as represented by the Aboriginal Justice Forum and the supporting network of Regional Aboriginal Justice Advisory Committees, as well as the establishment and growth of the Koori Court network within the Magistrates', Children's and County Courts. This relationship was, I believe, built on a foundation of respect, accountability and honesty, but a relationship that could always do with improvement.

16 From 2013 and for close to five years, I was the inaugural Commissioner for Aboriginal Children and Young People in Victoria. As Commissioner, I was responsible for advocating for and overseeing the provision of state government services to Aboriginal and Torres Strait Islander children, particularly the most vulnerable in the areas of child protection and youth justice.

17 During my appointment, I completed two landmark inquiries: 'Always Was Always Will Be Koori Children', an inquiry into the Victorian protection system and interaction with close to 1000 Koori children across Victoria; and *In the Child's Best Interests*, an inquiry into the Victorian child protection system's compliance with the Aboriginal Child Placement Principle. The recommendations from both these reports continue to influence the reforms in the child protection landscape.

Attached to this statement and marked '**AJ-1**' is a copy of the 'Always Was Always Will Be Koori Children' report.

Attached to this statement and marked '**AJ-2**' is a copy of 'In the Child's Best Interests'.

18 In 2018, I was appointed the Special Advisor for Aboriginal Self-Determination in the Department of Premier and Cabinet where I worked with the Koori community

to lead the development of the Victorian Government's Eleven Guiding Principles for Aboriginal Self Determination (**Guiding Principles**).

19 The Guiding Principles were adopted by the Victorian Government and included in the Victorian Aboriginal Affairs Framework 2018-2023 (**VAFF**), as launched in October 2019. The Guiding Principles are to guide the development and implementation of the Government Aboriginal policies and programs.

Attached to this statement and marked '**AJ-3**' is a copy of the VAFF.

20 In recognition of my work in government with the Aboriginal community, in 2006 I was awarded the Public Service Medal and admitted as a Victorian Fellow with the Institute of Public Administration Australia (**IPAA**). In 2013, I was appointed as an IPAA National Fellow.

21 Senior positions I have held prior to 1999 have included:

(a) 1981–1986: Manager, Policy and Secretariat Unit, Central Office and Regional Manager for North Queensland, Aboriginal Development Commission;

(b) 1986–1988: National Operations Manager, Aboriginal Hostels Limited;

(c) 1988–1989: Office of the Minister for Aboriginal Affairs and Manager, ABSTUDY, Department of Employment, Education and Training (Executive Development Scheme, Australian Public Service);

(d) 1989–1991: Manager, Aboriginal Unit, Department of Employment, Education and Employment, Victoria

(e) 1991–1995: Victorian State Director, Aboriginal and Torres Strait Islander Commission;

(f) 1996–1999: Manager, Community Relations, Aboriginal Affairs Victoria.

The importance of culture and community

2. From your perspective:

a. what does the term culture mean for Aboriginal and Torres Strait Islander people? How is it important?

22 For me, culture is everything. It is what drives me and gives me purpose and parameters to guide my responsibilities, obligations and outlook. Culture gives me my identity. I cannot imagine how children of the Stolen Generations and Aboriginal children raised outside of the community and family can relate without those cultural sign posts.

23 You start to have an understanding of the negative impact of not having cultural connections when you look at the over-representation of Aboriginal children in child protection in the youth justice and criminal justice systems.

24 A decade or so ago, Professor James Ogloff was commissioned to do research for the Aboriginal Justice Forum that looked at the mental health issues of incarcerated Aboriginal people. I recall that it was around 90 per cent and with a higher rate experienced by Aboriginal women. I believe that this over-representation was particularly driven by intergenerational trauma, along with loss of cultural and community connections given the presence of children from the child protection system.

Attached to this statement and marked '**AJ-4**' is a copy of the paper, Ogloff et. al, "Assessing the Mental Health, Substance Abuse, Cognitive Functioning, and Social / Emotional Well-Being Needs of Aboriginal Prisoners in Australia" (2017) 23(4) *Journal of Correctional Health Care* 398.

25 In 'Always Was, Always Will be Koori Children', I wrote that culture means:

> "Culture is about family networks, Elders and ancestors. It's about relationships, languages, dance, ceremony and heritage. Culture is about spiritual connection to our lands and waters. It is about the way we pass on stories and knowledge to our babies and children; it is how we greet each other and look for connection. It is about all the parts that bind us together." ('Always Was, Always Will be Koori Children', Introduction)

26 I know from what I have witnessed over my life time and particularly in the last twenty years, that connectedness to culture, country and community is the foundation stone for building stronger individual and collective identities. I cannot over stress the importance of strong culture in building positive self-esteem, resilience and improved outcomes across the other determinants of health, including education, economic stability and community safety. An example of this impact is provided below (see paragraph [29]).

b. Where a person's connection to 'culture' is not considered, is disturbed or is broken, what are the potential effects on the person's and their community's mental health and wellbeing?

27 I had significant exposure to the negative impact of cultural disconnections when I was Commissioner and heard the stories of close to one thousand children in out of home care, with the great majority placed outside of family, outside of kin and outside community. I also address this below in my answer to question 2(c).

c. How and why are community connections important for Aboriginal and Torres Strait Islander people?

28 There was no greater impact of being removed from family, culture and community that I witnessed than when I met with and spoke with imprisoned Aboriginal children and youth in the youth justice system. Locking children in concrete boxes for hours on end, already deprived in most cases from family and country and culture, is not a recipe for rehabilitation but one for recidivism.

29 There is no better example of this than a young Aboriginal man I met in a youth justice facility who was placed in the child protection system at an early age and had spent more of his teenage life incarcerated than free. When I first met him inside, he had fresh wounds along with a body of scars from self-harm. He literally broke my heart.

30 But with the support of the Youth Parole Board, Youth Justice and a regional Aboriginal Community Controlled Organisation, we were able to have him placed on his own country in the care of an Elder. After being on country and with an Elder, he was totally changed, telling me of his future plans and vision. He, for

the first time, had a positive outlook. The Elder provided him with positive role modelling and connection to country and family.

31 For me, there is no greater evidence than this man's story of what connection to country, culture and positive role models can play in building positive self-esteem and a healthy outlook.

32 There is no truer saying than the quote in the 'Korin Korin Balit Djak' report that states, at page 36:

> 'An Aboriginal child's resilience is built through their connection to family, community, teachings from Elders, ceremony, traditions, identity, connection to country'.

Attached to this statement and marked 'AJ-5' is a copy of the 'Korin Korin Balit Djak' report.

d. Where a person's links to community are not maintained or supported, what are the potential effects on the person's and their community's mental health and wellbeing?

33 In reflecting on what I saw in Taskforce 1000, as written in 'Always was, Always will be Koori Children':

> "The reasons for the over-representation of Aboriginal children in the out-of-home care system have been well documented. A history of separation from community, family, land and culture has left a legacy of disempowerment and trauma. In turn, a negative impact on family stability, early childhood health, education and wellbeing has resulted."

34 This is consistent with the findings of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families in the 'Bringing Them Home' Report that notes more eloquently:

> "It is difficult to capture the complexity of the effects for each individual...For the majority of witnesses to the Inquiry, the effects have been multiple and profoundly disabling....(including) ongoing impacts and their compounding effects causing a cycle of damage from which it is

difficult to escape unaided. Psychological and emotional damage renders many people less able to learn social skills and survival skills. Their ability to operate successfully in the world is impaired causing low educational achievement, unemployment and consequent poverty. These in turn cause their own emotional distress leading some to perpetrate violence, self-harm, substance abuse or anti-social behaviour."[1]

Attached to this statement and marked '**AJ-6**' is a copy of the 'Bringing Them Home' report.

35 I also draw the Commission's attention to the Department of Health and Human Services (**DHHS**) document 'Balit Murrup Aboriginal Social and Emotional Wellbeing Framework 2017-2027(**'Balit Murrup'**)' that is consistent with my report and the 'Bringing Them Home' report that:

> "Aboriginal people and communities are more likely than the general population to face risk factors for poor mental health and barriers to emotional and social wellbeing. This includes mental illness; drug and alcohol abuse; family violence; self-harm and suicide; all of which are experienced by Aboriginal Victorians at significantly higher rates than non-Aboriginal Victorians. For Aboriginal Victorians with a disability — physical, intellectual or cognitive — the challenges to social and emotional wellbeing can be multiplied. By improving the social and emotional wellbeing and mental health of Aboriginal people, families and communities, we can make a significant contribution to reducing the incidence, severity and duration of mental illness and suicide."[2]

Attached to this statement and marked '**AJ-7**' is a copy of the 'Balit Marrup' report.

3. Are there differences across Aboriginal and Torres Strait Islander communities in relation to what is meant by culture and community connections?

36 I am not an expert on the culture and the cultural difference between various Aboriginal communities and nations. But I do think they are very consistent

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[1] 'Bringing Them Home', page 177.
[2] 'Balit Murrup', page 12.

across the country. Individuals will always have their own interpretations of what culture means to them and their kin.

37 I have worked in North Queensland Aboriginal and Torres Strait Islander communities for five years in the mid-eighties, two of my children are from Erub Island in the Torres Strait and I have had exposure to Aboriginal and Torres Strait Islanders nationwide for all of my life and yes there are consistent themes. Yes, there will be different languages and different dance moves but our connection to country, to community and to family remains strong and consistent across the nation.

38 When Aboriginal people met for the first time the quest is to find connection, '*who are your mob and are you related to you know who*' rather than look for differences. That is how we think.

Cultural safety and cultural competence

4. From your perspective:

a. what is meant by the term 'cultural safety'?

39 Cultural safety is, for me, one of those terms that can have different meanings on different days and pending the situation. When I appeared before the Royal Commission into the Protection of and Detention of Children in the Northern Territory, I stated that:

> "Cultural Safety" is where Aboriginal workers, Aboriginal families, Aboriginal children can be confident that the system will not only comply but support, promote Aboriginality of Aboriginal children and families or they'll comply with the requirements, where they'll respect the need and respect Aboriginal kin and placements, workers."

40 In 'Always was, Always will be Koori Children', we wrote that:

> "Cultural safety has been described as: an environment that is safe for (Aboriginal) people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect,

shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening."[3]

41 The Commission for Children and Young People (**CCYP**), DHHS and the Department of Justice and Community Safety (**DJCS**) have Aboriginal Cultural Safety Frameworks and support materials that articulate what cultural safety means which is worth drawing the Commission's attention to:

(a) Cultural safety is an environment that is safe for Aboriginal people to live and work where there is no assault, challenge, or denial of their identity and experience.[4]

(b) It is about shared respect, shared meaning, shared knowledge and experience of learning together with dignity and true listening.[5]

(c) A culturally safe environment is when Aboriginal people feel safe, supported, included and confident to express and practice their connection to community, culture, identity, spirituality, land and waters.[6]

Attached to this statement and marked '**AJ-8**' is a copy of the 'Cultural safety for Aboriginal children, Tip Sheet: Child Safe Organisation', Commission for Children and Young People.

Attached to this statement and marked '**AJ-9**' is a copy of the 'Aboriginal Cultural Safety Framework', Department of Health and Human Services.

Attached to this statement and marked '**AJ-10**' is a copy of the 'Koori Cultural Respect Framework', Department of Justice and Community Safety.

42 I am currently leading the development of an Aboriginal Recruitment and Career Development Strategy at DJPR. Critical to the success of the program is that the workplace is culturally safe and Koori-friendly; where we will feel not only safe, but respected and given the opportunity to develop and career path in which we can grow

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[3] *Always was, Always will be Koori children*, page 1
[4] Cultural safety for Aboriginal children, Tip Sheet: Child Safe Organisation, Commission for Children and Young People
[5] Aboriginal Cultural Safety Framework , Department of Health and Human Services
[6] Koori Cultural Respect Framework, Department of Justice and Community Safety

b. What is meant by the term 'cultural competence'? Could you please provide an example of a culturally appropriate initiative?

43 For cultural competence to be sustainable, it needs to be part of the organisational culture; part of the daily norms and practices. Cultural competence practiced within an organisational context needs to be led from the executive and be part of day-to-day business, by maintaining and nurturing relationships and shaping policies and programs. Cultural competence will not be achieved alone through cultural awareness training and sitting around a camp fire chewing on gum leaves.

44 Cultural competence is not new territory, and numerous reports such as the DHHS Korin Korin Ballit Djak set out a clear vision of how to achieve and sustain a culturally safe Aboriginal mental health services. This includes:

(a) the need for the health and mental health service systems to prioritise culture, knowledge and expertise of Aboriginal people;

(b) that connection to culture, country and community for Aboriginal people should be a focus; and

(c) recognition of the importance of Aboriginal-led community initiatives.

45 For service delivery targeting the Koori community, cultural competence cannot be achieved and cultural safety cannot be experienced where there is a lack of self-determination involving the Aboriginal community identifying the need, including in service design, implementation and monitoring.

46 Wulgunggo Ngalu is a voluntary residential facility run by Corrections Victoria to reduce the breach rates of Aboriginal men on community-based orders. It is an excellent example of a culturally competent and culturally safe initiative that's achieving program objectives.

47 The concept for the Wulgunggo Ngalu was designed by the Aboriginal community in response to the Royal Commission into Aboriginal Deaths in Custody. Its physical structures were designed by an Aboriginal architect to reflect the blue wren, which is a totem of the local Aboriginal community.

48 Wulgunggo Ngalu has Aboriginal management, is primarily staffed by Aboriginal workers, and has an ethos and program that is culturally rich and land based with visiting Elders from across the state spending time with the residents. It is the only Corrections Victoria facility where you need to order the men to go home.

49 It has been consistently successful for over a decade for it has a self-determination ethos where the residents feel culturally safe; where it builds their cultural connections, knowledge and self-esteem. It is a service that was designed by and for Aboriginal people

5. In your experience, does the extent to which a service is culturally competent affect:

a. whether Aboriginal and Torres Strait Islander people will use the service?

50 The establishment nationwide of community Aboriginal health and legal services is a direct response to the lack of cultural competence as well as individual and institutional racism of many service providers. Aboriginal people, to the detriment of their health and wellbeing, would rather not attend services than be victims of racism and discriminatory practices.

51 A lack of cultural competence for medical and mental health specialists can also be evidenced in the lack of knowledge of particularly health issues that affect Aboriginal people and the impact of intergenerational trauma on Aboriginal people.

52 I am a serial client of the Victorian Aboriginal Health Service because it is a culturally safe place where I meet old friends and relatives. It is staffed and managed by Aboriginal people. For me, like countless other Koories, going to the health service is not only a medical experience but also a cultural experience. I am in somewhat splendid health because I enjoy going to the health service.

b. mental health and wellbeing outcomes for Aboriginal and Torres Strait Islander people

and their community? If so, in what ways?

53 In the same way that community Aboriginal Health Services have provided a positive intervention and contribution to the health needs of the Aboriginal

community, the same applies to the mental health needs of the community. In my time as Commissioner, I heard the personal stories of close to 1000 children in child protection (and out of home care). I identified the need to participate in regular debriefing as organised by the Victorian Aboriginal Health Service.

54 Understanding and addressing intergenerational trauma experienced by Aboriginal people is not the standard skill set of the mental health specialists, nor is the environment necessarily Koori friendly and culturally competent. In the 'In The Child's Best Interest' report, I explained how cultural competence can be applied at various levels of service delivery in relation to child protection. The following message from that report is as applicable and pertinent to the mental health needs of the Koori community:

> "It is essential that the child protection system becomes more Aboriginal-friendly and culturally competent. To support the government's commitment to self-determination, Aboriginal people must be represented at every level of the child protection sector, both within government and in the community. This representation should extend beyond casework roles to include management, leadership and executive positions. Aboriginal decision-makers should participate in all stages of child protection including the Aboriginal Children's Forum; the co-design of policies and programs; Area Panels that set local priorities; and Aboriginal community-controlled organisations that provide case management for Aboriginal children."[7]

55 I still agree today with the following comments noted in the DHHS report 'Balit Murrup' that:

> "Overall, the mental health and primary health service systems have been largely ineffective in responding to the high rates of psychological distress experienced within Aboriginal communities. Much of the service system has been unable to embrace Aboriginal concepts of health and wellbeing and has failed to understand the historical context and pervasiveness of

[7] 'In the Child's Best Interest' Report, page 3

racial oppression and social disadvantage. This can contribute to poorer outcomes for clients and increasing client dissatisfaction and distrust, which then discourages future access and perpetuates the cycle. Although Aboriginal people experience greater levels of psycho-social problems compared with the general population, they are under-represented in the service system because of:

(a) historical fear and distrust of mainstream and government services due to past policies and practices of removing children, discrimination, racism and negative staff attitudes;

(b) relatively few Aboriginal people working in the mental health system resulting in Aboriginal people being less likely to access health services or 'return' for follow-up treatment

(c) inflexible models of service delivery, including the use of inappropriate assessment and diagnostic tools

(d) lack of service coordination and integration between primary mental health and specialist clinical services

(e) poor investment in Aboriginal mental health and Aboriginal-led mainstream models

(f) the relative poverty of Aboriginal people affecting their capacity to access services

(g) limited 'mental health literacy' and awareness identifying and responding to social and emotional wellbeing problems in Aboriginal communities.

56 These barriers result in infrequent contact with primary health and early intervention services, leading to increased engagement with more complex tertiary services.

57 If not treated early, acute, episodic and chronic mental illness can lead to major disruption for individuals and their families across all areas of their lives. Improving access to mental health services and treatment outcomes for clients requires addressing the barriers of entry to mainstream services and ensuring Aboriginal community controlled health organisations are appropriately resourced

and trained to respond to increased demand to provide primary mental health care."[8]

Self-determination

6. From your perspective, what role does self-determination play in the wellbeing and mental health of Aboriginal and Torres Strait Islander people?

58 Self-determination is fundamental to achieving better health and well-being outcomes for Aboriginal people and community.

59 Premier Andrews is quoted in the VAAF, AJ-3, stating that "a decade on from the Closing the Gap agreement, there is no more evident truth: we only achieve better outcomes for Aboriginal people when that all-important work is led by Aboriginal people."[9] That is what self-determination is about.

60 The Burra Lotja Dunguludja Victorian Aboriginal Justice Agreement states :

> "The evidence is settled that self-determination is the only strategy that has generated the sustainable wellbeing – cultural, physical, spiritual, economic and social – that Aboriginal and Torres Strait Islander communities and the broader community desire. Self-determination relates to the capacity of the Aboriginal community itself to determine its preferred future and to create the human, institutional and financial infrastructure to bring those aspirations into being."[10]

Attached to this statement and marked '**AJ-11**' is a copy of the Burra Lotja Dunguludja Victorian Aboriginal Justice Agreement, Phases 1-4.

61 Aboriginal Victorians have long called for self-determination, particularly as the basis for all government policies and programs impacting on the Aboriginal community.

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[8] Balit Murrup, page 20.
[9] VAFF, page 6.
[10] Burra Lotja Dunguludja Victorian Aboriginal Justice Agreement Phase 4, page 11.

62 Aboriginal Victorian were at the United Nations over many years successfully demanding self-determination as a fundamental Human right for Indigenous peoples.

63 While Aboriginal self-determination means different things to different people, the *United Nations Declaration on the Rights of Indigenous Peoples* (**UNDRIP**) describes self-determination as the ability for Indigenous people to freely determine their political status and pursue their economic, social and cultural development. It also describes self-determination as a right that relates to groups of people, not only individuals.

64 While UNDRIP gives us a language to talk about self-determination, Aboriginal Victorians must not feel constrained by the definition set out in UNDRIP. Inherent to self-determination is the right of Aboriginal Victorians to define for themselves what self-determination means.

65 In 2018, I was honoured to have worked with the Aboriginal Executive Council and listened to Aboriginal people across Victoria in crafting the Guiding Principles for Aboriginal Self-Determination. The Victorian government accepted those Guiding Principles in the VAAF as the guiding principles that will underpin all future work to progress self-determination: Human Rights, Partnership, Investment, Cultural Integrity, Decision-making, Equity, Commitment, Empowerment, Aboriginal Expertise, Cultural Safety and Accountability.[11]

66 In developing the VAAF, the Aboriginal community identified four self-determination enablers which government must commit to and act upon over the next five years to make Aboriginal self-determination a reality:

(a) Prioritise culture

(b) Address trauma and support healing

(c) Address racism and promote cultural safety

(d) Transfer power and resources to communities.[12]

[11] VAAF report, page 24.
[12] VAAF report, page 25.

67 Put simply, we cannot achieve self-determination without the right foundations. Some examples of how such foundations can be implemented are described above in paragraphs 43, 44 and 48.

7. Could you please provide examples of service provision in Victoria (by government, in partnership with government and/or by Aboriginal communities) that have (or will) successfully support self-determination by Aboriginal and Torres Strait islander people?

68 **The Victorian Aboriginal Justice Agreement (AJA):** Arguably, the AJA is the most prominent and successful initiative driving self-determination in Victorian and the most successful Aboriginal Justice Agreement nationwide. Other Victorian partnership forums have been modelled on the principles and protocols as developed in the Aboriginal Justice Forum.

69 The AJA, launched in 2000 is a partnership agreement developed between the Victorian Government and the Victorian Aboriginal community to work together to improve Aboriginal justice outcomes and to reduce over-representation in the criminal justice system.

70 The AJA was developed on the principles of self-determination and in response to the recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody and the subsequent 1997 National Ministerial Summit on Indigenous Deaths in Custody.

71 Critical to the AJA's longevity is the Aboriginal Justice Forum and the network of Regional Aboriginal Justice Advisory Committees. In certain localities there are also a number of Local Aboriginal Justice Advisory Committees. Common to all three entities is that community and justice services come together to take ownership of the issues and the solutions. Aboriginal members in all three entities co-chair and set the agendas with Justice officers and meet on a regular set basis.

72 Central to the ethos of the AJA is where Aboriginal people are identifying the issues, identifying the solutions, and developing and implementing the services. Aboriginal stakeholders are also critical in the monitoring and evaluation of AJA initiatives.

73 Unique to the AJA is the level of accountability and transparency of government in its service delivery to the Aboriginal community. Fundamental to any service delivery that purports to be based on self-determination is building a trusting relationship in which accountability, transparency and honesty are at the core.

74 The development of the latest iteration of the AJA responds to the government's overarching policy commitment to further Aboriginal self-determination. There is a central focus to build on the strength of Aboriginal culture, families and communities to address the widening gap between the rates of Aboriginal and non-Aboriginal people under justice supervision, to meet the government's commitment to Closing the Gap by 2031.

75 **The Victorian Aboriginal Children and Young Person's Alliance**: The Alliance was formed in 2014 and comprises 13 Aboriginal Community Controlled Organisations (**ACCOs**) from around Victoria that are funded by DHHS to provide family and children's services and out-of-home care services for Aboriginal children. The Alliance, as hosted by the Victorian Aboriginal Community Controlled Health Organisation, has a collective voice along with the Victorian Aboriginal Childcare Agency in advocating for and positively influencing the future for Aboriginal children and young people and is a primary stakeholder in the Aboriginal Children's Forum.

76 The Alliance is the first time the majority of the ACCOs have had a collective voice to advocate for children across the state. This is an example of a good outcome from the Alliance.

77 **The Aboriginal Children's Forum (ACF)**: The ACF, as proposed by the Aboriginal community as a self-determining measure, was established in June 2015 by the Victorian Government in response to the significant over-representation of Aboriginal children in Victoria's child protection system.

78 Again, an example of a good outcome from good service provision was that 2015 was the first time that Aboriginal community controlled organisations had come together with government on a regular and continuing basis to drive change to a service system that had mixed outcomes for Aboriginal children and was in need of a dose of self-determination. Please see my two reports *Always was Always will be Koori children* and *In a Childs Best Interests*.

79 The primary aim of the ACF is to improve outcomes for Aboriginal children in out of home care, along with building the capacity of Aboriginal organisations to shape practices and policies in order to promote stronger Aboriginal families so children can thrive.

80 Membership of the ACF includes CEOs of ACCOs and non-Aboriginal Community Service Organisation that provide services for Aboriginal children and government representatives. The ACF meets quarterly throughout Victoria and is co-chaired by the CEO of a local ACCO and the Minister for Families and Children and/or the Secretary of DHHS. Whether this model could be applied to the development of Aboriginal workforce and in the area of mental health, is discussed in the following paragraphs.

8. Do you see opportunities for the principles of self-determination to be embedded across different service types (including 'mainstream' services)? If so, please provide examples of how this could be done.

81 Wherever government comes into contact with the Aboriginal people and community, there is a place for self-determination. In committing his government to the guiding principles of self-determination, Premier Andrews did not exclude any area or level of government.

82 As the Executive Director for Aboriginal Economic Development at DJPR, I am excited at the opportunities that await the outcomes of embedding of self-determination principles and partnerships in this economic portfolio.

83 Early self-determination initiatives will include the development of a new partnership forum bringing together DJPR's executive and industry stakeholders from the community that will drive the development of a new self-determination based Victorian Aboriginal Economic Development Strategy. Core to driving a culturally competent and safe environment and programs in DJPR will be an Aboriginal Recruitment and Career Development Strategy that targets pathways for Aboriginal people at all levels and in all areas of the department. This will be in addition to a cultural competency plan for DJPR as the foundation piece.

Community engagement

9. How can stronger relationships with the Aboriginal and Torres Strait Islander community be built and maintained?

84 Healthy, respectful and sustainable relationships between the Koori community, government and mainstream service providers don't happen overnight. They need careful nurturing and investment from the highest levels to be sustainable.

85 A good starting point is for the relationships to be on the based on the full suite of the 11 Guiding Principles of Self-determination:[13]

(a) **Human rights**: Self-determination initiatives honour the norms set out in the UNDRIP and Victoria's *Charter of Human Rights and Responsibilities Act 2006*.

(b) **Cultural Integrity**: As First Nations Peoples, the rich, thriving cultures, knowledge and diverse experiences of Aboriginal people, including where they fit with family, community and society will be recognised, valued, heard, influential and celebrated.

(c) **Commitment**: Aboriginal self-determination will be advanced and embedded through planned action that is endorsed by, and accountable to, all parties

(d) **Aboriginal expertise**: Government and agencies will seek out, value and embed Aboriginal culture, knowledge, expertise and diverse perspectives in policies and practice.

(e) **Partnership**: Partnerships will advance Aboriginal autonomy through equitable participation, shared authority and decision-making, and will be underpinned by cultural integrity.

(f) **Investment**: Investment to support self-determination will be sustainable, flexible and appropriate to strengthen Aboriginal peoples' aspirations and participation, including to contribute to the goals of economic participation, economic independence and building inter-generational wealth.

[13] VAAF report, page 24.

(g) **Decision-making**: Decision-makers will respect the right to free, prior and informed consent and individual choice and will prioritise the transfer of decision-making power to Aboriginal communities.

(h) **Empowerment**: Aboriginal people will have autonomy and participation in the development, design, implementation, monitoring and evaluation of legislation, policies and programs that impact their communities.

(i) **Cultural safety**: Programs and services accessed by Aboriginal people will be inclusive, respectful, responsive and relevant; and informed by culturally-safe practice frameworks.

(j) **Equity**: Systemic and structural racism, discrimination and unconscious bias and other barriers to Aboriginal self-determination will be eliminated.

(k) **Accountability**: All parties responsible for delivering outcomes involving Aboriginal people will be held accountable to Aboriginal standards and expectations, and subject to Aboriginal-led, independent and transparent oversight.

86 In my answer to question 10, 12 and 13 below, I give examples for how some of these principles can be and have been applied.

Reform

10. In your experience, what are the foundations and principles for designing and delivering successful major system reforms that affect Aboriginal communities in Victoria?

87 The foundations and principles for designing and delivering successful Koori friendly and culturally competent policies, programs and services need to comply with the Guiding Principles. In addition, below are some of my reflections based on my years of experience working across various departments, and in building partnerships with the Aboriginal community :

(a) The need for the service/program/initiative has been identified by the community or equally owned by the community.

(b) Community stakeholder's need to be involved from the very start, rather than designing a response and seeking endorsement for a model already developed.

(c) The timelines for the development of the service are consistent with community decision-making processes. Aboriginal decision-making processes must be respected, safeguarded and not rushed to meet external timelines.

(d) Community members are central to the development, implementation and evaluation of the services.

(e) The resources for the service provision should be transferred to community for decision-making and service delivery in a Koori friendly location.

(f) The services should be managed and delivered by Aboriginal people where possible with significant resources provided for personal and career development.

(g) Community-based Aboriginal service delivery should be on long term funding as opposed to short term funding.

(h) Accountability, transparency and full reporting back to community stakeholders is fundamental.

(i) Aboriginal people and organisations need to be allowed to make mistakes, as non-Aboriginal organisations are.

(j) For services provided by non-Aboriginal organisations who service the Aboriginal community, the organisation should have Aboriginal representation on its management committee, and employ Aboriginal staff.

(k) Where racism is identified, be it individual, systemic or structural, immediate action must be taken immediately to rectify and address the causal factors.

11. In thinking about past major system reforms the impact Aboriginal communities, where has the ambition not been met and why?

88 In my report 'Always Was Always Will be Koori Children', I highlighted a range of practices and reforms in the child protection system that were not being fully implemented to standard. However, it would be inappropriate for me to dwell on these as it has been close to three years since its tabling, and 18 months since leaving the role of Commissioner for Aboriginal Children and Young People.

89 But more broadly, my observations are that, despite many best practice reforms that have been driven under four iterations of the Victorian Aboriginal Justice Agreement, we are still seeing significant over-representation rates of young Aboriginal people, men and women enmeshed in the youth and criminal justice systems. Similarly over-representation pervades the child protection system.

90 The issues that impact on the health and well-being for our community is complex, inter-related and driven by a range of environmental factors. The legacy of intergenerational trauma is still very present in past, present and subsequent generations. Isolated reforms that happen in one pocket of the service system will not effectively address these complex issues.

91 Whilst our Aboriginal peak and advocacy groups play a critical role, there are many policy and program decisions that are outside their control, with outcomes driven by totally separate agendas and, to a degree, environmental factors.

92 What I can say, is that we have the benefit of lessons learnt from since invasion. As covered in questions 10, 12 and 13, we know the things that we must do and must have. In question 15, I highlight the things we must avoid, the things that will hinder success, if not totally deny it.

93 In the context of self-determination, this is not an exercise of "dump and run" or "here's the problem – you can fix it". A classic example of failure here is where the Lake Tyers Aboriginal community in the early 1960s successfully fought against the then state government's decision to sell their land. The intent was to relocate the families to Morwell and beyond and the land was then to be sold off for private investment.

94 Following the success of the 1967 Referendum and the Commonwealth assuming responsibility for Aboriginal affairs, the Victorian government handed back the title of Lake Tyers to the residents in 1970. In the government's haste to

'give back' Lake Tyers, the community was inevitably set up to fail. For well over a century from the mid-1860s the government of the day controlled the residents, their families and their social lives. The government controlled where and when people could work. Families and individuals were barred from returning to the community if they fell out of favour with the white manager. The manager stopped community from sustaining themselves on native foods and forced them onto rations. This caused massive breakdowns in family structures and in society, health and well-being.

95 There was limited effort by government to work with the Lake Tyers community to ensure a smooth transition, to put resources and infrastructure in place to help the community build their self-determination muscles. After a century of church and government control and dependence, returning Lake Tyers without a transition plan set the community up to fail.

96 What are the lessons learnt from this? We need to ensure Aboriginal organisations are equipped, funded and well-positioned on a sustainable basis to meet the existing needs of their communities, and to play a critical role in policy and advocacy. This means that they are well positioned to provide advice (and critique) emerging policies that may negatively impact on them.

97 In driving reforms in mental health, we need a community-based policy and research capability that advocates for the community providing the most informed work on improving Aboriginal mental health and well-being outcomes for our families. We need an entity that celebrates the Victorian government's commitment to self-determination - an entity that has the authority to drive reform and transform the system, address inadequacies, foster collaborative practice, grow our professional workforce of mental health practitioners, and transform the broader mental health system so that no matter where you live, in your time of need, you can walk into a service and you will receive the best informed service that you can receive.

12. How should Aboriginal communities be engaged on the design and delivery of major system reforms that affect them?

98 In successfully engaging Aboriginal communities on the design and delivery of major system reforms, the first step is to ensure that there is full compliance with the Guiding Principles, as detailed in my response to question 10.

99 I refer to the engagement and partnership mechanisms established in the development and continued implementation of the Aboriginal Children's Forum, Aboriginal Family Violence Partnership Forum, Aboriginal Justice Agreement and the associated Aboriginal Justice Forum. They are:

(a) Regular partnership forums and working groups with rotation through CBD, metropolitan and regional communities.

(b) When hosting regional forums, dinners for the partners to break bread and create working relationships, break down barriers and form collaborative connections.

(c) Meetings out of central offices should be in Koori friendly locations, particularly where community services and Aboriginal business can be supported.

(d) Creating multiple opportunities for Aboriginal input, for example, through local networks (Local Aboriginal Justice Action Committees, Indigenous Family Violence Regional Action Groups, Local Aboriginal Networks) and community consultations.

(e) Full participation by departmental executives, as expected by community bodies, and equitable participation in the working groups.

(f) Joint chairing (by government and community) of the partnership bodies.

(g) Providing an opportunity for the community stakeholders to caucus prior to forums and working groups. Providing resources to a community stakeholder to employ a caucus resource.

(h) Community members should be remunerated for their participation if they are not already in funded service positions.

(i) When meetings are held in metro and regional centres, the partnership group should hold open sessions with community members to gather their feedback, and directly hear from and question executive partners (as is the practice of the Aboriginal Justice Forum).

(j) Ensure strong and timely feedback loop to community. When issues are raised at Community Forums, it is of critical importance that responses are provided at the forum or followed up in a timely manner.

(k) Resource these Community Forums with staff that can engage consistently with the community pre- and post-forums and support associated working groups.

(l) Government must not passively listen and fail to act – this is known as 'ticking the box' and is tokenistic.

(m) Conduct regular meetings between the relevant minister and the community stakeholder group, rather than have the message filtered by departmental officers.

(n) Regularly and jointly celebrate the successes through social media and awards.

(o) Departments should have Aboriginal policy teams that drive the work internally and are the primary point of contact with community partners.

(p) Allocate time to hear from Aboriginal service provides when the partnership groups/forums are meeting in metropolitan and regional centres.

(q) Provide meeting papers in a timely manner (2 weeks) for a community stakeholders to consider and caucus.

(r) Community partners should be resourced where requested to undertake their own research.

(s) The terms of reference for all research and reviews for the partnership group should be designed with the Aboriginal stakeholders.

13. Based on your past experiences, what are your reflections on reforms where community, government and other key players have successfully worked together to design and deliver major system reform?

100 In responding to this question, I refer to my answers provided for questions 10 and 12. Further to that, common themes or traits of joint partnerships that have done great work are:

(a) Where there are positive and respectful relationships.

(b) Acknowledging that the process is as important as the outcomes.

(c) Taking the time to listen, respond and act.

(d) Providing the necessary and sustainable resources to drive change, and where service delivery has long term funding.

(e) Where there is full accountability, transparency and inclusion.

(f) Where there is a shared agenda by government and community.

(g) Where Aboriginal decision making is based on free, prior and informed consent.

(h) Where services are delivered by Aboriginal communities with Aboriginal boards of management, executives and workers.

(i) Where the service providers are culturally safe and Koori friendly.

(j) Where there is recognition that we, as the first people of this land, carry unaddressed intergenerational trauma.

14. What needs to be done to ensure that services – particularly services that affect mental health and wellbeing – are culturally safe and responsive for Aboriginal and Torres Strait Islander people? And particularly, Aboriginal and Torres Strait Islander children and youth?

101 In answering this question, I must stress that I consider that I am not the most appropriate person to inform the Commissioners. However I do take the opportunity to refer to a number of documents that may assist.

102 Having family members that have suffered significant mental health issues, I believe it is critical to their survival that we have mental health services that are culturally competent, Koori safe and readily accessible both in location and times of day.

103 I have had family members that have both committed suicide and attempted suicide. I don't know if a Koori friendly and culturally competent service would have prevented such incidents, but they certainly would have made a positive contribution in reducing the opportunities.

104 In undertaking a child death review of a Koori youth in child protection who had experienced mental issues, I fully recall sitting in the family home listening to the parents tell me that if only they had access and resources to purchase the necessary medication and treatment then their son would not have been place in residential care.

105 I particularly refer to the Mental Health Act guiding principles. The *Mental Health Act 2014* (Vic) provides a guiding principle in s 11(1)(h) as to how mental health services should be delivered to Aboriginal Victorians, it provides:

> "Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to."

106 I also refer to the contribution from Swan and Raphael, albeit made over 24 years ago. I consider it pertinent today as back then.

> ***Recognition that Aboriginal concept of health as holistic***
>
> "The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist."[14]

Attached to this statement and marked '**AJ-12**' is a copy of the article by Swan and Raphael (1995).

107 The Royal Commission into the Detention and Protection of Children in the Northern Territory was concerned at not only the prevalence of children with mental health issues (22 per cent of all children reviewed), but also the very young ages of these children;.8 per cent of children with mental health issues were under the age of five.[15]

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[14] Swan and Raphael, 1995.
[15] 'Always Was, Always Will be Koori Children', point 403-404.

108 As reported in the 'Always Was Always Will Be Koori Children' report, Taskforce 1000 survey data also examined whether children were receiving mental health treatment and support. Results indicated that 80 per cent of children had received treatment or support, and less than 8 per cent had required treatment in a mental health facility. The Commission noted many positive interventions for children occurred as a result of the Taskforce 1000 panel's approach. Through the presence of key agency and Government representatives, mental health and health specialists' referrals for services were fast-tracked and solutions to service access were resolved quickly.

109 The Commission heard about the negative impact on mental health for many children reviewed in Taskforce 1000 as a result of their experience of family violence, sexual and physical abuse and neglect, their dislocation from their family and the intergenerational trauma experienced by their parents and grandparents. The Commission found that it was apparent that there is a pressing need for the service system to work in a more holistic way with children and their families, recognising the Aboriginal concept of health and the need for Aboriginal-specific trauma responses.

110 Some concerns were raised with the Commission by family members and professionals about the extent to which the children's experiences of trauma had been considered in assessing and devising treatment for children with a disability. This is often done by mainstream service providers that do not employ a trauma-informed cultural focus. The Commission urged further exploration and development of culturally appropriate, trauma informed approach.[16]

111 The 'Always Was, Always Will be Koori Children' report also stressed the importance of holistic, wrap around services and the importance of supporting ACCOs to provide culturally appropriate and timely counselling and wrap-around services (Recommendation 3.1). This would likewise be applicable to mental health service provision to the Aboriginal community.

112 *The importance of early identification of Aboriginality* – The Commission highlighted, at point 215 of *Always Was, Always Will be Koori Children Report*,

[16] Ibid,, point 420, 'The importance of development of the culturally appropriate, trauma-informed diagnostic tools.'

that there was a problematic practice of late identification of Aboriginal children, and recommended a whole-of-government strategy to improve mechanisms to ensure all departments and government-funded services (including hospitals, health services, education, early childhood, police, justice, child protection, housing, disability and homelessness) are culturally competent and have rigorous methods and related training for early identification of a child's Aboriginality. This would also be applicable in a mental health context.

113 The Commission highlighted the critical importance of investment into multi-disciplinary 'hub' services, at point 167-169 of the 'Always Was, Always Will be Koori Children' report to address parental mental health issues (which also assists children in out-of-care homes). The Commission recommended that these services include Aboriginal-specific mental health services. As a result of observing best practice during Taskforce 1000, the Commission made a recommendation for the expansion of multi-disciplinary hub services throughout the state. The Commissioned noted a successful model operates through the Mallee District Aboriginal Services which provides more than 50 essential health services with a strong focus on healing, resilience and early years services. The Commission also strongly encouraged to consider opportunities for co-location for Aboriginal and mainstream staff in regional Victoria, along with regular joint training to promote closer working relationships, improved information exchange and improved outcomes for Aboriginal children in out-of-home care.

114 *The importance of building culturally competent services & workplaces* – A resounding observation of the Commission, at point 441–444 of 'Always Was, Always Will be Koori Children' report, was the lack of cultural proficiency in DHHS, community service organisations and the Department of Education and Training when delivering their services to Aboriginal children in out-of-home care. In response, the Commission recommended that DHHS includes specific targets and actions to increase the number of Aboriginal people working in child protection at all levels and in all areas. The Commission recommended that the strategies should be inclusive of but not limited to:

(a) employment and development of Aboriginal people in frontline, senior management and executive roles in child protection and across the department;

(b) succession planning, training and retention of staff;

(c) targets that align with the over-representation of Aboriginal children in the child protection system;

(d) tertiary and professional training and executive development of the Aboriginal workforce.

115 In review of the above extract from 'Always Was, Always Will be Koori Children', I do not walk back any of my comments made above. On reflection, I do feel that there was at the time a significant under-diagnosis of Aboriginal children with mental health issues, and I know this from gaps in the service delivery that I heard of on a daily basis.

116 We must address this gap for our most vulnerable children by providing well-resourced Koori friendly and culturally competent mental health services that are managed and staffed by Aboriginal professionals across the state.

117 Where there are gaps in the workforce, we should see a sustainable strategy to provide a long term tertiary scholarship programs to address them.

15. In your opinion, what are the key impediments to ensuring that services are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people in Victoria?

118 In part a number of the key impediments in achieving culturally competent and safe services that are responsive to the needs of the Koori community are:

(a) A lack of involvement of Koori stakeholders and community in the design, development, implementation and evaluation of the policy and service model and a lack of respect for Koori decision-making processes.

(b) A lack of resources to build the capacity of the organisations to become culturally competent.

(c) Culturally incompetent personnel designing, developing and delivering services to the Aboriginal community.

(d) A lack of cultural competency by service providers and a lack of sustainable executive leadership.

(e) Inappropriate and inadequate messaging that has minimal reach to the Koori community.

(f) A lack of Aboriginal management and workers at all levels and areas of the organisation and service provision.

(g) A lack of healthy partnerships and relationships with community stakeholders.

(h) The location for service delivery is not Koori friendly and where there are no Koori employed at point of service delivery. We need more than flags and gum leaves.

(i) A lack of accountability and transparency in the service provision.

(j) The lack of a strong ACCO in the community, such as in the Latrobe Valley, drives the reliance on external bodies to fill the gap which then reduces the community opportunity for reaching self-determination.

16. (Future Proofing) How can service providers and funders monitor and respond to any changing needs of Aboriginal and Torres Strait Islander people?

119 The most effective way that service providers and funders can respond to the changing needs of the Koori community is when the community are involved throughout the life of the service and where:

(a) the service has been developed and delivered in compliance with the self-determination principles;

(b) there are Koories involved in the service design, delivery and monitoring;

(c) regular feedback is given by Koori service users and they feel safe to provide that feedback;

(d) the service providers, in partnership with the Koori community stakeholders, consider the changing needs of the service and respond to the required changes;

(e) appropriate and sustainable funding and resources to meet the changing needs are provided;

(f) there is recognition that the Koori community and its representative organisations/structures are part of the solution and not the problem.

17. What is needed to ensure that reforms are sustainable?

120 Fundamental principles to sustaining successful reforms based on strong partnerships are that:

(a) The reforms must be based on the principles of self-determination. Anything less reduces the sustainability of the service in its success and longevity.

(b) The reforms must have bipartisan support.

(c) Community and government leadership and executives need to stay the distance and not delegate ownership and attendance at joint meetings.

(d) There must be regular partnership meetings in which the agenda is shared.

(e) There must be a shared vision of what success looks like and the process to get there.

(f) There must be sustainable and long term funding that is not diverted to alternate purposes.

(g) There must be regular monitoring and reviews in which the findings and recommendations are shared and owned by all parties and open to change.

(h) Relationships must be based on respect, honesty, accountability and transparency.

(i) There must be agreed principles and protocols to the relationship to maintain in the highs and low. The highs and lows of the reform are shared and jointly owned and responded to.

(j) Government must transfer not just decision making but also the resources that go along with that.

(k) The reforms must become part of the organisational culture, that remains and continues to grow even when key champions leave. They must be sustainable.

Royal Commission into
Victoria's Mental Health System

sign here ▶ 

print name Andrew Jackomos

date 11 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AJ -1

This is the attachment marked 'AJ-1' referred to in the witness statement of Andrew Jackomos dated "11 July 2019" .

ALWAYS WAS, ALWAYS WILL BE KOORI CHILDREN

Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria

Artwork © Coming Home (acrylic on canvas 2014) reproduced with permission of the artist, Eileen Harrison.

Eileen Harrison is a Gunai/Kurnai woman, artist and respected Elder from south-east Victoria.

All the baby emus in this painting are coming home. The black emus depict the mothers and the larger emus depict Elders wearing their possum skin cloaks. This work represents people coming home to their ancestral lands, their place. Country is where you belong.

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This report contains material that may cause distress. Aboriginal people are warned that this report may contain images or names of deceased persons.

Pseudonyms have been used for all case studies presented in this report.

Letter to the Legislative Council and the Legislative Assembly

COMMISSION FOR CHILDREN AND YOUNG PEOPLE

25 October 2016

Mr Andrew Young
Clerk
Legislative Council
Parliament House
Spring Street
EAST MELBOURNE 3002

Mr Ray Purdey
Clerk
Legislative Assembly
Parliament House
Spring Street
EAST MELBOURNE 3002

Dear Sirs,

'Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria

I hereby request that the Inquiry report produced by the Commission for Children and Young People be tabled in accordance with section 50 of the *Commission for Children and Young People Act 2012* (the Act).

I would be grateful if you could arrange for the report to be tabled in both the Legislative Council and Legislative Assembly on 26 October 2016.

I confirm that the Minister for Families and Children, the Minister for Education, the Minister for Health, the Minister for Police, the Attorney General and the Secretary to the Department of Health and Human Services have each been provided with a copy of the Inquiry report in accordance with section 49 of the Act.

Yours sincerely,

Liana Buchanan
Principal Commissioner

COMMISSION FOR CHILDREN AND YOUNG PEOPLE LEVEL 20, 570 Bourke Street, Melbourne 3000 P: (03) 8601 5884 www.ccyp.vic.gov.au

VICTORIA State Government

Acknowledgements

The Commission greatly values the stories and experiences of Aboriginal children and young people in state care, which have helped inform this Inquiry and will continue to drive the future work of the Commission.

The vital role of families and carers and their important contribution to this Inquiry though the Taskforce 1000 Community Yarns are recognised by the Commission.

The Commission acknowledges and thanks the many individuals and organisations who have contributed to this Inquiry and the Taskforce 1000 project, which underpins much of the evidence presented in this report.

The Commission thanks all workers across government and community who have worked with the children and their families on a daily basis and over many years, providing invaluable insight through their presentations at Taskforce 1000 about the experiences of Aboriginal children in care. Their contributions have helped to improve the lives of the children reviewed and have contributed to systemic reform for children in the future.

The Commission also acknowledges the support and commitment of:

- former Minister for Community Services, Hon Mary Wooldridge, and the current Minister for Children and Families, Hon Jenny Mikakos, for their support of the concept of Taskforce 1000 and its eventual implementation
- previous DHS Secretaries and current DHHS Secretary, Ms Kym Peake, for co-chairing the Taskforce 1000 Steering Committee and for their commitment to driving change and improving practice for Aboriginal children in out-of-home care
- members of the Taskforce 1000 Steering Committee
- executive, management and staff in ACCOs and CSOs across Victoria for their participation in Taskforce 1000 and provision of services to Aboriginal children
- DHHS area managers who co-chaired Taskforce 1000 area panels
- DHHS divisional child protection practitioners involved in Taskforce 1000
- Commission staff who supported the Commissioner for Aboriginal Children and Young People during Taskforce 1000 and in the preparation of this report.

Commissioners' foreword

Historically, Aboriginal children have shouldered the brunt of our colonial past – exploited by settlers for free labour, preyed upon by missionaries seeking to save their souls and torn from loving families and communities in an effort to extinguish their culture and identity.

Tragically, we see today in Victoria that Aboriginal children continue to disproportionately bear the burden of our history. They witness the pain and the scars of their Elders. They may be dislocated from their ancestry and family history, where past government practices have severed these links. Their safety and security at home may be compromised by entrenched social disadvantage and dysfunction, borne of a history of dispossession, racism and marginalisation.

While child protection practices and attitudes have undoubtedly changed over the years, the concerning rate of Aboriginal children being removed from their homes has not. Almost 20 per cent of children in out-of-home care are Aboriginal, despite Aboriginal people representing less than 1 per cent of the Victorian population. Many of these children are placed away from their families and communities, often in non-Aboriginal households, where their ability to remain connected to their culture is compromised.

If we do not confront the reality of the over-representation of Aboriginal children in our child protection system, we risk allowing the ghosts of our colonial history to do more than haunt us. We risk allowing harmful outcomes for Aboriginal children to continue unabated.

This report outlines the findings of the Commission's systemic inquiry into services provided to Aboriginal children and young people in out-of-home care. It shines a light on a system that has failed to actively question and evaluate the impact of its actions on some of our most vulnerable children. It draws upon the work of the Taskforce 1000 project, an innovative model bringing together Aboriginal and non-Aboriginal service providers and policymakers to critically examine the circumstances of the almost 1,000 Aboriginal children in out-of-home care.

The Commission's Inquiry found significant departures from existing requirements to promote and preserve the cultural rights of Aboriginal children in care. Limited access to culturally appropriate education services and supports and widespread non-compliance with cultural planning – alongside a failure to adequately engage Aboriginal families, communities and organisations in decision-making – are exacerbating upheaval and distress for Aboriginal children in the child protection system.

This Inquiry found that, overwhelmingly, children are entering care as a result of family violence and parental substance abuse. More needs to be done to prevent and address this pathway for children entering care and to support Aboriginal families to remain together and thrive. There is no cure for a permanent loss of identity and culture; prevention is paramount.

This report has identified a number of opportunities to safeguard Aboriginal children's cultural rights. Increasing Aboriginal involvement and participation in the child protection system is central to this. Embedding a more robust performance measurement system that attaches responsibility for improvement to those in leadership positions, flowing through to those working directly with families, will drive greater compliance and accountability for all.

Many of the findings and recommendations in this report are not new or surprising. They are consistent with what we have learned from a number of previous inquiries that have examined government interaction with Aboriginal people, dating back to the Royal Commission into Aboriginal Deaths in Custody in 1991. Too many of the lessons gleaned from previous inquiries sit unaddressed, fuelled by a growing complacency and the acceptance of poorer outcomes for Aboriginal people as inevitable.

In light of this, the Commission is pleased to reflect on significant and timely reforms led by the Victorian Government to address the growing over-representation of Aboriginal children in the child protection system. Bipartisan support for the recommendations of this Inquiry will be crucial in enabling the transfer of targets and resources to ACCOs for the case management and placement of Aboriginal children.

Commissioners' foreword

The positive response to the *Koorie kids: Growing strong in their culture* submission from the Aboriginal community has seen a deliberate shift towards self-determination, evidenced through the plan to transfer case management of Aboriginal children in out-of-home care to Aboriginal community controlled organisations. The Aboriginal Children's Forum, a regular meeting of Aboriginal organisations, government representatives and the broader community sector, will also help maintain momentum and shared responsibility for reducing the number of Aboriginal children in the child protection system and improving meaningful cultural connection for those within it.

An Aboriginal child is not only a family member, but also a member of a clan and a first Australian, born imbued with a connection to Country and responsibilities to generations that have walked before and the countless generations that will follow. It is our collective responsibility to ensure every Aboriginal child has the opportunity to learn, practice and pass on their culture. They can only fulfil this obligation when they know who they are and where they have come from.

Yours sincerely

Liana Buchanan
Principal Commissioner

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

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Abbreviations and acronyms

ACCHO	Aboriginal community controlled health organisation
ACCO	Aboriginal community controlled organisation
ACPP	Aboriginal Child Placement Principle
ACF	Aboriginal Children's Forum
ACSASS	Aboriginal Child Specialist Advice and Support Service
ADHD	Attention deficit hyperactivity disorder
AFLDM	Aboriginal Family-Led Decision-Making
AIHW	Australian Institute of Health and Welfare
Alliance	Victorian Aboriginal Children and Young People's Alliance
CCYP Act	*Commission for Children and Young People Act 2012 (Vic)*
CEO	Chief Executive Officer
Charter	*Charter of Human Rights and Responsibilities Act 2006 (Vic)*
CIR	Client Incident Report
COAG	Council of Australian Governments
Commission	Commission for Children and Young People
CRIS[1]	Client Relationship Information System
CRISSP[2]	Client Relationship Information System for Service Providers
CSO	Community service organisation
CYFA 2005	*Children Youth and Families Act 2005 (Vic)*
DET	Department of Education and Training
DHS	Department of Human Services
DHHS[3]	Department of Health and Human Services
DoJR	Department of Justice and Regulation
FASD	Fetal alcohol spectrum disorders
FVPLS	The Aboriginal Family Violence Prevention and Legal Service Victoria
ICMS	Intensive Case Management Service
Inquiry	The Commission for Children and Young People Victoria's systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria
KEC	Koorie Education Coordinator
KESO	Koorie Engagement Support Officer
KPI	Key performance indicator
LAC	Looking After Children framework
LGBTI	Lesbian, gay, bisexual, transgender or intersex
NAIDOC	National Aborigines and Islanders Day Observance Committee
NAPLAN	National Assessment Program – Literacy and Numeracy
NDIS	National Disability Insurance Scheme
NSDC	National Sorry Day Committee
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RTO	Registered training organisation
SNAICC	Secretariat of National Aboriginal and Islander Child Care
TAFE	Technical and Further Education
Taskforce 1000	Taskforce 1000 was established in 2013 in response to the over-representation of Victorian Aboriginal children in out-of-home care. Taskforce 1000 examined the individual circumstances of 980 children and was co-chaired by the Secretary to DHHS and the Commissioner for Aboriginal Children and Young People, Mr Andrew Jackomos PSM
TSI	Torres Strait Islands
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAEAI	Victorian Aboriginal Education Association Incorporated
VAGO	Victorian Auditor-General's Office
VAHS	Victorian Aboriginal Health Service
VOCAT	Victims of Crime Assistance Tribunal

1 DHHS operates three integrated web-based client and case management systems. CRIS is the client information and case management system used by child protection, youth justice, disability services, early childhood intervention services and the refugee minor program.

2 CRISSP is based on CRIS and uses similar functionality. It is a system provided to ACCOs and CSOs that are funded to provide services in child protection placement and support, disability services, youth justice, early childhood intervention services and/or family services.

3 On 1 January 2015, the Victorian Government established the Department of Health and Human Services, bringing together the former Department of Health, Department of Human Services and Sport and Recreation Victoria. Reference to the former DHS is made in this report where relevant.

Definitions

Aboriginal

The term Aboriginal in this report refers to both Aboriginal and Torres Strait Islander People. Indigenous is retained when it is part of the title of a program, report or quotation.

The term Koori refers to Aboriginal people from south east Australia. The alternate spelling Koorie is also used in this report when it is part of the title of a program, report or quotation.

Children

The term children in this report refers to children and young people 0–17 years of age.

Cultural safety

Cultural safety has been described as 'an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.'[4]

'Culture is about family networks, Elders and ancestors. It's about relationships, languages, dance, ceremony and heritage. Culture is about spiritual connection to our lands and waters. It is about the way we pass on stories and knowledge to our babies and children; it is how we greet each other and look for connection. It is about all the parts that bind us together.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

Out-of-home care

Children who enter out-of-home care in Victoria are placed in one of the following placement types:

Kinship care

Kinship care is provided by the child's relatives or members of a child's social network (also called 'kith' placements) who have been approved to provide accommodation and care. This placement type is targeted at children up to 18 years of age who are subject to intervention by child protection services and assessed as requiring out-of-home care. The placement is supervised and supported according to the child's level of assessed need.

Home-based care

Home-based care includes foster care, adolescent community placement, shared family care and therapeutic foster care. Volunteer carers act as foster parents to children. Foster carers provide care in their own home and are usually not known to the child before the placement. This placement type is for children up to 18 years of age who are temporarily or permanently unable to live with their family of origin. ACCOs and CSOs are responsible for recruiting, training and supporting caregivers.

Residential care

Up to six children, usually seven years of age and older (children may be younger if they are part of a larger sibling group or in circumstances where a home-based care arrangement is not available), are placed in a residential building and cared for by paid staff. Residential services are the least used option in the out-of-home care service system.

Lead tenant

Lead tenant arrangements involve the provision of semi-independent accommodation and support for young people 15–18 years of age who are in transition to independent living. A volunteer lead tenant lives in a house with a small group of young people and provides them with support and guidance in developing their independent living skills.

4 Williams, R, 'Cultural safety: what does it mean for our work practice?', *Australia and New Zealand Journal of Public Health*, 23/2 (1999), pp. 213–214.

Taskforce 1000 reviewed

980
Aboriginal children in out-of-home care

88%
of children had experienced family violence

87%
of children were exposed to parental alcohol/substance use

42%
of children were placed away from their extended family

25%
of the children on Guardianship orders had no cultural support plan

86%
of children were case managed by a non-Aboriginal agency

over 40%
of children with siblings were separated from their brothers and sisters

over 60%
of children were placed with a non-Aboriginal carer

Executive summary

The Commission for Children and Young People's systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria was established in August 2014, pursuant to section 39 of the CCYP Act. This Inquiry was initiated to enable the Commission to effectively fulfil its role in co-chairing Taskforce 1000. This Inquiry report draws largely on the findings from Taskforce 1000, together with other sources of data and evidence available through the monitoring and inquiry functions of the Commission.

The Victorian child protection system is faced with a crisis. Data indicates that there has been a 59 per cent increase in the number of Victorian Aboriginal children in out-of-home care from 2013 to 2015,[5] and the numbers have grown since. This Inquiry has concluded that there are systemic failures and inadequacies that have contributed to the vast over-representation of Aboriginal children in the child protection and out-of-home care systems, and that there are practice deficits that have led to the degradation of Aboriginal culture for Aboriginal children who are placed in out-of-home care.

Taskforce 1000 was an 18-month project, co-chaired by the Commission and DHHS, which commenced in mid-2014 and concluded in early 2016. Through collaboration with ACCOs, CSOs, government departments and the Aboriginal community, Taskforce 1000 critically reviewed the case plans and circumstances of 980 Aboriginal children in out-of-home care in Victoria. As a result of the project, immediate and positive change was achieved for many of these children.

However, Taskforce 1000 demonstrated the need for reform and ongoing collaborative work to mitigate the drivers for Aboriginal children's escalating entry to care, improve the experience for Aboriginal children who require out-of-home care and prevent the cycle of abuse for future generations by ensuring that cultural safety and enrichment are the foundation for service provision.

Of grave concern to the Commission is the fact that evidence-based solutions have long been apparent to successive governments but have not been implemented. Previous landmark inquiries have demonstrated the harm that past government policies caused Aboriginal people. Despite this, action has been slow, resulting in the continued harm to our current generation of Aboriginal children.

This Inquiry has found that family violence, in combination with parental alcohol and/or drug abuse, is the leading causes for Aboriginal children's entry to care. Of the children reviewed, 88 per cent were impacted by family violence and 87 per cent were affected by a parent with alcohol or substance abuse issues. More needs to be done to equip families to overcome these issues. Aboriginal early years services are not adequately funded or resourced to meet the growing demand for assistance, and mainstream services lack the inclusion of Aboriginal people to provide culturally appropriate responses.

This Inquiry found that the child protection system fails to preserve, promote and develop cultural safety and connection for Aboriginal children in out-of-home care. Deficient practices by DHHS and CSOs, including non-compliance with legislative and practice requirements for cultural planning and inadequate inclusion and engagement with Aboriginal family, programs and community in decision-making, have resulted in the dislocation from culture and family for large numbers of Aboriginal children in out-of-home care.

Over 60 per cent of the children reviewed during Taskforce 1000 were placed with a non-Aboriginal carer, 41 per cent were placed away from their extended family and over 40 per cent of children with siblings were separated from their brother or sister. This Inquiry also found that almost half of the non-Aboriginal carers had not been provided with essential cultural awareness training. Support for kinship carers is seriously lacking and requires far greater resourcing, attention and effort to ensure that Aboriginal children have strong, capable and resilient carers.

5 Steering Committee for the Review of Government Service Provision, *Report on government services 2015, Volume F, Community services* (Canberra: Productivity Commission, 2016).

Executive summary

This Inquiry found that DET and DHHS have failed to comply with existing protocols and agreements to safeguard the cultural rights of Aboriginal children in out-of-home care. These rights include the ability to access Koori-specific education services, to have individual learning plans and to access mainstream schooling. The Commission heard of many Aboriginal children who had been placed in alternate or special school arrangements by DET because the education system was unable to cater for their trauma-related behaviours.

DHHS data for the 980 children reviewed during Taskforce 1000 has been analysed and presented in this Inquiry report. In addition, 22 case studies illustrate the scant regard for the human rights of Aboriginal children to access and practise their culture. The data provides a strong and compelling evidence base for the findings and recommendations of this report.

The Commission found that promising outcomes for Aboriginal children in out-of-home care were observed where there were inclusive approaches to collaboration between child protection, CSOs and ACCOs, particularly where the ACCOs are well resourced and well managed.

System redesign is a key recommendation of this Inquiry. The Commission endorses the *Beyond Good Intentions*[6] policy statement and has recommended that DHHS, in partnership with the ACF, develops a transition strategy and time line to transfer targets and resources to ACCOs over an agreed period for the case management and placement of all Aboriginal children within the child protection system (including, but not limited to, children placed in kinship care). This will take considerable collaborative effort.

In the interim, there is a pressing need for a new approach to child protection service delivery for Aboriginal children. Key recommendations of this Inquiry are for greater Aboriginal inclusion in the child protection workforce, especially at the executive level, together with specific Aboriginal child protection teams supported by specialist child protection practitioners for Aboriginal children. These measures will, in part, ensure that consideration of legislative and practice requirements for Aboriginal children are given the priority and attention that are needed, and promote a greater focus on the health and wellbeing of Aboriginal children in out-of-home care.

The Commission found that accountability and performance measures are not robust and that the service systems lack transparency and adequate oversight. Many recommendations have been made for greater accountability by DHHS, DET and CSOs through the introduction of KPIs for Aboriginal children in out-of-home care within the individual work plans of senior departmental executives. Additionally, the Commission has called for strengthened data collection, monitoring of compliance with practice requirements and public reporting of data by DHHS and DET in order to improve outcomes for Aboriginal children in out-of-home care.

The Apology to Australia's Indigenous Peoples[7] speech promised a new page in Australia's history. It promised a future where 'the injustices of the past must never, never happen again ... A future where we embrace the possibility of new solutions to enduring problems where old approaches have failed.' The grief, suffering and loss of the Stolen Generations are still very relevant today. Continuing reformist action by government and community services is urgently needed.

The Commission calls on the Victorian Government to accept the recommendations of this Inquiry report and, in the spirit of self-determination, that the Minister for Families and Children authorises the ACF to monitor and provide oversight for their implementation and continuous development.

Always was, always will be Koori children.

6 Centre for Excellence in Child and Family Welfare, *Beyond Good Intentions* (Melbourne: Centre for Excellence in Child and Family Welfare, 2018).

7 Commonwealth of Australia, *Parliamentary debates*, House of Representatives, 13 February 2008, p. 167 (Hon Kevin Rudd MP, Prime Minister).

Findings

Finding 1:

High numbers of Aboriginal children experiencing family violence in combination with parental alcohol and/or substance abuse are coming to the attention of child protection, leading to their removal from family and placement in out-of-home care.

Finding 2:

The present service system, particularly the Aboriginal community controlled sector, lacks sufficient resources for, and emphasis on, early years programs to support families and reduce the growing number of Aboriginal children entering the child protection and out-of-home care systems. Furthermore, there is concern that many mainstream services do not provide culturally responsive services to Aboriginal children.

Finding 3:

There is a lack of aftercare, monitoring and evaluation by DHHS of services and programs delivered internally and by funded agencies for Aboriginal children in out-of-home care.

Finding 4:

Aboriginal children in out-of-home care are provided with greater opportunity for meaningful engagement with culture when their placement, case management and guardianship are provided by an ACCO.

Finding 5:

DHHS and CSOs offer poor cultural safety to Aboriginal children in the out-of-home care system. This is in direct contravention to the rights guaranteed under the *Charter of Human Rights and Responsibilities Act 2006*. There is evidence of practice deficits in respecting and establishing children's Aboriginal identity and a lack of compliance with legislative and policy obligations.

Finding 6:

High numbers of Aboriginal children in out-of-home care are separated from their siblings and are not provided with adequate opportunity to have contact with them.

Finding 7:

Kinship carers require increased advocacy, support, assistance, training and education to provide culturally safe and trauma-informed care to Aboriginal children requiring out-of-home care.

Finding 8:

DHHS and DET do not fully comply with policy requirements relating to Aboriginal children in the out-of-home care system; this impacts negatively on Aboriginal children's education, cultural safety and wellbeing.

Finding 9:

There is inadequate coordinated attention to the health and wellbeing of many Aboriginal children in out-of-home care. There are service system gaps in the delivery of holistic and culturally appropriate health and wellbeing services.

Finding 10:

Many non-Aboriginal service systems that interact with and/or case manage Aboriginal children in out-of-home care lack high-level cultural proficiency.

Finding 11:

The child protection system lacks Aboriginal input at the executive level and there is insufficient regard to Aboriginal culture and values in service delivery.

Recommendations

1. That the Victorian Government accepts the recommendations of this Inquiry report and, in the spirit of self-determination, the Minister for Families and Children authorises the Aboriginal Children's Forum to monitor and provide oversight for their implementation and continuous development.

2. Keep Aboriginal children safe within their family.

2.1 Government to improve mechanisms to ensure all departments and government-funded services (including hospitals, health services, education, early childhood, police, justice, child protection, housing, disability and homelessness) are culturally competent and have rigorous methods and related training for early identification of a child's Aboriginality.

2.2 DHHS to work with ACCOs that are currently funded for child and family services to facilitate the expansion of their services (where agreed to by the ACCO) to become a multi-disciplinary, one-stop community hub for Aboriginal children and families in their community.

2.3 DET to target funding to both establish and sustain a range of Aboriginal community-based early years programs in areas with growing Aboriginal populations and high out-of-home care placement rates, in recognition of the role of community-based early years programs in prevention.

2.4 DHHS to lead cross-government efforts in partnership with the Latrobe Valley Aboriginal community to support their establishment of a local ACCO to promote, advocate and provide community-based health and human services.

2.5 DHHS to develop and implement an approach to address intergenerational trauma, grief and loss that is both child specific and Koori informed, and by working with the extended family groups and clans of children involved with child protection to promote healing and facilitate placement and reunion options within Aboriginal families and communities.

3. Strengthen healing-informed interventions to address family violence and intergenerational trauma.

3.1 DHHS to support ACCOs to provide culturally appropriate and timely counselling and wrap-around services for the growing number of children, their families and carers who have been victims of family violence and sexual abuse.

3.2 DHHS to facilitate the development and implementation of a comprehensive strategy to respond to the prevalence of family violence in Aboriginal families. DHHS, in partnership with Aboriginal organisations, to develop and deliver education programs for Aboriginal children and young people in out-of-home care, focusing on respectful relationships to break the cycle of intergenerational family violence. Furthermore, funding should be provided for evidence-based campaigns to promote respectful relationships across the Aboriginal community, with a specific focus on children and young people.

3.3 Government to ensure all Aboriginal children impacted by abuse or family violence have access to information about victim support, legal services and redress, including but not limited to VOCAT.

3.4 Government to work with Victoria Police to review the risk assessment and risk management report (L17) referral process to ensure that Aboriginal children and their families who have contact with police receive timely referral to their local Aboriginal family violence service and other culturally appropriate services.

3.5 DHHS, in partnership with Aboriginal services, to implement strengthened and regular training for all child protection and agency staff to ensure culturally appropriate and therapeutic responses are provided to Aboriginal children and families who have experienced family violence.

4. Ensure Aboriginal children in out-of-home care have meaningful access to their culture.

4.1 DHHS, in partnership with ACCOs, to facilitate the establishment of a statewide program for Aboriginal children in out-of-home care to search their family history and create family genograms to help them identify and connect to their family and community.

4.2 DHHS to develop and maintain a web-based portal for Aboriginal children, young people in out-of-home care and their carers to access information about Aboriginal community activities, Aboriginal services, cultural identity and history services, cultural events in the community where they live, and events, cultural celebrations and services across Victoria.

4.3 DHHS and CSOs to work collaboratively with ACCOs to facilitate regular opportunities for Aboriginal children and young people in out-of-home care, particularly children who do not have regular cultural connections, to connect with each other, the community and their culture. Where an ACCO exists, funding to be provided to resource a role with this function. Where there is no ACCO, DHHS to coordinate these opportunities.

4.4. DHHS and CSOs to work collaboratively with ACCOs to ensure that every Aboriginal child in out-of-home care can access an Aboriginal mentor (including an Aboriginal family member) who will assist in building the child's cultural identity and their connection to Country and family, and who will play an active part in supporting the child's cultural support plan and leaving care.

4.5 DHHS to expand recurrent funding to increase the capacity of ACCOs to contribute to the development and implementation of cultural support plans and programs for Aboriginal children and young people in out-of-home care, including those whom they do not case manage.

4.6 Cultural support plans must, at a minimum, include the child's family genogram and a plan for the child's return to Country and identify a suitable mentor who will enable the child's access to culture, leading to real experiences and cultural connections. Cultural programs for Aboriginal children in out-of-home care should be available on a local and regional basis, be recurrently funded and may include healing camps, access to the arts, connection to Country activities, recreation and educational opportunities.

4.7 DHHS to develop strategies and oversight mechanisms to ensure that high-quality cultural support plans are developed, implemented, monitored, reviewed and updated in a timely manner. DHHS must establish internal KPIs for compliance with these requirements and provide quarterly progress reports to the ACF and the Commission. The ACF will provide oversight and evaluation of the integrity and standards of the cultural planning processes as an ongoing responsibility.

5. Build the cultural competency of organisations providing services to Aboriginal children in out-of-home care.

5.1 DHHS, through its Aboriginal Employment Strategy, to include specific targets and actions to increase the number of Aboriginal people working in child protection at all levels and in all areas.

The strategies should be inclusive of, but not limited to:

- employment and development of Aboriginal people in frontline, senior management and executive roles in child protection
- succession planning, training and retention of staff
- targets that align with the over-representation of Aboriginal children in the child protection system
- tertiary and professional training and executive development of the Aboriginal workforce.

DHHS must provide employment data about the number of Aboriginal child protection staff by classification level in central office and in each division and area office in its annual report. DHHS to report to the ACF on the progress of the strategy on a six-monthly basis.

Recommendations

5.2 DHHS to facilitate the establishment and provision of recurrent funding for a child and family services sector professional body for Aboriginal human services workers (inclusive of the social work, youth work, youth justice and community welfare sectors) to promote the child protection profession to Aboriginal people and develop the existing workforce.

5.3 DHHS, in partnership with the ACF, to develop a transition strategy, time line and action plan to implement the transfer of targets and resources to ACCOs over an agreed period of time for the case management and placement of Aboriginal children, including, but not limited to, children placed in kinship care, as detailed in the ACF work plan and committed to in the *Beyond Good Intentions*[8] policy statement.

5.4 CSOs that receive funding for provision of out-of-home care services for Aboriginal children to demonstrate high-level cultural proficiency, including demonstrated Aboriginal inclusion action plans and annual training of all staff in cultural awareness and proficiency.

5.5 By 2018, DHHS, in partnership with the ACF, must review and strengthen DHHS standards concerning the cultural competency of CSOs. Assessment of a CSO's cultural competency under the DHHS standards must be carried out by the Aboriginal community.

5.6 DHHS, in collaboration with DET, to expand the provision of masterclasses to all staff working with Aboriginal children in out-of-home care to build the cultural competence of the organisations. Masterclasses have been piloted in the North division. This is a joint initiative by DHHS and Aboriginal partner agencies. The aim is to improve working relationships within the sector, and build the expertise and knowledge of practitioners and their understanding of the roles and functions of Aboriginal services in order to work in a culturally sensitive manner and achieve improved outcomes for Aboriginal children.

5.7 The Commission will work collaboratively with Victoria Legal Aid and the Law Institute of Victoria to ensure that all legal practitioners who work within the Children's Court jurisdiction are culturally proficient. This could include undergoing annual cultural and community awareness training to focus on building understanding of the importance of cultural support planning for Aboriginal children and the specific decision-making requirements for Aboriginal children as specified in the CYFA 2005.

8 Centre for Excellence in Child and Family Welfare, *Beyond Good Intentions*.

6. Improve child protection responses and service provision for Aboriginal children in out-of-home care.

6.1 Accountability and performance measures for improved outcomes for Aboriginal children to be incorporated in the individual performance plans of operational DHHS Deputy Secretaries.

Such measures will include demonstrated reductions in the number of Aboriginal children in out-of-home care, demonstrated reductions in the number of Aboriginal siblings who are separated in placement, and requirements that each Aboriginal child in out-of-home care:

- has been placed according to the ACPP[9]
- has had the required number of AFLDM conferences provided in the required time lines
- has a cultural support plan that has been developed with integrity, is implemented and reviewed annually
- is engaged and fully participates in mainstream education
- has had an Aboriginal health check upon entry to care, and then annually
- has an annual formal case review.

6.2 DHHS, in partnership with the ACF, to develop a suite of KPIs to reduce the number of Aboriginal children entering out-of-home care to be on par with non-Aboriginal children.

Data against these KPIs to be reported by DHHS to the ACF and the Commission on a quarterly basis and published in DHHS's annual report.

6.3 That government advocates, through COAG, for Close the Gap[10] targets to include equity in the number of Aboriginal children in out-of-home care and a reduction in the incarceration of Aboriginal children in youth justice.

6.4 That, as a priority and in partnership with Victoria Police and government agencies, there be a localised community-led strategy and response in the DHHS South division to address the extent of sexual abuse evident within Aboriginal families.

9 In Victoria, the ACPP is enshrined in Division 4 of the CYFA 2005 by prioritising and specifying the criteria for the placement of Aboriginal children who are unable to remain safely at home.

10 Close the Gap is a national campaign that was launched in 2006 by peak Australian Aboriginal bodies, non-government organisations and human rights organisations. Close the Gap aims to close the health and life expectancy gap between Aboriginal and non-Aboriginal Australians within a generation, by 2031.

6.5 DHHS to review and implement improvements to ACSASS to ensure the program has the capacity to meet current and anticipated demand, and to actively engage in key decisions relating to Aboriginal children in out-of-home care in a timely manner. It is recommended that for every increase in staffing to the child protection workforce there is a corresponding increase in the ACSASS workforce.

Improvements should include the opportunity for ACSASS delivery by local ACCOs in regional Victoria to enable local knowledge of the child and family to be considered in decision-making and to increase family engagement.

6.6 DHHS to review and implement improvements to the AFLDM model, remove any barriers to timely meetings and compliance with AFLDM practice guidelines, ensure the program has the capacity to meet current and anticipated demand, and actively engage in key decisions relating to Aboriginal children in out-of-home care in a timely manner.

Remuneration for community AFLDM convenors should be commensurate with DHHS AFLDM convenors, when workloads are comparable.

6.7 DHHS to report area AFLDM and ACSASS performance and compliance data and information to the ACF and the Commission on a quarterly basis. This data must also be published in DHHS's annual report.

6.8 DHHS to establish eight child protection specialist Principal Practitioners for Aboriginal Children positions (one rural and one metropolitan based in each of the four DHHS divisions). These positions are to provide specialist advice and consultation to divisional Aboriginal child protection teams, be delegated with case planning responsibility and play a key role in the oversight of best practice.

In addition, DHHS to establish a child protection Chief Practitioner for Aboriginal Children within DHHS's central office to provide support and oversight to the eight divisional specialist Principal Practitioners.

The Commissioner for Aboriginal Children and Young People to be part of the selection panel for each of these positions.

6.9 DHHS to create regular opportunities to bring AFLDM, ACSASS and other relevant Aboriginal services together on a quarterly basis with the proposed Aboriginal Chief and Principal Practitioners (see recommendation 6.8) for a professional forum to promote consistent approaches and best practice, and provide workplace training and career opportunities.

6.10 DHHS to establish area-based Aboriginal child protection teams to case manage all child protection matters relating to Aboriginal children.

6.11 DHHS to develop reunification guidelines specific for Aboriginal children in out-of-home care.

6.12 DHHS must develop a practice requirement that ensures Aboriginal siblings are case managed by one case manager within the proposed Aboriginal child protection teams (see recommendation 6.8).

Additionally, in collaboration with ACCOs, DHHS must ensure Aboriginal siblings have (in addition to their individual case plans) a sibling case management plan.

6.13 DHHS to ensure that child protection staff avoid the practice of interviewing children and young people at school, except in extenuating circumstances where immediate safety and risk issues are apparent, to avoid the stigmatisation of children receiving child protection services and to ensure Aboriginal children are given every opportunity for uninterrupted engagement with their education.

6.14 DHHS must consult with and seek approval from the Commissioner for Aboriginal Children and Young People and the proposed Chief Practitioner for Aboriginal Children in relation to any decision to change the identification of an Aboriginal child to 'non-Aboriginal'. CRIS enhancements must be made to ensure that a child's Aboriginal status cannot be reversed without this approval.

6.15 DHHS to ensure, as a priority, enhancements to the CRIS/CRISSP system, to be implemented by 2017, to:

- prominently record identification of a child's Aboriginality
- include mandatory completion of the Aboriginal status fields for the child's parents that must be completed before a case prior to the investigation phase being completed
- include mandatory completion of the Aboriginal status of the child's primary carer for children in out-of-home care
- differentiate between kith and kin placement type
- link and identify siblings more readily
- prominently record genograms and all other documentation pertaining to additional decision-making principles for Aboriginal children, inclusive of the AFLDM process and the ACPP
- ensure a child's Aboriginal status cannot be altered without approval (see recommendation 6.14).

Recommendations

6.16 DHHS must immediately review and amend all pro formas, templates and reporting documents (inclusive of reports, forms and applications, referral documents and CRIS templates) to ensure that a child's Aboriginality is clearly identified and that provisions relating to compliance with the legislative requirements under the CYFA 2005 pertaining to Aboriginal children are recorded.

6.17 DHHS to ensure that a thorough family search occurs during the investigation phase to inform the development of a genogram for every Aboriginal child. The genogram document should be regularly reviewed and updated at key phases of child protection involvement.

The family search must include consultation with relevant ACCOs and the proposed Aboriginal family search program (see recommendation 4.1).

DHHS to develop or acquire software capability, compatible with the CRIS database, that is capable of developing detailed genograms that can be shared, amended and reviewed. DHHS to collaborate with ACCOs in devising the format for such genograms.

6.18 The Aboriginal Child Placement Principle must be followed and promoted. DHHS to collect data and report on the application of and compliance with the Aboriginal Child Placement Principle. DHHS to develop guidelines and KPIs for the application of the ACPP.

This data is to be reported by DHHS to the ACF and the Commission on a quarterly basis and published in DHHS's annual report.

6.19 As an alternative to residential care, DHHS, in partnership with the ACF, to develop specialist therapeutic family-like care models for Aboriginal children. This group care must be delivered by ACCOs.

6.20 DHHS to review the adequacy of the training and training materials provided to DHHS staff and agency staff relating to the background and application of the Aboriginal Child Placement Principle. The terms of reference for the review must be formulated through collaboration with the ACF. The outcome of the review must be reported to the ACF and the Commission.

6.21 To promote self-determination and local community input, prior to a permanent care application being made to the Children's Court, endorsement for the permanent care application must be sought from a panel/s comprising:

- relevant and local Aboriginal community members
- VACCA and local ACCOs from across the state.

This must be done before an application is made to the Children's Court.

Legislative change to the CYFA 2005 is required to enable the establishment and authorisation of this panel.

6.22 DHHS to devise processes to monitor the implementation of cultural support plans following a Permanent Care order being made in respect to any Aboriginal child.

6.23 DHHS to work in partnership with the ACF on developing a strategy to divert Aboriginal children in out-of-home care from entering or progressing in the youth justice system.

This strategy should include building the capacity of ACCOs to develop and implement intensive diversionary strategies along the justice continuum as well as ensuring there are adequate resources and workers in the Koori Youth Justice program and the Koori Youth Justice Intensive Bail Support program.

6.24 To assist in the development and implementation of recommendation 6.23, the Commission also recommends that DHHS collects data and reports on the gender, age, locality and number of Aboriginal children and young people who are:

- on community-based orders
- on remand
- serving custodial sentences
- dual child protection and youth justice clients.

This data is to be reported by DHHS to the ACF and the Commission on a quarterly basis.

6.25 DHHS to ensure every Aboriginal child in out-of-home care has an annual case conference planning review, involving all members of the care team, which includes a review of:

- the child's genogram
- the child's health and education needs
- progress in implementing the child's cultural support plan
- compliance with the Aboriginal Child Placement Principle
- ensuring AFLDM conferencing has occurred
- parental involvement with the justice system and consideration of integrated case management with DoJR to support family reunion where appropriate.

CRIS enhancements will be required to support this by way of alerts to the allocated worker for completion of associated tasks to meet this annual requirement.

7. Aboriginal children in out-of-home care need resilient, supported and capable carers.

7.1 DHHS to review carer eligibility and assessment criteria to ensure potential Aboriginal kinship and home-based carers are not precluded on the basis of racial bias or past criminal offences that do not impact on their ability to provide safe and appropriate care to a child. There should be a timely review mechanism established, promoted and accessible for carer applicants to appeal outcomes.

7.2 DHHS, in partnership with ACCOs and CSOs, to develop and resource local area-based campaigns to increase the numbers of Aboriginal carers for Aboriginal children through local community conversations to overcome potential barriers to becoming a carer.

7.3 DHHS to fund additional Aboriginal kinship care support workers and develop initiatives to adequately support carers. The aim is to minimise placement breakdown, increase stability and improve outcomes for Aboriginal children through:

- providing culturally informed trauma training
- engaging the local ACCO in providing cultural training for carers, building the knowledge of carers and improving relationships with local Aboriginal cultures, people and place
- establishing and recurrently funding the operation of a community-based Aboriginal kinship carers network to provide advocacy, peer support and training
- provision of regular respite to assist and support carers to sustain the placement.

7.4 DHHS to resource kinship carers adequately to support their role and keep the placement stable. This must include:

- aligning kinship reimbursements for carers of Aboriginal children with home-based carer rates
- ensuring that, at the commencement of a placement, kinship carers are provided with the necessary material assistance for the optimal care of the child
- considering the physical, economic and emotional impact of placement decisions upon carers.

7.5 DoJR to resource and expand culturally appropriate parenting skills programs for incarcerated parents to assist sustainable family reunion (for instance, holistic responses, such as housing, parenting skills, income and work, drug and alcohol and mental health issues).

7.6 Key cultural competencies for all carers (kinship, home-based care and residential care) to be developed and benchmarked by the ACF.

All carers (including kith and kin) who look after Aboriginal children must be culturally competent and provided with locally delivered training by an approved ACCO and receive high-quality supervision and support.

DHHS, ACCOs and CSOs to improve the induction of kinship carers to ensure expectations of care are clear from the outset and ensure the cultural competency of all carers.

7.7 DHHS to develop a resource for all kinship and home-based carers to be provided at the time a placement commences, including information about carer eligibility for payments, support, carers' and children's rights, and information about decision-making and court processes.

7.8 At the time of placement, DHHS must ensure that carers are fully informed and updated about the child's health, trauma, specific behavioural issues and parental issues that may impact on the child's stability and wellbeing in order to provide optimal care.

7.9 DHHS, ACCOs and CSOs to ensure that all carers of Aboriginal children enable the child's engagement with Aboriginal community services (such as early years programs, health services, cultural, sporting and other community service programs) following the child's placement.

8. Aboriginal children in out-of-home care deserve optimal health, education and wellbeing outcomes.

8.1 DHHS, in partnership with VACCHO, to develop and implement a strategy and practice standard to ensure all Aboriginal children in out-of-home care have a specific Aboriginal children's health check upon entry to care, and then annually, at an ACCHO.

The strategy should ensure that funding for ACCHOs aligns with the initial and future demand for new services and in accordance with the numbers of Aboriginal children in out-of-home care.

8.2 DHHS, in collaboration with DoJR, to work with hospitals to embed a process to ensure that when an Aboriginal child is identified at the time of a birth, the application for their birth certificate is completed prior to discharge from hospital.

8.3 DHHS, in collaboration with paediatricians (in ACCOs where locally based), to assess and review the diagnosis and treatment of Aboriginal children in out-of-home care who have been diagnosed with a disability, ADHD, FASD and/or Autism spectrum disorder using a culturally appropriate trauma-informed approach.

Recommendations

8.4 DHHS to establish Aboriginal disability support workers in each division (as in North division) to work closely with the proposed Aboriginal child protection teams in each DHHS division.

8.5 DHHS and DET to work collaboratively with the Aboriginal community, VACCHO and VAHS to ensure adequate support and programs are available for Aboriginal children in out-of-home care who identify as LGBTI.

8.6 Accountability and performance measures for improved outcomes for Aboriginal children in out-of-home care to be incorporated in relevant departmental and school planning documents and also in the individual performance plans of DET Deputy Secretaries and school principals. Such measures should include:

- demonstrated engagement of a KESO for every child
- engagement of every child with a student support group
- an individual educational support plan for every child that is regularly reviewed and monitored
- demonstrated improvements for every child's numeracy, literacy and educational attainment
- demonstrated improvement in the child's school engagement and attendance.

8.7 All Aboriginal children in out-of-home care must be attending full-time mainstream schooling. Where this is not occurring, prior approval to be sought by the proposed DHHS Principal Practitioner for Aboriginal children. DHHS and DET must report on a quarterly basis to the ACF on the number of children in each area who attend part-time or alternate/special education programs.

8.8 DHHS and DET to report on a quarterly basis to the ACF and to the Marrung Central Governance Committee on the number of Aboriginal children in out-of-home care, by year level attained, that:

- have been expelled, suspended or disengaged from school
- attend a special school or special/alternative education program.

This data is to be provided on an area and statewide basis.

8.9 DET to review the KESO program to ensure that all KESO positions are filled on an ongoing basis and that all Aboriginal children in out-of-home care are engaged with a KESO worker.

The outcome of the KESO review is to be reported to the ACF, the Marrung Central Governance Committee and the Commission.

8.10 DHHS to ensure that a copy of the advice to schools and early years programs regarding the enrolment of an Aboriginal child is also provided to the KEC.

8.11 DET to provide and promote educational support and resources for all Aboriginal children in out-of-home care that are linked to their individual education plans, to help them reach excellence in education potential.

8.12 DET and DHHS, in collaboration with the ACF, to review and refresh the *Out-of-home care education commitment: A partnering agreement*[11] and the complementary *Early Childhood Agreement for Children in Out-of-Home Care*[12] to ensure that pre-school-aged children in out-of-home care who attend kindergarten are also afforded individual education plans and student support groups to ensure the best chance of educational engagement, achievement and leaving care.

8.13 DHHS to ensure all Aboriginal children approaching leaving care are provided with targeted funding packages to ensure they can attain independence.

DHHS to provide quarterly data to the ACF detailing the number of Aboriginal children leaving care, the number of targeted care packages provided and the net value of the care packages per child.

11 Department of Education and Early Childhood Development and the Department of Human Services, *Out-of-home care education commitment: A partnering agreement* (Melbourne: State of Victoria, 2011).

12 Department of Education and Early Childhood Development, *Early Childhood Agreement for Children in Out-of-Home Care* (Melbourne: State of Victoria, 2014).

9. A stronger, more collaborative service system will benefit Aboriginal children in out-of-home care.

9.1 DHHS to establish and maintain the network of area groups with statewide standards, protocols, reporting mechanisms and governance arrangements to develop and progress the work of Taskforce 1000. Each area group should:

- meet, at a minimum, on a quarterly basis to monitor implementation of the area action plans to improve outcomes for Aboriginal children in out-of-home care
- be co-chaired by the DHHS Area Director and ACCO representative
- develop a scorecard to measure progress of area action plan targets, as developed by the area group
- report progression of area action plans to the ACF on a quarterly basis
- ensure that ACCOs in each area are involved in the monitoring, evaluation and redesign of each of the area action plans so that they are reflective of the community's needs and to promote self-determination.

Membership and governance of these groups to be positioned at an executive level and include all government agencies, ACCOs and CSOs involved with Aboriginal children in out-of-home care.

9.2 DHHS to commit recurrent funding to translate the status of all Taskforce 1000 area coordinator positions to be ongoing and provide the necessary resources for project delivery.

9.3 Additional recurrent funding to be provided by government to the Commission to enable ongoing monitoring of Aboriginal children in out-of-home care in a collegiate and place-based approach, similar to Taskforce 1000 area panels (as described in recommendation 9.4).

9.4 Commencing in 2016–17, the Commission will initiate an inquiry that will review the circumstances of at least 10 per cent of Aboriginal children in out-of-home care to evaluate the services provided, or omitted to be provided, to them. This inquiry will be undertaken in partnership with DHHS, CSOs and ACCOs and other relevant government departments, utilising the Taskforce 1000 processes where appropriate.

9.5 DHHS, ACCOs and CSOs involved in out-of-home care services for Aboriginal children to develop an exchange program for Aboriginal staff to promote cultural competency and skills development, and build management capacity.

9.6 VACCA and ACCOs are strongly encouraged to consider co-location opportunities for staff in regional Victoria, along with regular joint training to promote closer working relationships, improved information exchange and improved outcomes for Aboriginal children in out-of-home care.

9.7 Relevant government agencies to develop processes to enable sharing of information relevant to the wellbeing of an Aboriginal child in out-of-home care and their family, to enable integrated case management.

Integrated case management for Aboriginal families to be considered where multiple government departments are involved with a family. Government agencies must work collaboratively to address intergenerational disadvantage and trauma.

Introduction

Most Victorian Aboriginal children are cared for in loving families, where they are cherished, protected and nurtured, where their connection to community and culture is strong, their Koori identity is affirmed and they are thriving, empowered and safe.

This report, however, is about the ever-growing number of Victorian Aboriginal children who come to the attention of child protection services and find themselves placed in out-of-home care. Aboriginal children in Victoria are 12.9 times more likely than non-Aboriginal children to be placed in out-of-home care.[13] As at 30 June 2015, there were 8,567 Victorian children in out-of-home care and 1,511 (17.6 per cent) of these children were known to be Aboriginal.[14] Considering Aboriginal children comprise only 1.6 per cent of all children in Victoria, this over-representation is cause for grave concern.

In 2013, peak Aboriginal and community service organisations warned the Victorian Government that the rate of Aboriginal child removal in Victoria was exceeding levels seen at any time since white invasion. The rate was amongst the highest in Australia and significantly higher than comparable international jurisdictions. Further, they warned that, for those Aboriginal children in out-of-home care, there was clear non-compliance with statutory requirements for their cultural safety.[15]

Reasons for the over-representation of Aboriginal children in the out-of-home care system have been well documented by many previous inquiries. A history of separation from community, family, land and culture has left a legacy of disempowerment and trauma. In turn, a negative impact on family stability, early childhood health, education and wellbeing has resulted.

Wellbeing outcomes for many Aboriginal people in 2016 in Australia remain poor. Aboriginal people still experience shorter life expectancy, are over-represented in the criminal justice system, have higher rates of infant mortality, higher rates of disability, poorer health and lower levels of education and employment than non-Aboriginal Australians.[16] Action by successive governments has been slow to effect real and sustainable change.

In 2008, the Australian Government delivered the long-awaited Apology to Australia's Indigenous peoples:

> 'That today we honour the Indigenous peoples of this land, the oldest continuing cultures in human history. We reflect on their past mistreatment. We reflect in particular on the mistreatment of those who were Stolen Generations – this blemished chapter in our nation's history. The time has now come for the nation to turn a new page in Australia's history by righting the wrongs of the past and so moving forward with confidence to the future. We apologise for the laws and policies of successive parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians. We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country.'
>
> Kevin Rudd, MP (Prime Minister). *Apology to Australia's Indigenous Peoples*[17]

The Apology referenced a 'blemished chapter in our history', yet it will be evident in this Inquiry report that the chapter has not closed, that future blemished chapters are still being written and that significant systemic reform is still needed.

The grief, suffering and loss experienced by the Stolen Generations continue to have enduring relevance today. '[M]oving forward with confidence to the future' remains an ideal yet to be attained, but it is one that we must endeavour to achieve.

Continuing reformist action by government and community services is urgently needed to mitigate the drivers for entry to out-of-home care and improve the experiences of Aboriginal children in care, to ensure that their cultural safety is the centrepiece for all decision-making and action.

13 Australian Institute of Health and Welfare, *Child protection Australia 2014–15*, Child welfare series no. 63 (Canberra: Australian Institute of Health and Welfare, 2016).

14 Ibid.

15 Victorian Aboriginal Community Controlled Organisations and Community Service Organisations (joint submission), *Koorie kids: Growing strong in their culture: Five year plan for Aboriginal children in out-of-home care* (Melbourne: VACCO, 2013).

16 Department of the Prime Minister and Cabinet, *Closing the gap: Prime Minister's report 2016* (Canberra: Department of the Prime Minister and Cabinet, 2016).

17 Commonwealth of Australia, *Parliamentary debates*, House of Representatives, 13 February 2008.

About this Inquiry

1. The systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria was initiated to enable the Commission to effectively fulfil its role in co-chairing Taskforce 1000.

2. In 2014, the former Department of Human Services,[18] in collaboration with the Commission, commenced an 18-month project known as Taskforce 1000. The purpose of Taskforce 1000 was to critically review the case plans and circumstances of almost 1,000 Aboriginal children in out-of-home care in Victoria and to look at opportunities to review and improve practice.

3. Significant barriers were apparent from the onset of Taskforce 1000 panels, which precluded the Commissioner for Aboriginal Children and Young People being able to effectively participate in the process and assist in creating positive change for the children being reviewed. Due to limitations in the Commission's legislative powers, identifying information about the children could not be provided by the former DHS to the Commission, despite the Commission's clear mandate for monitoring and oversight of vulnerable Victorian children.

4. To ensure that the Commission could fully participate in leading Taskforce 1000, it was determined that an inquiry be established. This Inquiry was established by the former Principal Commissioner for Children and Young People, Mr Bernie Geary, on 15 August 2014.

5. This Inquiry draws largely on the findings of Taskforce 1000 as a strong evidence base to generate widespread reform to the way child protection and out-of-home care are delivered to Aboriginal children in Victoria. Other sources of data and evidence available through the monitoring and inquiry functions of the Commission have also informed the findings and recommendations in this report.

18 On 1 January 2015, the Victorian Government established the Department of Health and Human Services, bringing together the former Department of Health, Department of Human Services and Sport and Recreation Victoria.

Role of the Commission for Children and Young People

6. The CCYP Act provides the legislative mandate for the operation of the Commission.

7. The Commission comprises the Principal Commissioner for Children and Young People, Ms Liana Buchanan, and the Commissioner for Aboriginal Children and Young People, Mr Andrew Jackomos PSM.

8. The Commission is an independent statutory body established to promote improvement and innovation in policies and practices relating to the safety and wellbeing of Victorian children and young people, with a particular focus on vulnerable children and young people.

9. The Commission achieves this mandate through:

- providing independent oversight of services for children and young people, particularly those in out-of-home care, child protection and youth justice
- advocating for improved policy, program and service responses to children and young people
- supporting organisations that work with children and young people to prevent abuse and ensuring these organisations have child-safe practices
- bringing the experiences of children and young people to the attention of government and the community
- promoting the rights, safety and wellbeing of children and young people.

1. Background

1.1 Census data

10. Historical records estimate that between 20,000 and 60,000 Aboriginal people lived in what is now known as Victoria at the time of European invasion in 1835.[19] The Victorian Aboriginal population was rich and diverse, with over 30 different languages[20] spoken within numerous distinct but strongly related communities, each bound by family, tradition, land and spiritual ancestors. Invasion resulted in the devastating loss of lives, tradition and language for Aboriginal people.

11. The most recent census data available estimated that as at 30 June 2011, there were 47,333 Aboriginal and/or Torres Strait Islander people living in Victoria, making up 0.9 per cent of the population.[21] Nationally, Aboriginal and Torres Strait Islander people comprise 3 per cent of the Australian population.

12. The 2011 census also reported that 47.4 per cent of the Victorian Aboriginal population resides in greater Melbourne.[22] There is great diversity within the Victorian Aboriginal population, with numerous language groups and communities.

13. Census data indicates that the Victorian population of Aboriginal people is a young and growing one. This is explained by high birth rates, migration to Victoria and increasing rates of identification. Population growth between 2006 and 2011 translates to an annual increase in the Victorian Aboriginal population of 5.8 per cent, contrasted with a 1.4 per cent increase in the non-Aboriginal population over the same period.[23]

14. Disadvantage is a reality for many Aboriginal families. Census data in 2011 illustrated the socioeconomic inequity experienced by Aboriginal people in Victoria. Statistics indicated that for Victorian Aboriginal people:

    - the personal weekly average income is $172 less than for non-Aboriginal people
    - the average weekly household income is $256 less than for non-Aboriginal households
    - the average household occupancy is greater than non-Aboriginal households
    - they are less likely to attain Year 12 or equivalent or be tertiary educated than non-Aboriginal people.[24]

15. The 2011 census data reported that the median age for Victorian Aboriginal people was 22 years of age, compared with 37 years of age for non-Aboriginal Victorians. More than half were less than 25 years old. Only 4.35 per cent of Victorian Aboriginal people were over 65 years old, compared to 14.2 per cent of the non-Aboriginal Victorian population.

16. These statistics highlight the higher birth rates for the Victorian Aboriginal population and the reduced life expectancy for Victorian Aboriginal people. These are issues that are replicated in other jurisdictions in Australia.

19 Department of Premier and Cabinet, *The Kulin people of central Victoria*, http://www.dpc.vic.gov.au/index.php/25-aboriginal-affairs?start=9, accessed 20 July 2016.

20 See Appendix 3. Victorian Aboriginal Corporation for Languages, *Aboriginal languages of Victoria*, <http://www.vaclang.org.au/Resources/maps.html>, accessed 20 July 2016.

21 Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, cat. no. 3238.0.55.001, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>, accessed 20 July 2016.

22 Australian Bureau of Statistics, *Census of population and housing – Counts of Aboriginal and Torres Strait Islander Australians, 2011*, cat. no. 2075.0, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/2075.0>, accessed 20 July 2016.

23 Department of Planning and Community Development, *Victorian Aboriginal Affairs framework 2013–2018* (Melbourne: Department of Planning and Community Development, 2012).

24 Australian Bureau of Statistics, *Census of population and housing – Counts of Aboriginal and Torres Strait Islander Australians, 2011*.

1.2 Aboriginal children receiving child protection services in Victoria

17. National child protection data is reported annually by the AIHW. As at 30 June 2015, there were 1,272,576 non-Aboriginal children in Victoria. Of those, 29,194 (2.3 per cent) were receiving child protection services. This is consistent with national figures for non-Aboriginal children receiving child protection services.[25]

18. Compared with national data, the situation for many Aboriginal children in Victoria is poorer. As at 30 June 2015, there were 21,146 Aboriginal children in Victoria, and of those, 4,109 were receiving child protection services. This translates to 19 per cent of all Victorian Aboriginal children receiving child protection services. This is higher than the national figure of 14.5 per cent.[26]

1.3 Aboriginal children in out-of-home care in Victoria

19. In Victoria, out-of-home care is provided to children and young people by DHHS, ACCOs and CSOs in situations where it is unsafe for the child to remain in the family home due to risk of harm. Most children placed in out-of-home care are subject to a Children's Court order at the instigation of DHHS child protection. In limited circumstances, children are placed in out-of-home care by way of a voluntary child care agreement whereby the parent acknowledges the risks and is willing to engage with child protection to address the issues at hand.

20. Children who enter out-of-home care in Victoria are placed in one of the following placement types:

- kinship care (placement within the child's family network)
- kith care (placement within the child's social network)
- home-based care
- residential care
- lead tenant.

21. As at 30 June 2015, there were 8,567 children in out-of-home care in Victoria, with 17.6 per cent of children (1,511 children) identified as Aboriginal and 82.2 per cent (7,049) non-Aboriginal children.[27]

22. Data reported in the 2014–15 AIHW report indicated that, nationally, Aboriginal children were 9.5 times more likely than non-Aboriginal children to be in out-of-home care. In Victoria the figures were even higher; the rate of Aboriginal children in out-of-home care was 12.9 times higher than that for non-Aboriginal children.[28]

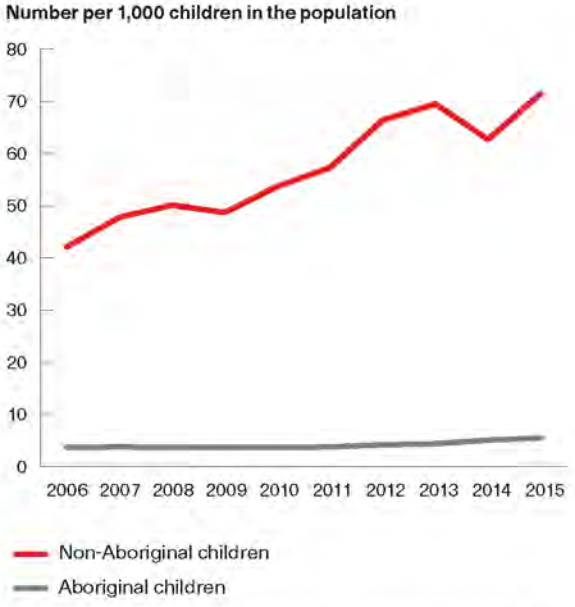
Aboriginal children in Victoria are

12.9 times more likely

to be in out-of-home care than non-Aboriginal children

23. Not only are Aboriginal children over-represented in out-of-home care, the growth rate over the past 10 years for entry to care is greatly exceeding rates for non-Aboriginal children, as shown in Figure 1. From 2006 to 2015, there was a 70 per cent increase in the number of Aboriginal children in out-of-home care in Victoria (from 42.1 to 71.5 per 1,000 children in the population).

Figure 1: Children (0–17 years of age) in out-of-home care in Victoria, by Aboriginal status, 30 June 2006 to 30 June 2015



Source: Australian Institute of Health and Welfare, *Child protection Australia 2005–06, 2006–07, 2007–08, 2008–09, 2009–2010, 2010–11, 2011–12, 2012–13, 2013–14, 2014–15.*

25 'Child protection services' refers to all phases from investigation from out-of-home care to protection orders. Australian Institute of Health and Welfare, *Child protection Australia 2014–15.*

26 Ibid.

27 Aboriginal status for seven children was recorded as 'unknown'. Ibid.

28 Ibid.

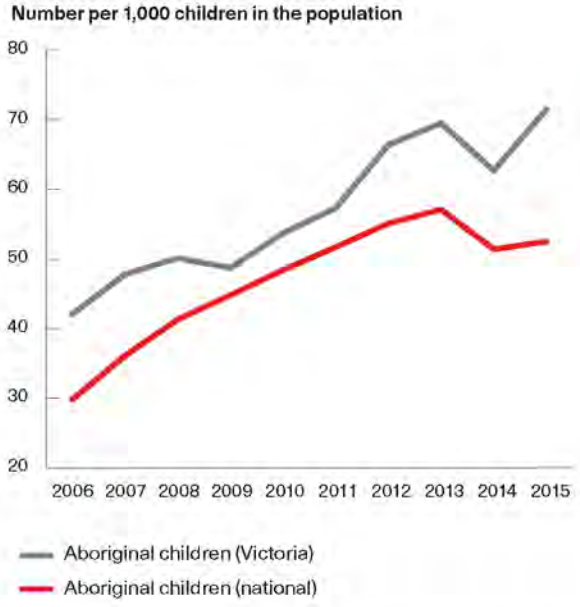
24. While these trends are evident across Australia, the rate of Aboriginal children placed in out-of-home care in Victoria is greatly surpassing national figures, as illustrated in Table 1 and Figure 2.

Table 1: Children (0–17 years of age) in out-of-home care in Victoria and nationally, by Aboriginal status, 2006–15

	Aboriginal children	Non-Aboriginal children
Victoria		
2006	42.1 per 1,000	3.7 per 1,000
2015	71.5 per 1,000	5.5 per 1,000
Nationally		
2006	29.8 per 1,000	4.1 per 1,000
2015	52.5 per 1,000	5.5 per 1,000

Source: Australian Institute of Health and Welfare, *Child protection Australia 2005–06, 2014–15*.

Figure 2: Aboriginal children (0–17 years of age) in out-of-home care in Victoria and nationally, 30 June 2006 to 30 June 2015



Source: Australian Institute of Health and Welfare, *Child protection Australia 2005–06, 2006–07, 2007–08, 2008–09, 2009–2010, 2010–11, 2011–12, 2012–13, 2013–14, 2014–15*.

25. These statistics indicate that there are grave and complex issues in Victoria that need to be overcome for a growing number of vulnerable Aboriginal children. Solutions will require sustained and collaborative attention, systemic transformation and new approaches to the delivery of services for vulnerable Aboriginal children.

26. Reducing the number of Aboriginal children in out-of-home care must be a key priority for government, funded agencies and the community. The Commission considers that dedicated effort must be directed towards addressing the drivers for children's entry to care, particularly the high rates of family violence combined with parental alcohol and drug use that see many children subjected to sexual abuse, physical abuse and trauma. This effort must occur concurrently with greater investment in culturally appropriate early years programs and services to strengthen families and create safe, nurturing environments in which Aboriginal children can grow.

27. The Commission recommends that DHHS, in partnership with the ACF, develops a suite of KPIs to reduce the number of Aboriginal children entering out-of-home care to the same rate as non-Aboriginal children. This data should be reported by DHHS to the ACF and the Commission on a quarterly basis and published in DHHS's annual report.

1.4 Key Victorian inquiries

28. Specific scrutiny about the experience of Aboriginal children within the child protection system has only occurred recently. Other than this Inquiry, there has been only one other inquiry, also conducted by the Commission, which has dealt specifically with the experiences of vulnerable Aboriginal children within the child protection system.[29]

29. A number of major inquiries over the past 10 years have focused more generally on child protection services provided to all vulnerable children in Victoria.

30. There have been consistent findings in these previous inquiries of serious performance and accountability issues, along with issues of inadequate safety for children in care, poor responses to children at risk and the need for major systemic change to better care for and protect our most vulnerable children.

29 Commission for Children and Young People, *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria* (Melbourne: Commission for Children and Young People, 2016). This report was tabled in the Victorian Parliament in October 2016.

1. Background

31. The 2012 Victoria's Vulnerable Children Inquiry was a substantial systemic review of the child protection system, resulting in the call for major change to the service delivery of child protection in Victoria.[30] Ninety recommendations were made including a call for reform to legislation, the Children's Court, regulation and monitoring of services and building workforce capacity and the need for additional programs and services for vulnerable families, children and young people. A whole-of-government strategy was suggested to collaboratively target vulnerability across the service system spectrum, from early intervention services through to tertiary services. A key component of the report was the emphasis on the need for services to be planned, designed and delivered at a local area base.

32. Since 2009, the Victorian Ombudsman has conducted three inquiries pertaining to child protection.[31] The inquiries have included those related to out-of-home care, child protection services in general and child protection service delivery issues in specific localities of the state. It is disappointing that the non-compliance with practice instructions for Aboriginal children, and poor cultural regard that were identified and reported in these inquiries continue to be evident in 2016.

33. There have been three Victorian Auditor-General audits of relevance to this Inquiry: one relating to residential care services for Victorian children, and two relating to service access for vulnerable people. Common themes evident in the audit reports are poor oversight by DHHS in provision of services, lack of program compliance and accountability, and poor outcomes for service users.

34. The Royal Commission into Family Violence was established in February 2015 and reported to the Victorian Parliament in March 2016. The Royal Commission heard evidence from 220 victims and produced a report containing 227 recommendations, which the Victorian Government accepted and agreed to implement.

35. Many of the findings and recommendations have relevance to this Inquiry as they relate to vulnerable children, with Aboriginal children and their families specifically considered by the Royal Commission. The Royal Commission reported that family violence is a leading contributor to Aboriginal child removal, homelessness, poverty, poor physical and mental health, drug and alcohol use and incarceration.[32]

36. The Commission has welcomed the Royal Commission's report, its considered evidence and findings, particularly the concerted focus on the specific and unique issues that pertain to Aboriginal children and their families. Further discussion about the findings and implications for practice are contained in Chapter 4 of this Inquiry report.

37. The Commission's 2015 report *"...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or exploitation whilst residing in residential care* revealed numerous systemic inadequacies in the present system of residential care in Victoria. This inquiry into residential care services arose following detection by the Commission of an increase in reports of alleged sexual harm of children who were placed in residential care.[33] The Commission found that the residential care system in Victoria offers poor cultural safety for Aboriginal children and contributes to their isolation from community and culture. This is exacerbated by Aboriginal children being accommodated in facilities managed and staffed by non-Aboriginal people and organisations, who often have limited cultural training or awareness.[34]

38. In 2014, the Commission commenced an examination of the rate of compliance with and systemic barriers to implementing the ACPP, through an inquiry into compliance with the Aboriginal Child Placement Principle in Victoria.[35] The inquiry report, *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*, was tabled in the Victorian parliament in October 2016.

39. Although strong compliance with the legislative requirements of the ACPP was evident within the written DHHS policy and practice guidelines, there was clear evidence of poor translation to practice, with partial to minimal compliance evident across the following domains:

    - identification of Aboriginality at the completion of the investigation phase
    - consultation with ACSASS at every significant decision point
    - ensuring an AFLDM conference was convened at the point of substantiation and issuing of a protection order
    - evidence that the child was placed at the highest possible level of the ACPP hierarchy
    - completion of a cultural support plan.

30 Cummins, P, Scott D and Scales, B, *Report of the Protecting Victoria's Vulnerable Children Inquiry: Volume 1* (Melbourne: Department of Premier and Cabinet, 2012).

31 Ombudsman Victoria, *Own motion investigation into the Department of Human Services child protection program* (Melbourne: Ombudsman Victoria, 2009); Ombudsman Victoria, *Own motion investigation into child protection – out of home care* (Melbourne: Ombudsman Victoria, 2010); Ombudsman Victoria, *Investigation regarding the Department of Human Services child protection program (Loddon Mallee Region)* (Melbourne: Ombudsman Victoria, 2011).

32 State of Victoria, *Royal Commission into Family Violence: Report and recommendations*, Vol V, Parl Paper No. 132 (Melbourne: State of Victoria, 2016).

33 Commission for Children and Young People, *"...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care* (Melbourne: Commission for Children and Young People, 2015).

34 Ibid.

35 Commission for Children and Young People, *In the child's best interests*.

40. The inquiry report, *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*, details a number of systemic barriers to the implementation of the ACPP including the insufficient capacity and funding of agencies, inadequacy of legislation in articulating the intent of the ACPP, inadequacy of policy and practice guides, insufficient number of Aboriginal carers, poor workforce cultural proficiency within child protection that fails to prioritise cultural connectedness, and deficits in the oversight and accountability by DHHS. Over 50 recommendations for systemic change were made and accepted in principle by the Victorian Government.

1.5 Victorian initiatives

1.5.1 Victorian Aboriginal Children and Young People's Alliance

41. The Alliance was formed in 2014 and comprises 13 ACCOs from around Victoria that are funded by DHHS to provide family and children's services and out-of-home care services for Aboriginal children. The Alliance has a collective voice in advocating for and positively influencing the future for Aboriginal children and young people.

42. The Alliance has developed a three-year strategic plan that aims to address many systemic issues facing Aboriginal children in out-of-home care. Eight key priorities were set and progress is underway in implementing these – most notably, the establishment of the Aboriginal Children's Forum in mid-2015. Progress continues with other key strategies, including a strong focus on improving the cultural safety of children in out-of-home care, and transitioning case management of Aboriginal children to ACCOs.

1.5.2 Aboriginal Children's Forum

43. The ACF was established in June 2015 by the Victorian Government in response to the significant over-representation of Aboriginal children in Victoria's child protection system. The ACF's intention is to build the capacity of Aboriginal organisations to shape practices and policies in order to promote stronger Aboriginal families so children can thrive.

44. The ACF meets quarterly throughout Victoria and is co-chaired by the CEO of a local ACCO and the Minister for Families and Children or the Secretary of DHHS. Membership includes CEOs of ACCOs and CSOs that provide services for Aboriginal children and government representatives.

45. At a summit in August 2015, eight key priority issues were devised to guide the future work of the ACF. These included the need to:

- develop an outcomes framework inclusive of cultural needs and rights of Aboriginal children in out-of-home care
- build the life skills and cultural identity of Aboriginal children and young people in out-of-home care in readiness for family reunion, leaving care and ensuring successful transition to adulthood
- build the capacity of Aboriginal families, communities, ACCOs and the sector to care for their children and young people
- place all Aboriginal children and young people in out-of-home care under the authority, care and case management of an ACCO
- ensure every Aboriginal child and family has full access to a continuum of prevention, early intervention and placement services delivered through the ACCO sector
- better support Aboriginal and non-Aboriginal carers to provide culturally competent placements and maintain and grow the pool of Aboriginal carers
- ensure compliance with the CYFA 2005 as it relates to Aboriginal children and make recommendations to strengthen that Act
- ensure Aboriginal families and children have access to an accountable universal service system that supports the needs of Aboriginal children in out-of-home care.[38]

46. The Commission considers that the ACF has a crucial and pivotal role in advocating for self-determination and in bringing together government and community to provide policy direction and to monitor the implementation and accountability of outcomes for Aboriginal children in out-of-home care. The ACF is well placed to oversee many of the recommendations of this Inquiry.

38 Department of Health and Human Services, *Aboriginal Children's Summit Communique*, 13–14 August 2015, <http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/aboriginal-childrens-summit-and-ongoing-forums>, accessed 20 July 2016.

1.5.3 Roadmap for Reform

47. The Victorian Government announced the Roadmap for Reform in April 2016, setting an agenda to 'shift from crisis response, to prevention and early intervention'. Allocation of $168 million was announced for these initiatives, with $16.48 million over two years allocated specifically for improved outcomes for Aboriginal children in out-of-home care.

48. The Roadmap for Reform acknowledges the systemic issues and need for early intervention that has repeatedly been identified through recent Victorian inquiries, including the Commission's *"...as a good parent would..."* inquiry into residential care, the Royal Commission into Family Violence, VAGO inquiries and Victoria's Vulnerable Children's Inquiry.

49. The Commission welcomes these initial announcements and commitment by government for greater focus on early intervention and attention to the cultural safety needs for Aboriginal children and families and the commitment to the principle of Aboriginal self-determination in the Roadmap for Reform agenda.

50. The Commission considers that it is critically important that government ensures that case management transfer, decision-making and placement of Aboriginal children shift from mainstream services to ACCOs. Also of critical importance is the need for a culturally rich and competent workforce across the welfare sector. These are important first steps in creating much needed change; however, there is much more that can and should be done, which will be outlined in further sections of this report.

1.6 Key national inquiries relating to Aboriginal people

51. An examination of two key national inquiries follows: the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, and the Royal Commission into Aboriginal Deaths in Custody.

1.6.1 Royal Commission into Aboriginal Deaths in Custody

52. These inquiries, now over two decades old, continue to have lasting relevance today. Many of the systemic findings continue to be observed in our current approaches to child welfare, policies and practices regarding Aboriginal people. Progress by successive governments has been poor in addressing disadvantage and effecting change.

53. In August 1987, the RCIADIC was established to investigate the deaths of 99 Aboriginal people who died while in police custody or in prison between 1 January 1980 and 31 May 1989. There was community concern about the large number of deaths and the accompanying poor explanations for their occurrence. The final report was delivered in 1991, and 339 recommendations were made.

54. The recommendations focused on the adequacy of the police and coronial responses to deaths in custody; the provision of educational, vocational and legal services for Aboriginal youth; cultural diversity and the need for culturally sensitive practices to be embedded throughout the service system; managing alcohol and substance abuse; improving police relations with and treatment of Aboriginal people; improving custodial care; and the continued recognition of the importance of reconciliation.

55. The RCIADIC found that Aboriginal people did not die at a higher rate than non-Aboriginal people in custody; however, Aboriginal people were found to be significantly over-represented in all forms of custody. What the RCIADIC did find was that 66 of the 99 deaths were Aboriginal people who had been removed as children from their family, community and culture.

56. Accountability for the implementation of the recommendations of the RCIADIC has been poor. The RCIADIC was a Commonwealth undertaking, yet the recommendations were directed at state and territory governments to implement operational changes. In 2005, the Victorian Aboriginal Justice Forum completed an implementation review of the RCIADIC recommendations. This was followed in 2015, with the *Review of the Implementation of RCIADIC, May 2015*, commissioned by Amnesty International Australia, which found that Victoria had implemented only 27 of the recommendations made by the RCIADIC.

1.6.2 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families

57. In August 1995, the Australian Government commissioned the Commonwealth Human Rights and Equal Opportunity Commission to conduct a national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. The inquiry was led by the late Sir Ronald Wilson and Professor Mick Dodson, who was at that time the Aboriginal and Torres Strait Islander Social Justice Commissioner. Undertaking an extensive program of hearings across the country, nearly 800 submissions were received by the inquiry. The majority of submissions came from Aboriginal individuals and groups, as well as government and church organisations.

58. The landmark *Bringing them home* report documented the findings of the inquiry into the separation of Aboriginal and Torres Strait Islander children from their families.[37] The report found that the laws, policies and practices that separated children from their families have contributed directly to the alienation of Aboriginal societies today.

59. The report poignantly documented the distress, trauma and abuse suffered by generations of Aboriginal people. It acknowledged their grief, their loss and the pervading harm and disadvantage that have rippled through generations of families as a consequence. It found that children's experiences of forcible removal and of being placed in 'care' adversely impacted on their wellbeing and development.

60. For over 130 years, from 1835 to 1970, it is estimated that tens of thousands of Aboriginal children, now known as the Stolen Generations, were removed from their families and raised in institutions or with non-Aboriginal families simply because of race.[38]

'The impact of invasion and colonisation forever changed the lives of Aboriginal children, their families and communities.'[39]

61. *Bringing them home* provided an analysis of the history of forcible removals of successive governments and revealed the intergenerational impact of these policies on families and community. The report highlighted that entrenched disadvantage and dispossession have resulted in the continued removal of Aboriginal children from their families today, and also that Aboriginal children in out-of-home care are more likely to come into contact with the juvenile justice system.

62. It was commonplace that children of the Stolen Generations experienced multiple placements and total separation from their family, community, culture and language. Conditions in many of the institutions were harsh, punitive and often abusive. Many adult survivors reported experiencing racial hatred and vilification. There was widespread physical and sexual abuse of many children in institutional and other forms of 'care'.

63. Fifty-four recommendations were made in the *Bringing them home* report. They focused on the need for extensive reparation to be made to the Stolen Generations, program and service responses, and the need for a new framework to promote the wellbeing of Aboriginal children based on self-determination.

64. The NSDC was formed in 1998 in response to the tabling of the *Bringing them home* report. The NSDC has produced periodic scorecards regarding the progress by government in implementing the recommendations of *Bringing them home*. The most recent scorecard found that only 13 of the 54 recommendations have been implemented.[40]

1.7 National initiatives

1.7.1 Close the Gap

65. Close the Gap is a national campaign that was launched in 2006 by peak Australian Aboriginal bodies, non-government organisations and human rights organisations. Close the Gap aims to close the health and life expectancy gap between Aboriginal and non-Aboriginal Australians within a generation, by 2031.[41]

66. The campaign has shaped government policy and led to the setting of Close the Gap targets through COAG and the issuing of a Statement of Intent, to achieve equality in health status and life expectancy for Aboriginal and Torres Strait Islander peoples.[42]

67. In 2008, COAG set the following Close the Gap targets:

- the achievement of Aboriginal and Torres Strait Islander health equality within a generation by 2031
- ensuring access to early childhood education for all Aboriginal four year olds in remote communities by 2013
- halving the gap in reading, writing and numeracy achievements for children by 2018
- halving the mortality rate for children under five years by 2018
- halving the gap for Year 12 attainment rates in Aboriginal students by 2020
- halving the gap in employment outcomes between Aboriginal and non-Aboriginal Australians within a decade by 2018.

37. Commonwealth of Australia, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Sydney: Human Rights and Equal Opportunity Commission, 1997).

38. Cummins, P, Scott, D and Scales, B, *Report of the Protecting Victoria's Vulnerable Children Inquiry: Volume 1.*

39. Frankland, R, Bamblett, M and Lewis, P, 'Forever business: A framework for maintaining and restoring cultural safety in Victoria', *Indigenous Law Bulletin*, 7/24 (2011), pp. 27–30.

40. Refer to Appendix 6 for further information about the 2015 NSDC scorecard.

41. For more information about the Close the Gap campaign, visit the Australian Human Rights Commission website at <www.humanrights.gov.au>.

42. Human Rights and Equal Opportunity Commission, *Close the Gap: Indigenous health equality summit, statement of intent* (Canberra: Human Rights and Equal Opportunity Commission, 2008).

68. Progress on achieving the set targets has been slow. The most recent *Progress and priorities report 2016* by the Close the Gap Steering Committee notes that there have been small gains in life expectancy for Australia's Aboriginal population, with gains of 1.6 years for males and 0.6 years for females from 2005–07 to 2010–12 noted. However, a life expectancy gap of approximately 10 years remains for Aboriginal people compared to non-Aboriginal Australians.[43]

69. The *Progress and priorities report 2016* informs that Aboriginal people experience a mortality rate that is 1.7 higher than that for non-Aboriginal Australians. Some progress has been made in the death rate of certain diseases, namely respiratory and circulatory diseases. However, further improvement is needed to address the higher rates of avoidable deaths through early detection and timely, effective healthcare. Some of the identified barriers in achieving this have included access to and uptake of treatment, language barriers and institutional racism.[44]

70. National improvements have been noted in the mortality rate for children between 1998 and 2013. There has been a 64 per cent decline in the mortality rate for children under one year old and a 31 per cent decline in the mortality rate for children 0–4 years old.[45]

71. Further effort is required to address the higher rates of low birth weight babies being born in the Aboriginal population, to reduce smoking during pregnancy and increase education and awareness of the dangers of alcohol use during pregnancy. Additionally, improved access to and engagement with antenatal care for expectant mothers is identified as a key challenge.[46]

72. Child protection measurements are not included in Close the Gap targets. This is a limitation given the high over-representation of Aboriginal children in the child protection and out-of-home care systems throughout Australia. A national campaign to reduce these numbers and address the precipitating causes is considered important to support and enable state-based initiatives.

73. The Commission has recommended that government advocates through COAG for equity in the number of Aboriginal children in out-of-home care to be included in Close the Gap targets.

1.7.2 National framework for protecting Australia's children 2009–2020

74. On 30 April 2009, COAG endorsed the national framework for protecting Australia's children 2009–2020.[47] The framework was established in response to the growing numbers of children entering the child protection systems in Australia and the need for a coordinated national approach to the problem. Six supporting outcomes were articulated, with one specifically focusing on Aboriginal children: 'Indigenous children are supported and safe in their communities'.

75. While states and territories retain responsibility for child protection services, the national framework aims to improve comparability across jurisdictions, share learning and facilitate evidence-based approaches to service delivery and policies, ultimately leading to a reduction in child abuse and neglect in Australia. A series of three-year action plans work to achieve particular priorities through to 2020, with oversight provided by COAG.

76. Specific priorities for addressing the over-representation of Aboriginal children in the child protection system have been articulated in the first two action plans:[48]

- support Aboriginal community-building activities in areas such as culture and connectedness, strengthening families and communities in targeted areas that put children at risk and speaking up about abuse
- support the education, professional development and retention of the child protection and welfare workforce including a focus on enabling the Aboriginal workforce to be more actively involved in tertiary child protection
- collaborative approaches for child safety and wellbeing for children and their families who move between jurisdictions
- build the capacity of Aboriginal organisations though partnerships with mainstream providers
- nationally consistent reporting of the application of the ACPP
- community mentor programs for Aboriginal children transitioning from out-of-home care
- expand training and support to grandparent and kinship carers
- develop and trial programs to prevent sexual abuse.

43 Holland, C, *Close the Gap: Progress and priorities report 2016* (Sydney: Close the Gap Campaign Steering Committee, 2016).

44 Ibid.

45 Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander health performance framework 2014 report* (Canberra: Australian Health Ministers' Advisory Council, 2015).

46 Holland, C, *Close the Gap: Progress and priorities report 2016*.

47 Commonwealth of Australia, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020* (Canberra, 2009).

48 Commonwealth of Australia, *Protecting children is everyone's business: National framework for protecting Australia's children: Implementing the first three-year action plan 2009–2012* (Canberra, 2009); Commonwealth of Australia, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020 – Second Action Plan 2012–2015* (Canberra, 2012).

77. The third action plan has an overarching focus on the application of the ACPP through the establishment of a working group to provide advice and expertise on the implementation of actions and strategies. The third action plan also has a focus on the first 1,000 days of a child's life to address factors that contribute to vulnerability, particularly mental health, family violence, substance abuse, homelessness and disability. Other areas for action include helping children in out-of-home care to thrive in adulthood, organisational improvements to support best practice on child-safe standards and developing future research and reporting on progress.[49]

78. The national standards for out-of-home care are a set of voluntary national standards published in 2011 that are a priority project under the national framework. Twenty-two national measures have been devised to improve the outcomes and experiences for children in care through focusing on domains of health; education; care planning; connection to family, culture and community; transition from care; training and support for carers; belonging and identity; and safety, stability and security.[50]

49 Commonwealth of Australia, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020: Driving change: intervening early, third three-year action plan, 2015–2018* (Canberra, 2015).

50 Commonwealth of Australia, *An outline of national standards for out-of-home care: A priority project under the national framework for protecting Australia's children 2009–2020* (Canberra, 2011).

2. Legislative requirements

2.1 Charter of Human Rights and Responsibilities Act 2006

Charter of Human Rights and Responsibilities Act 2006
Section 19
Cultural rights:

(1) All persons with a particular cultural, religious, racial or linguistic background must not be denied the right, in community with other persons of that background, to enjoy his or her culture, to declare and practise his or her religion and to use his or her language.

(2) Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community—

(a) to enjoy their identity and culture; and

(b) to maintain and use their language; and

(c) to maintain their kinship ties; and

(d) to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.

79. Cultural rights, including connections to family, kin and community, are rights that are interrelated to, and impact upon, the enjoyment of all human rights. Aboriginal children living in out-of-home care have a fundamental right to preserve their Aboriginal identity. Maintaining identity is about remaining connected to family, extended family, local Aboriginal community, wider community and culture. It is about relationships and rich experiences.

2.2 Children Youth and Families Act 2005

80. The CYFA 2005 provides the legislative basis for government intervention and protection of children who are assessed as being at risk of significant harm within their family, for the provision of community services to support children and families, for the provision of youth justice and for confirming and articulating the role of the Children's Court of Victoria as a specialist court dealing with such matters relating to children.

81. The CYFA 2005 considers the specific rights and needs of Aboriginal children within the child protection and out-of-home care systems in the following sections:

- section 12: Additional decision-making principles
- section 13: Aboriginal Child Placement Principle
- section 14: Further principles for placement of an Aboriginal child
- section 18: Secretary may authorise principal officer of Aboriginal agency to act
- section 176: Cultural support for an Aboriginal child
- section 323: Restrictions on the making of Permanent Care order in respect of an Aboriginal child
- section 332: Internal review – decision of principal officer of Aboriginal agency.

2.3 Additional decision-making principles for Aboriginal children

82. The CYFA 2005 specifies that the best interests of the child must be paramount in any decisions or actions taken in respect of a vulnerable child and that, when determining whether a decision or action is in the best interests of a child, the need to protect the child from harm, to protect the child's rights and promote the child's development must always be considered.

83. In addition to the overarching best interests principles that apply for all children, the CYFA 2005 also provides guidance to DHHS and community services about additional decision-making principles for Aboriginal children. These can broadly be summarised as principles relating to:

- recognition of Aboriginal self-management and self-determination in seeking the views of the Aboriginal community to inform decision-making
- regard to the need to prioritise the placement of an Aboriginal child requiring out-of-home care within a hierarchy, whereby placement with Aboriginal extended family or relatives is the highest order consideration (the ACPP)
- the cultural needs and rights of an Aboriginal child.

2.3.1 The Aboriginal Child Placement Principle

84. The ACPP is a national principle that has been adopted in every Australian jurisdiction and confirmed in legislation. The ACPP arose in Australia in the late 1970s in a time when policy direction in Australia shifted from assimilation to promotion of self-determination and the best interests of children, and was driven by Aboriginal and Torres Strait Islander child care agencies drawing on the experiences of Native Americans.[51]

85. The SNAICC argues that the ACPP is not simply about where or with whom an Aboriginal child is to be placed, but instead it goes further by recognising the expertise of Aboriginal people to make the best decisions concerning Aboriginal children and recognising the importance of maintaining Aboriginal children in their family, community, culture and country.[52]

86. In Victoria, the ACPP is enshrined in Division 4 of the CYFA 2005 by prioritising and specifying the criteria for the placement of Aboriginal children who are unable to remain safely at home.

87. The hierarchy of placement options for Aboriginal children requiring out-of-home care is specified in section 13 of the CYFA 2005 as follows:

    a. within the child's Aboriginal extended family or relatives and, where this is not possible, other extended family or relatives

    b. if, after consultation with the relevant Aboriginal agency, the first option is not possible or feasible, the child may be placed with:

        i. an Aboriginal family from the local community and within close geographical proximity to the child's natural family

        ii. an Aboriginal family from another community

        iii. as a last resort, a non-Aboriginal family living in close proximity to the child's natural family

    c. any non-Aboriginal placement must ensure the maintenance of the child's culture and identity through contact with the child's community.

51 Secretariat of National Aboriginal and Islander Child Care, *Aboriginal and Torres Strait Islander child placement principle: Aims and core elements* (Melbourne: Secretariat of National Aboriginal and Islander Child Care, 2013).

52 Ibid.

2. Legislative requirements

2.3.2 Further principles for the placement of Aboriginal children

88. Section 14 of the CYFA 2005 requires consideration when placing a child of the self-identification and expressed wishes of the child, ensuring that, if a child's parents are from different Aboriginal communities, there is opportunity for continuing contact with the other parent's family, community and culture should the child not be placed with them. In addition, if the child is placed with non-Aboriginal family members, it is specified that arrangements must be made for the child's continuing contact with their Aboriginal family.

2.3.3 Section 18 amendments to the Children Youth and Families Act 2005

89. Self-determination was introduced into the CYFA 2005 through section 18, which empowered Aboriginal agencies to have responsibility for the care and protection of Aboriginal children subject to protection orders. It was envisaged at the time that a phased approach would provide for greater case planning and case management responsibilities for Aboriginal children by Aboriginal agencies.

90. In practice, however, there were impediments to the implementation of section 18 due to a lack of clarity around definitions of the term 'principal officer', limitations in the ability to share information between DHHS and the Aboriginal agency, inability to delegate functions to other suitable employees within the Aboriginal agency and no provision for internal review or external review through the Victorian Civil and Administrative Tribunal relating to any decisions made under section 18. Associated with these impediments were funding and resource issues in progressing work plans.

91. A two-year pilot authorising case management of a small group of children to VACCA under section 18 occurred from 2013 to 2015. The project provided the opportunity to test and refine arrangements required for the implementation of section 18 in an operational context. It facilitated a better understanding of the infrastructure and operating requirements and highlighted areas requiring additional development, capacity building and resource requirement to realise the potential of section 18 provisions.

92. An evaluation reported positive outcomes for the children involved in the VACCA pilot project, highlighting that a small number of them were reunited with their family.[53]

93. Government passed legislation in November 2015 to amend section 18 of the CYFA 2005. These amendments addressed the anomalies by allowing DHHS to authorise the principal officer of an Aboriginal agency to assume responsibility for the welfare of a child subject to a Children's Court protection order, making a provision for internal and external review mechanisms and enabling a person acting as principal officer of an Aboriginal agency to perform the functions of section 18.

94. A further section 18 pilot, by the Bendigo and District Aboriginal Co-operative, commenced in Bendigo in 2016. This pilot targeted children at risk of entering care and those with a plan for family reunion. Mallee District Aboriginal Services has also indicated to the ACF that it is ready to commence a section 18 initiative and is currently awaiting a response from DHHS.

53 Naughton & Co, S 18 *'As if' project evaluation report* (Melbourne: Naughton & Co, 2015).

2.3.4 Cultural support for Aboriginal children

95. Prior to March 2016, section 176 of the CYFA 2005 specified that every child subject to a Guardianship or Long-term Guardianship order was provided by the Secretary of DHHS with a cultural plan. Amendments to the CYFA 2005 from 1 March 2016 saw requirements for cultural planning expanded to include **all** Aboriginal children in out-of-home care. This is a significant acknowledgement of the human and cultural rights of all Aboriginal children in care and the accompanying responsibility of those agencies providing and managing out-of-home care in enabling these rights.

96. As at 30 June 2015, there were 806 Aboriginal children subject to Guardianship orders in Victoria who were within scope of the previous legislative requirements of section 176.[54] Following the legislative amendments, the number of children in scope increased to more than 1,500, as at 30 June 2015.[55]

97. It will be a major challenge for DHHS, ACCOs and CSOs to ensure every Aboriginal child in out-of-home care is provided with a meaningful cultural plan that is relevant to the child's age, development and circumstances. The challenge extends to the need for all cultural plans to have integrity, to be lived and to be reviewed annually for all children and as their circumstances change.

2.3.5 Restrictions on making Permanent Care orders for Aboriginal children

98. Section 323 of the CYFA 2005 requires that the Children's Court must not make a Permanent Care order to place a child in the sole care of a non-Aboriginal person or persons, unless:

- a suitable placement cannot be found with an Aboriginal carer
- the decision to seek the order has been made in consultation with the child, where appropriate
- the Secretary of DHHS has ensured that the proposed order is in accord with the ACPP.

For the court to make a Permanent Care order for an Aboriginal child, there must be:

- a report from an Aboriginal agency that has recommended the order, and
- a cultural plan that has been prepared for the child.

54 Australian Institute of Health and Welfare, *Child protection Australia 2014–15*.

55 The most recent AIHW data indicates that as at 30 June 2015, there were 1,507 Aboriginal children in out-of-home care. Ibid.

3. Learning from Taskforce 1000

Taskforce 1000 reviewed

980

Aboriginal children in out-of-home care

3.1 What was Taskforce 1000?

> 'All Aboriginal children coming into child protection suffer some form of trauma; it is the degree and nature of the trauma that we need to work with to normalise the child's view and perception of self, of relationships of family and of trust.'
>
> Andrew Jackomos PSM
> Commissioner for Aboriginal Children and Young People

99. Taskforce 1000 was an action research project that commenced in mid-2014 and concluded in early 2016. The legacy of Taskforce 1000 continues with each of the 17 DHHS local areas throughout Victoria committing to ongoing practice and systemic improvement through locally based action plans that arose out of the project.[56]

100. A Steering Committee provides oversight of the implementation of the action plans. The Steering Committee meets quarterly, and is made up of the Secretaries of relevant government departments (DHHS, DET and DoJR), the Commissioner for Aboriginal Children and Young People, CEOs of ACCOs and CSOs as well as peak bodies such as VACCHO and the Alliance.

101. DHHS identified that 980 Aboriginal children in out-of-home care were within scope of review for Taskforce 1000 as they were on a child protection order. Children in out-of-home care who were subject to permanent care applications were out of scope for Taskforce 1000.

102. Area panels progressed in three phases throughout Victoria:

- Phase 1 (pilot) – 222 children (July–December 2014) across Inner Gippsland, Mallee, Western Melbourne and Southern Melbourne areas
- Phase 2 – approximately 350 children (April–August 2015) across Inner Eastern and Outer Eastern Melbourne, Central Highlands, Outer Gippsland, Barwon and North Eastern Melbourne areas
- Phase 3 – approximately 450 children (August–December 2015) across Bayside Peninsula, Goulburn, Western District, Brimbank Melton, Loddon, Hume Moreland and Ovens Murray areas.

56 See Appendix 6 for details about core membership of the Taskforce 1000 Steering Committee.

3.2 Demographics

103. Cases and life stories of 980 children were presented to Taskforce 1000 panels. The majority of the children (97.5 per cent) were Aboriginal and a small proportion (less than 2 per cent) were Torres Strait Islander. Boys and girls were almost equal in number and most children (78.4 per cent) were under the age of 12. Table 2 details demographic information for the children reviewed during Taskforce 1000.

Table 2: Gender, age and Aboriginal status of children reviewed during Taskforce 1000

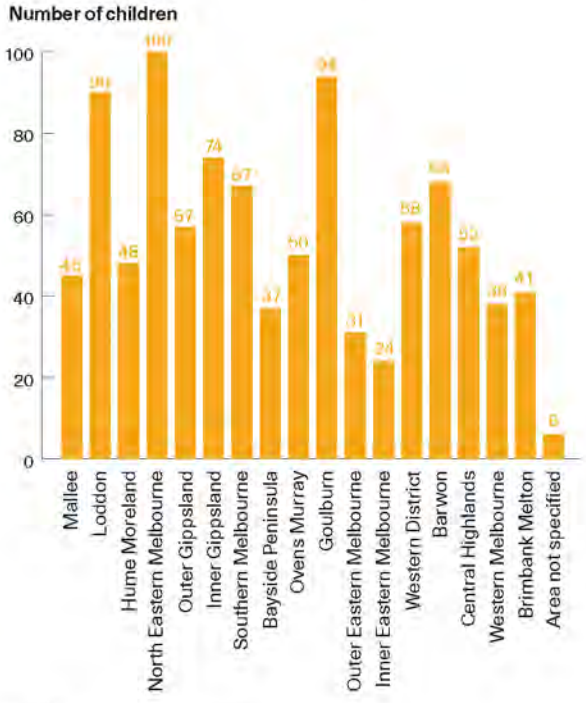
Demographic	Number	Percentage
Aboriginal status		
Aboriginal	955	97.5
TSI	15	1.5
Both	10	1.0
Total	**980**	**100.0**
Gender		
Male	479	48.9
Female	501	51.1
Total	**980**	**100.0**
Age		
0–2 years	139	14.2
3–4 years	120	12.2
5–6 years	140	14.3
7–8 years	131	13.4
9–10 years	122	12.4
11–12 years	117	11.9
13–14 years	96	9.8
15–16 years	85	8.7
17–18 years	30	3.1
Total	**980**	**100.0**

n = 980
Source: Appendix 1, Table A2.

104. DHHS provides service implementation over four divisions (North, South, East and West) across the state. Each division covers rural, outer-metropolitan and inner-metropolitan Victoria. The four divisions each manage resources and oversee operations across a total of 17 different areas.[57]

105. The children who were subject to review in Taskforce 1000 were case managed across each of the four divisions, ranging from 201 children in the East division to 283 children in the North division.[58] As can be seen in Figure 3, the DHHS areas with the highest proportion of children reviewed during Taskforce 1000 were Loddon (9.2 per cent) and North Eastern Melbourne (10.2 per cent) in the North division, followed by Goulburn (9.6 per cent) in the East division.[59]

Figure 3: Children reviewed during Taskforce 1000, by DHHS area



n = 980
Source: Appendix 1, Tables A3–A6.

57 Refer to Appendix 2. Department of Health and Human Services, *Department of Human Services – Areas*, <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0003/836157/DHS_Victoria_Map_Areas-LGAs.pdf>, accessed 20 July 2016.

58 Appendix 1, Table A2.

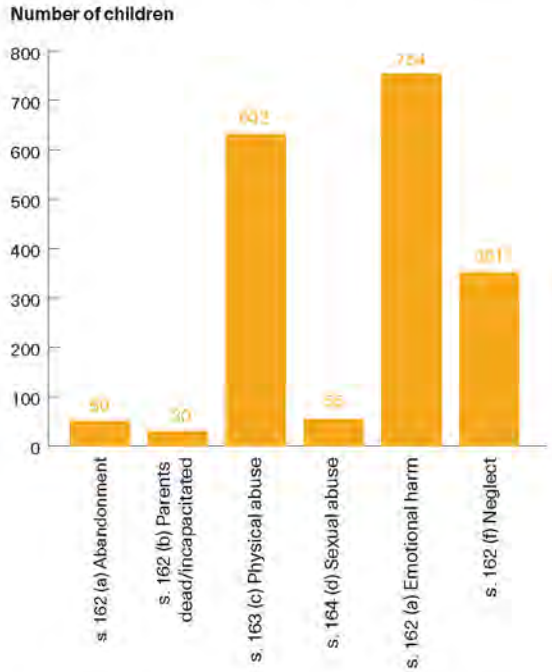
59 Appendix 1, Tables A3, A4, A5 and A6.

3. Learning from Taskforce 1000

106. Information about the Aboriginal status of the children's parents was also sought as part of the Taskforce 1000 project. Across each of the four divisions, there were higher proportions of Aboriginal mothers (69.5 per cent for the total cohort of children) than Aboriginal fathers (55 per cent). Only 9.5 per cent of children had Aboriginal parents from the same Aboriginal community.[80] In practice, this means that service providers must be aware of such diversity and ensure that all relevant Aboriginal communities are consulted and engaged through case planning to ensure relevant and meaningful cultural connection.

107. The most common grounds proven in Protection Applications before the Children's Court for the 980 children reviewed during Taskforce 1000 were grounds of emotional abuse, followed by physical abuse and neglect, as shown in Figure 4.[81]

Figure 4: Proven grounds in Protection Applications for children reviewed during Taskforce 1000



n = 1,372
Source: Appendix 1, Table A16.

108. More than half the children reviewed during Taskforce 1000 were subject to Custody orders, and more than a quarter were subject to Guardianship orders. Table 3 provides a breakdown of the type of protection orders for children reviewed in Taskforce 1000. Amendments to the CYFA 2005 came into effect on 1 March 2016, with a suite of new protection orders that are intended to better reflect case planning requirements and to hasten progress towards achieving permanency for children with the objective of reducing harmful delays experienced by children. The Commission is conducting an inquiry into the impact of these amendments after the first six months of their operation.

Table 3: Type of protection order for children reviewed during Taskforce 1000

Type of protection order	Number
Interim Accommodation order	45
Interim Protection order	32
Supervised Custody order	98
Custody order	510
Custody to Third Party order	11
Guardianship order	259
Long-term Guardianship order	20
Therapeutic Treatment order	1
Blank	4
Total	980

n = 980
Source: Appendix 1, Table A17.

3.3 Preparation for Taskforce 1000 area panels

109. A survey of 168 questions gathered information about each child reviewed during Taskforce 1000. The survey was devised by DHHS with input from the Steering Committee. The survey questions covered a range of broad topics including basic demographic information; issues pertaining to the child's safety, health, disability, wellbeing and education; reasons for entering care; and cultural connection. The survey captured point-in-time information for every child reviewed. The child's DHHS child protection worker completed the survey prior to the child's case being presented and discussed at Taskforce 1000 area panels. The Commission has analysed the survey data for this report.

110. Additionally, a detailed genogram was completed by the DHHS child protection worker, with the assistance of ACCOs, to identify the child's immediate and extended family members, the Aboriginal clan and Country that the respective family members had connection with and the current placement arrangements for the child.

80 Appendix 1, Table A7.

81 Most children had substantiations for more than one type of harm, therefore, the total number of grounds (n = 1,872) is greater than the 980 children reviewed during Taskforce 1000. Section 162 of the CYFA 2005 specifies the grounds for when a child is in need of protection. See Appendix 4 for CYFA 2005, section 162 – When is a child in need of protection?

'The genograms painted a picture of the impact of invasion and colonisation, of intergenerational disengagement and disempowerment. They were critical in understanding how past government policies have impacted on Aboriginal children, their families and community today. Through the genograms, we saw generations of connection with the criminal justice and child protection systems, unemployment, poverty, poor education, high rates of suicide and the over-riding impact of the past impacting on the present.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

111. Data limitations are evident for the Taskforce 1000 survey responses. In particular, it must be noted that the Commission was initially provided with DHHS data that had many incomplete and missing fields that necessitated reissuing of the survey for greater accuracy.

112. Other limitations include:

- reliability issues, which are apparent with a large number of different staff (341 DHHS staff in total) completing the surveys
- the subjective approach to completion of the surveys by the child protection practitioners and reliance on the CRIS child protection record, which was often found to be inaccurate
- data for non-Aboriginal children in out-of-home care that was not obtained, therefore comparative analysis of practice issues in the context of a child's Aboriginal status is not possible
- the survey responses are a 'snapshot in time'
- the survey design offers many free text responses rather than set answers, rendering thematic analysis difficult
- mandatory responses to questions were not required, therefore blank responses were apparent for a number of key questions.

113. Despite the limitations, the data does provide a unique opportunity to extrapolate key issues and themes facing the current cohort of Aboriginal children in out-of-home care in Victoria. An analysis of the data has been completed by the Commission for this Inquiry and is discussed in subsequent sections.

3.4 Taskforce 1000 area panels

114. Area panels were co-chaired by the Commissioner for Aboriginal Children and Young People and the relevant DHHS Area Director. Panel membership included senior representatives from government departments, including DET, DoJR, Victoria Police, ACCOs and CSOs.

115. Each child's case was presented in a de-identified manner to the broader panel, with only the co-chairs being provided with the child's identifying details.[62]

116. The child's DHHS child protection worker provided an oral presentation outlining the child's family background, current care situation, assessment of risk, reasons for entry to care, services involved, case plan and goals for the child. Attention to the child's education, health, wellbeing and cultural connection was addressed in each presentation. Each presentation, including subsequent questions from panel members, took approximately 30 minutes. In many cases the presentation was jointly delivered by the child protection worker with the CSO worker and/or ACCO worker.

117. In addition to the formal panel process, the Commissioner for Aboriginal Children and Young People hosted a Community Yarn at each local area to provide Aboriginal children, their families and carers a forum to meet personally with the Commissioner and raise specific issues for resolution. The Commission considers this was an essential component of the Taskforce 1000 project, empowering children to be heard and empowering the Aboriginal community and carers to be part of the change process.

118. Panel members were given the opportunity at the conclusion of the presentation to clarify facts, seek further detail and question the rationale for action or inaction taken, with the intention of using the panel expertise to collectively address any pressing issues facing the case management, barriers for reunion with family or broader service provision for the child.

62 As referenced earlier in this report, the Commission for Children and Young People was initially precluded from being provided with identifying information about the children, necessitating the Commission to formally establish this Inquiry in order to be an effective co-chair for Taskforce 1000. See 'About this Inquiry', paragraphs 1–5.

3. Learning from Taskforce 100

119. Panels were able to effect immediate positive change for many of the children through the collaboration of key decision-makers at the table. Some examples included remedying issues pertaining to:

- adequacy of housing
- access to counselling
- school access and engagement
- helping to identify extended family who had not been known, to aid in reconnecting children to family
- accessing critical information from other government departments and agencies to better inform case planning and decision-making
- practical assistance such as transportation to access services and early years programs
- referrals for children's health screens at ACCOs
- improved service connection and sector knowledge of what is available to help vulnerable children and their families.

120. Minutes were maintained by the DHHS Area Director, with key action items for each child identified and agreed to by the panel for further follow-up and action. Panels then reconvened one month later to report back on progress for the action items for each child.

121. In addition, broader systemic themes were noted at each area panel. These issues were then developed into an area action plan to address the underlying systemic and case practice issues at a local and statewide level, impacting on service provision for the children and families.

3.5 Taskforce 1000 area action plans

122. Operational issues and changes to practice were achieved during and following the Taskforce 1000 area panels. Over time, systemic issues became evident around resourcing, compliance, accountability and awareness of services. The formulation of area action plans to address these broader issues and create systems change in each locality is seen as a higher-level achievement of Taskforce 1000.

123. Each area action plan consisted of:

- priority areas being addressed
- progress indicators and related performance targets for each priority
- specific actions pertaining to each priority area, with timeframes for completion.

124. The Commission was provided with the area action plan reports for each of the 17 DHHS geographical areas. The Commission conducted a thematic analysis of the content of the area plans to inform the recommendations of this Inquiry.

125. It was evident that the actions could be categorised as:

- addressing compliance with existing legislation, policy or practice standards
- altering or improving existing practices
- creating new processes, whether that be policies, activities, bodies, groups or meetings
- information and data gathering
- awareness raising.

126. Ten broad themes were consistently evident within each of the 17 area action plans:

- best practice: observed where there were good working relationships between DHHS, CSOs and well-resourced and managed ACCOs
- prevention: defined actions pertaining to mainstream and Aboriginal community services
- early intervention: actions relating to access to services (child protection, Child FIRST, drug and alcohol, housing and culturally accessible services)
- placement planning: actions including early identification of Aboriginality, ensuring that AFLDM processes are enabled and occur, improving compliance with the ACPP, planning support for at-risk families, promotion of sibling placement practices, improving search mechanisms for extended family, and addressing and considering barriers for family reunion

- family and community support: actions related to the recruitment, retention and training of carers to be culturally competent; and increased kinship support, legal support and support for incarcerated parents in parenting skills development
- identity and cultural connection: actions focusing on meaningful and high-quality cultural support planning
- education and employment: actions that address greater engagement, achievement and progress throughout the education spectrum
- service collaboration: actions to address gaps in service delivery and greater collaboration, case conferencing and use of multi-disciplinary teams
- workforce capacity: actions designed to build the capacity of ACCOs; redistribute funding to ACCOs; improve data systems, monitoring and accountability; and improve Aboriginal inclusion within the mainstream service sector
- systemic issues: higher level actions to enable broad systemic change, including funding, legislative considerations and policy and practice changes.

127. Upon examination, the themes receiving the most attention on a statewide basis were those relating to:
    - workforce capacity (98 actions)
    - service collaboration (69 actions)
    - health and wellbeing (58 actions)
    - family and community support (58 actions).

128. Most activity was directed on a statewide basis towards improving workforce capacity and capability in recognition of the present deficits in organisational cultural competence. Some examples of these actions include:
    - development of recruitment strategies for more Aboriginal child protection workers, managers and senior executive staff and more Aboriginal staff in other relevant government departments and CSOs
    - practice improvement and training on the identification of Aboriginality
    - staff training to raise awareness through the use of masterclasses to improve cultural competence
    - establishment of practice excellence panels to add value to case planning and service delivery.

129. Masterclasses have been piloted in the North division. This is a joint initiative by DHHS and Aboriginal partner agencies to improve working relationships within the sector. This will build the expertise and knowledge of practitioners in understanding roles and functions of Aboriginal services, allowing them to work in a culturally sensitive manner to achieve improved outcomes for Aboriginal children. The Commission received favourable feedback from participants about the benefit of these workshops. The Commission has recommended that DHHS, in collaboration with DET, expands the provision of masterclasses to all staff working with Aboriginal children in out-of-home care to build the cultural competence of the organisations.

130. Service collaboration actions included the need for service mapping, greater collaboration with Aboriginal agencies, developing agreed practices for information sharing, role clarification and improving pathways between services. There was strong recognition that role clarity between government departments, CSOs and ACCOs could be improved, with most area plans having specific actions to address this.

131. Actions that related to health and wellbeing also featured prominently across all of the area plans. Improving access for children in out-of-home care to engage with and receive treatment from services including dental and eye health, mental health, drug and alcohol treatment, speech therapy and acute health were notable common issues. Emphasis on culturally appropriate and sensitive health and wellbeing service provision was also targeted alongside actions to ensure timely health assessments upon entry to care, and annually, by an Aboriginal community controlled health organisation.

132. Improving family and community support was the fourth-highest theme evident in the area action plans. Addressing support and training needs for carers was strongly articulated in the area plans. There is a need for training and up-skilling of carers to manage children's complex trauma-related behaviours and improve knowledge about brain development, substance abuse, mental health and sexual development. Specific attention was also given to better practical support for kinship carers through the provision of respite care, support groups, attending to the health of older kinship carers and practical assistance around transport and housing. This will prevent placement breakdown.

133. Progression of the actions of the 17 area action plans is monitored by DHHS on a monthly basis. In addition, the plans are being progressed by Taskforce 1000 coordinators, with support from the Taskforce 1000 Steering Committee.

3. Learning from Taskforce 100

134. Two Taskforce 1000 coordinators were appointed in each of the four DHHS divisions (equivalent to eight full-time positions) from October 2015. The temporary 12-month positions have been created to work within the DHHS division to implement the tasks and actions identified in the area action plans in collaboration with stakeholders. The Commission is concerned about the temporary nature of these positions, given that DHHS has stated its continuing commitment to implementation of the area action plans.

135. The Commission has recommended that DHHS establishes and maintains the network of area groups with statewide standards, protocols, reporting mechanisms and governance arrangements to develop and progress the work of Taskforce 1000. Each area group should:

- meet on a quarterly basis, at a minimum, to monitor implementation of the area action plans to improve outcomes for Aboriginal children in out-of-home care
- be co-chaired by the DHHS Area Director and ACCO representative
- have membership and governance at an executive level, and include all government agencies, ACCOs and CSOs involved with Aboriginal children in out-of-home care
- develop a scorecard to measure progress of area action plan targets
- report on the progress of area action plans to the ACF on a quarterly basis
- ensure that ACCOs in each area are involved in the monitoring, evaluation and redesign of each of the area action plans to ensure they are reflective of the community's needs and to promote self-determination.

3.6 Taskforce 1000 stakeholder consultation

136. Following the completion of Taskforce 1000 area panels across the state, the Commission sought the views of stakeholders about the process and outcomes of the Taskforce 1000 project to inform future work.

137. Three workshops were held with ACCOs, CSO staff and DHHS child protection staff to capture reflections and feedback. A report was prepared to inform the Inquiry and assist in formulating overall recommendations.[63] In addition to the workshops, the Commission also surveyed staff from both government and Aboriginal organisations that had had input in the development of area action plans to gather feedback about the development of the plans and the progression of Taskforce 1000 goals.

3.6.1 Feedback from stakeholder workshops

138. Stakeholders who participated in the workshops spoke positively about the impact of the Taskforce 1000 project, not only for the individual children reviewed, but also for the wider service sector practice. It appeared that the project itself changed attitudes, challenged mindsets and enhanced understanding for professionals working with Aboriginal children in out-of-home care. Furthermore, it provided an opportunity for professional development in understanding the critical roles that Aboriginal self-determination and culture play in healing and developing resilience for the future.

139. Key issues identified through the workshops include:

- the need to continue the momentum by enabling the Taskforce 1000 coordinator role to continue to drive change
- renewed focus on prevention and the need to work with the whole family, not just the child
- putting culture at the forefront
- identification of the key practice issues and suggested solutions to improve service delivery.

63 The report, *Rapid Impact: Taskforce 1000 Reflection*, will be available from http://www.ccyp.vic.gov.au October 2018.

3.6.2 Feedback from stakeholder survey

140. Twenty-one respondents provided feedback to the Commission through an online survey in March 2016. Approximately 60 per cent of the respondents were from within DHHS, almost 30 per cent were from ACCOs and the remainder were from other government departments including DET and DoJR.

141. Respondents advised that the area action plans were largely driven and developed by DHHS, with input from ACCOs and other CSOs and government departments. It was noted that many respondents indicated ACCOs were not able to take a lead role in the development of the action plans. One respondent stated:

'[it] appeared to be very much a DHHS direction'.

142. The need for greater Aboriginal input and ownership of the action plans and governance arrangements for their implementation was voiced by a number of respondents, and is best summed up by this comment:

'they need to be led by ACCOs and community Elders rather than DHHS...change should not be imposed on people'.

143. The Commission was concerned that in many of the areas ACCOs did not take a lead role in the development and implementation of the area action plans.

144. Initial feedback to the Commission, however, indicated that on the whole respondents were satisfied with the area action plans and targets that have been developed, with many noting it will be a matter of time before outputs can be assessed.

145. The survey also sought to obtain feedback about the integration of the newly appointed Taskforce 1000 coordinators in DHHS.

146. Strong feedback was provided through the stakeholder survey about the inadequacy of the temporary nature of the positions, the need for funding to be provided to enable delivery of outcomes and the need for clearer coordination and communication between the positions for effective outcomes.

[redacted]

147. Varying practices were noted in reporting lines for the Taskforce 1000 coordinator positions, some being attached to child protection line management and others being attached to client outcomes and service improvement management. In effect, this seems to have resulted in inconsistent reporting lines, poor communication channels and poor systemic coordination across the state.

148. Given the crucial and pivotal role that the Taskforce 1000 coordinators play in maintaining the momentum of Taskforce 1000 outcomes, the Commission supports the need for dedicated, recurrent funding the roles and the provision of resources to enable delivery of outcomes. Further, it is clear that a strategy is required to streamline communication between the Taskforce 1000 coordinators to facilitate information exchange through the DHHS central office, divisions and broader stakeholders. Some suggestions from the survey respondents include regular information bulletins being provided to all stakeholders, and opportunities for Taskforce 1000 coordinators to meet regularly for peer support.

4. Inquiry findings

Finding 1:

High numbers of Aboriginal children experiencing family violence in combination with parental alcohol and/or substance abuse are coming to the attention of child protection, leading to their removal from family and placement in out-of-home care.

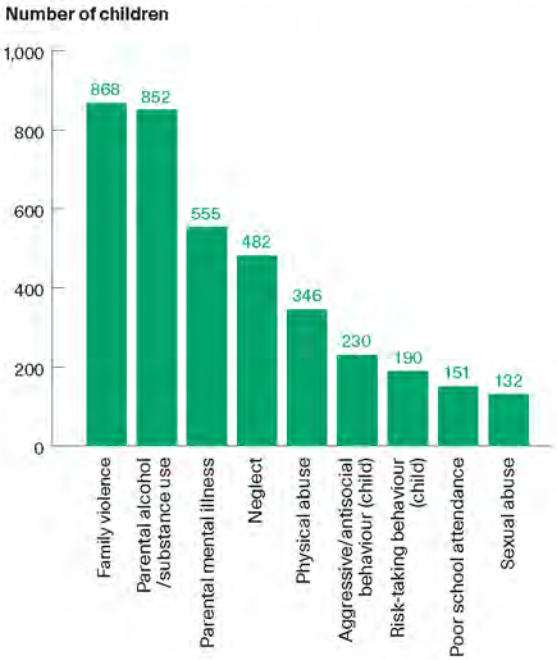
4.1 Drivers for child protection involvement and entry to out-of-home care

149. Taskforce 1000 survey data indicates that most children and their mothers had been exposed to multiple risk factors, which led to child protection involvement and subsequent placement in out-of-home care, as shown in Figure 5. The often causal relationship and interconnectedness between these risk factors is complex.

150. The major drivers leading to statutory child protection involvement for the children reviewed during Taskforce 1000 were exposure to family violence and parental alcohol and/or substance abuse. Of the 980 children reviewed, 868 were known to have been exposed to violence within the family home, most often perpetrated by a male family member, and 852 children were exposed to a parent with alcohol or substance abuse issues.

151. It appeared to the Commission, however, that these figures significantly under-represented the extent of family violence experienced by the children reviewed during Taskforce 1000. This is most likely due to the survey data limitations described earlier in this report.

Figure 5: Known risk factors for children reviewed during Taskforce 1000



n = 980 children
Source: Appendix 1, Table 48.

4.1.1 Family violence

88%

of children had experienced family violence

'Family violence is a foreign curse and a criminal act impacting from time of invasion, colonisation and disempowerment that today encompasses most Aboriginal communities.

There is no doubt and no question from the evidence that in Victoria, the primary victims of family violence are Koori women and children and the level of violence is growing worse by the day. It is eating away at our communities and destroying our families, some over many generations that have been victims of family violence, from birth to death.

It is the number one driver, along with alcohol and drug abuse, of Victorian Koori children being removed into out-of-home care. Its continuation is a major reason why many Koori children cannot be reunited with their parents.

We all want our children not to be removed and placed in out-of-home care, but the first priority must be for them to be safe, feel safe and enjoy life every hour of every day.

I am grateful for the work being done by our communities, services and workers to prevent and intervene in family violence situations and I do acknowledge the commitment by the Victorian Government to make a difference.

The reality, however, is that we need to do more, far more, to provide the right level of and correctly targeted support, advocacy, prevention and safety to Koori women and children. This is still to be achieved, but it is not impossible.

Until we reduce the impact of family violence in our community we will not achieve sustainable reduction in the over-representation of our children being removed. And sadly we know that many of the children in the care of the state will go on to be perpetrators of family violence themselves, having learnt the lessons of their role models at home. But we can achieve change with the right programs, support, counselling, prevention and intervention. It is possible.[1]

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

152. It is now widely understood that exposure to family violence and abuse within the home can lead to adverse outcomes for a child's emotional, physical and mental health, often adversely impacting on future life choices, education and wellbeing. Data available to this Inquiry has indicated the strong need for targeted responses to address family violence and the associated issues of parental functioning, child abuse and neglect. It was evident that a significant number of children reviewed in Taskforce 1000 had behavioural disturbances and poor records of school attendance.

153. Victoria is at the forefront of reform following the recent Royal Commission into Family Violence. A sophisticated knowledge about the lasting and devastating impact of violence, particularly on children's physical and psychological development, has emerged. This is informing systemic change to prevent violence occurring, better protect those at risk and improve the support for survivors of family violence through the coordination of services, policies and systems.

154. Evidence was heard during the recent Royal Commission into Family Violence about the heightened risk of child neglect, physical abuse, emotional abuse and sexual abuse in situations where children are exposed to intimate partner violence.

155. Victoria Police data considered by the Royal Commission indicated a 76 per cent increase in reported family violence incidents at which children were present for the years 2009–10 and 2013–14. Evidence about the devastating impact of family violence on children was heard in numerous submissions, including serious adverse impacts on their health, wellbeing and brain development.[64]

156. The Royal Commission heard evidence of strong links between exposure to family violence and a child's risk of developing high blood pressure and type 2 diabetes as an adult. Furthermore, children and young people who have experienced family violence are at greater risk of drug and alcohol abuse and post-traumatic stress disorder as adults. Family violence is clearly a major public health issue.[65]

64 State of Victoria, *Royal Commission into Family Violence: Report and recommendations*, Vol II, Parl Paper No. 132 (Melbourne: State of Victoria, 2016).

65 Ibid.

4. Inquiry findings

157. The over-representation of Aboriginal people in family violence statistics was highlighted in the Royal Commission's report. The report indicated evidence that Aboriginal people may be at least 6.5 times more likely to report being a victim of family violence than non-Aboriginal persons. Aboriginal women were 34.2 times more likely to be hospitalised as a result of family violence. However, these statistics must be considered in the context of widespread under-reporting of the extent of family violence in Aboriginal communities.[66]

158. The added vulnerability for Aboriginal people experiencing family violence was highlighted by the Royal Commission, which observed:

> 'Aboriginal and Torres Strait Islander peoples are disproportionately affected by family violence; they face unique barriers to obtaining support, whether from mainstream or from culturally appropriate services. Many Aboriginal people are apprehensive and reluctant to seek assistance from mainstream agencies, partly because of discrimination, racism and lack of understanding some Indigenous people experience when doing so. The effects of trauma associated with dispossession, child removal and other practices also inform Aboriginal people's distrust of agencies such as police and child protection.'[67]

159. The Royal Commission found a dearth of culturally appropriate early intervention support services to strengthen families and reduce the number of Aboriginal children entering the child protection system. Specific recommendations were made for significant, increased investment in ACCOs for targeted prevention and early intervention services, as well as culturally sensitive crisis services.

160. At Taskforce 1000 area panels, the Commission heard in almost every case presentation that family violence had featured as either a current familial issue or had been a factor for past generations within the family. High rates of family violence and parental alcohol/substance abuse were evident for most children reviewed in Taskforce 1000 and were equally prevalent in both rural and metropolitan locations.

4.1.2 Parental alcohol and substance abuse

161. Parental abuse of alcohol and substances appears to be a widespread problem within the population of children reviewed during Taskforce 1000, highlighting the need for culturally sensitive responses to address the underlying causes.

87%

of children were exposed to parental alcohol/substance use

162. In its submission to the Royal Commission into Family Violence, VACCA highlighted that parental stress related to poverty, mental illness, serious physical illness and drug and alcohol abuse is closely linked to risk factors for violent behaviour.[68] Parental stress within Aboriginal families must also be understood within the context of past government policies that led to the Stolen Generations and the entrenched disadvantage that resulted. VACCA observed that those children who are removed as a result of family violence are often also removed from their kinship groups, community, culture and land. These are all factors that are integral to building a child's resilience and healing trauma.[69]

163. Case study 1 was presented at Taskforce 1000 and illustrates the isolation and disconnection from culture that was experienced by a five-year-old girl who was removed from her family as a result of family violence and parental substance abuse.

66 State of Victoria, *Royal Commission into Family Violence: Summary and recommendations*, Parl Paper No. 132 (Melbourne: State of Victoria, 2016).

67 Ibid.

68 Victorian Aboriginal Child Care Agency, *Submission in response to the Royal Commission into Family Violence* (Melbourne: Victorian Aboriginal Child Care Agency, 2016).

69 Ibid.

Case study 1: Chloe

Chloe spent her first five years with her mother and father, and spent significant periods of time being cared for by her non-Aboriginal maternal grandmother. When Chloe was five years old, a report to child protection raised concerns about parental substance abuse and family violence. Chloe was voluntarily placed with her grandmother. Child protection later issued a Protection Application and sought a Custody order.

It was not until child protection had been involved for nearly five months that it was understood that Chloe was Aboriginal. There was no evidence on Chloe's child protection file of any consultation with an ACCO or consideration of her Aboriginality in the case plan.

Neither Chloe nor her grandmother was connected to culturally appropriate activities or organisations. It was more than a year after child protection involvement that consultation with an ACCO occurred and a referral was made for an AFLDM conference.

Although Chloe had some contact with her extended Aboriginal family, this only happened once every six months as they lived some distance from her.

In the absence of an AFLDM conference, it was not known if there was extended family that could care for Chloe and provide her grandmother with respite or assist with engaging Chloe in her culture. Chloe's six-monthly contacts with her extended family were her only opportunity for cultural connection. It was not clear what support, counselling or healing opportunities had been offered to Chloe.

164. Through the Taskforce 1000 project, the Commission heard of two innovative programs operating in Victoria to prevent family violence: the Sisters Day Out and Dilly Bag programs. These programs are run by the Community Legal Education Program within the community-based FVPLS. The programs are not recurrently funded despite being considered good examples of effective prevention and early intervention programs for women.[70]

Sisters Day Out and Dilly Bag

Both of these programs bring Aboriginal women together in a safe and supportive environment for social connection, education and information to empower women in at-risk situations.

The Sisters Day Out program provides self-care and wellbeing activities such as beauty, relaxation therapies and dance sessions to promote physical wellbeing and health. Along with the fun elements of the workshop, service information and family violence education are also provided.

The Dilly Bag programs are an intensive series of workshops that emphasise self-care and healing from trauma, promote cultural connection and aim to reduce Aboriginal women's vulnerability to family violence through personal development and group activities.

165. Recommendations from the Royal Commission that pertain to Aboriginal people and are of relevance to this Inquiry include:

- the need to work in partnership with Aboriginal communities
- the need to increase investment in early years 'wrap-around' programs to interrupt and reverse the trajectory into child protection
- the need to expand the Aboriginal component of Child FIRST to reduce the high rate of removal of Aboriginal children
- the need for priority funding be provided to ACCOs for culturally appropriate family violence services, one-door integrated services that focus on cultural strengthening, legal services, crisis accommodation and support and early intervention services
- the need for organisations delivering services to be culturally competent and to undertake cultural safety reviews
- the need for improved data collection.[71]

This Inquiry has confirmed the importance of these recommendations being implemented in partnership with the Aboriginal community.

70. Aboriginal Family Violence Prevention and Legal Service Victoria, *Evaluation report of the Aboriginal Family Violence Prevention and Legal Service Victoria's early intervention and prevention program*, (Melbourne: Aboriginal Family Violence Prevention and Legal Service Victoria, 2014).

71. State of Victoria, *Royal Commission into Family Violence: Report and recommendations*, Vol V.

166. As a result of this Inquiry, the Commission has formulated a number of additional recommendations to strengthen healing-informed interventions to address family violence and intergenerational trauma. A multi-faceted approach is necessary to:

- support survivors of family violence through timely and culturally sensitive counselling, and ensure priority access to information about victim support, legal services and redress
- prevent and disrupt the pattern of intergenerational violence through education of children in out-of-home care about respectful relationships
- provide evidence-based campaigns to promote respectful relationships across the Aboriginal community with a special focus on children and young people
- skill the child protection workforce through regular training to ensure culturally appropriate responses to family violence that ensure a child's connection to culture are maintained.

4.1.3 Parental mental health

almost

60%

of children were affected by parental mental illness

167. Poor mental health is one of the leading contributors to the burden of disease for Aboriginal people of all ages and is the second-highest contributor to the health gap in life expectancy.[72] Research has shown that while the presence of parental mental illness does not on its own result in poor outcomes for children, it is the interaction with other variables that can result in risk for children.[73]

168. Taskforce 1000 survey data indicated that more than 60 per cent of the children reviewed came to the attention of child protection as a result of parental mental health issues in combination with other risk factors. For many children this was a barrier to them being able to return home safely.

169. The Victorian Government launched its 10-year plan for mental health in November 2015. In formulating the 10-year plan, government heard numerous submissions from service users about the present systemic limitations. Many people shared their concerns about services that are fragmented, siloed, difficult to navigate, hard to access, crisis driven, facing increasing demand, under resourced, stigmatised and stigmatising.[74] These issues were clearly echoed during Taskforce 1000 area panels where experiences of long waiting lists, poor engagement with services and a lack of Aboriginal-specific services were common issues raised.

170. The Commission is encouraged that the government's 10-year plan for addressing mental health has a strong focus on Aboriginal health. The expansion of and adequate resourcing for Aboriginal-specific mental health services must occur, with priority access for parents whose children are at risk of entering out-of-home care.

171. The Aboriginal concept of health is a holistic one that incorporates spiritual, environmental, ideological, social, economic, mental and physical factors. Accordingly, the response to improving Aboriginal health must be holistic and attend to each of these factors.

172. As a result of observing best practice during Taskforce 1000, a recommendation has been made by the Commission for the expansion of multi-disciplinary hub services throughout the state. A successful model operates through the Mallee District Aboriginal Services, providing more than 50 essential health services with a strong focus on healing, resilience and early years services.

72 Department of Health and Human Services, *Victoria's 10-year mental health plan* (Melbourne: Department of Health and Human Services, 2015).

73 Nicholson, J, Biebel, K, Hinden, B, Henry, A and Stier, L, *Critical issues for parents with mental illness and their families* (USA: Center for Mental Health Services, 2001).

74 Department of Health and Human Services, *Victoria's 10-year mental health plan*.

4.1.4 Abuse and neglect

173. Taskforce 1000 survey data indicated almost half of the children reviewed had experienced neglect, 35 per cent had experienced physical abuse and just over 13 per cent had experienced sexual abuse. Most children's experience of abuse and neglect was in the context of family violence and parental alcohol and substance abuse.

174. High rates of sexual abuse in some areas of the state, such as Loddon, Inner and Outer Gippsland and Ballarat, were evident during Taskforce 1000 panel presentations. This is somewhat supported by the Taskforce 1000 survey data that indicated rates of sexual abuse of:

- 31 per cent of Aboriginal children in Loddon
- 29 per cent of Aboriginal children in Western District
- 21 per cent of Aboriginal children in Central Highlands.

175. The Commission, however, formed the view that the extent of sexual abuse was not accurately represented in many survey responses. Often there were cases presented where sexual abuse was evident following case discussions after the Taskforce 1000 area panel presentation, yet this information had not been accurately captured in the survey response.

176. Caution should be exercised when interpreting prevalence rates of sexual abuse data, given the learning derived through the research and findings from the Royal Commission into Institutional Responses to Child Sexual Abuse. This showed that most data relating to the prevalence of sexual abuse is likely to underestimate the real situation due to methodological issues, the hidden nature of sexual abuse and barriers to disclosure.[76]

177. During Community Yarns in the South division, the Commission met with a number of senior Aboriginal women who spoke about high levels of male-perpetrated sexual behaviour and abuse towards women and children, which had become normalised within their community. The Commission was struck by the urgent need for intervention and support for these vulnerable children and families and, as a result, has recommended localised community-led responses in partnership with government agencies, Victoria Police and counselling and support services.

178. At a Taskforce 1000 presentation, the Commission heard of a disturbing case in the Loddon area, where Victoria Police had failed to follow up credible allegations of sexual abuse made in late 2013 by a group of five siblings to their DHHS child protection practitioner. The Commission heard that Victoria Police hadn't interviewed the alleged perpetrator until early 2016.

    As a result, the Commissioner wrote to the Minister for Police and the Chief Commissioner of Victoria Police to seek an opportunity to discuss the issues raised and the systems, policies and practices of Victoria Police. Victoria Police acknowledged to the Commission the disappointing timeframe for responding to the allegations and advised of action taken since to address these concerns.

179. Access to timely counselling was an issue persistently raised by many families and practitioners during Taskforce 1000. The Commission heard of many children who had experienced sexual abuse and not been offered counselling. In the "*...as a good parent would...*" inquiry report, these issues were also evident for a significant cohort of children who had experienced sexual abuse in residential care. In that report it was observed that many children:

- are not provided with adequate acknowledgement and assistance after they disclose sexual abuse
- are reluctant to discuss traumatic events with a counsellor that they don't know, especially when they are in an unfamiliar location.

76 Royal Commission into Institutional Responses to Child Sexual Abuse, *Interim Report, Volume 1* (Canberra: Commonwealth of Australia, 2014).

4. Inquiry findings

180. Case study 2 details the lack of therapeutic care, counselling and support for a boy who, from the age of five, experienced repeated abuse and trauma, including sexual abuse. The deterioration in the boy's mental health and wellbeing was a familiar theme in many of the children's cases that were heard during Taskforce 1000, as were the failures of those agencies with legal responsibility for the children's care to ensure timely access to counselling and support.

Case study 2: Bert

Bert was five years old when he first came to the attention of child protection. Over the following eight years, there were 10 further reports to child protection about his wellbeing. The majority of these reports were closed without investigation. The concerns reported to child protection involved Bert and his younger siblings being exposed to significant family violence perpetrated by their father.

In 2013, Bert again came to the attention of child protection. He had experienced multiple episodes of harm and his mental health required medication. It was identified that Bert needed treatment to deal with the impact of the abuse and trauma he had experienced.

Before entering out-of-home care, Bert and his two younger siblings disclosed their experiences of sexual abuse to Victoria Police, but charges were not laid against the perpetrator.

Of particular concern to the Commission was that Bert had not received any counselling. His case records revealed that, although he had been referred in late 2013 to a sexual assault counselling service, the service closed the referral because he was not in a stable placement.

When Bert's case was presented at Taskforce 1000, he still had not been provided with counselling. Despite being responsible for the day-to-day care of Bert, DHHS and the CSO that was contracted to care for him had failed to address his trauma.

By this time Bert could no longer live with his family. He had become physically abusive towards his six younger siblings, he was using drugs and he had disengaged from school. Bert had four in-patient placements in a mental health facility in Melbourne, a long way from his family in rural Victoria.

Bert had three home-based care placements, all of which broke down because of his deteriorating mental health and suicide attempts. He then had two residential care placements, where he was bullied by other residents and exposed to inappropriate sexual behaviours. There were 91 incident reports in relation to Bert while he was in care. Bert was on a Custody order and case managed by a local CSO.

181. Case study 3 illustrates the adverse impact on a young boy's wellbeing and development following significant harm as a result of family violence and neglect. The resulting poor attention to the maintenance of his culture, failure to provide counselling and poor opportunity to heal was clearly evident when his case was presented at Taskforce 1000.

Case study 3: Stevie

Stevie is the youngest of five children. Stevie's father is Aboriginal. Stevie and his siblings were subject to 16 reports to child protection from 1999 to 2006 relating to family violence, failing to ensure the children's safety and environmental neglect. The reports were predominantly closed at intake.

In 2007, when Stevie was nearly nine years old, a further report led to Stevie and his siblings being placed on a protection order. The order was breached in 2009 and Stevie was placed in the care of his non-Aboriginal maternal grandmother and his siblings were placed elsewhere. When he was removed from his parent's care, Stevie was exhibiting highly aggressive behaviours. He was placed on a Guardianship order.

Stevie's behaviour settled dramatically while he was with his grandmother and his school attendance and behaviour also improved greatly. However, the placement eventually broke down. This was assessed to be due to increased contact with his mother.

Stevie was placed in residential care by child protection when he was 16 years old. He remained there until he was transitioned into independent living around his 18th birthday. During his time in residential care, he was case managed by a non-Aboriginal CSO.

By the time Stevie's case was presented to the Taskforce 1000 panel in December 2015, he was totally disconnected from his family and culture and had no Aboriginal role models or mentors.

Child protection case plans note that Stevie no longer identified as Aboriginal, although file notes indicated that he had previously strongly identified as Aboriginal. During the years of child protection involvement, there was no AFLDM conference. There was no evidence that there had been any attempt to link Stevie with culturally appropriate counselling and cultural healing.

A review of Stevie's file shows that a cultural support plan was completed in June 2015 – eight years after child protection first became involved. It was evident that, despite more than nine years of involvement, child protection had limited knowledge of Stevie's father or his extended family.

4.2 Early years support

Finding 2:

The present service system, particularly the Aboriginal community controlled sector, lacks sufficient resources for, and emphasis on, early years programs to support families and reduce the growing number of Aboriginal children entering the child protection and out-of-home care systems. Furthermore, there is concern that many mainstream services do not provide culturally responsive services to Aboriginal children.

182. In the absence of easily accessible, culturally appropriate support services to strengthen the capacity of families to provide optimal care, the trajectory to child protection intervention is increasingly the outcome for many Aboriginal children and their families.

183. In Victoria, there are a number of government-funded programs and supports available for Aboriginal children and families to promote greater education engagement, attainment and achievement. These supports range from in-home assistance and support, Koorie maternity services, Aboriginal kindergarten programs, Koorie pre-school assistants and KESOs who are tasked with assisting families to engage and access services from birth through to completing school. It is noted that the government recently launched the *Marrung – Aboriginal Education Plan 2016–2026*,[76] that will build on current and existing programs and services for Aboriginal children and young people, including 15 hours of free kindergarten for three-year-old and four-year-old Aboriginal children.

184. Of concern, however, has been the practice of cost shifting by government, resulting in poor resourcing of commitments to early years programs. The 2014 *Residential care services for children* audit by VAGO found that in order to purchase additional capacity in the residential care system, at a cost of $11.3 million in 2011–13 and $24 million in 2013–14, DHHS cost-shifted money allocated for other programs. The audit report revealed that covering the $11.3 million shortfall in 2011–13 came at the expense of early intervention programs including:

- $3.4 million taken from a health and education assessment initiative
- $2.8 million taken from a leaving care initiative
- $2.8 million taken from various disability services initiatives
- $1 million taken from the cradle to kinder initiative
- $1 million taken from ACCOs for capacity building
- $300,000 taken from the development of family violence risk assessment tools.[77]

185. The 2014 audit commented that flaws in the DHHS data measurement system resulted in a lack of knowledge about how many Aboriginal families are accessing services, the frequency of service use and the unmet demand for services.[78]

186. The report concluded that while DHHS monitors the contractual performance of family service providers, it does not measure effectiveness of service delivery and has not established an outcomes framework to assist in measuring the impact on families. In effect, this means that vulnerable children and families are not always able to access services when needed.

187. The issue of accessing early years intervention and support was highlighted in the 2015 VAGO audit, *Early intervention services for vulnerable children and families*.[79] It considered the effectiveness of access for vulnerable children and their families to community-based services, specifically Child FIRST and Integrated Family Services. These services provide a crucial role in receiving referrals about vulnerable children and their families where there are wellbeing concerns. Their aim is to strengthen the capacity of families and hopefully avoid the need for statutory child protection intervention.

76 Department of Education and Training, *Marrung – Aboriginal Education Plan 2016–2026*, <http://www.education.vic.gov.au/about/programs/aboriginal/Pages/marrung.aspx>, accessed 20 July 2016.

77 Victorian Auditor-General, *Residential care services for children* (Melbourne: Victorian Auditor-General's Office, 2014).

78 Victorian Auditor-General, *Early intervention services for vulnerable children and families* (Melbourne: Victorian Auditor-General's Office, 2015).

79 Ibid.

188. The audit found that, because of the growing demand and complexity of referrals, Child FIRST and Integrated Family Services are increasingly providing intervention to high-needs families, which means families with low to medium needs are missing out.

189. Many ACCOs provide community-based services such as early childhood programs, community health, and family healing and preservation services. The value of these services for improved life outcomes for vulnerable children became very clear during Taskforce 1000 area panels. The Commission heard examples of these services acting early in the prevention of family violence and acting proactively to secure the safety of vulnerable children.

Bumps to Babes and Beyond

The Bumps to Babes and Beyond program is one example of a successful initiative to intervene early with vulnerable families. Operating in Mildura, through a partnership between the Mallee District Aboriginal Services and the Queen Elizabeth Centre, the program engaged with women and their families during the antenatal period to strengthen the bond between parents and children during pregnancy and the first 18 months of life. An evaluation of the program indicated many positive outcomes, including:

- children remained in the care of their mothers
- 86 per cent of mothers breastfed at the point of discharge from hospital
- decrease in mothers' depression between intake and three months post birth
- engagement by mothers in all antenatal appointments
- all children were up to date with immunisations and attended all scheduled visits with the maternal and child health nurse
- significant increases in community supports and networks six months post birth.[60]

190. Following on from this initiative, the Mallee District Aboriginal Services developed and refined an intensive case management model to support families through early parenthood. Support workers assist with parenting information and demonstrations, advise on newborn care, breastfeeding, child development and child and maternal health and provide social opportunities for parents to connect and support each other. The service helps transport parents to appointments to facilitate engagement and overcome service access obstacles.

Bubup Wilam for Early Learning

Bubup Wilam for Early Learning is an Aboriginal child and family centre in the northern Melbourne suburb of Whittlesea. At Taskforce 1000, the Commission heard of the innovative work conducted through the centre, which assists many vulnerable children and their families. The centre has partnerships with other organisations to provide holistic care for young children, including attention to their health and wellbeing. The centre supports referrals for families who need to access specialist services such as housing, welfare and health and provides case management for families with complex needs. The philosophy of the centre is based on principles of Aboriginal self-determination and community control, making it accessible and welcoming to families who might not feel able to seek out mainstream support services.

191. It was clear that although there are many examples of strong ACCOs, there is no uniform access across the state to these services for Aboriginal people. This was particularly noticeable in the Latrobe Valley in Gippsland, where the lack of prominent services for Aboriginal children and families was evident. This has led to a specific recommendation for government to support the Latrobe Valley Aboriginal community in the establishment of a local ACCO to promote, advocate and provide community-based health and human services.

192. The Commission is disappointed that, as a result of Commonwealth funding changes, Bubup Wilam's future viability is in question. The Commission calls upon the three levels of government to work closely with Bubup Wilam to identify opportunities to continue to provide its valuable service to vulnerable Aboriginal children and their families. DET advised that it continues to support Bubup Wilam's kindergarten programs and is encouraging the centre to access existing program supports and to also seek other sources of funding.

193. A recommendation has also been made through this Inquiry for DET to provide funding to establish and sustain a range of Aboriginal community-based early years programs in areas of the state with growing Aboriginal populations.

60 Burrows, A, Allen, B and Gorton, S, *Evaluation of the Bumps to Babes and Beyond program: A partnership between the Queen Elizabeth Centre and Mallee District Aboriginal Services* (Melbourne: Queen Elizabeth Centre and Mallee District Aboriginal Services, 2014).

4.3 Practice challenges

Finding 3:

There is a lack of aftercare, monitoring and evaluation by DHHS of services and programs delivered internally and by funded agencies for Aboriginal children in out-of-home care.

194. Other Victorian inquiries have found deficits in program monitoring and evaluation to be a common theme in service delivery for vulnerable children.

195. The 2012 Victoria's Vulnerable Children Inquiry found that the approach to monitoring and reviewing CSO performance by DHHS did not do enough to identify, address or prevent major and unacceptable shortcomings in the quality of out-of-home care. Further, it commented on the lack of rigorous evaluation of the efficacy of early intervention programs.[81]

196. In May 2014, an audit examining the access to mainstream services for Aboriginal Victorians was published by VAGO. The report considered services provided by or funded by government and assessed whether departments can demonstrate that improved access has contributed to or was expected to contribute to improved outcomes. The audit found that, with the exception of the Department of Health, departments did not know if the work being undertaken was improving access or why outcomes are not improving for Aboriginal Victorians.

197. In May 2015, the VAGO audit, *Early intervention services for vulnerable children and families*, found that DHHS does not measure the effectiveness of service delivery of family service providers.[82]

198. This Inquiry has also observed that there is a focus on outputs as opposed to outcomes. Despite DHHS being aware of the program limitations and the failure to meet program requirements for consultation with ACSASS, provision of AFLDM conferences, application of the ACPP and provision of cultural support planning, little has been done to evaluate, adequately resource or address the barriers for compliance with these essential programs that are enablers of cultural safety for Aboriginal children.

81 Cummins, P, Scott, D and Scales, B, *Report of the Protecting Victoria's Vulnerable Children Inquiry: Volume 1.*

82 Victorian Auditor-General, *Early intervention services for vulnerable children and families.*

4.3.1 Case management

Finding 4:

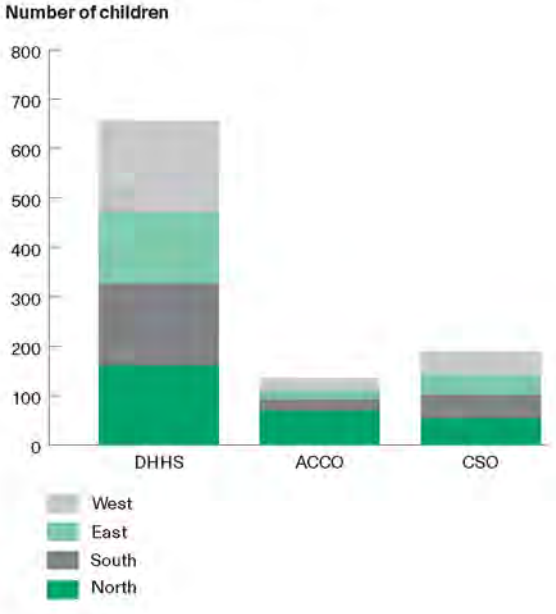
Aboriginal children in out-of-home care are provided with greater opportunity for meaningful engagement with culture when their placement, case management and guardianship are provided by an ACCO.

86%

of children reviewed in Taskforce 1000 were case managed by a non-Aboriginal agency

199. Most of the children (656 children) reviewed in Taskforce 1000 were case managed by DHHS. This was followed by CSOs (189 children) and ACCOs (135 children). In addition to child protection involvement, a small proportion of the children had other DHHS programs involved, including disability (49 children) and youth justice (28 children). Figure 6 provides a breakdown of case management by DHHS division. The North division had the highest proportion of children managed by an ACCO. This may reflect the stronger role and presence of ACCOs in the North division, notably VACCA and Mallee District Aboriginal Services.

Figure 6: Agencies with case management responsibility for children reviewed during Taskforce 1000, by DHHS division



n = 960 children
Source: Appendix 1, Table A13.

4. Inquiry findings

200. This Inquiry sought to understand whether the type of agency providing case management had a bearing on the provision of cultural connection for the child. This was examined by considering a range of factors:

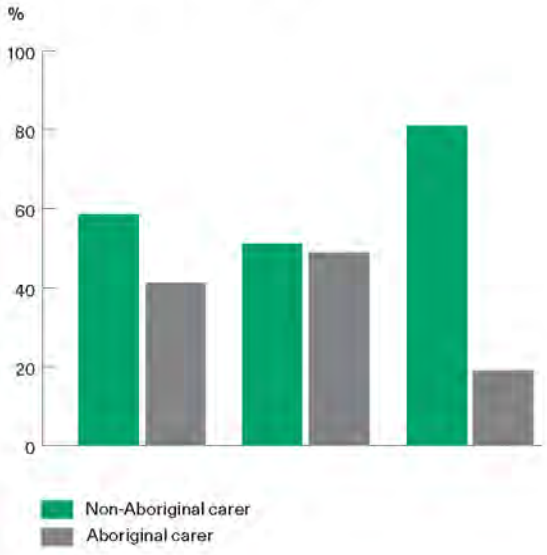
- Aboriginal status of the child's primary carer
- provision of cultural awareness training for non-Aboriginal carers
- facilitation of contact with the child's extended family and their Aboriginal community.

201. Most children (62 per cent) reviewed during Taskforce 1000 were cared for by a non-Aboriginal primary carer.[83] Figure 7 shows that just under half the children case managed by an ACCO were cared for by an Aboriginal primary carer, and 41 per cent of the children case managed by DHHS had an Aboriginal primary carer.

over 80%

of children case managed by a CSO were placed with a non-Aboriginal carer

Figure 7: Aboriginal status of the primary carer of children reviewed during Taskforce 1000, by agency with case management responsibility

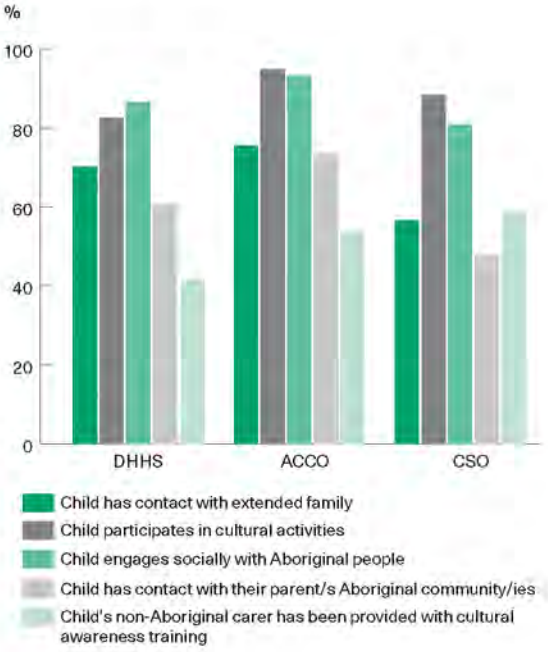


n = 980
Source: Appendix 1, Table A22.

202. In early 2016, the Commission sought a commitment at the Ministerial Advisory Committee for Children in Out-of-Home Care for the development of joint initiatives involving DHHS, ACCOs and CSOs to recruit more carers (both Aboriginal and non-Aboriginal) for Aboriginal children. The Commission considers that the approach being undertaken in Bendigo, involving a partnership between DHHS, Anglicare and the Bendigo and District Aboriginal Corporation, should be replicated in other parts of the state. While there has been support for this commitment, action is still needed.

203. As shown in Figure 8, where a child's case was managed by an ACCO, they were more likely to have contact with Aboriginal extended family members, be provided with opportunities to participate in cultural activities and more likely to be engaged socially with an Aboriginal person.

Figure 8: Provision of cultural connection to children reviewed during Taskforce 1000, by agency with case management responsibility



n = 980
Source: Appendix 1, Table A22.

204. Cultural awareness training is offered by some Aboriginal organisations in Victoria to carers and workers. The training is usually a one-day workshop that provides introductory knowledge and understanding to assist carers and workers to work in a culturally respectful manner with Aboriginal children and their families. The Commission heard some criticism that the training is too generalised and lacks a localised, place-based approach with input from local Elders and respected persons drawing on local Aboriginal culture and history.

83. See Appendix 1, Table A15.

205. This Inquiry found that greater focus by DHHS, CSOs and ACCOs is required to ensure all non-Aboriginal carers are provided with cultural awareness training. Almost half of the non-Aboriginal carers have no relevant cultural training. Cases managed by CSOs and ACCOs fared slightly better in the provision of cultural awareness training than those managed by DHHS. It is essential that all carers of Aboriginal children have a rich understanding of the importance of culture in order to confidently promote connections and healing for the child.

almost half

of non-Aboriginal carers had no cultural training

206. Overall, children case managed by CSOs appeared to have poorer connections with their Aboriginal culture. Less than 60 per cent of all children case managed by a CSO were provided with opportunities to have contact with their Aboriginal extended family members, and less than 50 per cent were provided with contact with their parents' Aboriginal community.

207. These results indicate poor cultural safety is evident for a large number of children case managed by DHHS and, in particular, by CSOs. This raises questions about the regulation, oversight and accreditation of agencies that provide out-of-home care services for Aboriginal children. These issues are further explored in section 4.5 of this report.

less than 60%

of children case managed by a CSO had contact with their Aboriginal family

208. In order to improve outcomes for Aboriginal children within the child protection system, a clear priority is for the children's case management and placement in out-of-home care to be provided by Aboriginal organisations. Such a transition will take time and will require a partnership approach between DHHS, CSOs and ACCOs to develop a strategy, time line and action plan to reallocate resources and build the capacity of ACCOs to take on important functions that will enable self-determination.

209. Interim measures of reform are considered necessary to improve the service delivery to Aboriginal children presently receiving child protection and out-of-home care services. A number of recommendations have been formulated by the Commission. They focus on:

- ensuring Aboriginal children in out-of-home care have meaningful access to their culture
- requiring organisations that presently provide out-of-home care services to Aboriginal children to be culturally competent.

4. Inquiry findings

210. Case study 4, which was presented at Taskforce 1000, is an example of poor attention to a child's need for cultural connection. The Commission was able to intervene and ensure the child could access an Aboriginal playgroup.

Case study 4: Bodhi

Child protection received a report in relation to Bodhi on the day he was born that identified concerns about his mother's capacity to care for him. Bodhi's mother was separated from his non-Aboriginal father, who had a history of substance abuse. After services were linked with his mother, the situation deteriorated and Bodhi was place in home-based care on a Custody order. Bodhi experienced at least three placement changes before being placed in a kinship placement with Aboriginal carers.

The placement lasted six months; however, Bodhi was removed when he was one year old due to quality of care issues. Bodhi then moved to a placement with non-Aboriginal carers.

When Bodhi's case was presented at Taskforce 1000 in rural Victoria, the Commission was concerned that there was no cultural support plan in place and that no AFLDM conference had been held. Although ACCOs had been consulted during decision-making, they were not part of regular meetings. At the urging of the Commission, Bodhi was placed in an Aboriginal playgroup to allow him to socialise with other Aboriginal children and facilitate connection with his culture. The Commission noted that there had been no initiative by DHHS to connect Bodhi to his Aboriginal culture.

4.3.2 Identity

Finding 5:

DHHS and CSOs offer poor cultural safety to Aboriginal children in the out-of-home care system. This is in direct contravention to the rights guaranteed under the *Charter of Human Rights and Responsibilities Act 2006*. There is evidence of practice deficits in respecting and establishing children's Aboriginal identity and a lack of compliance with legislative and policy obligations.

211. It was evident to the Commission, during both Taskforce 1000 area panel presentations and through enquiries made to the Commission directly, that there are a number of practice challenges and issues relating to respecting and establishing a child's Aboriginal identity. These issues involve:

- late identification by service providers of children's Aboriginal status, resulting in children's cultural rights and needs not being upheld
- de-identification of children's Aboriginal status by service providers.

Late identification of Aboriginal status

212. Numerous cases were presented to Taskforce 1000 area panels where there had been years of involvement with DHHS prior to a child's Aboriginal status being known. Often this was because child protection practitioners relied on the advice of the initial report to child protection and failed to re-check at key points of child protection involvement, or they simple failed to ask families the question at all.

213. This finding is consistent with file audits conducted during the *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*. The audits found that in 10 per cent of cases reviewed Aboriginal children were not identified during intake or investigation phases, and in some cases it was many years before identification occurred. Further, there was poor compliance evident, with practitioners failing to check the Aboriginal status of a child and that of their parents during the first home visit. Only 38 per cent of cases reviewed (25 children) had their Aboriginality confirmed at the first home visit.[84]

84 Commission for Children and Young People, *In the child's best interests*.

Questions were not asked about a child's Aboriginal status, so as

'not to embarrass the parents'

214. The impact of failing to ascertain a child's Aboriginal status is significant. It results in key legislative provisions of the CYFA 2005 not being considered, particularly the application of the ACPP in decision-making for the placement of a child and cultural support plan requirements for Aboriginal children in out-of-home care.

Failing to establish a child's Aboriginality can lead to a direct

contravention of the Charter

215. As a result of the problematic practice of late identification of Aboriginal children, the Commission has recommended a whole-of-government strategy to improve mechanisms to ensure all departments and government-funded services (including hospitals, health services, education, early childhood, police, justice, child protection, housing, disability and homelessness) are culturally competent and have rigorous methods and related training for early identification of a child's Aboriginality.

216. Recent research in Western Australia has shown that one in five Aboriginal children under the age of 16 had unregistered births, resulting in identity issues for children and difficulties accessing rights of citizenship, obtaining a passport or driver's licence and opening bank accounts.[85] Anecdotal evidence at Taskforce 1000 indicated this is very much a problem in Victoria, too. Accordingly, the Commission has recommended that DHHS, in collaboration with DoJR, works with hospitals to embed a process to ensure that, where an Aboriginal child is identified at the time of birth, that the application for their birth certificate is completed prior to discharge from the hospital.

217. It is also evident that intensive training is required to both educate child protection practitioners about the importance of establishing a child's Aboriginality at the earliest possible stage of intervention, and assist practitioners to become confident in how to sensitively broach the question with families. Specialist training is considered necessary to address these deficits. This will help improve early identification.

218. The Commission reviewed the functionality of CRIS, and noted the need for a number of enhancements to ensure accurate and prominent recording of a child's Aboriginal status:

- provide a stronger visual cue on the front page and subsequent summary pages to identify that a child is Aboriginal
- enhance the Aboriginal status field to include the date that the child was confirmed to be Aboriginal and how the confirmation was obtained
- include mandatory completion of the Aboriginal status of the child's parents before a case can proceed to investigation phase
- include mandatory completion of the Aboriginal status of the child's primary carer for children in out-of-home care
- prevent the de-identification of Aboriginality without senior endorsement within DHHS, by ACSASS and approval from the Commissioner for Aboriginal Children and Young People.

Furthermore, it is considered necessary that DHHS reviews and amends all pro formas, templates and reporting documents, inclusive of reports, forms and applications, referral documents and CRIS templates, to ensure that a child's Aboriginality is clearly identified and to ensure provisions relating to compliance with the legislative requirements under the CYFA 2005 for Aboriginal children are recorded.

219. Other measures that will support the early identification extend to police, health and education systems that have mandatory reporting to DHHS about the wellbeing of a child deemed at risk.

220. Taskforce 1000 area panels heard of examples in which health services and maternity hospitals had not routinely checked the Aboriginal status of children and families who access their services. In the event that a report was made to child protection about a child at risk, the child was referred as non-Aboriginal and this was accepted at face value by DHHS.

85. Gibberd, A, Simpson, J and Eades, S, 'No official identity: a data linkage study of birth registration of Aboriginal children in Western Australia', *Australian and New Zealand Journal of Public Health (2016)*.

4. Inquiry findings

221. Many reports to child protection arise from Victoria Police through a referral form (L17 report), which notifies DHHS of serious incidents where a child has been exposed to family violence. The Commission heard of many examples in which the Aboriginal status of the child or the parents was not correctly identified on the L17 form. This was because the question had not been asked by police at the time of involvement with the family, or because errors had been made in completion of the referral. Consequently, the child's status on the child protection record had been entered as 'not Aboriginal' and further timely clarification had not occurred. This sets in place a chain of events that translates to children being denied their cultural rights.

222. Taskforce 1000 identified numerous cases across regional Victoria where local ACCOs were not providing publicly funded services to Aboriginal children in out-of-home care. In cases where the child did not have a Certificate of Aboriginality this was often a result of the child's parents and forebears being members of the Stolen Generations. The Commission has raised this issue at the ACF, the Aboriginal Justice Forum and with the Minister for Aboriginal Affairs for priority attention.

223. The following case studies illustrate the impact of delayed identification of a child's Aboriginality. Case study 5 discusses a health service that did not identify the Aboriginal status of a vulnerable infant at risk in his mother's care. DHHS had been involved with the infant's siblings for a long period and had not been aware that the children were Aboriginal. These failures led to poor practice and engagement with Aboriginal-specific services. In case study 6, a young girl had child protection involvement for 11 years before her Aboriginality was established, resulting in lengthy delays in the engagement of Aboriginal services, cultural support planning and opportunities for engagement with her community and culture. Case study 7 details significant delays in the identification of Aboriginality for a group of three siblings.

Case study 5: Troy

Troy was subject to an unborn report from a health service due to concerns about maternal substance abuse. At the time of the report, the mother's three older children were on protection orders and in the care of their maternal grandparents. The unborn report did not identify Troy or his siblings as Aboriginal. Child protection was unaware of Troy's mother's Aboriginality, despite their long involvement with the family.

Following his birth, Troy was placed with his maternal grandparents who were not prepared to care for him long term. Troy's placement referral and court report at the time stated he was not Aboriginal. It was not until after more than 12 months of child protection involvement that an ACCO was contacted (via email) to ascertain what involvement was needed. At that time, child protection was seeking a Guardianship order. File notes indicated that the court hearing was adjourned to allow the mother to 'prove' her Aboriginality.

A permanent care plan was endorsed and the cultural support plan stated that Troy's Aboriginality could not be verified. At the time, Troy's mother was working with an ACCO. A non-Aboriginal CSO was contracted to manage Troy's case.

During this time Troy did not have regular access to his siblings, and file notes indicated that it was the maternal grandmother's responsibility to ensure that access occurred.

The Commission was extremely concerned to note that a permanent care case plan was endorsed by DHHS without an AFLDM conference. In fact, it was not until presentation at Taskforce 1000 that it was identified that an ACCO permanent care assessment and AFLDM conference were needed.

Case study 6: Lucy

Lucy first came to the attention of child protection as a newborn. There were five reports by the time she was four years old. The risks identified related to her mother's substance abuse, her mother wanting to relinquish care, sexual abuse and her mother taking overdoses that required Lucy to call the ambulance. One of these reports resulted in Lucy being placed on a Custody order, which was allowed to lapse while she was still in the care of her mother.

In 2008, when Lucy was nine years old, there was a further report in relation to her and her one-year-old brother. The concerns related to their mother's substance abuse and serious mental health issues. The children went into the care of a non-Aboriginal CSO, but were returned to their mother and placed on a Supervision order. At the end of the order, Lucy disclosed serious abuse by her mother, while her mother accused her of assaulting the young brother. Lucy was placed in home-based care on a Guardianship order.

Lucy went on to have multiple placements in home-based care and was eventually placed in residential care. She was case managed by DHHS and a non-Aboriginal CSO at different times. Court reports from that period state that Lucy was not Aboriginal. It was not until 2011, more than two years after the sixth report and 11 years after the very first report, that it was documented that Lucy was Aboriginal. It is unclear how DHHS became aware of Lucy's Aboriginality. At the time of this Inquiry, the front page of Lucy's electronic child protection file still stated that she was not Aboriginal.

At the Taskforce 1000 presentation it was reported that consultations had occurred with an ACCO at intake; however, the notes on the child protection file indicate that consultation did not occur until 2012. An ACCO was not part of the care team meeting for Lucy. It was not until just prior to the Taskforce 1000 presentation that a cultural support plan was created. At the time of the Taskforce 1000 presentation, an AFLDM conference had still not been held, despite services being aware for nearly four years that Lucy and her brother were Aboriginal.

The Commission was extremely concerned to hear that it took six reports and extensive involvement before child protection ascertained that Lucy was Aboriginal. Even once this was established, no more effort was made to engage an ACCO in the care team or to ensure that Lucy's carers had appropriate cultural training.

Case study 7: Lily, River and Bob

In early 2008, Bob (eight years old), Lily (five years old) and River (eight months old) were placed on Supervision orders due to concerns of parental substance abuse and lack of supervision. Bob was reported to be petrol sniffing and fire lighting. The children remained in the care of their mother (and at times their father) while living with their maternal grandmother. The Supervision order was extended until it was eventually breached in late 2011, due to ongoing parental substance abuse.

All three children were placed on Custody orders. Lily and River remained in the care of their maternal grandmother and Bob went to live with his paternal aunt. Bob's placement with his aunt broke down and he returned to Victoria to live with his siblings and grandmother.

The case was managed by a CSO and in August 2014 – more than six years after the current child protection involvement commenced – it was made known to the CSO that the children were Aboriginal.

Despite previous involvement with Bob and current involvement with Lily and River, child protection was not aware that their father was Aboriginal. It was not until the maternal grandmother told child protection that she was receiving services from a local ACCO that child protection inquired into the children's Aboriginality. When presented at Taskforce 1000, the child protection practitioner stated that little was known about the children's father or heritage, yet it was clear that they had failed to ask questions of the paternal aunt, who was known to them.

The Commission was very concerned that these children had not been identified as Aboriginal for so many years and that, even once child protection became aware that they were Aboriginal, there was an absence of cultural planning and no provision of an AFLDM conference.

4. Inquiry findings

De-identification of Aboriginal status

224. An emerging issue of concern to this Inquiry has been instances of the de-identification of Aboriginal children, effectively dislocating these children from accessing and engaging with their culture. The Commission heard of cases, such as the one outlined in case study 8, where significant decisions regarding a child's identity were made in the absence of appropriate consultation, scrutiny or regard.

225. Accordingly, recommendations have been made to alter present case practice in recognition of the significance of decisions about a child's intrinsic identity by requiring consultation with the Chief Practitioner for Aboriginal Children and the Commissioner for Aboriginal Children and Young People, and the enhancement of the CRIS system to prevent a child's status from being changed without appropriate approvals.

Case study 8: Violet

There were two reports to child protection while Violet was an infant. They related to her being born opiate-dependent and her mother's poor mental health. At the time ACCOs worked with her mother. A Supervision order was issued and Violet was placed in the care of her father. Violet's mother ceased contact with her.

After the Supervision order lapsed, there were three further reports to child protection when Violet was three, four and six years old. Each report related to different concerns, including sexual abuse, parental substance abuse and denying the mother contact. Each report was closed at intake.

At the time of the sixth report, Violet was seven years old. Her father had been found unconscious from a drug overdose and eventually passed away. At the time of intake, child protection consulted with ACCOs and Violet was placed with a carer known to her father. Violet was placed on a Guardianship order and the court gave dispensation of service as child protection could not locate her mother. There is no evidence that child protection consulted with ACCOs to assist in finding Violet's mother or that an AFLDM conference was considered.

An ACCO advised child protection that it was Violet's father that was Aboriginal, not her mother. Violet's case was contracted to a non-Aboriginal CSO as the local ACCO was unable to take on case management. Violet's mother contacted services seeking support to have contact with Violet, who also wanted to see her mother. This contact did not happen, nor was there a cultural support plan or an AFLDM conference. When Violet's placement broke down after two years, she was placed with a family she knew. There was no evidence that child protection attempted to engage with Violet's mother or assess her, despite Violet's younger brother being in her care and there being no concerns.

Further research into Violet's father found that he was not Aboriginal and in 2013 the non-Aboriginal CSO de-identified Violet as being Aboriginal. There was no evidence of consultation or rationale for this decision.

Violet's carers were deemed appropriate to be considered as permanent carers; however, in December 2014 they could not be endorsed as Violet's Aboriginal status was considered unclear. The CSO was advised that there was a two-year waiting period for non-Aboriginal carers to be assessed by the ACCO. During this time Violet's mother was asked to confirm her Aboriginality on more than one occasion, which she found very distressing. Carers were unwilling for Violet's Aboriginality to be discussed with her without some confirmation. Eventually, in 2015, child protection changed Violet's status back to Aboriginal.

The Commission was extremely concerned that Violet's Aboriginal status could be changed without any consultation or rationale. The ramifications for Violet and her mother have been profound. Violet was confused about her identity and her mother was very distressed about being questioned repeatedly. By the time this case was presented to the Taskforce 1000 panel an AFLDM conference had still not occurred and a cultural support plan had not been developed, despite DHHS being Violet's guardian for five years.

4.3.3 Aboriginal Child Specialist Advice and Support Service

226. ACSASS provides expert advice and case consultation to child protection about culturally appropriate intervention in respect of all reports regarding the abuse or neglect of Aboriginal children and regarding significant decisions in all phases of child protection.

227. DHHS presently funds provision of ACSASS through two agencies: VACCA through the Lakidjeka ACSASS program, and the Mallee District Aboriginal Services.[86] Lakidjeka ACSASS provides a statewide service except for Mildura, where the Mallee District Aboriginal Services provides coverage.

228. ACSASS is an important service for Aboriginal children and their families as it provides an approach that is cognisant of the issues affecting Aboriginal people and their interactions with government welfare service provision.

229. A protocol between DHHS and ACSASS provides guidance about their respective roles and responsibilities and facilitates contact between the organisations.[87] ACSASS plays an important role in ensuring compliance with the application of the ACPP hierarchy and in ensuring maintenance of the child's connection to culture.

230. The protocol requires DHHS to consult with ACSASS prior to making significant decisions. These decisions include:

- classification of a report
- substantiation
- the permanency objective for a child
- care arrangements
- contact between a child, their parents and others
- cultural support
- education, health or development
- involvement of other agencies and services
- preparation and review of a case plan
- removal or return of a child from parental care
- court applications
- entry or exit at a secure welfare service
- placement changes
- breaches, revocations and extensions of orders
- family reunion decisions
- case transfers.[88]

231. Survey data from Taskforce 1000 found that, despite sound practice and policy requirements evident in the DHHS *Child protection manual* and protocol with ACSASS, many Aboriginal children do not receive the benefit of services provided by ACSASS. The results indicate that, of the 980 children reviewed:

- 132 children's cases were not consulted with ACSASS at the time of the most recent child protection report
- 109 children's cases were not consulted with ACSASS at the time of the child's most recent placement change
- 98 children's cases were not being consulted with ACSASS prior to permanent care being recommended.[89]

These findings are consistent with that of the Commission's report *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*.

'There is a lack of accountability and oversight by DHHS and its funded agencies in ensuring children's connections with family and community are made possible through ACSASS involvement.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

232. During Taskforce 1000 area panel presentations, the Commission heard of examples where ACSASS consultation by DHHS either did not occur early enough to allow meaningful involvement or did not occur at all. Case study 9 was presented for discussion during Taskforce 1000. It is an example of repeated failures to consult ACSASS at key decision points for two sisters who had been removed from their parents' care. These failures meant that the children were denied the fundamental right to their culture, there was no development of a cultural support plan, there was no ability for their extended Aboriginal family and community to be consulted and inform decision-making, and – of most concern – a permanent care decision was authorised by DHHS without involvement from ACSASS.

86 Formerly known as the Mildura Aboriginal Corporation (MAC). In 2013, the organisation changed its name to the Mallee District Aboriginal Services to reflect the broad geographical region it services.

87 Department of Human Services, *Program requirements for Aboriginal Child Specialist Advice and Support Service* (Melbourne: Department of Human Services, 2012).

88 Department of Health and Human Services, *Child protection manual, Policies and procedures, Additional requirements for Aboriginal children*, <http://www.cpmanual.vic.gov.au/policies-and-procedures/aboriginal-children/additional-requirements-aboriginal-children>, accessed 20 July 2016.

89 See Appendix 1, Table A18.

Case study 9: Angela and Belinda

There were five reports to child protection in relation to Belinda. They noted concerns in relation to neglect, parental substance abuse and family violence. Only one of these reports was substantiated. None identified her father as Aboriginal.

Belinda was three years old at the time of the sixth report, which was also the first report for her 11-month-old sister, Angela. Child protection issued a Protection Application and the girls remained in the care of their parents on a Supervision order. Following further family violence, the girls were in the care of their mother, but after their parents reconciled the girls were placed in home-based care on a Custody order.

After being placed in an emergency placement, the girls were then placed in a longer-term placement. However, as the girls settled in, Belinda engaged in very concerning behaviours that frightened her sister. Belinda was moved to another home-based care placement. When her behaviour improved, Angela moved to that placement also.

In 2010, file notes show that child protection became aware that the father was Aboriginal. However, there was no evidence that ACSASS was consulted, nor was a referral made for an AFLDM conference or a cultural support plan. In April 2011, a case plan meeting made the decision for non-reunion. Later that year, a decision was made to work towards permanent care. All this was done without ACSASS being involved in any of the decision-making.

In 2012, the girls were contracted to a CSO, again without any evidence of an ACCO being consulted and without a cultural support plan. Court reports indicated that DHHS considered that the ACPP had been be complied with through the girls having parental access for two hours every three weeks.

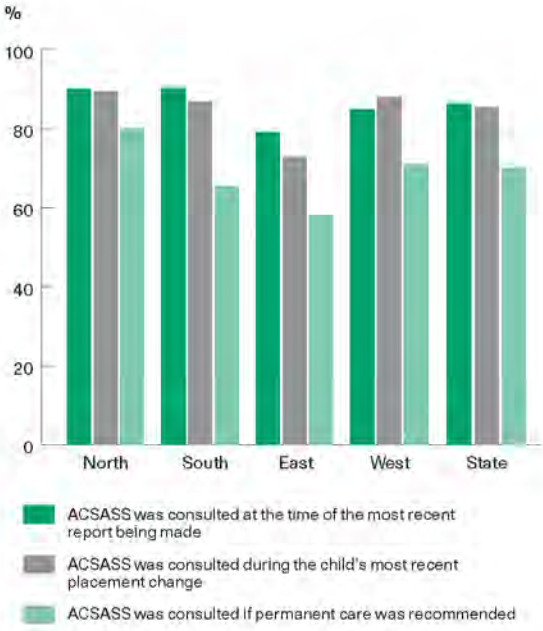
At the Taskforce 1000 presentation, it was reported that the father had only been identified as Aboriginal 12 months earlier and that a cultural support plan was being developed.

It was also reported that the girls had not had contact with their family due to their father's conflict with his family; however, an AFLDM referral – which could have considered this situation – had not been made. These two young girls have been denied access to their culture while in the care of child protection and long-term decisions have been made about their care without ACCOs being involved in the decision-making process.

233. Figure 9 presents survey data responses for the 980 children regarding compliance with requirements to consult ACSASS at three points of significant decision-making:

- at the time of the most recent child protection report
- at the time of the child's most recent placement change (if applicable)
- if permanent care was being recommended (if applicable).

Figure 9: Compliance with DHHS policy on consultation with ACSASS for children reviewed during Taskforce 1000, by DHHS division



n = 980
Source: Appendix I, Table A18.

234. The results indicate that compliance with the requirement to consult ACSASS was highest at the time of the initial report. On average, 86 per cent compliance was evident. Some divisions performed better than others; the North and South divisions were compliant in 90 per cent of cases compared with lower rates in the West division (85 per cent) and lower still in the East division (79 per cent).

235. Compliance rates averaged 85 per cent for consultation at the time of the child's most recent placement change, with lower rates again evident in the East division (73 per cent). Poor compliance was evident for consultation with ACSASS in cases where permanent care was being recommended, with just 70 per cent of applicable cases being referred for consultation. Results for the East division of DHHS were again lower (just under 60 per cent).

236. These results indicate that there are deficiencies in quality assurance and accountability processes that must be overcome within DHHS – particularly in the East division – to ensure key decisions are not made for Aboriginal children without collaborative involvement of the ACSASS program. This will, in part, address some of the problem, but there are broader resourcing and access issues to overcome.

237. A research report published by SNAICC found that the resourcing of cultural advice services is inadequate across Australia. In particular, the report identified that:

> 'in Victoria, inadequate resourcing of ACSASS services has been commonly recognised as a barrier to effective service delivery'.[90]

238. In 2012, the Victoria's Vulnerable Children's Inquiry recommended that government should establish funding arrangements with ACSASS to enable cultural advice to be provided across the full range of statutory child protection activities. Although the ACSASS program has received increased funding for two years in the 2016–17 State Budget, it is considered inadequate to fully meet the increasing number of Aboriginal children receiving child protection services and entering out-of-home care.

239. Accordingly, the Commission has recommended that DHHS reviews and implements improvements to ACSASS to ensure that the program is able to meet current and anticipated demand and can actively engage in key decisions relating to Aboriginal children in out-of-home care in a timely manner. It is recommended that for every increase in staffing to the child protection workforce there be a corresponding increase in the ACSASS workforce.

240. In response to systemic flaws identified in the current ACSASS service model, the Commission has recommended that improvements should include the opportunity for ACSASS delivery by ACCOs in regional Victoria to promote self-determination, to enable incorporation of local knowledge of the child and family to be considered in decision-making and to increase family engagement with local services. Additionally, VACCA and ACCOs are strongly encouraged to consider co-location opportunities for staff in regional Victoria, along with regular joint training to promote closer working relationships, improved information exchange and improved outcomes for Aboriginal children in out-of-home care.

90 Secretariat of National Aboriginal and Islander Child Care, *Aboriginal and Torres Strait Islander child placement principle: Aims and core elements*.

4.3.4 Aboriginal Family-Led Decision-Making

241. The AFLDM process utilises traditional Aboriginal approaches to solving family problems and involves Aboriginal Elders, the child and extended family and relevant community members making decisions about how to respond to protective concerns, develop cultural support plans and keep the child safe in the future.[91] The model utilises a co-convenor approach – one from DHHS child protection and one from the Aboriginal community – to facilitate the meeting. The Commission understands that community co-convenors are remunerated at lower rates than DHHS convenors.

242. DHHS policy states that the 'child protection practitioner is responsible for directly notifying the AFLDM DHS convenor by email within 24 hours after a substantiation decision has been made in relation to an Aboriginal child'.[92] Furthermore, an AFLDM conference is recommended to support preparation of a case plan, review of a case plan or changes to a child's protection order.

243. In practice, the Commission found that the AFLDM process is poorly observed and utilised, and has limited DHHS and funded agency oversight. There were numerous examples heard at Taskforce 1000 of AFLDM referrals failing to occur. It was clear to the Commission that accountability for ensuring that children were provided with the AFLDM process lacked clarity. On many occasions, senior practitioners and managers were unable to explain the absence of AFLDM processes to Taskforce 1000.

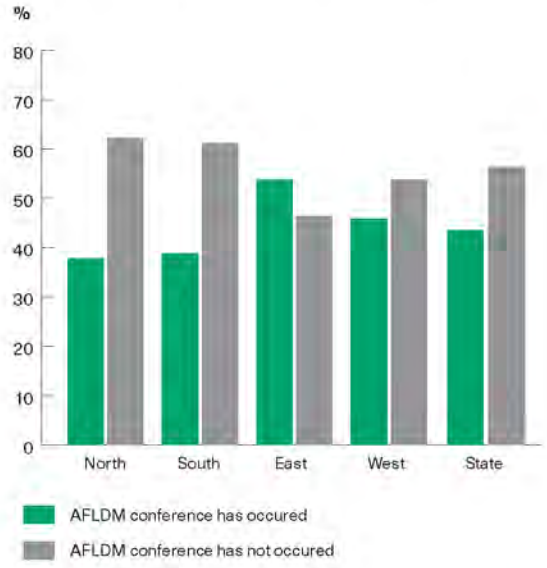
244. Figure 10 presents Taskforce 1000 survey data about compliance with AFLDM processes. Overall, it is evident that much less than half the children reviewed (426 children, or 43 per cent) were provided with an AFLDM conference. This clearly indicates that there is widespread non-compliance with the DHHS practice requirements that exist. The DHHS divisions with the poorest compliance were the North and West divisions, with less than 40 per cent of cases in both divisions having had an AFLDM conference. The East division was the only one that achieved an AFLDM conference for half the children who were reviewed. Even this result is still far short of expected DHHS practice requirements.

91 Department of Health and Human Services, *Child protection manual, Aboriginal Family-Led Decision-Making, Initiating an AFLDM meeting – practitioner's responsibilities* (internal document).

92 Ibid.

less than half
of the children had been provided with an AFLDM conference

Figure 10: Compliance with DHHS policy about provision of AFLDM conferences for children reviewed during Taskforce 1000, by DHHS division



n = 980
Source: Appendix 1, Table A18

'The continuing concern is not only the lack of family connection afforded by an AFLDM conference, but the lack of management accountability and oversight in many DHHS child protection offices.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

245. Case studies 10 and 11 are examples of non-compliance with AFLDM practice requirements.

Case study 10: Beau

Three-year-old Beau had been the subject of four reports to child protection, mainly in relation to family violence and parental substance abuse, before he and his younger sister were removed from their parents' care. Beau initially stayed with paternal relatives. He then spent time in out-of-home care before being placed with non-Aboriginal carers. Eventually another newborn sister was also placed with them.

When he came into care, child protection knew that Beau's mother was Aboriginal. His first case plan notes show that child protection were aware of the need to develop a cultural support plan and have an AFLDM conference. However, despite this being raised in many meetings over many years, it was not until after a decision was made to permanently place Beau and his sisters and an ACCO requested a cultural support plan, that one was developed.

Beau's story was presented at a Taskforce 1000 panel in late 2014, when he was seven years old. The Commission was particularly concerned that an AFLDM conference was not held when Beau was first placed into care. The genogram that was developed in February 2014 revealed a large extended maternal family that could have been drawn upon to care for Beau and his sisters, provide cultural connection or offer respite care to his carers. Unfortunately for Beau and his family, it was not until shortly before the case was presented at Taskforce 1000 that the first AFLDM conference was held, four years after Beau first came to the attention of DHHS.

Case study 11: Emma

At the time of her birth, Emma was removed from the care of her mother because of concerns about her mother's homelessness and substance abuse. After a short period with carers, Emma was placed with people who were believed to be her father and paternal grandparents. DNA testing later established that this was not the case.

Initially, Emma's mother and her partner lived with the carers. When her parents' relationship broke down, the carers appeared to assume all parenting responsibility, although her mother did visit and stay for periods of time and appeared to have a bond with Emma.

Emma was placed on a Custody order. By the time Emma was two years old, the case plan was for non-reunion and for Emma to remain with her carers. The case was contracted to a local ACCO.

At the Taskforce 1000 panel presentation, the Commission was advised that, despite Emma being in care since birth, an AFLDM conference had not been held, nor was there a cultural support plan. A genogram demonstrated that Emma's mother had a large family who had not been involved in decision-making for her care.

246. The Commission's report, *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*, detailed poor compliance with AFLDM processes. A disproportionate and low number of AFLDM conferences had occurred (250 referrals, with 141 proceeding to an AFLDM conference in 2014–15) in comparison with the 1,250 meetings that had been intended according to the funding provided.[93]

247. The ACPP inquiry found particular systemic barriers in meeting practice requirements for AFLDM processes:

- ongoing vacancies in filling convenor roles
- lack of clarity of role responsibility between the co-convenors
- lack of training and understanding of referral processes
- poor briefing of Elders about their role
- over-representation of DHHS staff, inhibiting a truly family-led process
- limited involvement of ACSASS due to workload demands and late notice of meetings.

248. During Taskforce 1000, the Commission heard of an example of inadequate planning by DHHS regarding the safety and wellbeing of a mother who had been a victim of family violence. The Commission was told that the mother was required to attend an AFLDM conference with her violent ex-partner being present or she would be excluded from participation in the meeting process. The Commission was advised that a separate meeting was not offered for the mother and considerable pressure was allegedly placed on her to participate. This demonstrates disregard for the safety of the mother involved and lack of flexibility and understanding by the professionals concerned.

249. It is clear that accountability mechanisms and oversight must be strengthened and improved, alongside overall improvements to the AFLDM model. In order to improve accountability processes, the Commission has recommended that DHHS reports compliance and performance data about the provision of AFLDM conferences to the ACF and the Commission, and that this data is also published in DHHS's annual report. Furthermore, clearer positional accountability of operational DHHS Deputy Secretaries to improve outcomes for Aboriginal children has been recommended, with one key measure including the provision of the required number of AFLDM conferences within the required time lines.

250. The Commission has recommended that DHHS reviews and implements improvements to the AFLDM model through the removal of barriers to timely meetings and compliance with guidelines, in order to meet current and future demand. The Commission also considers that remuneration of community AFLDM convenor positions should be commensurate with the DHHS convenor position, when workloads are comparable.

93 Commission for Children and Young People, *In the best interests of the child*.

4.3.5 Application of the Aboriginal Child Placement Principle

Compliance with the ACPP

251. Division 4 of the CYFA 2005 outlines the priorities and criteria for the placement of Aboriginal children who are not able to remain safely at home through the ACPP. A hierarchy of placement options is specified, with preference given to the child's placement with Aboriginal extended family or relatives.[94]

252. Despite these legislative requirements, DHHS does not presently collect data or formally monitor whether or not the ACPP has been applied. DHHS advised the Commission that there is 'no existing measure' relating to compliance with the ACPP.[95]

DHHS does not collect data or monitor
whether or not the ACPP has been applied

253. DHHS instead measures a 'proxy measure': the proportion of Aboriginal children placed with relatives or other Aboriginal carers. The problem with this measure is that it does not take into account whether the hierarchy of placement options was considered for an Aboriginal child's placement in out-of-home care or if the child's kinship carers are Aboriginal.

254. The Commission's report, *In the child's best interests: Inquiry into compliance with the Aboriginal Child Placement Principle in Victoria*, found that there was partial to minimal compliance evident that children were placed at the highest level of the ACPP hierarchy or that the child's kinship carers were Aboriginal.

255. An obvious gap at present is the absence of a robust measurement of compliance with the ACPP. The Productivity Commission has reported that work is underway to develop such a measure as part of the *National framework for protecting Australia's children: Second three-year action plan, 2012–15*.[96]

256. In effect, failing to measure compliance with the ACPP gives a strong message that this principle is not important and, in doing so, fails to ensure cultural safety for Aboriginal children. Greater accountability must be shown by DHHS in ensuring that every Aboriginal child requiring out-of-home care has been afforded due consideration of their cultural needs and wellbeing through application of the ACPP. Measurement of compliance is essential in being able to ensure that the grief, suffering and loss of the Stolen Generations are not replicated for the present generation of Aboriginal children.

257. Accordingly, the Commission recommends greater rigour, accountability, proficiency, workforce capability and overall compliance with the ACPP. Specifically, recommendations have been made for:

- DHHS to review the adequacy of the training and training materials provided to DHHS and agency staff relating to the application of the ACPP
- DHHS to develop guidelines and KPIs for the implementation of the ACPP
- DHHS to collect compliance data and report on the application of the ACPP to the ACF and the Commission on a quarterly basis and also in its annual report
- accountability for the application of the ACPP to be incorporated into the individual performance plans of operational DHHS Deputy Secretaries.

258. In the absence of data on the compliance with the ACPP, this Inquiry has considered the following factors:

- type of out-of-home care provided
- Aboriginal status of the child's primary carer
- provision of cultural awareness training for non-Aboriginal primary carers.

Types of out-of-home care

259. Children who enter out-of-home care in Victoria are placed in one of the following placement types:

- kinship care (also includes kith placements)
- home-based care
- residential care
- lead tenant.[97]

260. According to the *Report on government services 2016*, most children (55 per cent) in out-of-home care in Victoria are placed in kinship care. For Aboriginal children, the use of kinship care is slightly higher (58 per cent).[98] Table 4 provides a breakdown of placement types.

94 Refer to Chapter 2 of this report for the full hierarchy of the ACPP.

95 DHHS advice to the Commission, 5 January 2016.

96 Steering Committee for the Review of Government Service Provision, *Report on government services 2015, Volume F Community services*.

97 See 'Definitions' section in this report for further information.

98 Steering Committee for the Review of Government Service Provision, *Report on government services 2015, Volume F, Community services*.

Table 4: Victorian children in out-of-home care by Aboriginal status and placement type, 30 June 2015

Placement type	Aboriginal children	Non-Aboriginal children	Total
Number			
Residential care	73	365	438
Home-based care	358	1,119	1,477
Kinship care	884	3,822	4,706
Other home-based care	192	1,699	1,891
Independent living	4	44	48
Total	**1,511**	**7,049**	**8,560**
Percentage (%)			
Residential care	4.8	5.2	5.1
Home-based care	23.7	15.9	17.5
Relative/kinship care	58.5	54.2	55.0
Other home-based care	12.7	24.1	22.1
Independent living	0.3	0.6	0.6
Total	**100.0**	**100.0**	**100.0**

Source: Steering Committee for the Review of Government Service Provision, *Report on government services 2016, Volume F, Community services*. Table excludes data for seven children of unknown Aboriginal status.

261. In Victoria, there has been a recent move towards reducing the number of all children in residential care placements, particularly in light of recent inquiries that have found residential care often results in poor outcomes for children.[99]

262. In March 2015, DHHS introduced 'targeted care packages' to reduce the numbers of children in residential care by shifting children, where possible, to home-based care arrangements. This was done in recognition of the fact that residential care is a less desirable form of out-of-home care. Aboriginal children and children under the age of 12 were prioritised by DHHS for provision of these packages.[100] Allocation of $43 million was provided to support the transition of these children to home-based care arrangements.

263. DHHS reported that, as at 29 February 2016, 109 children, including 14 Aboriginal children, had been transitioned from residential care through the application of targeted care packages and were supported to live with home-based carers, extended family, their parents or independently.[101]

264. It is an encouraging development that DHHS has been working to reduce the number of Aboriginal children in a form of care that has been found to offer poor physical and cultural safety. However, there is a degree of caution warranted, as noted by VAGO in its 2016 follow-up report on residential care, that targeted care packages '...are not recurrently funded and will depend on children and young people leaving the out-of-home care system or alternative sources for future growth'.[102] Sustained commitment and support will be required in the long term to ensure placement stability and improved outcomes for these children.

99 For example, Commission for Children and Young People, *"...as a good parent would..."* and Victorian Auditor-General, *Residential care services for children*.

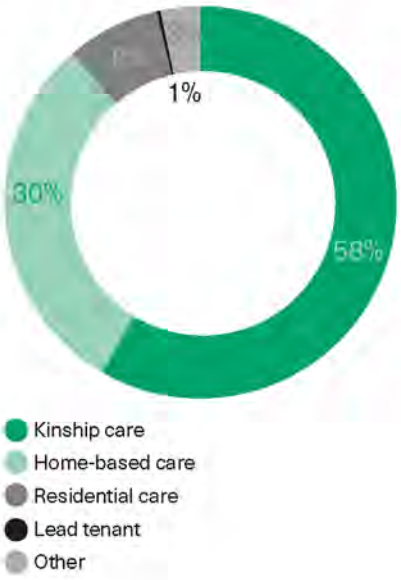
100 Mikakos, J. (Minister for Families and Children), *$43 million to move vulnerable kids out of residential care* [media release], 16 March 2015, Premier of Victoria, <www.premier.vic.gov.au/43-million-to-move-vulnerable-kids-out-of-residential-care>, accessed 20 July 2016.

101 Department of Health and Human Services, *Roadmap for reform: Strong families, safe children* (Melbourne: Department of Health and Human Services, 2016).

102 Victorian Auditor-General, *Follow up of residential care services for children* (Melbourne: Victorian Auditor-General's Office, 2016).

265. Figure 11 provides an overview of placement types for children reviewed during Taskforce 1000. Almost 60 per cent of children were placed with family. Thirty per cent were placed in home-based care, and residential care accounted for less than 8 per cent of placements.

Figure 11: Out-of-home care placement type for children reviewed during Taskforce 1000



n = 980
Source: Appendix 1, Table A19.

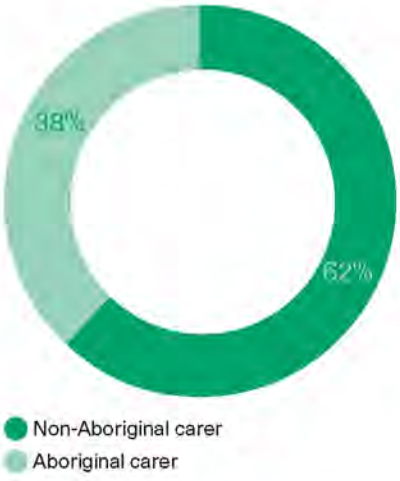
266. During Taskforce 1000, the Commission observed that DHHS included non-family carers within the child's community network, such as neighbours, family friends or community members, within the category of 'kinship care'. It would be more correct to classify such forms of care as 'kith placements'. This is a problematic practice, as accurate data is not available on the use of kith placements, particularly as it applies to compliance with the ACPP.

Aboriginal status of carers and provision of cultural awareness training for non-Aboriginal carers

267. Taskforce 1000 survey data considered the Aboriginal status of the child's primary carer. Figure 12 shows that most Aboriginal children were placed with non-Aboriginal carers. Rates across the state ranged from 56 per cent in the North division to 66 per cent in the South division.[103]

over 60%
of children were placed with a non-Aboriginal carer

Figure 12: Aboriginal status of child's primary carer for children reviewed during Taskforce 1000



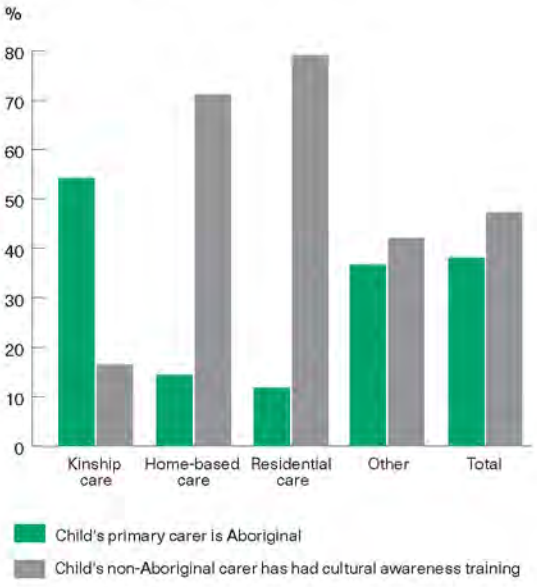
n = 979 (data was missing for the Aboriginal status of one child's primary carer)
Source: Appendix 1, Table A15.

268. As previously mentioned, children case managed by an ACCO were more likely to be cared for by an Aboriginal primary carer (48 per cent) than children whose case management was provided by DHHS (41 per cent) or a CSO (19 per cent).

269. A further breakdown of the primary carer's Aboriginal status by type of placement and provision of cultural awareness training for non-Aboriginal carers is presented in Figure 13. It was evident that over half (54 per cent) of kinship carers were Aboriginal and very few home-based carers (14 per cent) or residential carers (11 per cent) were Aboriginal. This highlights the need for increased recruitment of Aboriginal carers into these forms of out-of-home care to improve children's opportunities to be cared for in a culturally appropriate and safe environment.

103. Appendix 1, Table A15

Figure 13: Aboriginal status of child's primary carer and provision of cultural awareness training for non-Aboriginal primary carers for children reviewed in Taskforce 1000, by placement type



n = 979 (data was missing for the Aboriginal status of one child's primary carer)
Source: Appendix 1, Table A21.

270. Provision of cultural awareness training for non-Aboriginal carers was extremely poor, with less than half (47 per cent) of all non-Aboriginal primary carers having undergone such training. This was most noticeable for kinship carers; only 16 per cent of non-Aboriginal carers had undergone such training. Given the large numbers of children placed in kinship care and the fact that most of these carers are non-Aboriginal, this is a concerning result and indicates the need for greater attention to the training and cultural support for these carers. These issues are discussed further in this report.

4.3.6 Cultural support planning

Children, Youth and Families Act 2005
Section 176 Cultural plan for Aboriginal child:

(1) The Secretary must prepare a cultural plan for each Aboriginal child placed in out of home care under a guardianship to Secretary order or long term guardianship to Secretary order.

(2) A cultural plan must set out how the Aboriginal child placed in out of home care is to remain connected to his or her Aboriginal community and to his or her Aboriginal culture.

(3) For the purposes of subsection (2), a child's Aboriginal community is—

a. the Aboriginal community to which the child has a sense of belonging, if this can be ascertained by the Secretary; or

b. if paragraph (a) does not apply, the Aboriginal community in which the child has primarily lived; or

c. if paragraphs (a) and (b) do not apply, the Aboriginal community of the child's parent or grandparent.

(4) The Secretary must monitor compliance by the carer of a child with a cultural plan prepared for a child.[104]

Compliance and accountability

271. Prior to March 2016, section 176 of the CYFA 2005 specified that every child subject to a Guardianship or Long-term Guardianship order be provided by the Secretary of DHHS with a cultural plan. This legislative requirement exists in recognition of the fundamental human right to access culture and the significance that cultural connection plays in providing safety, identity, resilience and wellbeing. Despite these provisions, failures to comply with the legislative requirements have been evident over many years.

272. In 2009, the Ombudsman Victoria *Own motion investigation into the Department of Human Services child protection program*[105] found that there was poor compliance with the CYFA 2005 section 176 cultural planning requirements for Aboriginal children. Only 20 per cent of children who were required to have a plan had one developed.

104 Section 176 of the CYFA 2005 was amended in March 2016 to require that a cultural support plan be provided for any Aboriginal child in out-of-home care, irrespective of the type of protection order that the child is subject to. This legislation came into effect after the conclusion of Taskforce 1000 and is therefore not applicable to the cohort of children reviewed in this Inquiry.

105 Ombudsman Victoria, *Own motion investigation into the Department of Human Services child protection program*.

4. Inquiry findings

273. In 2014, VAGO found in its audit report, *Residential care services for Victorian children*, poor compliance with cultural planning for Aboriginal children. The report noted that a DHS divisional audit had found that 81 per cent of children who were within scope of the legislative requirements at that time did not have a cultural support plan. The report found that DHS does not actively monitor or report on compliance with cultural support planning requirements.[106] A 2016 follow-up report by VAGO found that, in relation to compliance with cultural support planning for Aboriginal children, DHHS has not improved its performance in complying with these requirements. These issues are consistent with findings in this Inquiry report.

274. The Commission has found continued and widespread non-compliance with the CYFA 2005 section 176 requirements.

275. Survey data from the Taskforce 1000 project indicated that, of the 980 children reviewed, 279 children were subject to Guardianship or Long-term Guardianship orders.[107] Therefore, it would be expected that all of these children had a cultural plan that reflected the child's Aboriginal community and detailed how the child would remain connected to that community while in out-of-home care.

276. The reality was very disappointing. Almost one-quarter of the children (67) on Guardianship or Long-term Guardianship orders had no cultural plan at all, despite the legislative requirements of DHHS to provide one.[108]

277. This was a surprising and concerning revelation considering the relatively small number of children (279) that were within scope of this requirement at the time. This raises questions about the cultural competence, oversight and accountability of DHHS in providing out-of-home care services to Aboriginal children. It could also be argued that lessons have not been learned from the experiences of the Stolen Generations, whose culture was eroded or removed entirely by government policies and practices.

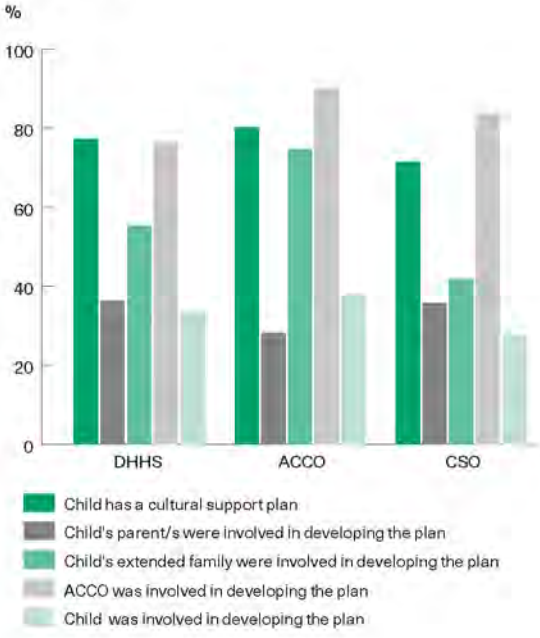
'Because the objective was to absorb the children into white society, Aboriginality was not positively affirmed. Many children experienced contempt and denigration of their Aboriginality and that of their parents or denial of their Aboriginality. In line with the common objective, many children were told either that their families had rejected them or that their families were dead. Most often family members were unable to keep in touch with the child. This cut the child off from his or her roots and meant the child was at the mercy of institution staff or foster parents.'[109]

278. As shown in Figure 14, it was evident that compliance with legislative requirements for cultural support planning for children on Guardianship or Long-term Guardianship orders varied according to the agency providing the child's case management:

- 71 per cent compliance for CSOs
- 77 per cent compliance for cases managed by DHHS
- 80 per cent compliance for cases managed by ACCOs.

279. Overall, there was limited engagement evident by all agencies providing case management with the child and the child's parents in developing the cultural support plan, indicating areas for future improvement. Engagement with the child's extended family in developing the cultural support plan was slightly more apparent, particularly for cases managed by an ACCO.

Figure 14: Compliance with legislation for cultural support plans for children on Guardianship orders reviewed during Taskforce 1000, by agency with case management responsibility



n = 279
Source: Appendix 1, Table A22.

280. The poor compliance evident during Taskforce 1000 by DHHS, CSOs and, to a lesser extent, ACCOs with the requirements of section 176 of the CYFA 2005 raises concern for how the cultural wellbeing and safety of all Aboriginal children in out-of-home care will be ensured, following recent legislative amendments.

281. In March 2016, section 176 of the CYFA 2005 was amended to ensure that all Aboriginal children in out-of-home care are provided with a cultural plan, irrespective of the protection order that the child is subject to.

106 Victorian Auditor-General, *Residential care services for children*.

107 Appendix 1, Table A17.

108 Appendix 1, Table A24.

109 Commonwealth of Australia, *Bringing them home*, p. 154.

282. DHHS, CSOs and ACCOs must now ensure approximately 1,500[110] Aboriginal children in out-of-home care are provided with a meaningful cultural plan that is relevant to the child's age, development and circumstances.

283. Clearly there is considerable apprehension about the commitment and capability of agencies providing out-of-home care to ensure compliance with the amended legislation for this significantly larger cohort of children. Recurrent investment and capacity building will be required to adequately resource ACCOs to take a lead role in contributing to the development and implementation of high-quality cultural plans that attend to a child's right to access and engage with cultural information, access appropriate mentors, engage in sporting and arts activities and celebrations and develop an appreciation and understanding of identity and connection to Country.

284. Infrastructure to support the promotion of cultural identity will be imperative. The Commission heard from the Aboriginal community and broader out-of-home care sector that there is a need for a central information source to support high-quality cultural planning.

285. The Commission considers that access to information through the development of a web-based portal to assist carers, children and community will be important to support contemporary and meaningful cultural connection for Aboriginal children in out-of-home care. It is acknowledged that funds have been allocated for two years in the Victorian State Budget 2015–16 to enable the establishment of the portal. There is a need, however, to ensure this initiative is funded in an ongoing capacity.

286. A recommendation has also been made for DHHS, ACCOs and CSOs to ensure that, following placement of a child in out-of-home care, the carer is engaged with Aboriginal community services (such as early years programs, health services, cultural, sporting and other community service programs).

287. Enhancement to the DHHS CRIS system is considered imperative to improve accountability by separately and prominently recording activities related to cultural support planning for Aboriginal children, such as:

    - grouping together genograms
    - documentation pertaining to additional decision-making principles for Aboriginal children inclusive of AFLDM processes, compliance with the application of the ACPP and cultural support plans.

    The Commission found, through conducting file reviews, that there is no field within the current CRIS system that contains such information separately for ready access.

288. The need for greater management oversight, accountability and understanding of the importance of cultural planning is identified as a substantial issue to be overcome. Despite the legislative requirement for cultural support planning, the Commission found that DHHS does not routinely check whether a cultural support plan has been developed, has been implemented or is reviewed annually.

289. Accordingly, the Commission has recommended that DHHS establishes internal KPIs for compliance with these requirements, and regularly reports to the ACF and the Commission on these indicators. The Commission is also concerned that there is no formal oversight of the implementation of a cultural support plan for children subject to a Permanent Care order and has recommended that DHHS devises processes to address this need.

290. Furthermore, the Commission has recommended that operational DHHS Deputy Secretaries, through their individual performance plans, hold responsibility for ensuring all Aboriginal children in out-of-home care have a cultural support plan that has been developed with integrity, is implemented and reviewed at least annually.

'I saw countless children who had been in out-of-home care for years in the South division, who had never had a cultural support plan or AFLDM conferences. I asked the DHHS directors and executive staff, "Who is responsible for ensuring this child has a cultural support plan?" Not a single person who was legally responsible for ensuring these legislated and practice requirements happened put their hand up. It was disgraceful that it didn't appear to matter to them.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

291. While agencies with case management of Aboriginal children in out-of-home care have clear statutory responsibility for compliance with the requirements of the CYFA 2005 in respect of decision-making and practice requirements for Aboriginal children, it is also incumbent on all parties involved in the Children's Court system to be culturally competent and cognisant of the need for children's cultural rights to be upheld when considering child protection matters before the court.

292. As a result, the Commission will work collaboratively with Victoria Legal Aid and the Law Institute of Victoria to ensure that all legal practitioners who work within the Children's Court jurisdiction are culturally proficient. This could include undergoing annual cultural and community awareness training to focus on building understanding of the importance of cultural support planning for Aboriginal children and the specific decision-making requirements for Aboriginal children as specified in the CYFA 2005.

110 Australian Institute of Health and Welfare, *Child protection Australia 2014–15*.

4. Inquiry findings

Quality of cultural support plans

293. The Commission found, through reviewing a sample of cultural plans that had been completed for children whose cases were presented to Taskforce 1000, that the quality of the plans was overwhelmingly poor. Many plans were rudimentary and could be considered tokenistic. They had not been updated or reviewed and had minimal input from the child's parents, extended family or Aboriginal community, nor did they consider the child's views. Involvement and engagement with ACCOs in completing the plans did not occur consistently.

294. Often the attempts to consider suitable cultural activities were cursory. For example, in one child's cultural plan, attending NAIDOC week was the sole activity cited.[11] A lack of sophistication and cultural competence was evident in many other plans. One documented a visit to the Northern Territory as a means of understanding Aboriginal culture; however, the Yorta Yorta child had no affiliation with the Aboriginal communities of the Northern Territory. The Commission also heard of simplistic attempts to acknowledge culture, such as displaying Aboriginal flags, artefacts and books in the home, without any deeper inclusion or participation in culture. What is apparent is the strong need for improved cultural competence within the sector. These issues will be explored further in this report.

295. The Commission has recommended that cultural support plans must, at a minimum, include the child's family genogram, a plan for the child's return to Country and identify a suitable mentor who will enable the child's access to culture and lead to real experiences and cultural connections. Cultural programs for Aboriginal children in out-of-home care should be available on a local and regional basis, be recurrently funded and may include healing camps, access to the arts, connection to Country activities, recreation and educational opportunities.

296. Case study 12 was reviewed during Taskforce 1000 and illustrates that, when timely engagement and involvement of an ACCO occurs, optimal cultural outcomes result.

Case study 12: Molly

There were nine reports in relation to Molly and her siblings, beginning when she was two months old. Molly had been exposed to physical, sexual and emotional abuse as well as neglect by her non-Aboriginal mother and her multiple non-Aboriginal partners. When Molly was four years old, the tenth report to child protection was received. Concerns related to her mother's capacity to care for her and her siblings. Molly had regular access to her father.

At the time of the report, the local ACCO was contacted. Molly was placed on a Supervision order with her mother, but this was breached and Molly was placed with a neighbour on a Custody order. This placement broke down due to Molly's trauma-related behaviours, which were difficult for the carer to manage. Molly spent a short period in residential care before being placed with a non-Aboriginal carer through the ACCO.

While in placement, with the support of a strong and therapeutic care team, an appropriate cultural support plan and a KESO, Molly's behaviours have settled. Molly has told child protection she feels safe and secure with her carers. Case planning is progressing towards permanency planning for Molly and the local ACCO has been contracted to case manage.

Molly's carers have attended cultural awareness training and strive to ensure that she is connected to her culture and family.

11 NAIDOC week is an annual event held in July across Australia to celebrate the history, culture and achievements of Aboriginal and Torres Strait Islander peoples. For more information, visit <www.naidoc.org.au>.

4.3.7 Sibling placement and contact

Finding 6:

High numbers of Aboriginal children in out-of-home care are separated from their siblings and are not provided with adequate opportunity to have contact with them.

297. As Taskforce 1000 progressed, an emerging area of significant concern became apparent to the Commission. Many children had been separated from their siblings in their out-of-home care placement.

298. Of the 980 children, 921 had siblings. Of these children, 777 had a sibling or siblings who were also in out-of-home care, but only 550 (59 per cent) were placed with their sibling. A sizeable proportion (34 per cent) had no contact with the siblings they were not living with.[112] These statistics are bleak and indicate that urgent action is needed to address the systemic barriers that have enabled such practice to occur.

over 40%
of children with siblings were separated from their brothers and sisters

299. The Commission heard many disturbing examples relating to sibling separation.

- Four siblings involved with child protection were case managed within the same DHHS office by two different child protection practitioners who were not aware that the children were siblings. When the two sets of children were discussed at Taskforce 1000, it was evident that the practitioners had formed significantly different assessments of the mother's capacity to provide care for the children and her connection to culture and community.
- Siblings case managed by a CSO, who were separated in two different home-based care placements, attended two different primary schools and were not provided contact with each other as it was deemed it would be too onerous for the carers.
- Siblings were separated because DHHS assessed that a kinship carer's public housing was unsuitable as it was too small. When the case was presented at Taskforce 1000, it was evident that child protection had not spoken with the housing officer to collaborate on a solution so that the children could be kept together with their kinship carer. This was a common scenario seen by the Commission across Victoria.
- There were many cases where knowledge of the existence of siblings was evident through historical child protection file notes, but the information was not revisited or considered in decision-making.

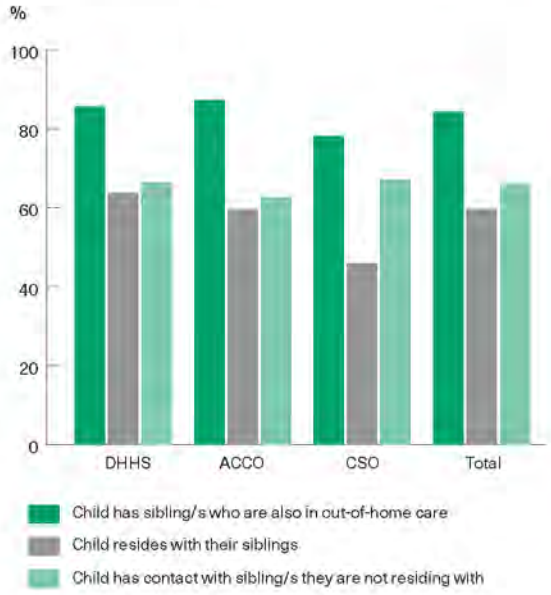
'The frequent lack of communication within DHHS, between child protection and housing, in prioritising suitable accommodation to co-locate sibling groups separated in the care of the state was disturbing.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

112 Appendix 1, Table A23.

300. There was little difference between the agencies providing case management, as shown in Figure 11. This suggests that there are limited placement options to keep sibling groups together in out-of-home care and inadequate resourcing to ensure regular contact can occur in the event that siblings cannot be placed together.

Figure 15: Sibling placement and contact for children reviewed during Taskforce 1000, by agency providing case management



n = 921
Source: Appendix 1, Table A23.

301. Case study 13 is an example that represents many that were heard during Taskforce 1000. A child was disconnected from her extended family and siblings, with no effort made by the agency responsible for her care to ensure she had contact with her siblings. Further, the case example demonstrates poor regard for cultural identity, planning and engagement.

Case study 13: Sally

Both Sally's parents are Aboriginal and have their own child protection history. Neither of Sally's parents had knowledge of their own ancestry, heritage or culture.

Sally is intellectually disabled and was diagnosed as having Autism spectrum disorder. Sally was placed in out-of-home care in 2012, and had experienced both home-based care and residential care. Sally was on a Custody order, case managed by a local CSO.

Sally was also a client of Disability Client Services and was supported by many services, but she was not linked to her Aboriginal community or culture. Aboriginal CSOs were not attending her care team meetings or supporting her to link with her culture. Following the Taskforce 1000 presentation, attempts were made to develop a cultural support plan; however, child protection reported this was difficult due to her parents' lack of knowledge of their culture and heritage.

When an AFLDM conference was held in rural Victoria in March 2015, nearly three years after Sally was placed in care, her parents reiterated that they had no knowledge of their Aboriginal heritage. It was unclear if services had supported them to explore their history or if the importance of doing this had been identified. Sally had spasmodic contact with one of her siblings, who resided with her parents. Sally had never met two of her other siblings and had no contact with any of her extended family members, either maternal or paternal. There was no evidence of a rationale for this lack of contact with siblings and extended family.

Sally was 14 years old when her case was presented to Taskforce 1000. By that time Sally had a long history of reports to child protection in Victoria and other jurisdictions.

The case plan meeting minutes indicated that Sally's cultural needs had not been met. Perhaps as a result, the child protection file notes from mid-2014 noted that Sally did not identify as Aboriginal. The Commission was very concerned that there was no evidence of any attempts to link Sally with her siblings, her extended family and her culture by DHHS, which had responsibility for her day-to-day care since 2012.

302. A recommendation has been made by the Commission that operational DHHS Deputy Secretaries be accountable, through their individual performance plans, for demonstrating reductions in the number of Aboriginal siblings separated in out-of-home care.

303. The Commission considers that the system must provide for greater capacity to keep siblings together and provide ACCOs with a greater say in where and how siblings will be placed. As a result, recommendations have been made to address the practice issues evident that have resulted in the separation of siblings, including:

- enhancements to the CRIS system to more readily identify and link siblings
- establish a case practice requirement that Aboriginal siblings are case managed by the same case manager
- that DHHS, in collaboration with ACCOs, ensures that, in addition to children's individual case plans, Aboriginal siblings are also provided with a sibling case management plan
- that, as an alternative to residential care, DHHS, in partnership with the ACF, develops specialist therapeutic family-like care models for Aboriginal children, delivered by ACCOs.

4.3.8 Family searching

304. Taskforce 1000 demonstrated the pressing need for a child-specific family search service to assist in genealogical searches and connect separated siblings and family members. Such a service would benefit Aboriginal children currently subject to child protection involvement and assist in compliance with the ACPP should an out-of-home care placement be required.

305. The absence of this type of service for children is a systemic flaw that has resulted in large numbers of children being denied relationships and the opportunity for placement with their extended Aboriginal family. The NSDC noted concern in its recent *Scorecard report 2015*, that there must be sustainable efforts to support family tracing services for the future, given the high rates of present-day removals.[113] Further, it reports that there are continuing concerns about the types of services available, their quality, their capacity and the barriers to accessing them. It notes that, for family search services, 'more people need their services than can use them'.[114]

Link-Up Victoria

Link-Up Victoria was established in 1990 to address the specific needs of Aboriginal people who were the victims of past government removal policies and practices that led to the Stolen Generations. The service is funded through the Commonwealth and assists Aboriginal people over the age of 18 who were adopted, placed in home-based care, institutionalised or forcibly removed to trace and be reunited with their families. The service operates a number of programs including counselling, referral, advocacy and prison-visiting services to Stolen Generation clients.[115]

306. There are currently service gaps for family search services for vulnerable Aboriginal children subject to child protection involvement. Link-Up Victoria is not funded to provide a service for children. This has led to the Commission considering the need for two related recommendations to remedy this service gap.

307. The Commission has recommended that DHHS, in partnership with ACCOs, facilitates the establishment of a statewide program for Aboriginal children in out-of-home care to search their family history and assist in the creation of detailed family genograms to identify and connect family and community.

308. Following the establishment of this service, the Commission has recommended that DHHS ensures consultation with the Aboriginal family search program occurs at key phases of intervention, to ensure the accuracy of family information is obtained and considered in decision-making and informing accurate genograms.

309. Case study 14 is an example of why a family search program is needed to ensure early identification of separated extended family, provide opportunity for the application of the ACPP and connect children with their culture.

113 Rule, J and Rice, E, *Bringing them home: Scorecard report 2015* (Canberra: National Sorry Day Committee Inc, 2015).

114 Ibid.

115 See <www.linkedupvictoria.org.au>.

Case study 14: Bradley

Bradley's mother is an Aboriginal woman who was adopted as a baby and placed in out-of-home care as a teenager. After conducting a review of Bradley's child protection file, it was clear that his mother had no links with her Aboriginal family.

Bradley's parents separated and from the age of four he was raised by his father. Bradley was the subject of 11 reports to child protection while in his father's care. Bradley experienced multiple episodes of abuse and harm before child protection placed him in out-of-home care at the age of 12. Bradley had no contact with his mother for 10 years and was placed in a number of placements with non-Aboriginal carers.

Information about Bradley's Aboriginality became known to child protection after some time. His mother was located through collaboration with a local ACCO and contact was established with her.

When Bradley's case was discussed at Taskforce 1000, it was apparent that he had a large extended family that had not been contacted or connected to him, including a nine-year-old sibling who was in out-of-home care in another area and a number of adult siblings.

4.3.9 Improve child protection responses

310. Deficient practices within the child protection system and poor resourcing of out-of-home care has been evident in previous inquiries. The 2010 Ombudsman Victoria, *Own motion investigation into child protection – out of home care*, found that the growing demand for services was not budgeted for and, consequently, many vulnerable children were placed in harmful and unsafe situations. It reported:

- unstable care arrangements for many children
- non-compliance with the ACPP
- poor compliance by out-of-home care providers in ensuring the cultural identity of Aboriginal children
- many Aboriginal children being placed away from their communities
- vulnerable children being placed with other children with histories of sexually abusive behaviour
- children with no history of drug or alcohol use placed with children who had substance abuse issues
- many siblings being separated
- many Aboriginal children being placed with non-Aboriginal carers
- very young children being placed in residential care
- children with intellectual disabilities being placed in inappropriate care arrangements.[116]

311. Issues specific to Aboriginal children in the child protection system were also addressed in the *Victoria's Vulnerable Children Inquiry report*.[117] A number of recommendations were made to improve outcomes for Aboriginal children and their families, including:

- the need to develop specific Aboriginal responses
- endorsing and monitoring of the Victorian Indigenous Affairs Framework[118]
- the need to build Aboriginal cultural competence into DHS standards for registering CSOs
- expanding cultural competency approaches across family and statutory services
- the creation of a dedicated Commissioner for Aboriginal Children and Young People within the Commission
- the adoption of a comprehensive plan to delegate the care and control of Aboriginal children removed from their families to Aboriginal communities.

312. Progress has been made on a number of these recommendations. One notable action was the appointment of Mr Andrew Jackomos PSM, Victoria's first Commissioner for Aboriginal Children and Young People, in 2013.

313. Convincing progress has not yet been achieved on accomplishing cultural competence within the sector or setting a comprehensive plan for self-determination through the delegation of children's care and case management to ACCOs. The establishment of the ACF in 2015 was a commitment by government, the Aboriginal community and the Commission to the development of an Aboriginal children's strategy. This will pave the way for the transfer of case management and placement of all Aboriginal children within the Aboriginal community.

314. Limitations of the child protection system continued to be identified by the Commission during Taskforce 1000. The Commission has recommended that DHHS provides an improved model of child protection service delivery for all Aboriginal children to address these persistent practice deficits.

116 Ombudsman Victoria, *Own motion investigation into child protection – out of home care*.

117 Cummins, P, Scott, D and Scales, B, *Report of the Protecting Victoria's Vulnerable Children Inquiry: Volume 1*.

118 The Victorian Indigenous Affairs Framework is now known as the Victorian Aboriginal Affairs Framework.

315. The Commission considers there is the need for dedicated area-based child protection teams to manage all child protection matters relating to Aboriginal children. To support the work of these teams, the Commission has recommended that eight child protection specialist Principal Practitioners for Aboriginal children positions (one rural and one metropolitan based in each of the four DHHS divisions) be established. These positions are to provide specialist advice and consultation to divisional Aboriginal child protection teams, be delegated with case planning responsibility and play a key role in the oversight of best practice.

316. In addition, it is considered necessary that DHHS establishes a child protection Chief Practitioner for Aboriginal Children within the department's central office to provide support and oversight to the eight divisional Principal Practitioners for Aboriginal Children.

317. The absence of regular case planning or review involving relevant government departments, CSOs and ACCOs was a common practice issue identified during Taskforce 1000. Accordingly the Commission has recommended that DHHS develops reunification guidelines that are specific to Aboriginal children in out-of-home care and ensures that every Aboriginal child in out-of-home care has an annual case conference planning review, involving all members of the care team, that includes a review of:

    - the child's genogram
    - the child's health and education needs
    - progress in implementing the child's cultural support plan
    - compliance with the ACPP
    - ensuring AFLDM conferencing has occurred
    - parental involvement with the justice system and consideration of integrated case management with DoJR to support family reunion where appropriate.

    CRIS enhancements will be required to support this through alerts to the allocated worker about the tasks that need to be completed to meet this annual requirement.

318. An interrelated recommendation is that relevant government agencies develop processes to enable sharing of information relevant to the wellbeing of an Aboriginal child in out-of-home care and their family, to enable integrated case management.

    Integrated case management for Aboriginal families should be considered where multiple government departments are involved with a family in order to work collaboratively to address intergenerational disadvantage and trauma.

319. In light of legislative amendments to the CYFA 2005 pertaining to permanency planning for children and the identified issues evident in this Inquiry that relate to the failures to ensure Aboriginal children's cultural safety, the Commission has proposed changed practices relating to permanent care proposals for Aboriginal children.

320. The Commission has recommended that, in order to promote self-determination and local community input, prior to a permanent care application being made to the Children's Court endorsement for the application must first be sought from a panel comprising:

    - relevant Aboriginal community members
    - VACCA and ACCOs from across the state.

    Legislative change to the CYFA 2005 will be required to enable the establishment and authorisation of this panel.

4.3.10 Support for kinship carers

Finding 7:

Kinship carers require increased advocacy, support, assistance, training and education to provide culturally safe and trauma-informed care to Aboriginal children requiring out-of-home care.

321. The reliance on kinship carers to provide care for children who cannot safely remain with family is increasing, in recognition that family is the preferred placement option. Kinship care is also a less expensive model of care for government to resource, with caregivers typically receiving the lowest rate of support payments compared to the rates available for home-based carers.[119]

322. Case studies 15 and 16 detail the cultural benefits that a kinship care arrangement has provided for a sibling group of three and for a teenage girl with a physical disability. They also highlight the challenges and pressures faced by kinship carers.

Case study 15: Bella, Pippa and Shelby

Bella and Pippa were removed from their parents' care when they were three and two years old and placed with their Aboriginal maternal grandmother. When their sister Shelby was born, she was also placed with their grandmother. Concerns for all three girls related to parental substance abuse and family violence.

The girls were placed on a Custody order, with DHHS maintaining case management. The grandmother and the girls engaged with their local ACCO and the local community provides support to the kinship carers. The girls participate in play and learning with other Aboriginal children in their community.

When the Taskforce 1000 panel discussed the plan for family reunion and respite arrangements, it became clear that this was not in the girls' best interests. Through collaboration, the services developed a plan that allows the girls to remain permanently in the care of their Aboriginal grandmother, with their mother being able to visit. The entire family is linked with their Aboriginal community, which provides practical and ongoing support.

Case study 16: Polly

Polly is a teenager with a significant physical disability. When Polly was five years old, a report to child protection revealed significant concerns about her home environment and maternal substance abuse. Following an investigation, Polly was removed from her mother's care and placed with her maternal aunt. Polly was subject to a Guardianship order and a permanent care plan is in place. Polly's sisters were placed with their father and returned to their mother for a period of time. Her aunt is responsible for ensuring contact occurs.

Polly lives with her aunt and uncle (and his mother) and their five children in a three-bedroom home. Polly's aunt also cares for two of Polly's cousins, who are managed by staff at a different DHHS office.

Polly's case has been contracted to a local ACCO. Polly's aunt and uncle ensure that all of the children in their care are engaged in culturally appropriate activities and are provided with ongoing support to develop their knowledge of their culture. A local ACCO was involved to assist in developing a cultural support plan for Polly and provide assistance to her carers if required.

While this placement provides stability and cultural connectedness, services have not helped Polly's aunt with access to a suitable car or housing. The Commission considers that kinship carers like Polly's aunt must have access to basic necessities, such as being able to transport the entire family in one vehicle and having room for all of the children in their home.

323. As previously mentioned, a significant proportion (45 per cent) of kinship carers for the children reviewed during Taskforce 1000 were non-Aboriginal. The Commission found that it was rare for these carers to be provided with cultural awareness training. For the small number who did receive this training, there was no indication as to the regularity or quality of training, or if there were positive outcomes for the children.

119 When provided with an opportunity to respond to a draft report of this inquiry, DHHS advised the Commission that kinship carers are eligible for the level one care allowance rate at the time of placement. Further, those carers may be eligible for a special negotiated increase within the rates structure where the child has extraordinary needs. The Commission considers that this is an unnecessary burden imposed on many kinship carers whose primary focus is on providing day-to-day care needs for the child.

324. Through Taskforce 1000, meetings with family members and general enquiries and contacts from carers, the Commission has heard of countless experiences from kinship carers of inadequate support and advocacy. This has threatened the sustainability of children's placements in kinship care. Some of the issues faced by kinship carers included:

    - although there are mainstream advocacy networks for home-based carers, grandparents and permanent carers, there are no specific Aboriginal kinship carer advocacy networks to champion the unique issues these carers face
    - lack of aftercare and support by DHHS and, to a lesser extent, CSOs and ACCOs following a child's placement
    - lack of respite care
    - minimal or no cultural awareness training or support being provided
    - lack of practical assistance by DHHS and, to a lesser extent, CSOs and ACCOs to overcome practical issues such as transportation, housing, taking children to appointments and provision of material goods (such as cots, prams and car seats)
    - low rates of carer payments and entitlements
    - lengthy and onerous 'red tape' procedures to seek review of caregiver payments
    - managing the intense trauma and behavioural issues displayed by children without adequate training about how to respond
    - high expectations of kinship carers despite their own health and associated issues relating to their often advanced age.

325. Case study 17 illustrates the challenges faced by a kinship carer in meeting the needs of her grandchild, who had experienced significant abuse, trauma and rejection resulting in multiple placement changes and difficulties settling into care.

Case study 17: Vicki

Vicki comes from a large Aboriginal family and has extended family members across regional Victoria. There were six reports to child protection in relation to Vicki and her older siblings, all of which were closed without legal intervention. The concerns related to family violence, parental alcohol abuse and the sexual abuse of one of Vicki's older siblings.

When Vicki was four years old, there was a further report with similar concerns. This resulted in Vicki remaining in her mother's care on a Supervision order while her older siblings were placed elsewhere. An investigation revealed that Vicki had been staying with her paternal grandmother for extended periods of time. During the period of the order, Vicki returned to her grandmother's care.

In early 2006 Vicki was placed in home-based care. The rationale for this is unclear in the child protection notes, but a later court report stated that this allowed her to be closer to her mother, siblings and her extended maternal family. Vicki was placed on a Custody order and later a Guardianship order. Vicki spent several years in out-of-home-care and spent her holidays with her paternal grandmother.

In 2007 an AFLDM conference was held with the maternal family. The paternal family were not represented and no long-term placement options were found. Vicki remained in out-of-home care until mid-2009, when a further AFLDM conference was held and it was agreed that Vicki would move to her paternal grandmother's care. This decision was supported by the ACCO. Vicki's grandmother moved across Victoria to ensure that Vicki had contact with her maternal family.

A case plan was developed for Vicki to remain in her paternal grandmother's care long term. Vicki and her grandmother were case managed by an ACCO.

As Vicki became older, her behaviour became more difficult. She became challenging and defiant, and there was significant conflict with her grandmother. The placement has broken down at least three times.

The Commission was concerned at the number of practice deficits, including the lack of support given to Vicki's grandmother. It was clear that without intensive support this placement may break down. Vicki had not been offered counselling to assist with the loss of her relationship with her mother or the impact of the abuse she experienced as a young child.

326. Taskforce 1000 survey data indicated that a kinship care placement had been considered for most of the children (92 per cent)[120] who were placed in residential or home-based care. This had not been realised for reasons that included:

- no kinship carer was willing or able to care for the child
- DHHS had assessed the proposed kinship carer as 'unsuitable'.

327. In its recent *Child protection Australia 2014–15* report, the AIHW reports that a shortage of Aboriginal carers is a significant issue. This is linked to factors that are unique to the Aboriginal community:

- the trauma and disadvantage associated with Stolen Generations impact on many Aboriginal adults today, to the extent that they are not able to care for children
- some Aboriginal people are unwilling to be associated with the 'welfare' system due to past government practices of forced removal
- there is a disproportionately high number of Aboriginal children compared to adults.[121]

328. The Commission has made a number of recommendations to better support the important role of kinship carers:

- DHHS, with ACCOs and CSOs, to develop local, area-based campaigns to increase the number of Aboriginal carers for Aboriginal children.
- DHHS to review carer eligibility and assessment criteria to ensure potential Aboriginal kinship and home-based carers are not precluded on the basis of racial bias or past criminal offences that do not impact on their ability to provide safe and appropriate care to a child. There should be a timely review mechanism established, which is well promoted and easily accessible, for potential carers to appeal outcomes.
- Timely completion of kinship care assessments.
- Alignment of carer payments for kinship care with home-based care rates.
- Greater support at the start of a placement to ensure kinship carers have the necessary material assistance, and careful consideration of the physical, economic and emotional impact of planning decisions on carers.
- DHHS to ensure that kinship carers are fully informed and updated about a child's health, trauma, specific behavioural issues and parenting issues that may impact on the stability of the child's placement.
- Development of a resource for kinship carers outlining their eligibility for support, carer's and children's rights and information about decision-making and court processes.
- Funding to be provided by DHHS to provide additional Aboriginal kinship support workers to help stabilise placements.
- DHHS to establish and recurrently fund an Aboriginal kinship carers network to provide advocacy, peer support and training.
- Respite care to be made available on a regular basis for kinship carers.
- Engagement of local ACCOs to provide cultural awareness training for carers and DHHS workforce.

4.3.11 Adverse outcomes for children in out-of-home care

329. Out-of-home care should be an environment that is safe and that provides a healing environment for children who cannot live with their family as a result of abuse or neglect. The fact that children in out-of-home care experience or are exposed to continuing harm while in care is cause for concern. This reflects on the adequacy of the system itself, the support and capacity of carers, the treatment and support needs for children and the level of oversight and accountability of the service providers and DHHS in delivery of services.

330. This section considers knowledge and data available relating to:

- child death inquiries conducted by the Commission
- analysis of incident report data available to the Commission.

Child death inquiries

331. In recent years, the Commission has conducted a number of inquiries and reviews pertaining to vulnerable children (including children who have died) who have received services from child protection, youth justice, health services, education services and other registered community services. The purpose of these inquiries is to improve outcomes for vulnerable children and their families by identifying systemic practices and issues and opportunities for improvements to practice.

120 See Appendix 1, Table A20.

121 Australian Institute of Health and Welfare, *Child protection Australia 2014–15*.

332. In the case of child death inquiries, it is the Commission's role to provide advice to Ministers, government departments and health and human services about service performance and opportunities for improvement.

333. The Commission considered and finalised 50 child death reviews in 2015–16. Four of these related to Aboriginal children. Most child death inquiries related to children who died as a result of an acquired or congenital illness. A number of children died as a result of an accident, suicide or non-accidental trauma. Other inquiries related to the sudden unexpected death of an infant.

334. Practice issues of significance for Aboriginal children that have been identified over the past three years through the Commission's child death inquiry process are:

- failures to consistently and sufficiently reflect an understanding of the policies and legal requirements in decision-making processes for Aboriginal children in the child protection system
- deficits in the engagement of Aboriginal extended family in decision-making
- inadequate consultation and involvement of ACCOs in key decision-making events, such as the decision to contract a case to a mainstream CSO, case planning and placement decisions
- service deficits in provision of Aboriginal ICMSs to high-risk Aboriginal young people.

335. As a result, the Commission recommended that DHHS works collaboratively with ACCOs and the Commission to undertake a formal process to explore the merits of establishing divisional Aboriginal ICMSs to meet the needs of high-risk Aboriginal children and young people. In response, DHHS accepted the recommendation.[122] This recommendation arose as a result of the apparent lack of intensive case management and outreach services for high-risk Aboriginal young people in the child protection system.[123]

336. A consistent issue identified in a number of child death inquiries concerning Aboriginal children relates to under-intervention by services involved with Aboriginal children and families. A lack of robust cultural understanding and engagement has often led to poor outcomes for at-risk Aboriginal children. The Commission has observed practices where cumulative harm has not been adequately assessed and addressed by child protection for Aboriginal children, seemingly based on misinterpreting cultural sensitivity.

> '...child protection practitioners were often nervous about intervening with Aboriginal families for fear of perpetuating the Stolen Generations, seeming disrespectful or being accused of the same and doing something wrong. The practice consequence of these beliefs tends to be under-intervention, characterised by superficial assessments and minimalist actions.'[124]

Incident reports for children in out-of-home care

337. The Commission receives data and information from DHHS on a daily basis. These relate to adverse events that may allege incidents of serious harm to children in out-of-home care, and are provided through Category One CIRs.[125] The Commission analyses the reports as part of the Commission's monitoring functions and considers emerging trends and themes that may inform the need for further enquiry.

338. In the Commission's 2015 inquiry into residential care services for children at risk of sexual abuse or sexual exploitation, a number of practice deficits pertaining to the department's use of CIRs were identified and reported in the inquiry report *'...as a good parent would...'*.[126]

339. Specifically, limitations were identified in the paper-based method of incident reporting that result in inefficiencies and misinterpretation. The reporting system is not child focused and lacks an effective feedback loop. Further, as the incident reports are considered allegations only, there are no formal links between the original allegation, the investigation, whether or not the allegation is substantiated and the outcome for the child or the development of strategies to prevent further harm.

340. Despite the limitations of the CIR reporting system, the reports do offer insight into the issues faced by children in the out-of-home care system in Victoria. The Commission closely monitors both the systemic issues and individual care issues as they arise and raises these directly with DHHS for review and action as needed. In addition, the Commission has initiated independent inquiries as a result of emerging trends and issues apparent in the incident reports.

341. Category One CIR data for 2013–14 and 2014–15 for children in out-of-home care is presented in Table 5. For both of the years reviewed, Aboriginal children made up approximately 20 per cent of the reports received. This was higher than the overall proportion of Aboriginal children in out-of-home care (17.6 per cent).

122 Commission for Children and Young People, *Annual Report 2014–15* (Melbourne: Commission for Children and Young People, 2015).

123 When provided with an opportunity to respond to a draft report of this Inquiry, VACCA suggested clarification of the type of intensive services should be provided. The Commission considers that through collaboration, DHHS and local ACCOs are best placed to identify the specific programs and services needed on an area basis.

124 Unpublished child death inquiry pertaining to an Aboriginal child, Commission for Children and Young People, 2015.

125 In February 2016, this was formalised through legislative change to the CCYP Act. The amendment also increased the scope of reports provided to the Commission, extending to CIRs relating to children and young people in youth detention. DHHS manages its incident reporting system through the classification of reportable incidents into two categories. Category One CIRs are defined as those that relate to a serious outcome such as a client death or severe trauma. Category Two incidents are those that involve the health, safety and/or wellbeing of clients or staff.

126 Commission for Children and Young People, *'...as a good parent would...'*.

Table 5: Children subject to DHHS Category One CIRs by Aboriginal status, 2013–14 and 2014–15

Year	Aboriginal	Non-Aboriginal	Total
Number			
2013–14	173	661	834
2014–15	282	1,000	1,282
Percentage			
2013–14	20.74	79.25	100.0
2014–15	22.0	78.0	100.0

Source: Commission for Children and Young People, unpublished data analysis.

342. The top three incident types reported for both Aboriginal and non-Aboriginal children across the two-year period reviewed related to:

- sexual abuse (including sexual – behaviour, sexual – exploitation, sexual assault – indecent, and sexual assault – rape)
- physical assault
- behavioural concerns (including behaviour – dangerous, and behaviour – disruptive).[127]

343. Through analysis of the nature and volume of incident reports, it is apparent that Aboriginal children were proportionally more likely than non-Aboriginal children to be subject to reports relating to sexual abuse and physical assault. Thirty-seven per cent of Aboriginal children were subject to reports of sexual abuse, compared with 33 per cent of non-Aboriginal children. Seventeen per cent of Aboriginal children were subject to reports of physical assault, compared with 11 per cent of non-Aboriginal children.[128]

344. Most of the incident reports received by the Commission over the two-year period were for children living in residential care (60 per cent), followed by reports for children living in home-based care (20 per cent) and kinship care (11 per cent). A small percentage of reports were for children in other forms of care, such as lead tenant placements. The rate of reporting is in inverse proportion to the numbers of children placed in these forms of care. These trends were evident for Aboriginal and non-Aboriginal children. These results support the view that children placed in home-based family settings fare better than children placed in institutional forms of care such as residential care.

345. Case study 18 illustrates the experiences of many children in out-of-home care. It describes the decline in a young girl's wellbeing following multiple placement changes, trauma, loss and lack of meaningful cultural connection.

Case study 18: Harriett

Harriett was a baby when she was removed from her mother's care. For 10 years, while on a Guardianship order, Harriett and her older sister were placed with a non-Aboriginal home-based carer. Harriett had contact with her family and was supported by a local ACCO.

As Harriett became older, she displayed some challenging trauma-related behaviours. This led to the placement ending, as younger children in the home were at risk.

Harriett then had three placements, including one some distance from her community, before a planned transition to a therapeutic residential unit. During this time, no grief and loss counselling was provided to Harriett, who identified her former carer as her 'mum'. Harriett wanted to return to her 'mum', but – despite there being contact – this was not assessed as a viable option.

Although Harriett's case records showed some early attempts at cultural planning when she was first placed in home-based care, these plans did not develop. By the time Harriett was placed in residential care, her contact with her community had decreased. There was minimal involvement from ACCOs in case planning, and it was apparent that Harriett lacked social experiences with people from her community and that there was an absence of positive role models and mentors in her life.

Harriett's options for placement became increasingly limited as a result of her challenging and dangerous behaviours. Over a two-year period, there were 170 incident reports relating to Harriett's at-risk behaviours in residential care, some of which resulted in her placement in secure welfare.

It was apparent that poor attention by DHHS to Harriett's cultural needs and her past trauma and loss were negatively impacting on her wellbeing in residential care.

127 Appendix 1, Table A1

128 Appendix 1, Table A1

4.4 Education

Finding 8:

DHHS and DET do not fully comply with policy requirements relating to Aboriginal children in the out-of-home care system; this impacts negatively on Aboriginal children's education, cultural safety and wellbeing.

'It is widely understood that early childhood development and high-quality school education are key determinants of choice and opportunity for young people throughout their lives. Students who stay on at school and complete Year 12 are much more likely to undertake additional education and training. In turn, they will have more, and better, employment options. Research also indicates that increased education is linked to a range of other social benefits, including better living conditions, better nutrition, lower rates of imprisonment, and a longer and healthier life.'[129]

4.4.1 Victorian Aboriginal education strategies

346. Over the past 10 years, there have been a number of strategies to improve educational outcomes for Aboriginal students in Victoria. These approaches have included additional specific add-on services and initiatives, through to wider-ranging whole-of-life approaches to ensure greater inclusion for Aboriginal people in the mainstream education system.

347. The VAEAI is the peak Koori community organisation for education and training in Victoria. It provides advice on ways to improve the educational experience of Aboriginal students through monitoring and advocacy and has long-standing working relationships with governments. The VAEAI has worked closely with government in the development of a number of strategies to improve educational outcomes for Aboriginal students.

348. In 2007, the former Department of Education and Early Childhood Development conducted a review of education provision for Aboriginal students.[130] The review found that Victoria was well behind other jurisdictions in recognising the cultural identity of the Aboriginal population within a curriculum framework. Additionally, it was found there was insufficient focus on educational outcomes for Aboriginal students and poor systemic accountability for improving outcomes. A number of approaches were identified to address these systemic shortcomings:

- improved workforce support and professional development for the Koori support workforce
- provision of pre-school education to address school readiness for Aboriginal children
- understanding that issues external to the school system impact on education outcomes
- the importance of engagement between school staff, parents and community
- the need to challenge and shift low expectations that are held for Aboriginal students
- the need for specific and individual approaches for every Aboriginal student.

349. In response to the review, *Wannik Learning Together – Journey to Our Future: Education strategy for Koorie students* was developed and implemented as part of reform to the education system.[131] Key features of the strategy were:

- improvements to cultural awareness and inclusion through teaching practices
- curriculum content
- greater accountability for improved outcomes for Aboriginal children.

350. The strategy requires that every Aboriginal student be provided with an individual education plan that is developed between the teacher, student, parent or caregiver and Koori support worker. Additional individual numeracy and literacy support and specific engagement strategies for students at key developmental phases to prevent disengagement from education were also articulated, along with additional support and incentives for Aboriginal children with academic potential to encourage them to excel.

129 Department of Education and Training, *Wannik Learning Together – Journey to Our Future* <http://www.education.vic.gov.au/about/programs/aboriginal/Pages/wannikteachlearn.aspx>, accessed 20 July 2016.

130 Ibid.

131 Department of Education and Early Childhood Development, *Wannik Learning Together – Journey to Our Future: Education strategy for Koorie students* (Melbourne: Department of Education and Early Childhood Development, 2008).

351. At the time of preparing this report, the existing Victorian Government released the *Marrung – Aboriginal Education Plan 2016–2026* strategy. This is a 10-year education plan to build the capacity of universal services.[132]

352. In recognition of the need for consistent and agreed practices to support the education of school-aged children in out-of-home care, a *Partnering agreement* was formalised in 2011 between the Department of Human Services and Department of Education and Early Childhood Development along with the Catholic Education Commission and Independent Schools Victoria.[133] While the *Partnering agreement* applies to government, Catholic and independent schools, it cannot be mandated in independent schools because they are individual legal entities.

353. The *Partnering agreement* promotes a cooperative approach between the education and out-of-home care systems to improve the educational experience and outcomes for school-aged children in out-of-home care. A key initiative was the establishment of student support groups, made up of education staff, the child and their family, case managers and other support services, to collaboratively develop individual education plans to support the child's educational achievement and engagement.

354. The *Partnering agreement* indicates that an individual education plan must outline a meaningful education program, be flexible and future oriented, be strength based, be reviewed regularly (a minimum of twice a year), and clearly explain the responsibilities of the student support group.[134]

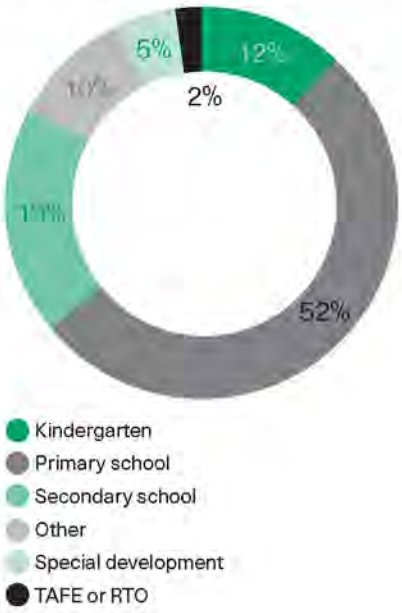
355. In September 2015, the Victorian Government announced the establishment of Lookout Education Support Centres, with $13.2 million over four years committed to the initiative and a further $4.8 million ongoing from 2019–20.[135] The press release indicates that the initiative sees the establishment of four sites across the state, staffed by educational experts and support staff, to work in partnership with schools to enrol students, monitor and evaluate educational progress, set targets and coordinate resources and activities to improve attendance, engagement and achievement.

356. Complementing the *Partnering agreement* is the *Early Childhood Agreement for Children in Out-of-Home Care*, an agreement between DHHS, DET and the Municipal Association of Victoria and Early Learning Association Australia. The *Early Childhood Agreement* aims to build capacity and collaboration within the service system to achieve greater participation for young children in out-of-home care.[136]

4.4.2 Educational enrolment

357. Taskforce 1000 survey data indicated that of the 980 children, 85 per cent were enrolled in an educational setting. The remaining 15 per cent were under pre-school age. Most of the enrolled children were in primary school. Eighty-five children were classified as being in an education setting nominated as 'other'. DHHS advised the Commission that 'other' refers to settings such as early learning centres, child care with early start kindergarten programs, family day care or child care centres. A small proportion of children were enrolled in a special developmental education setting. A breakdown of the type of educational setting is shown in Figure 16.

Figure 16: Type of education setting for children reviewed during Taskforce 1000



n = 837
Source: Appendix 1, Table A33.

132 Department of Education and Training, *Marrung – Aboriginal Education Plan 2016–2026*.

133 Department of Education and Early Childhood Development and the Department of Human Services, *Out-of-home care education commitment: A partnering agreement* (Melbourne: State of Victoria, 2011).

134 Ibid.

135 Mikakos, J. (Minister for Families and Children), *Improving education for children in out-of-home care* (media release), 22 September 2015, Premier of Victoria, <http://www.premier.vic.gov.au/improving-education-for-children-in-out-of-home-care/>, accessed 20 July 2018.

136 Department of Education and Early Childhood Development, *Early Childhood Agreement for Children in Out-of-Home Care* (Melbourne: State of Victoria, 2014).

358. Taskforce 1000 survey data indicated that of the 837 children enrolled in education, 166 had not attained 12 months' learning in the previous year. Of further concern was that for 51 of the 837 children, DHHS did not know if 12 months' education attainment had been achieved when completing the Taskforce 1000 survey.[137]

359. During Taskforce 1000 area panels, the Commission heard of many examples where children had been diverted from mainstream education into special developmental education settings or reduced hours of schooling in response to their trauma-related behaviours and the inability of schools to work with them.

360. In many areas of Victoria – in particular the West division – the Commission was advised of high numbers of Aboriginal children in out-of-home care who had been moved by DET from mainstream school settings to special school arrangements. The rationale for these decisions was not clear and concern was raised about the appropriateness of such decisions.

361. The Commission was advised by some education officers, including some KESOs, that some Aboriginal children were being 'sidetracked' into special development and alternate education settings so they would not negatively impact on a school's NAPLAN rating.[138]

362. The Commission considers that greater scrutiny, transparency and accountability for such decisions are essential to ensure children's best interests are being served and that their educational potential is realised and encouraged.

363. The Commission believes that concerted efforts should be made to reduce the reliance on special and alternative education programs for Aboriginal children in out-of-home care. The Commission has recommended that there be consultation with the proposed DHHS Chief Practitioner for Aboriginal Children to approve special education programs for Aboriginal children in out-of-home care, as well as quarterly reports from DHHS to the ACF about the numbers of children in special education arrangements. This will provide greater transparency on this issue. Furthermore, operational DHHS Deputy Secretaries, through their individual performance plans, should demonstrate improvements in engagement and mainstream education participation for all Aboriginal children in out-of-home care.

4.4.3 Poor compliance with educational policy requirements

364. The Commission was keen to observe how the various strategies and policies for Aboriginal students and, more specifically Aboriginal children in out-of-home care translate into practice for the children reviewed during Taskforce 1000. The evidence indicated that the policy requirements are not observed for all children. Many children miss out on individual education plans and student support groups. This further disadvantages the most vulnerable children within Victoria's education system.

365. The Commission looked at the following areas within the survey data for children reviewed during Taskforce 1000:

- existence of an individual education plan
- establishment of a student support group
- involvement of educational professionals in case planning
- attendance at school
- use of suspension and expulsion.

366. Poor compliance by DET and DHHS with key policy and practice requirements for children's educational wellbeing was evident in the Taskforce 1000 survey data. Approximately 170 children, or 23 per cent of children from primary school age onwards , did not have an individual education plan. A significant proportion of children did not have a student support group or an educational professional involved in case planning. These results are disappointing and indicate much work is required by DHHS, DET, ACCOs and CSOs to ensure greater coordination, communication and focus on these most vulnerable children.

367. Individual education plans are not required for pre-school aged children in out-of-home care. The Commission considers, however, that it is essential for pre-school aged children in out-of-home care to be provided with such a plan, particularly given the trauma, abuse history and impact of parental drug and alcohol abuse on prenatal development that has bearing on a child's education potential. Early years investment is crucial for Aboriginal children who carry such trauma.

137 Appendix 1, Table A34.

138 DET advises through its *Information for parents and carers* that NAPLAN is an annual national assessment for all students in Years 3, 5, 7 and 9. All students in these year levels are expected to participate in tests in reading, writing, language conventions and numeracy. NAPLAN is the measure through which governments, education authorities, schools, teachers and parents can determine whether children are meeting important outcomes in literacy and numeracy. Individual schools' averaged NAPLAN results are published on the My School website <www.myschool.edu.au>.

368. During Taskforce 1000, it was pleasing to see that some early years programs had taken the initiative to develop individual education plans for pre-school aged children when they were not required to do so. Nine out of 103 children had an individual education plan, 13 had a student support group and 34 had an educational professional involved in case planning.

369. There is no DET policy that requires the development of individual education plans or the establishment of student support groups for children in out-of-home care who attend kindergarten. There is clear evidence that attention to early years development is vitally important to educational success, wellbeing and life trajectory. An urgent refresh of the *Partnering agreement* and complementary *Early Childhood Agreement* is therefore considered imperative to ensure that children in out-of-home care who attend kindergarten are also afforded individual education plans and student support groups to ensure the best chance of educational engagement, achievement and leaving care.

370. The data revealed that almost 20 per cent of the children enrolled in education had not attained 12 months' learning over the past year. This was most noticeably the case for children enrolled in secondary schooling and TAFE/registered training organisations.

371. Of concern to the Commission was the lack of knowledge about the educational progress of 51 children by the case worker completing the survey. This may indicate poor familiarity with the child's circumstances or inadequate consideration of the fundamental importance of each child's education by those tasked with case management. It also indicates the need for far greater collaboration and coordination between government departments, CSOs and ACCOs that have shared responsibility for vulnerable children in out-of-home care.

4.4.4 School suspension and expulsion

372. The *Partnering agreement* acknowledges that school exclusion, either through suspension or expulsion, can significantly impact on a child's educational outcome and future life chances, making it very difficult for already marginalised children to reintegrate back into the education system.[139] It is therefore troubling that so many children reviewed during Taskforce 1000 had experienced such disengagement and dislocation from education.

373. DET has advised the Commission that it has a number of policies, procedures and resources to manage student disengagement and to monitor and improve school attendance. DET further advised the Commission that it is reviewing its expulsion policy to ensure it aligns with the government's Education State agenda, and to reduce the number of students who disengage from education.

> 'Suspension and expulsion are serious disciplinary measures and are best reserved for incidents when other measures have not produced a satisfactory response or where there is an immediate threat to another person and immediate action is required.'[140]

374. The high rate of suspensions and expulsions evident for the children reviewed during Taskforce 1000 was disturbing and is presented in Table 6 below. Forty-eight out of 157 (30.5 per cent) secondary school students had been suspended and 50 out of 435 (11.4 per cent) primary school children had been suspended. Most alarmingly, one child was noted to have been suspended from kindergarten. A total of 18 children had an experience of school expulsion. This data indicates a system that is facing significant challenges, with a need for alternate responses and strategies. Further contextual information was not offered by DHHS or DET about the reasons for these suspensions and expulsions.

Table 6: Incidence of suspension and expulsion for children enrolled in education reviewed during Taskforce 1000

Suspensions	
Kindergarten	1
Primary school	50
Secondary school	48
Special developmental	10
TAFE or RTO	3
Other	20
Total	**132**
Expulsions	
Primary school	4
Secondary school	4
TAFE or RTO	1
Other	9
Total	**18**

Source: Appendix 1, Table 28c

139 Department of Education and Early Childhood Development and the Department of Human Services, *Out-of-home care education commitment: A partnering agreement*.

140 Department of Education and Training, 'Student engagement and inclusion guidance', <http://www.education.vic.gov.au/school/principals/participation/Pages/discipline.aspx>, accessed 20 July 2016.

375. Through discussions with a number of education professionals at Taskforce 1000, the Commission also heard of concerning practices where a number of Aboriginal children were disengaged from school without formal processes or data collection, and no apparent accountability or transparency measures.

376. The present Managing Challenging Behaviours Program offered by DET does not seem to have adequate reach. The program is not compulsory and requires greater focus on the needs of the growing cohort of children who have experienced abuse and neglect and require alternate placement.[141]

377. DET offers practice guidelines to schools on the suspension and expulsion of Aboriginal children. Specifically, a KESO is to be engaged to support the school, family and child to find the best outcome and mobilise resources to assist. However, the Commission heard of systemic flaws with the KESO program, including:

- insufficient resourcing of KESOs for the number of Aboriginal children within the education system
- long-term KESO positions that are vacant and have not been filled
- examples of poor communication and information exchange from schools with KESOs about the identity of Aboriginal children enrolled in schools
- failure by schools to notify the local KESO when an Aboriginal child in out-of-home care is newly enrolled in the school, negating the opportunity for the child to access the Aboriginal support and cultural connection that they are entitled to receive
- poor communication by DHHS with schools and early years programs regarding enrolment for Aboriginal children in out-of-home care
- inconsistent school enrolment practices leading to poor identification of Aboriginal children within the education system.

378. Accordingly, the Commission has recommended DET reviews the KESO program and reports on the outcome of the review to the ACF and the Marrung Central Governance Committee. Furthermore, an improved and consistent mechanism for identifying Aboriginal children at the point of school enrolment and subsequent transitions is crucial.

379. The Commission recommends that DHHS and DET report on a quarterly basis to the ACF and the Marrung Central Governance Committee on the number of Aboriginal children in out-of-home care who have been suspended, expelled or disengaged from school by year level attained. It is expected that this will ensure greater accountability and transparency as well as contributing to solutions to keep vulnerable Aboriginal children engaged and achieving in school.

Through feedback from families, children and parents at Community Yarns, the Commission has recommended that DHHS ensures that child protection staff avoid the practice of interviewing children and young people at school, except in extenuating circumstances where immediate safety and risk issues are apparent. This avoids the stigmatisation of children receiving child protection services and ensures that Aboriginal children are given every opportunity for uninterrupted engagement with their education.

4.4.5 Accountability for educational outcomes

380. Practice guidelines and training are insufficient on their own in ensuring that children are afforded the best services possible. Greater positional accountability is also required to ensure compliance with policies, protocols and practice requirements.

381. Specific recommendations have been made by the Commission to ensure DET Deputy Secretaries and school principals are accountable, through annual professional performance review processes, for ensuring children in out-of-home care receive the education and support services that they are entitled to within the education system. Specifically, key measures for every Aboriginal child in out-of-home care should include:

- demonstrated engagement of a KESO
- engagement with a student support group
- an individual educational support plan that is regularly reviewed and monitored
- demonstrated improvements in numeracy, literacy and educational attainment
- demonstrated improvement in school engagement and school attendance.

141. DET provided feedback to the Commission on the draft report of this inquiry and advised that as at August 2016, the Managing Challenging Behaviours Program has reached 1,300 school staff, with a further 2,182 staff working through the online course. DET does not mention over what timeframe the 1,300 staff completed the course. DET also advised it offers a professional learning program for staff working with students displaying extreme and challenging behaviour associated with a disability.

382. Case study 19 describes a young child with a traumatic background who experienced disrupted education. The education system was unable to respond to his needs, including there being no provision of Aboriginal-specific education supports through the engagement of a KESO.

Case study 19: Joshua

Joshua was the youngest of three siblings. There were seven reports to child protection in relation to environmental neglect, physical abuse and parental substance abuse. In early 2011 Joshua was removed from his mother's care. He was five years old.

Although child protection quickly established that Joshua was Aboriginal, there was no evidence in the file of any consultation with an ACCO for nearly a year, despite Joshua being on a Custody order. In that year, Joshua experienced at least five different home-based care placements and at least two changes of primary school.

Joshua displayed trauma-related behaviours at placement and at school. After approximately a year of child protection involvement Joshua was placed in residential care, where he remained for more than 18 months. During that time, there was no evidence of a referral by DHHS for an AFLDM conference and there was no evidence that a cultural support plan had been developed.

Joshua was then moved to a home-based care placement. His trauma-related behaviours settled, although they remained concerning. He was placed on a Guardianship order in early 2014. The carers relinquished care after seven months, following a quality of care investigation. Joshua went on to experience multiple placement and schooling changes before entering a therapeutic residential care placement.

Despite his young age, Joshua has spent most of his schooling on reduced hours in an alternate program as a result of the inability of the education system to respond to his trauma behaviours. There was no evidence in his child protection file that a KESO was engaged at any stage of his education.

4.5 Children's health and wellbeing

Finding 9:

There is inadequate coordinated attention to the health and wellbeing of many Aboriginal children in out-of-home care. There are service system gaps in the delivery of holistic and culturally appropriate health and wellbeing services.

'Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.'[142]

383. Social determinants of health are defined by the World Health Organization as the conditions in which people are born, grow, live and age.[143] Factors such as education, unemployment, appropriate housing and poverty impact on the health, welfare and wellbeing of families and children.

384. The AIHW reported in its *Australia's welfare 2015* report that Aboriginal children often experience poorer early health outcomes compared with non-Aboriginal children, placing them at risk of disadvantage in other aspects of life. The report highlights the:

- greater incidence of Aboriginal mothers who smoke during pregnancy
- higher proportions of Aboriginal babies with low birth weight
- higher Aboriginal infant mortality rates
- higher rates of childhood injuries and hospitalisations for Aboriginal children.[144]

142 Victorian Aboriginal Health Service, 'Aboriginal health', <http://www.vahs.org.au/definitions/>, accessed 20 July 2016.

143 World Health Organization, 'Social determinants of health', <http://www.who.int/features/factfiles/sdh/01_en.html>, accessed 20 July 2016.

144 Australian Institute of Health and Welfare, *Australia's welfare 2015*, Australia's welfare series no 12 (Canberra: Australian Institute of Health and Welfare, 2015).

385. Additionally, research has shown that children in out-of-home care are at increased risk of a complex array of health difficulties as a result of their prior experience of abuse and neglect. The health issues include:

- physiological and neurological impacts
- impacts of cumulative harm
- impacts of harmful stress responses.[145]

4.5.1 National clinical assessment framework for children and young people in out-of-home care

386. The development of the National clinical assessment framework for children and young people in out-of-home care occurred in recognition of the health issues facing children in out-of-home care.[146] The framework aims to provide consistent national approaches to health assessments and services for children in out-of-home care, to provide advice about the role of clinicians and appropriate assessment tools, to guide jurisdictions to develop policies, and assist clinicians with early detection of health issues.

387. The framework applies a holistic, consistent and coordinated approach to healthcare assessments for children in out-of-home care encompassing physical health, developmental, psychosocial and mental health domains.

388. The framework includes a number of standards:

- a preliminary health check that should be commenced as soon as possible upon entry to out-of-home care and ideally no later than 30 days after entry to care
- a comprehensive health and developmental assessment within three months
- development of a health management plan, including a personal health record that is integrated into the child's other case management plans
- consistency of care and the appointment of a health coordinator
- follow-up monitoring to ensure the clinical needs of children are appropriately addressed, managed and identified.

389. However, adequate consideration and attention to children's physical health, mental health and general wellbeing in out-of-home care remains a major challenge, which was evident to the Commission during Taskforce 1000. A recent Victorian parliamentary research paper has stated that poor attention to children's health in out-of-home care in Victoria over the past two decades has been well documented and is a result of many factors including, but not limited, to:

- child protection legislation underestimating the lifelong impact of child maltreatment on physical, developmental and psychological health and, at the same time, deflecting attention from the individual health needs of children placed in out-of-home care
- poor data availability as a result of deficient collection and analysis of children's health needs, which has resulted in policy and practice not being fully informed
- allocation of responsibility for the identification of a child's complex and chronic health issues, associated decision-making and service coordination and delivery being diffuse and unwieldy, with contracted agencies and kinship carers increasingly expected to manage these tasks
- an absence of adequate and reliable health histories of the children, combined with weak systems for collecting and sharing such vital information, leaving health professionals struggling to effectively assess the child's health needs
- universal health systems not being adequately supported to cater for the specific needs of children in out-of-home care
- recommendations of medical professional colleges not being actively embraced in legislation
- a focus on reparative healthcare for children who have experienced maltreatment receiving less attention than public health awareness of child maltreatment prevention.[147]

145 Webster, S, *Children and young people in statutory out-of-home care: health needs and health care in the 21st century* (Melbourne: Parliamentary Library and Information Services, Department of Parliamentary Services, Parliament of Victoria, 2016).

146 Department of Health, 'National clinical assessment framework for children and young people in out-of-home care, March 2011', <http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc>, accessed 20 July 2016.

147 Webster, S, *Children and young people in statutory out-of-home care*.

4.5.2 Looking After Children framework

390. LAC is a framework that identifies both the needs of children and young people in care and an action plan to meet those needs. Seven developmental domains are considered, including a child's health, emotional and behavioural development, education, family and social relationships, identity, social presentation and self-care skills. The DHHS *Child protection manual* states:

> 'At a simple level, the LAC framework attempts to strengthen communication and collaboration between carers, DHHS staff, CSO staff, other professionals, clients and their families. It prompts all members of the child's out-of-home care team to consider the things any good parent would naturally consider when caring for their own children.'[148]

391. DHHS requires that, within two weeks of a placement commencing, the out-of-home care service provider must commence recording important factual pieces of information about the child in the LAC Essential Information Record. This information includes details about who can give authority for medical treatment, Medicare information and important health information. Additionally, out-of-home care service providers are required to commence a LAC Care and Placement Plan for children under the age of 14 and a LAC Care and Transition Plan for children 15 years old and over.

392. The Commission's *"...as a good parent would..."* inquiry report revealed widespread non-compliance with LAC information recording requirements by DHHS and out-of-home care service providers for children in residential care. Essential information was routinely absent from children's files, such as information about known illnesses and medical conditions, health alerts, dental assessments outcomes, immunisation information, record of hospitalisation, record of GP details and Medicare card number.

393. As a result, the Commission recommended that funding and accreditation of out-of-home care service providers must be linked to demonstrated outcomes for children, including adherence to the recordkeeping requirements of LAC, to ensure up-to-date information about children's health and wellbeing is accurately documented.

394. Taskforce 1000 provided the opportunity to further examine how the service systems approach and manage the health of children in out-of-home care. The following health and wellbeing domains were considered for each of the children reviewed in Taskforce 1000:

- physical health
- mental health
- disability
- substance abuse.

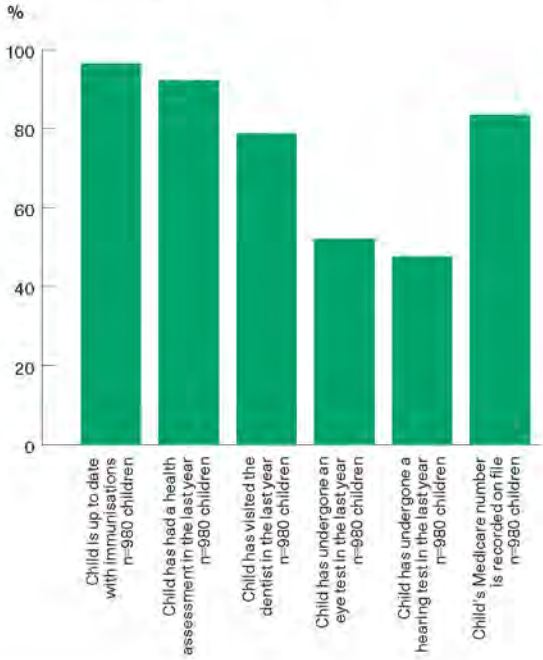
4.5.3 Children's physical health

395. The Taskforce 1000 survey appraised a number of general physical health factors for every child reviewed with attention to:

- basic recording of medical records
- currency of physical health assessment and immunisation
- eye health
- dental health
- ear health.

396. Figure 17 presents Taskforce 1000 survey data that indicates that most children (96 per cent) were up to date with their immunisation schedule and most (92 per cent) had received a health assessment within the last 12 months.

Figure 17: Attention to physical health for children reviewed during Taskforce 1000



Source: Appendix 1, Table A25.

148 Department of Health and Human Services, 'Looking after children', *Child protection manual*, <http://www.cpmanual.vic.gov.au/advice-and-protocols/service-descriptions/out-home-care/looking-after-children>, accessed 20 July 2016.

397. Robust attention to all areas of health for the children reviewed during Taskforce 1000 appeared unsatisfactory, in particular:

    - dental health (78 per cent had visited a dentist)
    - eye health (52 per cent had undergone an eye test)
    - hearing (47 per cent had undergone a hearing test).

    These results were reasonably consistent across the state; however, it was noted that results were poorer for children in the West division (57 per cent had visited a dentist and 43 per cent had undergone an eye test) and the East division (46 per cent had undergone an eye test and 36 per cent had undergone a hearing test).

398. Case study 20 was presented at Taskforce 1000 and details failures by DHHS to attend to the significant dental decay of a young boy who had been in state care on a Guardianship order for five years. It was not until this child's case was presented at Taskforce 1000 that treatment was sought as a result of the intervention of the Commission.

Case study 20: Darcy

Darcy first came to the attention of child protection through an unborn report. He was placed in out-of-home care with a kinship carer soon after birth. Darcy remained on a Guardianship order for five years in the same placement. Darcy entered care due to parental drug use, family violence, parental mental health issues and physical harm.

The local ACCO was consulted at the time of the report and continues to be consulted. DHHS has case management responsibility for Darcy and his carer ensures that his connection to culture and community is strong.

Darcy's Aboriginal mother is intellectually disabled. This has impacted on her capacity to parent. There have been two unsuccessful family reunion attempts, but Darcy has supervised contact with his parents. Darcy has a 10-year-old maternal sibling who lives in out-of-home care in another division and with whom he has infrequent contact.

At the Taskforce 1000 presentation it was determined that an AFLDM conference had not been held, nor was there a cultural support plan developed despite Darcy being in out-of-home care for the majority of his life. The Commission was concerned that this had not occurred, particularly because of the age of the carer, the carer's capacity to provide long-term care and the need for permanency planning.

At the Taskforce 1000 presentation the Commission was informed that Darcy's teeth were rotten and required extensive dental work. The Commission requested that Darcy be taken to an Aboriginal health service for treatment and for clarification in relation to the cause. The Commission was extremely concerned that DHHS, as Darcy's guardian, had failed to ensure regular dental treatment and review, and that his basic care needs had not been met.

399. During Taskforce 1000, the Commission heard from many Aboriginal health services throughout Victoria about the need for improved health strategies for Aboriginal children in out-of-home care to ensure all children are afforded healthcare that is culturally appropriate and meets best practice guidelines.

400. The Commission considers that ACCHOs are best placed to meet the health and wellbeing needs of Aboriginal children in out-of-home care. ACCHOs provide a broader approach to health assessment and treatment, inclusive of case management and important linkages to culture and community for Aboriginal people accessing the services.

401. The Commission has recommended the development of a strategy between DHHS and VACCHO, the peak body for Aboriginal health in Victoria. This strategy should ensure that:

    - all Aboriginal children in out-of-home care have a health check that is specific for Aboriginal children upon entry to care, and then annually, at an ACCHO
    - funding for ACCHOs aligns with initial demand for new services and future demand in accordance with the number of Aboriginal children in out-of-home care.

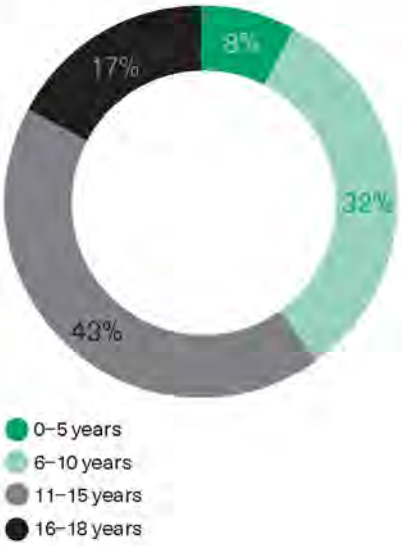
402. Further, the Commission has recommended that operational DHHS Deputy Secretaries have responsibility, through their individual performance plans, for ensuring that every Aboriginal child in out-of-home care has an Aboriginal health check upon entry to care and then annually.

4. Inquiry findings

4.5.4 Children's mental health

403. The Commission was concerned at not only the prevalence of children with mental health issues (22 per cent of all children reviewed), but also the very young ages of these children. As shown in Figure 18, 8 per cent of children with mental health issues were under the age of five.

Figure 18: Children with mental health issues reviewed during Taskforce 1000, by age



n = 216
Source: Appendix 1, Table A26.

404. Taskforce 1000 survey data also examined whether the children were receiving mental health treatment and support. Results indicated that 80 per cent of children had received treatment or support and less than 8 per cent had required treatment in a mental health facility.[149]

405. Many positive interventions for children occurred as a result of the Taskforce 1000 panel approach. Through the presence of key agency and government representatives, mental health and health specialists' referrals for services were fast-tracked and solutions to service access were resolved quickly.

406. The Commission heard about the negative impact on mental health for many children reviewed in Taskforce 1000 as a result of their experience of family violence, sexual and physical abuse and neglect, their dislocation from their family and the intergenerational trauma experienced by their parents and grandparents. It was apparent that there is a pressing need for the service system to work in a more holistic way with children and their families, recognising the Aboriginal concept of health and the need for Aboriginal-specific trauma responses.

407. Feedback received from carers during the Community Yarns highlighted the need for carers, both home-based and kin, to be made fully aware of the child's trauma and behaviours prior to a placement commencing, and for the carers to be appropriately trained. Some concerning examples included carers not being fully briefed about children's trauma-related behaviours such as:

- self-harming behaviours
- sexually abusive behaviours
- fire-lighting behaviours
- cruelty to animals.

408. The Commission has recommended that DHHS develops and implements an approach to address intergenerational trauma by working with the extended family groups and clans of children involved with child protection in order to promote healing and facilitate placement and reunion options within family and community.

409. Through Community Yarns the Commission also became aware of the need for specific support for Aboriginal children and young people who identify as LGBTI.

410. Research has shown that the mental health of LGBTI people is amongst the poorest in Australia, with data indicating a higher likelihood of:

- meeting the criteria for a major depressive episode
- psychological distress
- anxiety disorders
- suicidal ideation, self-harming behaviours and suicide.[150]

411. Furthermore, the research indicated that for LGBTI young people there are much higher levels of psychological distress evident, with rates of suicide being six times more likely than for their heterosexual peers.

412. The risk for adverse mental health for Aboriginal LGBTI young people is evident, particularly for those children and young people who have also experienced the child protection and out-of-home care systems. A young Aboriginal person quoted by the National LGBTI Alliance commented:

> 'When making the decision to come out we often feel a sense of isolation and disconnection of country we identify with and the land location we identify our kinship, often resulting in drug and alcohol dependency to suppress feelings connected to the whole 'Coming Out' process... There is a mental challenge to balance culture, connection to land and sexuality acceptance within our kinships.'[151]

149 Appendix 1, Table A27.

150 Rosenstreich, G, *LGBTI people: Mental health and suicide* (2nd edition), Sydney: National LGBTI Health Alliance, 2013).

151 Ibid.

413. Of particular concern was the lack of Aboriginal-specific social support and advocacy for LGBTI children, particularly for transgender children. A recommendation has been made that DHHS and DET work collaboratively with the Aboriginal community, VACCHO and the VAHS to ensure adequate supports and programs are available for Aboriginal children in out-of-home care who identify as LGBTI.

414. The Taskforce 1000 survey data indicated that the use of substances was apparent for 75 of the 980 children (8 per cent) reviewed during Taskforce 1000. Of these children, less than half (48 per cent) had been referred to or were engaged with a drug and alcohol service. Only 14 of the 75 children (19 per cent) had accessed a drug treatment or detox facility.[152]

415. The Commission was advised by many health professionals of the need for resourcing of and greater access to culturally appropriate mental health and drug and alcohol services for Aboriginal children in out-of-home care.

4.5.5 Children and disability

416. The Australian Bureau of Statistics reported that, in 2009, 7 per cent of Australian children (0–14 years of age) had a disability. This ranged from disabilities without a specific limitation or restriction to disabilities with profound or severe limitations. Census data also indicated that:

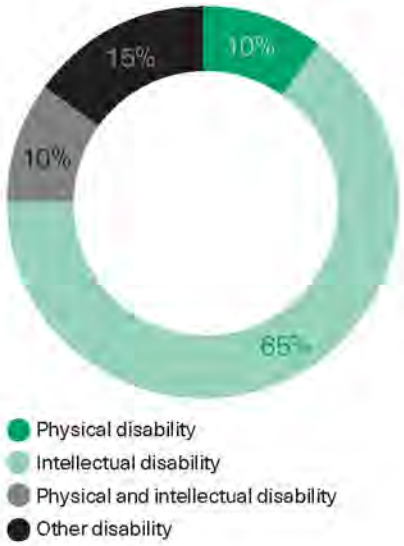
- the rate and severity of disability was higher among boys than girls
- sensory and speech disabilities were more common in children 0–4 years of age
- intellectual disabilities were more common in children 5–14 years of age (partly due to lack of formal testing in very young children).

Further, it reported that 13 per cent of children with a disability were reported as having Autism or related disorders. This is a two-fold increase since 2003.[153]

417. Census data also indicated that Aboriginal children 0–14 years of age had higher rates of disability than non-Aboriginal children (14.2 per cent compared with 6.6 per cent), with statistically different results for Aboriginal boys (19.9 per cent compared with 8.3 per cent) and Aboriginal girls (8.9 per cent compared with 4.8 per cent).

418. While the survey data from Taskforce 1000 is not comparable to census data, it was noted that 14 per cent of the children reviewed during Taskforce 1000 were indicated to have a known disability, as shown in Figure 19. Of this cohort of children, intellectual disability featured prominently, accounting for 65 per cent of the disabilities noted.

Figure 19: Children reviewed during Taskforce 1000 with a known disability, by type of disability



n= 136
Source: Appendix 1, Table A30.

419. During Taskforce 1000, from discussions with carers, health professionals and disability advocates it became clear to the Commission that children with a disability living in, or at risk of entering, out-of-home care are not highly visible. Anecdotal evidence was provided to the Commission about the prevalence of a number of children diagnosed with Autism spectrum disorder, FASD and ADHD.

420. Some concerns were raised with the Commission by family members and professionals about the extent to which the children's experiences of trauma had been considered in assessing and devising treatment for children with a disability. This is often done by mainstream service providers that do not employ a trauma-informed cultural focus.

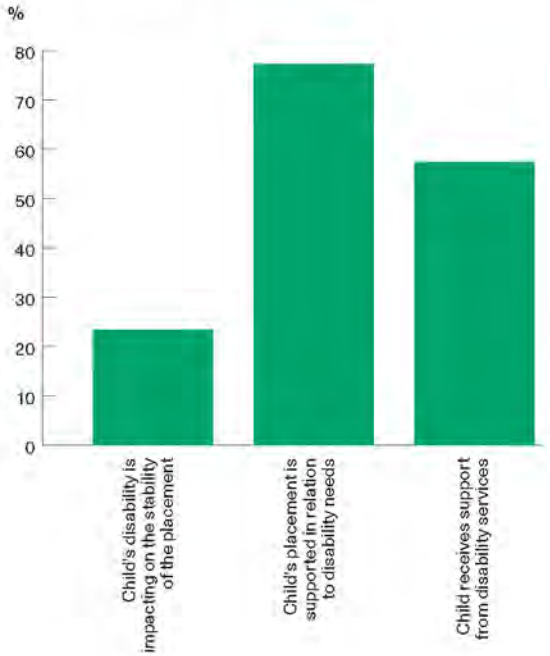
421. The Commission considers that further exploration is warranted and has recommended that DHHS, in collaboration with paediatricians in ACCOs, assess and review the diagnosis and treatment of Aboriginal children in out-of-home care who have been diagnosed with a disability, including Autism spectrum disorder, FASD and ADHD, using a culturally appropriate, trauma-informed approach.

422. Figure 20 provides information about the support for the cohort of children reviewed in Taskforce 1000 who have a disability. It was apparent that disability services were not fully engaged with all children who had a disability. Only 57 per cent of children with a disability were receiving support from disability services, and 27 per cent were not receiving support within their placement in relation to their disability needs. Further, for almost 25 per cent of the children their disability was impacting on the stability of their placement. There is an obvious need for enhanced support for this most vulnerable group of children.

152 Appendix 1, Table A29.

153 Australian Bureau of Statistics, *Australian social trends – children with a disability* (2014), cat. no. 4102.0 (Canberra: Australian Bureau of Statistics, 2014).

Figure 20: Support for children with a disability reviewed during Taskforce 1000



n = 136
Source: Appendix 1, Table A31.

423. The NDIS will provide Australians under the age of 65 who have a permanent and significant disability with lifelong support to improve their outcomes and quality of life. The NDIS has adopted a different approach to service provision, taking a lifelong, individualised-funding approach and it's being rolled out from July 2016 following introduction in trial sites.[154] Access to the scheme for eligible, vulnerable children in out-of-home care will be important and requires advocacy and support for the children, their families and carers to navigate the system.

424. The Commission has recommended that Aboriginal disability support workers are established in each DHHS division, as is the case in North division, to work closely with the newly formed Aboriginal child protection teams to support children, their carers and their families to access services. The Commission commends Matthew Duggan, the Koori Disability worker in North division, on the work he performs and outcomes he has achieved for Aboriginal children with disabilities.

425. Case study 21 details the poor support provided by DHHS as the legal guardian to two children with significant disabilities to assist the children's Aboriginal home-based carer in providing stable care for the children.

154 For more information about the NDIS, visit <www.ndis.gov.au>.

Case study 21: Anne and Adam

Anne and Adam were born with significant disabilities that impact their ability to communicate. When they were young their parents separated. They stayed in their mother's care, and she was responsible for providing for their significant care needs. The children no longer had contact with their Aboriginal father or their Aboriginal family.

When Anne and Adam were 10 and 13 years old, their mother died suddenly. The children were placed with their regular respite care on Guardianship orders as no family could be located. Child protection was not aware that the children were Aboriginal until their father was located nearly three months later. A long-term home-based care placement was found that could provide for their significant care needs. The Aboriginal home-based carer is committed to the children, although she needs respite from the high workload.

The Commission was contacted by services involved with the children, who voiced concern at the lack of support provided to the carer and children. Specifically, there was a need for respite and a vehicle that could safely transport the children. It was of great concern that DHHS, as the children's legal guardian, did not appear to be adequately supporting the children in their placement to promote their stability and the overall viability of a placement that was culturally appropriate.

4.6 Leaving care issues

426. Although the scope of Taskforce 1000 did not extend to children leaving care or youth justice, the process of the Taskforce 1000 project did provide the Commission with the opportunity and insight into the challenges facing many children leaving statutory care.

427. Young people leaving care are amongst the most vulnerable and disadvantaged groups in our society. Research has shown that when young people transition from out-of-home care they have little emotional, social and financial support.[155] Further, their educational outcomes are poorer compared with their peers.[156] They are over-represented in the youth justice system[157] and are at higher risk of mental illness, homelessness and early parenthood.[158]

155 Osborn, A and Bromfield, L, *Young people leaving care*, Research Brief No 7 (Melbourne: Australian Institute of Family Studies, 2007).

156 Mendes, P, Michell, D and Wilson, J, 'Young people transitioning from out-of-home care and access to higher education: A critical review of the literature', *Children Australia*, 39/4 (2014).

157 Mendes, P, Baldwin, S and Snow, P, 'Young people transitioning from out-of-home care: A critical analysis of leaving care policy, legislation and housing support in the Australian state of Victoria', *Child Abuse Review*, 23/6 (2014).

158 Osborn, A and Bromfield, L, *Young people leaving care*.

428. The trajectory from out-of-home care to youth justice is a disturbing reality for many young people. This is particularly the case for Aboriginal young people. Research has found that Aboriginal young people are particularly vulnerable to becoming immersed in a cycle of contact with the criminal justice system. The cycle is intensified by contributing factors such as limited education and employment opportunities, drug and alcohol dependence and insecure accommodation.

429. During Taskforce 1000, the Commission heard through case discussion with professionals at area panels, meetings with family members, children and their carers of significant service system deficits for children leaving care and post care. These concerns are:

- the trajectory for some children into the youth justice system
- the poor support offered to children post care
- inadequate leaving care packages
- homelessness and associated increased contact with the criminal justice system
- unresolved trauma from abuse
- poor education outcomes
- limited employment opportunities
- children being dislocated from their families, their culture and identity
- the inadequacy of leaving care packages and the lack of accountability and integrity of the process in providing packages.

'It was quite clear that many parents of the 980 children we saw had been in the care of the state and the state pushed them out of the door ill-prepared. The same thing sadly seems to be happening to the current generation of Koori kids leaving care.'

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

430. The Commission has recommended that DHHS ensures all Aboriginal children approaching leaving care are provided with targeted funding packages to assist in their attainment of independence. Further, that DHHS provides quarterly data to the ACF detailing the number of Aboriginal children leaving care, the number of targeted care packages provided and the net value of the care packages per child.

431. It is apparent that further investigation and inquiry is needed in this area. Commencing in 2016–17, the Commission will conduct an inquiry into the circumstances of a minimum 10 per cent sample of Aboriginal children in out-of-home care and will evaluate services provided or omitted to be provided. Additional recurrent funding for the Commission from government will be required to fulfil this task.

432. The audit will be undertaken in partnership with DHHS, CSOs, ACCOs and other government departments using Taskforce 1000 processes. The sample group may include Aboriginal children who have left care and Aboriginal children who have involvement with both child protection and youth justice programs.

4.7 Youth justice

433. In 2014–15, the rate of Aboriginal young people 10–17 years of age under supervision in Victoria on an average day was 136.5 per 10,000. For non-Aboriginal children the rate was 12.4 per 10,000. Victorian Aboriginal young people were 11 times more likely to be on supervision on an average day.[159]

434. The Commission knows, through its independent visitor program to youth justice centres,[160] that many of the young people involved with youth justice have previously been placed in out-of-home care and have often been let down by a system that does not adequately support their transition to adulthood.

435. The Taskforce 1000 survey data indicated that a small but concerning number of children reviewed (28 out of 980 children) were already dual clients of both child protection and youth justice at the time their case was presented at Taskforce 1000.

436. In 2015–16, the Commission conducted an inquiry into the circumstances of a vulnerable Aboriginal young person who had involvement with both the child protection and youth justice systems. The inquiry revealed systemic failings and the need for reflective practice and systemic reform. His circumstances are discussed in case study 22.

159 Australian Institute of Health and Welfare, *Youth justice in Australia 2014–15*, AIHW bulletin no. 133 (Canberra: Australian Institute of Health and Welfare, 2016).

160 The Commission operates independent visitor programs at the Parkville Youth Justice Precinct (since 2012) and the Malmsbury Youth Justice Centre (since 2013). Trained independent visitors conduct monthly visits to the centres to hear the voice of young people in custody, support them to have issues addressed and identify ways to improve their experience of being in custody. Exit interviews are also held with young people to provide feedback on their experience of being in custody for service improvement.

4. Inquiry findings

Case study 22: Lucas

Lucas first came to the attention of child protection when he was four months old, as a result of an alcoholic and violent father. His four siblings (all of whom were more than 10 years older than Lucas) had little contact with their father. Those children escaped the father's brutality before their teens. One child told the inquiry that they were 'terrorised' by their father. Child protection reports show that Lucas's basic needs were neglected and his life threatened. When he was 13 months old, he was allegedly seen wandering unsupervised near a main road. A collection of government and volunteer organisations were a permanent presence in Lucas's life. At the time of completing the inquiry, the Commission observed that Lucas has been placed in 13 separate out-of-home care placements.

In 2009, at the age of seven and in his parents' care, Lucas presented with a black and swollen eye. He disclosed to child protection that his father hit him in front of other people who 'just sat there laughing'. At this time, both his parents were using speed and alcohol and neglecting to feed or clothe him. In 2010, when Lucas was eight years old, he was assessed as having a borderline intellectual disability (IQ of 73).

At the age of nine, with the state now acting as his guardian, Lucas routinely chromed, sniffed petrol and consumed alcohol and cannabis. Lucas was assessed by a social worker who diagnosed him with post-traumatic stress disorder, oppositional defiance disorder and an emerging substance abuse disorder. He was crying, scared and unsettled at night, and suffered from recurrent nightmares about his mother dying. He described dark, shadowy figures hovering over his bed.

Lucas's lack of presentation at school and his disengagement with education should have been major red flags, given that engagement with education is universally recognised as a major protective factor.

In 2012, at the age of 10, Lucas was apprehended by the police when he became hysterical after an altercation with his father and threatened to kill himself.

By the age of 12, Lucas had experienced numerous episodes of isolation in police and youth justice detention. He had been restrained, handcuffed and subjected to routine unclothed searches. Lucas spent 110 days incarcerated at Parkville during the Commission's inquiry into his circumstances; 75 days of which were unsentenced detention. Studies show that the experience of incarceration for Aboriginal children increases the chances of reoffending, often disconnecting and isolating the child from family, community, cultural and support networks.

Lucas's experience was unique, yet it represents the experiences of many Aboriginal children in Victoria who are placed in out-of-home care. These children are often separated from kin and community, become a target of police attention and are fast-tracked to youth detention.

The inquiry revealed many missed opportunities by child protection to analyse or adequately respond to Lucas's situation. They relied too heavily on the questionable assurances of his parents and did not pay appropriate attention to the fact that his four older siblings had fled similar violence at the earliest opportunity.

The inquiry discovered that not enough effort was made by authorities to involve Lucas's siblings. There were also many occasions when Lucas was particularly vulnerable and required extra assistance and support navigating the legal and justice systems.

437. A recommendation has been made by the Commission that DHHS works in partnership with the ACF to develop a strategy to divert Aboriginal children in out-of-home care from entering or progressing into the youth justice system. The strategy should include building the capacity of ACCOs to develop and implement intensive diversionary strategies along the justice continuum, as well as ensuring there are adequate resources and workers in the Koori Youth Justice program and the Koori Youth Justice Intensive Bail Support program. Furthermore, the Commission has recommended that government advocates through COAG for a reduction in the incarceration of Aboriginal children and young people to be included in Close the Gap targets.

438. To assist in the development and implementation of the strategy, the Commission has also recommended that DHHS provides data relating to the gender, age, locality and number of Aboriginal children and young people who are:

- on community-based orders
- on remand
- serving custodial sentences
- dual child protection and youth justice clients.

This data should be reported by DHHS to the ACF and the Commission on a quarterly basis.

4.8 Organisational change: capacity building and cultural competence

Finding 10:

Many non-Aboriginal service systems that interact with and/or case manage Aboriginal children in out-of-home care lack high-level cultural proficiency.

Finding 11:

The child protection system lacks Aboriginal input at the executive level and there is insufficient regard to Aboriginal culture and values in service delivery.

439. Promising outcomes for Aboriginal children in out-of-home care were observed during Taskforce 1000 where there were inclusive approaches to collaboration between child protection, CSOs and ACCOs, particularly where the ACCOs were well resourced and well managed. In line with the recommendations from the *Koorie kids: Growing strong in their culture*[161] submission and the *Beyond Good Intentions*[162] policy statement, and as previously mentioned in this report, the Commission has recommended that a strategy and time line be established by DHHS in partnership with the ACF to transfer the targets and resources to ACCOs over an agreed period of time for the case management and placement of Aboriginal children.

440. This period of time should be between five and 10 years, depending on the level of resourcing provided by government to enable the transition. The Commission recommends that a strategy be developed under the policy direction of the ACF and with the establishment of a transition unit within DHHS to manage the strategic transfer of targets from DHHS and CSOs to the Aboriginal community. Adequate resourcing to ensure organisational stability and capacity will be required to achieve this goal.

161 Victorian Aboriginal Community Controlled Organisations and Community Service Organisations (joint submission), *Koorie kids: Growing strong in their culture*.

162 Centre for Excellence in Child and Family Welfare, *Beyond Good Intentions*.

4. Inquiry findings

441. A resounding observation through this Inquiry, however, has been the lack of cultural proficiency by DHHS, CSOs and DET in the delivery of their services to Aboriginal children in out-of-home care.[163]

442. This has been evidenced by:

- the delayed identification of Aboriginal children within the child protection system
- non-compliance with legislative provisions of the CYFA 2005 for cultural support planning for Aboriginal children in out-of-home care
- disregarding policy and practice requirements for Aboriginal children within the child protection system pertaining to the provision of AFLDM processes and timely engagement with ACSASS at key decision-making phases
- failure to collect and measure data relating to the application of the ACPP
- widespread practices of sibling separation for Aboriginal children in out-of-home care
- failure to provide cultural awareness training for all carers of Aboriginal children in out-of-home care
- non-compliance with practice requirements for Aboriginal children in out-of-home care relating to the existence of an individual education plan, establishment of a student support group and involvement of educational professionals in case planning
- the inability of the education system to respond to the trauma-related behaviours of many Aboriginal children in out-of-home care, resulting in suspensions and expulsions and diversion into special schooling, alternate programs or disengagement from school.

443. Systemic barriers identified during this Inquiry are:

- the current approach by DHHS to the accreditation of CSOs providing out-of-home care with standards that do not adequately assess cultural competence
- the lack of robust oversight and accountability by DHHS and DET for ensuring compliance with policy requirements as they pertain to Aboriginal children in out-of-home care
- the lack of significant Aboriginal representation in the child protection workforce and a total absence of senior executive representation
- the lack of open, timely and transparent review of the ACSASS and AFLDM program.

444. In response, the Commission has recommended that DHHS, through its Aboriginal Employment Strategy 2016–2021, includes specific targets and actions to increase the number of Aboriginal people working in child protection at all levels and in all areas.

The strategies should be inclusive of but not limited to:

- employment and development of Aboriginal people in frontline, senior management and executive roles in child protection and across the department
- succession planning, training and retention of staff
- targets that align with the over-representation of Aboriginal children in the child protection system
- tertiary and professional training and executive development of the Aboriginal workforce.

Additionally, it is recommended that DHHS must provide employment data about the number of Aboriginal child protection staff by classification level in central office and in each division and area office. This data should be reported by DHHS to the ACF on a six-monthly basis and published in DHHS's annual report.

445. The Commission observed the need for a peak professional body for current and aspiring Aboriginal human services practitioners to promote and encourage more Aboriginal people into the sector. A successful example of such a body is the Tarwirri Indigenous Law Students and Lawyers Association of Victoria.

163. DET provided feedback to the Commission on the draft report and noted that the DET *Marrung – Aboriginal Education Plan 2016–2026* will support a range of cultural competency initiatives. The Commission commends this initiative and notes that there are many appropriate and timely initiatives, but at the time of this report being finalised, the commitments are yet to be implemented. The Commission looks forward to seeing practice change as a result of the initiative.

Tarwirri, the Indigenous Law Students and Lawyers Association of Victoria

Tarwirri is a Victorian-based association founded in 2002. Tarwirri was established to increase and enhance the representation, professional profile and excellence of Aboriginal and Torres Strait Islander legal professionals and law students within the legal landscape and broader community. Some of the activities of Tarwirri include providing advice and support for law students and graduates in gaining work experience, job placements, identifying opportunities for Aboriginal and Torres Strait Islander lawyers and students, annual conferences, networking, peer support and the promotion of law to Aboriginal youth.[164]

446. The Commission has recommended that DHHS facilitates the establishment of and provides recurrent funding for a child and family services sector professional body for Aboriginal human services workers (including the social work, youth work, youth justice and community welfare sectors) to promote the child protection profession to Aboriginal people and develop the existing workforce.

447. Furthermore, the Commission has recommended that DHHS, ACCOs and CSOs involved in out-of-home care services for Aboriginal children develop an exchange program for staff to promote cultural competency and skills development and to build management capacity.

448. Persistent findings in many other inquiries pertaining to the provision of child protection and out-of-home care services have pointed to poor organisational accountability, oversight and performance monitoring by DHHS of CSOs. Despite prescriptive and detailed human services standards[165] that DHHS requires funded agencies to achieve, the accreditation and monitoring process remains problematic.[166]

449. CSOs undergo accreditation against the DHHS standards every three years. The present process sees funded agencies financing the review, deciding when the review will occur and selecting who will conduct the review from DHHS-approved external auditors.

450. Although there has been collaboration with VACCA in developing a culturally informed addendum and evidence guide as part of the human service standards, there is a lack of Aboriginal input into the assessment of an organisation's cultural competence. These organisations are given the responsibility to provide care and protection for Aboriginal children. This is contrary to the government's policy on self-determination.

451. The Commission is encouraged that CSOs that support self-determination and are Koori friendly have signed up to the Centre of Excellence Policy for the transfer and case management of Aboriginal children to the Aboriginal community.

452. Recommendations have been made by the Commission to ensure:

- CSOs that receive funding for the provision of out-of-home care services for Aboriginal children must demonstrate high-level cultural proficiency, including demonstrated Aboriginal inclusion action plans and annual training of all staff in cultural awareness and proficiency
- DHHS, in partnership with the ACF, to review and strengthen the DHHS standards pertaining to cultural competency by 2018. Assessment of an organisation's cultural competency under the DHHS standards must be performed by the Aboriginal community.

164 For more information about Tarwirri, visit <www.tarwirri.com.au>.

165 Department of Health and Human Services, *Human services standards evidence guide* (2015), <https://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/human-services-standards>, accessed 20 July 2016.

166 As has been previously found and reported in Cummins, P, Scott, D and Scales, B, *Report of the Protecting Victoria's Vulnerable Children Inquiry*; Commission for Children and Young People, *"...as a good parent would..."*; and Victorian Auditor-General, *Residential care services for children*.

5. Opportunity to respond

453. Section 48 of the CCYP Act requires that natural justice be afforded to any health service, human service or school about any material that is adverse in this report prior to the report being provided to the relevant Ministers or Secretaries of the departments.

454. Accordingly, the Commission provided extracts of the draft report to the following agencies to allow them the opportunity to respond to any adverse material:

- DHHS
- DET
- DoJR
- Victoria Police
- 36 CSOs funded by DHHS for out-of-home care provision and case management
- 15 ACCOs providing out-of-home care services and ACSASS services.

455. The Commission received responses from the following agencies:

- Anglicare Victoria
- Berry Street Victoria
- Catholic Care
- Centre for Excellence in Child and Family Welfare
- DET
- DHHS
- MacKillop Family Services
- Melbourne City Mission
- Quantum Support Services
- Upper Murray Family Care
- VACCA
- Victoria Police
- Wesley Mission Victoria.

456. The Commission considered each response and, where necessary, amendments have been made within the final report to provide more detailed information and address any factual inaccuracies.

457. All responses welcomed the opportunity to comment on the draft report and indicated support for the findings and recommendations. Strong support for implementing reform was noted by all respondents.

Anglicare Victoria

'We have reviewed the draft extract and endorse the recommendations as outlined.'

Berry Street Victoria

'We commend the Commission for undertaking this important work and the leadership that Andrew Jackomos has provided. We look forward to working with you, ACCOs, DHHS and the government to progress this important work.'

Catholic Care

'[We] commend the Commission for undertaking this inquiry and [we are] highly supportive of the recommendations contained in the report. Catholic Care remains ready to work with your office in supporting and implementing any reforms that will improve outcomes for Aboriginal children and young people in Victoria.'

Centre for Excellence in Child and Family Welfare

'The Centre commends the Commission for the diligence, commitment and leadership shown throughout the conduct of this ground-breaking Inquiry. We acknowledge the findings and strongly support the recommendations of the Taskforce 1000 project. The Inquiry report powerfully highlights the significant issues facing Aboriginal children and young people in out-of-home care. It is a poor reflection on all of us and of great concern that many Aboriginal children and young people in care are not safe, healthy, engaged in culture or connected to their family and community... We look forward to working collaboratively with the child and family services sector peak body for Aboriginal human service workers and identifying opportunities to build a strong partnership between the peaks.'

DET

'[DET] welcomes the Commission's Inquiry and considers this an opportunity to reflect on how services for Aboriginal children and young people in out-of-home care can be improved.'

DHHS

'...the draft report provides invaluable advice regarding the areas for attention and priorities for action. The department's partnership with the Commission in the Taskforce 1000 initiative has meant that many of the findings contained in the draft inquiry report are familiar to the department.'

MacKillop Family Services

'The report highlights a range of key deficiencies in the care and support provided to Aboriginal children, young people and their families. MacKillop supports the findings and recommendations, and congratulates the Commission on this fine work. The recommendations accurately identify the system reform and practice development required to address both the growing number of Aboriginal children and young people entering out-of-home care and the changes required to improve the safety and connection to culture of children and young people who cannot live at home. MacKillop looks forward to working in partnership with all key stakeholders to progress the recommendations contained in the report.'

Melbourne City Mission

'In particular, we wish to commend Commissioner Jackomos for his leadership in initiating a systemic inquiry. We share the Commission's concerns and fully support the recommendations contained in the Commission's draft report.'

Upper Murray Family Care

'...the contents and recommendations are consistent with [the] experience of Taskforce process.'
'...the report is critical in improving a situation that cannot be accepted in civilised society.'

VACCA

'VACCA views this inquiry as having the capacity to bring about systemic improvements in the lives of our children. VACCA endorses many of the recommendations and findings...'

Victoria Police

Victoria Police advised the Commission of its support for recommendation 3.4 and commented on action underway to review the barriers and issues in recording accurate information about Aboriginality and advised that a review of policies is occurring to ensure clearly defined processes are in place for police members.

Victoria Police also anticipates improvements for L17 referrals to services through the establishment of the new Safety and Support Hubs, as recommended by the Royal Commission into Family Violence.

Victoria Police also advised of its support for recommendation 6.4, and advised the Commission that together with other departments, it will work collectively to support community-led strategies to address the extent of sexual abuse evident within Aboriginal families, particularly in the South division.

Wesley Mission Victoria

'Wesley supports the findings and recommendations outlined in the extract of the draft report. In particular, Wesley strongly supports the view that meaningful connection to culture and cultural safety is best provided for Aboriginal children and young people when case management, placement and guardianship is provided by ACCOs.

5. Opportunity to respond

458. Table 7 presents feedback from agencies that has been considered by the Commission but has not altered findings, recommendations or content of the final report.

Table 7: Summary of feedback provided through the opportunity to respond

Section of report	Agency	Response by agency	Commission's reply
Paragraph 201: 'Most children (62 per cent) reviewed during Taskforce 1000 were cared for by a non-Aboriginal primary carer..'	VACCA	'The data developed for the ACF states Aboriginal carers as 9 per cent of all carers. It is respectfully recommended that the data presented [in paragraph 201] be confirmed as accurate as it may include non-Aboriginal carers as Aboriginal.'	The data presented was provided by DHHS to the Commission from the surveys conducted during Taskforce 1000. The data in this report represents a point-in-time snapshot of the 980 children reviewed in Taskforce 1000. Limitations of the data in this report are described in paragraphs 111 and 112 of this report. The Commission acknowledges that data presented at the ACF in June 2016 indicated that in March 2016 just under 9 per cent of Aboriginal children and young people in out-of-home care were known to be living with at least one Aboriginal carer and that in the majority of cases (68 per cent), the Aboriginality of carers was not recorded. The true rate of placement with Aboriginal carers is unclear and the need for improvements to data collection was recognised. The Commission has recommended that enhancements are made to the CRIS database (see recommendation 6.15) to require mandatory completion of the Aboriginal status of the child's parents and primary carer.
Paragraph 201: 'Most children (62 per cent) reviewed during Taskforce 1000 were cared for by a non-Aboriginal primary carer..'	DHHS	'This information suggests Aboriginal children are being placed with non-familial carers. It is suggested that it would be more comprehensive to include data indicating the breakdown of kinship and foster carers for this cohort of children.'	Paragraph has not been changed. Comprehensive data on the breakdown of carer type and Aboriginal status is presented in Figures 11 and 13 and commentary in paragraphs 265 and 269.
Paragraphs 392–393: 'The Commission's "*...as a good parent would...*" inquiry report revealed widespread non-compliance with LAC information recording requirements by DHHS and out-of-home care service providers for children in residential care. Essential information was routinely absent from children's files, such as information about known illnesses and medical conditions, health alerts, dental assessments outcomes, immunisation information, record of hospitalisation, record of GP details and Medicare card number.' 'As a result, the Commission recommended that funding and accreditation of out-of-home care service providers must be linked to demonstrated outcomes for children, including adherence to the recordkeeping requirements of LAC, to ensure up-to-date information about children's health and wellbeing is accurately documented.'	VACCA	'VACCA supports the importance of demonstrating outcomes for Aboriginal children in care and continuing focus on their health and wellbeing. However, LAC as a tool is cumbersome, not user friendly and not an outcome tool. VACCA suggests that it would be more appropriate to consider that a review of the LAC tool occur to rectify current concerns or the adoption of another more appropriate tool addressing health and wellbeing domains.'	Paragraph has not been changed. This recommendation was accepted by government in response to the Commission's 2015 "*...as a good parent would...*" Inquiry report.

Section of report	Agency	Response by agency	Commission's reply
Recommendation 2.1: 'Government to improve mechanisms to ensure all departments and government-funded services (including hospitals, health services, education, early childhood, justice, child protection, housing, disability and homelessness) are culturally competent and have rigorous methods and related training for early identification of a child's Aboriginality.'	DET	'DET acknowledges Aboriginality is a sensitive matter, particularly given the impact of colonisation and past government policies relating to the forced removal of children. DET does encourage children and young people and their families/carers to self-identify as Aboriginal at the time that they enrol in a kindergarten, school or other educational setting. DET has communicated with kindergarten service providers regarding the importance of asking families if they identify as Aboriginal or Torres Strait Islander as part of the kindergarten enrolment process. Given this, DET requests that the reference to education and early childhood be deleted.'	Recommendation has not been changed. Persistent systemic issues were observed during Taskforce 1000 regarding the adequacy of service systems to identify Aboriginality. The Commission considers all government departments should be aiming for continuous improvement in this area.
Recommendation 6.6: 'DHHS to review and implement improvements to the AFLDM model, remove any barriers to timely meetings and compliance with AFLDM practice guidelines, ensure the program has the capacity to meet current and anticipated demand, and actively engage in key decisions relating to Aboriginal children in out-of-home care in a timely manner.' 'Remuneration for community AFLDM convenors should be commensurate with DHHS AFLDM convenors, when workloads are comparable.'	VACCA	'VACCA supports the remuneration of AFLDM convenors commensurate to their [child protection] counterparts. However, it is suggested that this recommendation be expanded to include all key child and family welfare positions such as ACSASS and others.'	Recommendation has not been changed as it pertains specifically to the AFLDM model.
Recommendation 6.8: 'DHHS to establish eight child protection specialist Principal Practitioners for Aboriginal Children positions (one rural and one metropolitan based in each of the four DHHS divisions). These positions are to provide specialist advice and consultation to divisional Aboriginal child protection teams, be delegated with case planning responsibility and play a key role in the oversight of best practice.' 'In addition, DHHS to establish a child protection Chief Practitioner for Aboriginal Children within DHHS's central office to provide support and oversight to the eight divisional specialist Principal Practitioners.' 'The Commissioner for Aboriginal Children and Young People will be part of the selection panel for each of these positions.'	VACCA	'It is unclear what the role of the Practitioners would be vis a vis ACSASS. It is important to distinguish the respective roles.'	Recommendation has not been changed. The proposed roles will complement the ACSASS role. The Commission considers it necessary for the establishment of these positions in order to improve the cultural competence of child protection through the appointment of Aboriginal people in senior child protection roles.

5. Opportunity to respond

Section of report	Agency	Response by agency	Commission's reply
Recommendation 8.6: 'Accountability and performance measures for improved outcomes for Aboriginal children in out-of-home care to be incorporated in the individual performance plans of DET Deputy Secretaries and school principals. Such measures should include: · demonstrated engagement of a KESO · engagement of every child with a student support group · an individual educational support plan for every child that is regularly reviewed and monitored · demonstrated improvements for every child's numeracy, literacy and educational attainment · demonstrated improvement in the child's school engagement and attendance.'	DET	'DET considers it would be more effective to include accountability and performance measures for Aboriginal children in out-of-home care within overarching strategic planning documents. This would have a flow on effect to executive and employee performance plans where appropriate and relevant.'	Recommendation has not been changed but has been strengthened with the suggestion by DET that 'relevant departmental and school planning documents' be included.
Recommendation 8.9: 'DET to review the KESO program to ensure that all KESO positions are filled on an ongoing basis and that all Aboriginal children in out-of-home care are engaged with a KESO worker.' 'The outcome of the KESO review is to be reported to the ACF, the Marrung Central Governance Committee and the Commission.'	DET	'. that the words "to review the KESO program" be removed from this recommendation. The actions proposed relate to operation of the KESO program rather than systemic matters. For this reason, the proposed actions can be progressed without a formal review, including through discussions between DET and the Commission.'	Recommendation has not been changed. The Commission observed systemic and persistent issues with the KESO program throughout the state during Taskforce 1000.
Case Study 8: Violet	VACCA	'the state-wide permanent care program...has been grossly inadequately funded. Extensive delays are also due to a lack of AFLDMs, cultural support plans and any attempts to reunify the child with their family...prior to a Permanent Care order being granted.' 'It is suggested that a recommendation regarding the adequacy of the resourcing of the program would be helpful in making timelier decision making. Furthermore, the new shortened time lines for permanency is a serious concern given that AFLDMs, cultural support plans and family work is not undertaken in a timely manner.'	These matters are beyond the scope of this Inquiry. The Commission will refer these matters to the Review of the Adequacy of Permanency Amendments Inquiry being undertaken by the Commission in 2016–17.
Other	VACCA	'Given the lack of reunifications that occur for Aboriginal children, which was referenced through Taskforce 1000, it is suggested that a finding be added expressing concern about this and accordingly a recommendation be made to support the development of Aboriginal guidelines and accountability to regional panels for reunification plans.'	Specific data about reunification rates was not available to the Commission during Taskforce 1000. The Commission acknowledges that, anecdotally, this is a significant issue and a matter that will be referred to both the ACF and to the Commission's Review of the Adequacy of Permanency Amendments Inquiry being undertaken by the Commission in 2016–17.

Appendices

Appendix 1: Data tables

Table A1: Children subject to Category One CIRs by Aboriginal status and incident type, 2013–14 and 2014–15

	Aboriginal children	Non-Aboriginal children	Total
Absent/escape	78 (7.7%)	323 (8.5%)	401 (8.3%)
Absent/missing person	77	317	394
Escape – from centre	0	6	6
Escape – from temporary leave	1	0	1
Behaviour concern	121 (12.0%)	465 (12.2%)	586 (12.2%)
Behaviour – dangerous	120	449	569
Behaviour – disruptive	1	16	17
Community concern/privacy	68 (6.7%)	259 (6.8%)	327 (6.8%)
Breach of privacy/confidentiality	35	134	169
Community concern	33	125	158
Death	1 (0.1%)	19 (0.5%)	20 (0.4%)
Death – client	1	6	7
Death – other	0	13	13
Medical concern	57 (5.7%)	344 (9.0%)	401 (8.3%)
Illness	24	156	180
Injury	23	102	125
Medical condition (known) – deterioration	9	81	90
Medication error – incorrect	0	1	1
Medication error – missed	0	1	1
Medication error – other	1	3	4
Physical assault	172 (17.0%)	434 (11.4%)	606 (12.6%)
Poor quality of care	73 (7.2%)	256 (6.7%)	329 (6.8%)
Property damage/disruption	5 (0.5%)	14 (0.4%)	19 (0.4%)
Sexual	374 (37.1%)	1,276 (33.5%)	1,650 (34.3%)
Behaviour – sexual	129	404	533
Behaviour – sexual exploitation	52	275	327
Sexual assault – indecent	110	350	460
Sexual assault – rape	83	247	330
Substance abuse – drug/alcohol	23 (2.3%)	54 (1.4%)	77 (1.6%)
Suicide/self-harm	37 (3.7%)	364 (9.6%)	401 (8.3%)
Self-harm	19	199	218
Suicide attempted	18	165	183
Total	**1,009 (100.0%)**	**3,808 (100.0%)**	**4,817 (100.0%)**

n = 4,817

Source: Commission for Children and Young People, unpublished data analysis, DHHS Category One CIRs received for children in out-of-home care, 2013–14 and 2014–15 by Aboriginal status and incident type.

Note: Many children are subject to multiple reports, so the number of reports received is greater than the number of individual children named in the reports.

Appendices

Table A2: Gender, age and Aboriginal identification and status of children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Aboriginal status										
Aboriginal	276	97.5	230	97	195	97	254	98	955	97.5
TSI	6	2.1	4	1.7	3	1.5	2	0.8	15	1.5
Both	1	0.4	3	1.3	3	1.5	3	1.2	10	1.0
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Gender										
Male	142	50.2	112	47.3	111	55.2	114	44.0	479	48.9
Female	141	49.8	125	52.7	90	44.8	145	56.0	501	51.1
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Age										
0–2 years	42	14.8	25	10.5	23	11.4	49	19.0	139	14.2
3–4 years	30	10.6	29	12.2	26	13.0	35	13.5	120	12.2
5–6 years	37	13.1	52	22.0	18	9.0	33	12.8	140	14.3
7–8 years	36	12.7	31	13.1	27	13.4	37	14.3	131	13.4
9–10 years	34	12.0	24	10.1	30	15.0	34	13.1	122	12.4
11–12 years	38	13.4	26	11.0	26	13.0	27	10.4	117	11.9
13–14 years	32	11.3	20	8.4	23	11.4	21	8.1	96	9.8
15–16 years	28	10.0	23	9.7	15	7.4	19	7.3	85	8.7
17–18 years	6	2.1	7	3.0	13	6.4	4	1.5	30	3.1
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Does the child identify with an Aboriginal or TSI community?										
Yes	202	71.4	141	59.5	116	57.7	155	59.9	614	62.7
No	39	13.8	59	24.9	50	24.9	56	21.6	204	20.8
Don't know	42	14.8	36	15.2	35	17.4	47	18.1	160	16.3
Blank	0	0	1	0.4	0	0	1	0.4	2	0.2
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100
Does the child have siblings?										
Yes	269	95.0	223	94.1	196	97.5	233	90.0	921	94.0
No	14	5.0	14	5.9	5	2.5	26	10.0	59	6.0
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0

n = 980
Source: Taskforce 1000 survey data 2014–15

Table A3: DHHS North division – children reviewed during Taskforce 1000, by DHHS area and as a proportion of the state

	Mallee	Loddon	Hume Moreland	North Eastern Melbourne	Total
Number of children	45	90	48	100	283
Percentage of North division	15.9	31.8	17.0	35.3	100.0
Percentage of Victoria	4.6	9.2	4.9	10.2	28.9

n = 283
Source: Taskforce 1000 survey data 2014–15.

Table A4: DHHS South division – children reviewed during Taskforce 1000, by DHHS area and as a proportion of the state

	Outer Gippsland	Inner Gippsland	Southern Melbourne	Bayside Peninsula	Area not specified	Total
Number of children	57	74	67	37	2	237
Percentage of South division	24.1	31.2	28.3	15.6	0.8	100.0
Percentage of Victoria	5.8	7.6	6.8	3.8	0.2	24.2

n = 237
Source: Taskforce 1000 survey data 2014–15.

Table A5: DHHS East division – children reviewed during Taskforce 1000, by DHHS area and as a proportion of the state

	Ovens Murray	Goulburn	Outer Eastern Melbourne	Inner Eastern Melbourne	Area not specified	Total
Number of children	50	94	31	24	2	201
Percentage of East division	24.9	46.8	15.4	11.9	1.0	100.0
Percentage of Victoria	5.1	9.6	3.2	2.4	0.2	20.5

n = 201
Source: Taskforce 1000 survey data 2014–15.

Table A6: DHHS West division – children reviewed during Taskforce 1000, by DHHS area and as a proportion of the state

	Western District	Barwon	Central Highlands	Western Melbourne	Brimbank Melton	Area not specified	Total
Number of children	58	68	52	38	41	2	259
Percentage of West division	22.4	26.2	20.1	14.7	15.8	0.8	100.0
Percentage of Victoria	5.9	6.9	5.3	3.9	4.2	0.2	26.4

n = 259
Source: Taskforce 1000 survey data 2014–15.

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Table A7: Parental Aboriginal status for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Mother										
Aboriginal	207	73.1	161	68.0	126	62.6	187	72.2	681	69.5
TSI	4	1.4	3	1.3	0	0	2	0.8	9	0.9
Both	0	0	2	0.8	3	1.5	4	1.5	9	0.9
Neither	70	24.8	69	29.1	71	35.3	63	24.3	273	27.9
Unknown	2	0.7	2	0.8	3	1.5	1	0.4	6	0.6
Blank	0	0	0	0	0	0	2	0.8	2	0.2
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Father										
Aboriginal	164	58	146	61.6	119	59.2	109	42.1	538	55.0
TSI	2	0.7	2	0.8	6	3.0	0	0	10	1.0
Both	0	0	0	0	0	0	0	0	0	0
Neither	102	36.0	80	33.8	61	30.3	124	47.9	367	37.4
Unknown	15	5.3	9	3.8	15	7.5	26	10.0	65	6.6
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Are both parents from the same Aboriginal community?										
Yes	38	13.4	23	9.7	25	12.4	7	2.7	93	9.5
No	185	65.4	146	61.6	95	47.3	163	62.9	589	60.1
N/A	60	21.2	65	27.4	81	40.3	89	34.4	295	30.1
Blank	0	0	3	1.3	0	0	0	0	3	0.3
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Yes	202	71.4	141	59.5	116	57.7	155	59.9	614	62.7
No	39	13.8	59	24.9	50	24.9	56	21.6	204	20.8
Don't know	42	14.8	36	15.2	35	17.4	47	18.1	160	16.3
Blank	0	0	1	0.4	0	0	1	0.4	2	0.2
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A8: Risk factors evident for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Family violence	260	91.8	198	83.5	177	88.0	233	89.9	868	88.5
Parental alcohol/substance use	261	92.2	179	75.5	183	91.0	229	88.4	852	86.9
Parental mental illness	172	60.7	108	45.5	112	55.7	163	62.9	555	56.6
Neglect	173	61.1	79	33.3	102	50.7	128	49.4	482	49.1
Physical abuse	115	40.6	63	26.5	68	33.8	100	38.6	346	35.3
Aggressive/antisocial behaviour (child)	78	27.5	41	17.2	47	23.3	64	24.7	230	23.4
Risk-taking behaviour (child)	74	26.1	29	12.2	34	16.9	53	20.4	190	19.3
Poor school attendance	44	15.5	35	14.7	30	14.9	42	16.2	151	15.4
Sexual abuse	49	17.3	27	11.3	20	9.9	36	13.8	132	13.4
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A9: DHHS North division – risk factors evident for children reviewed during Taskforce 1000, by DHHS area

	Mallee		Loddon		Hume Moreland		North Eastern Melbourne		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Family violence	42	93.3	79	87.7	45	93.7	94	94.0	260	91.8
Parental alcohol/substance use	36	80.0	81	90.0	45	93.7	99	99.0	261	92.2
Parental mental illness	24	53.3	48	53.3	34	70.8	66	66.0	172	60.7
Neglect	15	33.3	52	57.7	30	62.5	76	76.0	173	61.1
Physical abuse	7	15.5	42	46.6	19	39.5	47	47.0	115	40.6
Aggressive/antisocial behaviour (child)	6	13.3	30	33.3	15	31.2	27	27.0	78	27.5
Risk-taking behaviour (child)	1	2.2	26	28.8	20	41.6	27	27.0	74	26.1
Poor school attendance	2	4.4	16	17.7	8	16.6	18	18.0	44	15.5
Sexual abuse	2	4.4	28	31.1	7	14.5	12	12.0	49	17.3
Total	45		90		48		100		283	

n = 283
Source: Taskforce 1000 survey data 2014–15.

Table A10: DHHS South division – risk factors evident for children reviewed during Taskforce 1000, by DHHS area

	Outer Gippsland		Inner Gippsland		Southern Melbourne		Bayside Peninsula		Area not specified		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family violence	51	89.4	64	86.4	51	76.1	30	81.0	2	100.0	198	83.5
Parental alcohol/substance use	39	68.4	53	71.6	54	80.5	31	83.7	2	100.0	179	75.5
Parental mental illness	25	43.8	22	29.7	37	55.2	23	62.1	1	50.0	108	45.5
Neglect	19	33.3	22	29.7	23	34.3	15	40.5	0	0	79	33.3
Physical abuse	12	21.0	19	25.6	19	28.3	12	32.4	1	50.0	63	26.5
Aggressive/antisocial behaviour (child)	8	14.0	11	14.8	15	22.3	6	16.2	1	50.0	41	17.2
Risk-taking behaviour (child)	4	7.0	4	5.4	10	14.9	10	27.0	1	50.0	29	12.2
Poor school attendance	5	8.7	12	16.2	8	11.9	9	24.3	1	50.0	35	14.7
Sexual abuse	4	7.0	11	14.8	8	11.9	4	10.8	0	0	27	11.3
Total	57		74		67		37		2		237	

n = 237
Source: Taskforce 1000 survey data 2014–15.

Appendices

Table A11: DHHS East division – risk factors evident for children reviewed during Taskforce 1000, by DHHS area

	Ovens Murray		Goulburn		Outer Eastern Melbourne		Inner Eastern Melbourne		Area not specified		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family violence	45	90.0	83	88.2	27	87.0	20	83.3	2	100.0	177	88.0
Parental alcohol/substance use	42	84.0	92	97.8	26	83.8	21	87.5	2	100.0	183	91.0
Parental mental illness	30	60.0	50	53.1	14	45.1	16	66.6	2	100.0	112	55.7
Neglect	20	40.0	53	56.3	15	48.3	13	54.1	1	50.0	102	50.7
Physical abuse	15	30.0	37	39.3	7	22.5	9	37.5	0	0	68	33.8
Aggressive/antisocial behaviour (child)	6	12.0	28	29.7	6	19.3	6	25.0	1	50.0	47	23.3
Risk-taking behaviour (child)	4	8.0	17	18.0	6	19.3	6	25.0	1	50.0	34	16.9
Poor school attendance	4	8.0	14	14.8	4	12.9	7	29.1	1	50.0	30	14.9
Sexual abuse	4	8.0	8	8.5	4	12.9	4	16.6	0	0	20	9.9
Total	50		94		31		24		2		201	

n = 201
Source: Taskforce 1000 survey data 2014–15.

Table A12: DHHS West division – risk factors evident for children reviewed during Taskforce 1000, by DHHS area

	Western District		Barwon		Central Highlands		Western Melbourne		Brimbank Melton		Area not specified		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family violence	55	94.8	62	91.1	50	96.1	31	81.5	33	80.4	2	100.0	233	89.9
Parental alcohol/substance use	57	98.2	63	92.6	39	75.0	31	81.5	37	90.2	2	100.0	229	88.4
Parental mental illness	38	65.5	40	58.8	40	76.9	21	55.2	22	53.6	2	100.0	163	62.9
Neglect	29	50.0	41	60.2	24	46.1	17	44.7	17	41.4	0	0	128	49.4
Physical abuse	31	53.4	28	41.1	19	36.5	12	31.5	10	24.3	0	0	100	38.6
Aggressive/antisocial behaviour (child)	16	27.5	26	38.2	4	7.6	7	18.4	11	26.8	0	0	64	24.7
Risk-taking behaviour (child)	11	18.9	25	36.7	4	7.6	4	10.5	9	21.9	0	0	53	20.4
Poor school attendance	13	22.4	13	19.1	2	3.8	10	26.3	4	9.7	0	0	42	16.2
Sexual abuse	17	29.3	2	2.9	11	21.1	5	13.1	1	2.4	0	0	36	13.8
Total	58		68		52		38		41		2		259	

n = 259
Source: Taskforce 1000 survey data 2014–15.

Table A13: Case management responsibility for out-of-home care placement for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
DHHS	161	56.9	166	70.0	143	71.1	186	71.8	656	66.9
ACCO	69	24.4	23	9.7	18	8.9	25	9.7	135	13.8
Non-Aboriginal CSO	53	18.7	48	20.3	40	20.0	48	18.5	189	19.3
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A14: Additional DHHS programs involved with children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Disability	25	8.8	9	3.8	8	4.0	7	2.7	49	5.0
Youth justice	6	2.1	8	3.4	9	4.5	5	1.9	28	2.8
Other	0	0	3	1.3	4	2.0	0	0	7	0.7
Blank	15	5.3	24	10.1	11	5.5	29	11.2	79	8.1
N/A	237	83.8	193	81.4	169	84	218	84.2	817	83.4
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A15: Aboriginal status of child's primary carer for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Aboriginal	121	42.8	75	31.6	73	36.3	96	37.1	365	37.3
TSI	0	0	3	1.3	0	0	0	0	3	0.3
Aboriginal and TSI	2	0.7	0	0	0	0	3	1.1	5	0.5
Neither Aboriginal nor TSI	160	56.5	158	66.7	128	63.7	160	61.8	606	61.8
Blank	0	0	1	0.4	0	0	0	0	1	0.1
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

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Table A16: Substantiated abuse type for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
s. 162(a) Abandonment	11	2.0	12	3.1	11	3.1	16	2.8	50	2.7
s. 162 (b) Parents dead or incapacitated	9	1.6	6	1.6	6	1.7	9	1.6	30	1.6
s. 162 (c) Physical abuse	187	33.4	135	35.3	113	31.9	197	34.2	632	33.8
s. 162 (d) Sexual abuse	16	2.8	13	3.4	8	2.3	18	3.1	55	2.9
s. 162 (e) Emotional harm	218	38.9	168	44.0	146	41.2	222	38.6	754	40.3
s. 162 (f) Neglect	119	21.2	48	12.6	70	19.8	114	19.8	351	18.7
Total	560		382		354		576		1,872	

n = 1,872
Source: Taskforce 1000 survey data 2014–15.

Note: Most children experienced more than one type of harm, therefore the total number of substantiated grounds is greater than the number of children reviewed during Taskforce 1000. Section 162 of the CYFA 2005 specifies the grounds for when a child is in need of protection.

Table A17: Type of protection order for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Interim Accommodation order	20	7.1	11	4.7	11	5.5	3	1.1	45	4.6
Interim Protection order	8	2.8	7	3.0	3	1.5	14	5.4	32	3.3
Supervised Custody order	33	11.7	15	6.3	21	10.4	29	11.2	98	10.0
Custody order	137	48.4	124	52.3	104	51.7	145	56.0	510	52.0
Custody to Third Party order	1	0.3	1	0.4	7	3.5	2	0.8	11	1.1
Guardianship order	78	27.6	69	29.1	46	22.9	66	25.5	259	26.5
Long-term Guardianship order	6	2.1	5	2.1	9	4.5	0	0	20	2.0
Therapeutic Treatment order	0	0	1	0.4	0	0	0	0	1	0.1
Blank	0	0	4	1.7	0	0	0	0	4	0.4
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Note: Legislative change to the CYFA 2005 came into effect on 1 March 2016 to enable the Children's Court to make more timely decisions about children's long-term care. This was supported by simplified Children's Court orders to clarify the purpose of the intervention. As a result, a new suite of orders was introduced. Data depicted in this table pre-date the 1 March 2016 changes.

Table A18: Compliance with DHHS policy on ACSASS consultation, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Was ACSASS consulted at the time of the most recent report being made?										
Yes	255	90.1	214	90.3	159	79.1	220	85.0	848	86.5
No	28	9.9	23	9.7	42	20.9	39	15.0	132	13.5
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Was ACSASS consulted during the child's most recent placement change?										
Yes	198	89.6	152	86.9	102	72.9	184	88.0	636	85.4
No	23	10.4	23	13.1	38	27.1	25	12.0	109	14.6
N/A	62	–	62	–	61	–	50	–	235	–
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
If permanent care was recommended, was ACSASS consulted prior to referral to VACCA's permanent care program?										
Yes	77	80.2	55	65.5	32	58.2	66	71.0	230	70.1
No	19	19.8	29	34.5	23	41.8	27	29.0	98	29.9
N/A	187	–	153	–	146	–	166	–	652	–
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Has an AFLDM conference occurred?										
Yes	107	37.8	92	38.8	108	53.7	119	45.9	426	43.5
No	176	62.2	145	61.2	93	46.3	139	53.7	553	56.4
Blank	0	0	0	0	0	0	1	0.4	1	0.1
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0

n = 980
Source: Taskforce 1000 survey data 2014–15.

Note: Percentages have been calculated excluding N/A responses.

Table A19: Type of placement for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		Total	
	No.	%	No.	%	No.	%	No.	%
Kinship care	170	60.1	126	53.2	118	61	572	58.4
Home-based (foster) care	75	26.5	82	34.6	62	30.5	298	30.4
Residential care	27	9.6	22	9.3	14	5	76	7.7
– General residential care	22		17		12		62	
– Therapeutic residential care	5		5		2		14	
Lead tenant	1	0.3	0	0	2	0.4	4	0.4
Other	10	3.5	7	2.9	5	3.1	30	3.1
Total	283		237		201		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Note: Percentages for residential care have been calculated to combine both therapeutic and general residential care.

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Table A20: Consideration of placement in kinship care for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Has a kinship placement been considered?										
Yes	105	92.9	100	90.1	77	92.8	94	93.1	376	92.1
No	5	4.4	8	7.2	4	4.8	7	6.9	24	5.9
N/A	3	2.7	3	2.7	2	2.4	0	0	8	2.0
Total	113	100.0	111	100.0	83	100.0	101	100.0	408	100.0
Why is the child not in a kinship placement?										
No kinship carer able to care for the child	37	32.7	18	16.2	22	26.5	29	28.7	106	26.0
Kinship carer assessed as unsuitable	36	31.9	64	57.7	34	41.0	33	32.7	167	40.9
No kinship carer willing to care for the child	20	17.7	7	6.3	18	21.7	10	9.9	55	13.5
Other	12	10.6	10	9.0	6	7.2	20	19.8	48	11.8
N/A	8	7.1	12	10.8	3	3.6	9	8.9	32	7.8
Total	113	100.0	111	100.0	83	100.0	101	100.0	408	100.0

n = 408
Source: Taskforce 1000 survey data 2014–15.

Table A21: Aboriginal status of child's primary carer and cultural awareness training provision for non-Aboriginal primary carers for children reviewed during Taskforce 1000, by type of placement

	Kinship care		Home-based care		Residential care		Lead tenant		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Aboriginal status of child's primary carer												
Aboriginal and/or TSI	310	54.2	43	14.4	9	11.8	0	0	11	36.7	373	38.1
Neither Aboriginal nor TSI	262	45.8	254	85.3	67	88.2	4	100	19	0	606	61.8
Blank	0	0	1	0.3	0	0	0	0	0	63.3	1	0.1
Total	572	100.0	298	100.0	76	100.0	4	100.0	30	100.0	980	100.0
Non-Aboriginal primary carer has had cultural awareness training	43	16.4	181	71.2	53	79.1	2	0	8	2.1	287	7.3

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A22: Cultural connection for children reviewed during Taskforce 1000, by case management responsibility

	DHHS		ACCO		CSO		Total	
	No.	%	No.	%	No.	%	No.	%
Child has contact with Aboriginal or TSI extended family members	461	70.2	102	75.5	107	56.6	670	68.3
In the past 12 months, the child has been provided with opportunities for participation in activities to foster appreciation of culture	542	82.6	128	94.8	167	88.3	837	85.4
In the past 12 months, the child has been able to engage socially with someone who is Aboriginal or TSI	568	86.5	126	93.3	153	80.9	847	86.4
One of the child's primary carers is Aboriginal or TSI	271	41.3	66	48.8	36	19.0	373	38.0
Child's primary carer is neither Aboriginal nor TSI	384	58.6	69	51.1	153	81.0	606	62.0
Non-Aboriginal carer has been provided with cultural awareness training	160	41.6	37	53.6	90	58.8	287	47.3
Child has contact with their parent/s' Aboriginal or TSI community	397	60.5	99	73.3	90	47.6	586	59.7
Total	656		135		189		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Note: Missing data for one case (DHHS case management) was evident for Aboriginal status of child's primary carer.

Table A23: Sibling placement and contact for children reviewed during Taskforce 1000, by case management responsibility

	DHHS case management		ACCO case management		CSO case management		Total	
	No.	%	No.	%	No.	%	No.	%
Child has sibling/s who are also in out-of-home care	524	85.6	110	87.3	143	78.1	777	84.3
Child resides with their sibling/s	391	63.8	75	59.5	84	45.9	550	59.7
Child has contact with sibling/s they are not residing with	406	66.3	79	62.6	123	67.2	608	66.0
Total	612		126		183		921	

n = 921
Source: Taskforce 1000 survey data 2014–15.

Table A24: Compliance with the CYFA 2005 cultural support plan requirements for children on Guardianship orders, by case management responsibility

	DHHS		ACCO		CSO		Total	
	No.	%	No.	%	No.	%	No.	%
There is a cultural support plan	85	77.2	57	80.2	70	71.4	212	75.9
Child's parent/s were involved in developing the cultural support plan	40	36.3	20	28.1	35	35.7	95	34
Child's extended family were involved in developing the cultural support plan	61	55.4	53	74.6	41	41.8	155	55.5
ACCO was involved in developing the child's cultural support plan	84	76.3	64	90.1	82	83.6	230	82.4
Child was involved in developing the cultural support plan	37	33.6	27	38	27	27.5	91	32.6
Total	110		71		98		279	

n = 279
Source: Taskforce 1000 survey data 2014–15.

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Table A25: Physical health factors for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Is the child up to date with immunisations?										
Yes	272	96.1	231	97.4	188	93.5	254	98.1	945	96.4
No	10	3.5	3	1.3	13	6.5	4	1.5	30	3.1
Blank	1	0.4	3	1.3	0	0	1	0.4	5	0.5
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
When was the child's last health assessment?										
0–6 months ago	225	79.5	188	79.4	158	78.6	189	73	760	77.5
7–12 months ago	45	15.9	33	13.9	25	12.4	41	15.8	144	14.7
More than 12 months ago	10	3.5	10	4.2	9	4.5	16	6.2	45	4.6
No health assessment	3	1.1	5	2.1	8	4	12	4.6	28	2.9
Blank	0	0	1	0.4	1	0.5	1	0.4	3	0.3
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Has the child visited a dentist in the last 12 months?										
Yes	193	81.1	166	79.4	134	81.2	149	73.4	642	78.8
No	44	18.5	41	19.6	30	18.2	54	26.6	169	20.7
Blank	1	0.4	2	1.0	1	0.6	0	0	4	0.5
Total*	238		209		165		203		815	
Has the child visited an optometrist/undergone an eye test in the last 12 months?										
Yes	167	59.0	141	59.5	92	45.8	111	42.9	511	52.1
No	115	40.6	94	39.7	109	54.2	147	56.7	465	47.5
Blank	1	0.4	2	0.8	0	0	1	0.4	4	0.4
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Has the child had a hearing check in the last 12 months?										
Yes	157	55.5	108	45.6	73	36.3	129	49.8	467	47.7
No	125	44.1	126	53.1	128	63.7	127	49	506	51.6
Blank	1	0.4	3	1.3	0	0	3	1.2	7	0.7
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0
Is the child's Medicare card number recorded on the CRIS file?										
Yes	273	96.5	204	86.1	171	85.1	208	80.3	856	83.4
No	8	2.8	31	13.1	30	14.9	50	19.3	119	12.1
Blank	2	0.7	2	0.8	0	0	1	0.4	5	0.5
Total	283	100.0	237	100.0	201	100.0	259	100.0	980	100.0

n = 980
Source: Taskforce 1000 survey data 2014–15.
* Percentages for dental visit have excluded N/A responses.

Table A26: Mental health concerns in children reviewed during Taskforce 1000, by age and DHHS division

	North	South	East	West	Total
	No.	No.	No.	No.	No.
0–5 years	3	3	5	6	17
6–10 years	18	15	12	24	69
11–15 years	29	21	18	24	92
16–18 years	11	10	10	7	38
Total	61	49	45	61	216
Percentage (of all children reviewed)	21.5	20.6	22.3	23.5	22.0

n = 216
Source: Taskforce 1000 survey data 2014–15.

Table A27: Mental health support and treatment for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Child is receiving mental health treatment/support	47	77.0	42	85.7	32	71.1	51	83.6	172	79.6
Child has been placed in a mental health facility	3	4.9	6	12.2	5	11.1	3	4.9	17	7.8
Total	61		49		45		61		216	

n = 216
Source: Taskforce 1000 survey data 2014–15.

Table A28: Substance use by children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Child abuses substances	20	7	20	8.4	23	11.4	12	4.6	75	7.6

n = 380
Source: Taskforce 1000 survey data 2014–15.

Table A29: Treatment and support for substance use in children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Child has been referred to or is engaged with a drug and alcohol service	5	25	11	55	13	56.5	7	58.3	36	48
Child has accessed a drug treatment/detox facility	1	5	3	15	8	34.7	2	16.6	14	18.6
Total	20		20		23		12		75	

n = 75
Source: Taskforce 1000 survey data 2014–15.

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Table A30: Children with a disability reviewed during Taskforce 1000, by DHHS division

	North	South	East	West	Total
	No.	No.	No.	No.	No.
Intellectual disability	36	19	17	17	89
Physical disability	7	2	2	3	14
Intellectual and physical disability	4	4	2	3	13
Other	7	4	6	3	20
Disability sub-total	54	29	27	26	136
Percentage	19.1	12.2	13.4	10.0	13.9
No disability	229	208	174	233	844
Percentage	80.9	87.8	86.6	90.0	86.1
Total	283	237	201	259	980

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A31: Disability support for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Child receives support from disability services	31	57.4	17	58.6	14	51.8	16	61.5	78	57.3
Child's placement is supported in relation to disability needs	40	74.0	23	79.3	21	77.7	21	80.7	105	77.2
Child's disability is impacting on the stability of the placement	15	27.7	3	10.3	5	18.5	9	34.6	32	23.5
Total	54		29		27		26		136	

n = 136
Source: Taskforce 1000 survey data 2014–15.

Table A32: Type of education setting for children reviewed during Taskforce 1000, by DHHS division

	North		South		East		West		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Kindergarten	27	9.5	32	13.5	19	9.45	25	9.7	103	10.5
Primary school	122	43.1	109	46.0	85	42.3	119	45.9	435	44.4
Secondary school	53	18.7	30	12.7	36	17.9	38	14.7	157	16.0
TAFE or RTO	1	0.4	3	1.3	7	3.5	2	0.8	13	1.3
Other	14	4.9	25	10.5	19	9.4	27	10.4	85	8.7
Special developmental	23	8.1	10	4.2	6	3.0	5	1.9	44	4.5
N/A	42	14.9	27	11.4	29	14.5	42	16.2	140	14.3
Blank	1	0.4	1	0.4	0	0	1	0.4	3	0.3
Total	283		237		201		259		980	

n = 980
Source: Taskforce 1000 survey data 2014–15.

Table A33: Type of education setting for children enrolled in education reviewed during Taskforce 1000

	Kindergarten	Primary school	Secondary school	TAFE or RTO	Special developmental	Other	Total
Number	103	435	157	13	44	85	837
Percentage	12.3	52.0	18.8	1.55	5.3	10.1	100.0

n = 837
Source: Taskforce 1000 survey data 2014–15.

Table A34: Educational progress for children enrolled in education for children reviewed during Taskforce 1000, by education setting

	Kindergarten		Primary school		Secondary school		TAFE or RTO		Special developmental		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Has the child attained 12 months' learning in the past 12 months?														
Yes	73	70.9	361	83	126	74.6	4	30.8	30	68.2	31	36.5	614	73.4
No	17	16.5	56	12.9	36	21.3	7	53.8	9	20.4	41	48.2	166	19.8
Don't know	13	12.6	15	3.4	6	3.5	2	15.4	5	11.4	11	12.9	51	6.1
Blank	0	0	3	0.7	1	0.6	0	0	0	0	2	2.4	6	0.7
Total	103		435		169		13		44		85		837	

n = 837
Source: Taskforce 1000 survey data 2014–15.

Table A35: Provision of education plans and support for children reviewed during Taskforce 1000, by educational setting

	Kindergarten		Primary school		Secondary school		TAFE or RTO		Special developmental		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Child has an individual education plan	9	8.7	377	86.6	124	78.9	5	38.4	38	86.3	17	20.0	570	68.1
A student support group has been established for the child	13	12.6	362	83.2	128	81.5	4	30.7	39	88.6	17	20.0	563	67.2
Education professionals have been involved in the child's case planning	34	33.0	323	74.2	118	75.1	9	69.2	37	84	35	41.1	556	66.4
The child attends school regularly	93	90.2	430	98.8	132	84.0	8	61.5	43	97.7	32	37.6	738	88.1
The child has been suspended	1	0.9	50	11.4	48	30.5	3	23.0	10	22.7	20	23.5	132	15.7
The child has been expelled	0	0	4	0.9	4	2.5	0	0	1	2.2	9	10.5	18	2.1
Total	103		435		157		13		44		85		837	

n = 837
Source: Taskforce 1000 survey data 2014–15.

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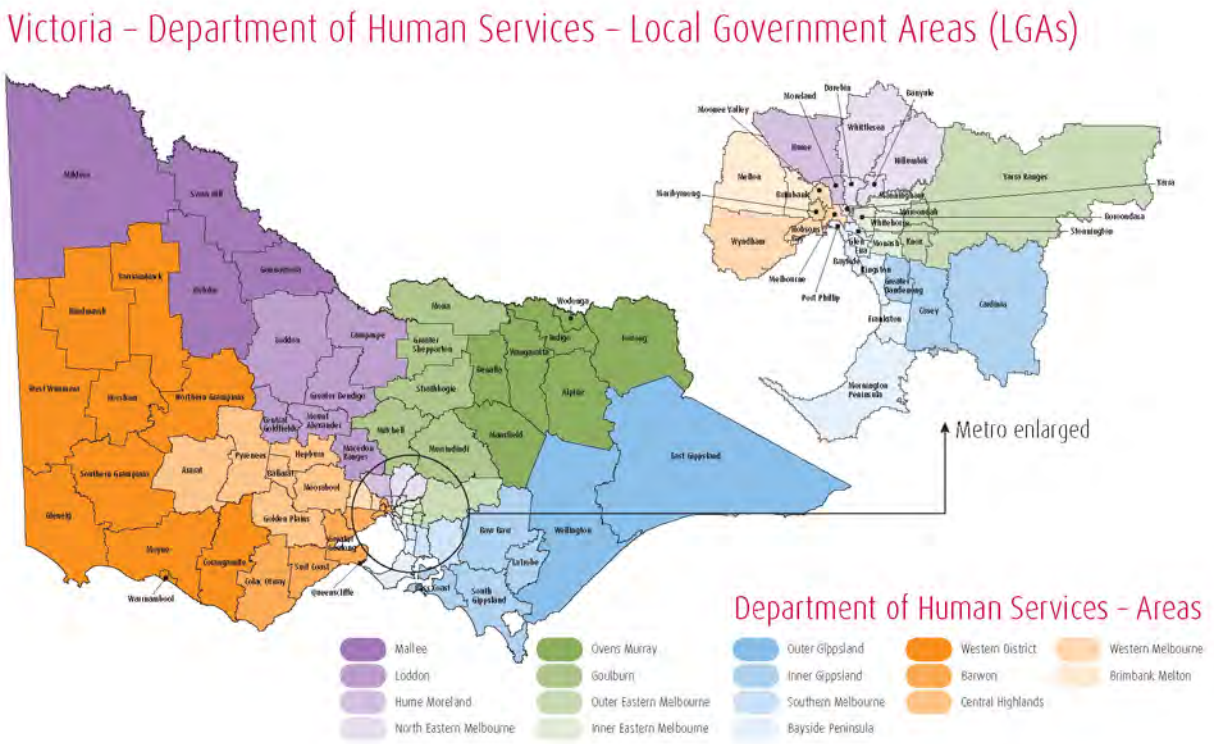
Appendix 2: DHHS area map



Appendix 3: Aboriginal languages of Victoria map

Aboriginal Language Map of Victoria - reproduced with permission from the Victorian Aboriginal Corporation for Languages

Appendix 4: Extract, CYFA 2005, s. 162 When is a child in need of protection?

Children, Youth and Families Act 2005

Section 162

When is a child in need of protection?

(1) For the purposes of this Act a child is in need of protection if any of the following grounds exist—

(a) the child has been abandoned by his or her parents and after reasonable inquiries—

(i) the parents cannot be found; and

(ii) no other suitable person can be found who is willing and able to care for the child;

(b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;

(c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

(d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

(e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

(f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

S. 162(2) amended by No. 48/2006 s. 12.

(2) For the purposes of subsections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.

Appendix 5: Survey questions, Taskforce 1000, 2014–15

Child details

Q1 CRIS Client ID

Q2 Child/young person's name

Q3 Gender

Q4 Age

Q5 Is the child Aboriginal or Torres Strait Islander or both?

Child protection history

Q6 Current substantiated abuse type?

Q7 What order is the child currently subject to?

Q8 Current final order start date

Q9 How many previous child protection reports have been received?

Q10 Has the child/young person experienced or had exposure to risk factors?

Case management

Q11 Who has case management responsibility for the child/young person?

Q12 Is the child a client of another DHS program area?

Q13 If yes, please select the program area

Case allocation

Q14 Is the child or young person's case currently allocated?

Q15 If no, how long has it been unallocated, in months?

Q16 DHS division responsible for child or young person's case management?

Q17 DHS area responsible for child/young person's case management?

Placement

Q18 What type of placement is the child/young person currently residing in?

Q19 What is the start date of the current placement?

Q20 DHS division where child/young person resides?

Q21 DHS area where child/young person resides?

Q22 What type of organisation provides or oversees the current placement?

Q23 How many placement changes have there been during the current period of child protection involvement?

Q24 Please identify the primary reason/s for the placement changes

Q25 Child or young person's relationship to primary carer?

Q26 Is the placement with the maternal or paternal side of the family?

Q27 Is one of the primary carers Aboriginal, Torres Strait Islander, both or neither?

Q28 If the child is placed with kith/kin, have carers been assessed to provide permanent care?

Q29 If no, please explain why not

Q30 Has the possibility of a kinship placement been explored?

Q31 If yes, why is the child/young person not in kinship care?

Q32 If additional supports were available, could the child/young person reside in a kinship placement?

Q33 If yes, please select the additional supports required

Q34 If the child/young person is placed with a non-Aboriginal/non-Torres Strait Islander carer, has the carer received cultural awareness training?

Q35 If the child/young person is placed with a non-Aboriginal/non-Torres Strait Islander carer, has the carer been introduced to Aboriginal organisations/services?

Child/young person's family of origin

Q36 Has a genogram been completed for the child/young person's family?

Mother

Q37 Is the child/young person's mother Aboriginal, Torres Strait Islander, both or neither?

Q38 In relation to the child/young person's mother, have any of the following contributed to her child being placed in out-of-home care? (incarceration, illicit substance abuse, alcohol abuse, mental health concerns, physical disability, intellectual disability, other disability, medical/health concerns, victim of family violence, perpetrator of family violence, homelessness) Other – please explain

Q39 What factors, if any, have impacted on the child/young person's ability to currently reside with their mother? Other – please explain

Q40 Does the child/young person have contact with their mother?

Q41 If yes, how often does the child/young person have contact with their mother?

Q42 Is contact with the mother supervised?

Q43 If the child/young person is not having contact with their mother, please explain what factors are inhibiting contact/access

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Father

Q44 Is the father Aboriginal, Torres Strait Islander, both or neither?

Q45 In relation to the child/young person's father, have any of the following contributed to his child being placed in out of home care? (incarceration, illicit substance abuse, alcohol abuse, mental health concerns, physical disability, intellectual disability, other disability, medical/health concerns, victim of family violence, perpetrator of family violence, homelessness) Other – please explain

Q46 What factors, if any, have impacted on the child/young person's ability to currently reside with their father? Other – please explain

Q47 Does the child/young person have contact with their father?

Q48 If yes, how often does the child/young person have contact with their father?

Q49 Is contact with the father supervised?

Q50 If the child/young person is not having contact with their father, please explain what factors are inhibiting contact/access

Siblings

Q51 Does the child/young person have siblings?

Q52 How many siblings does the child/young person have?

Q53 Are any of the child/young person's siblings in out-of-home care?

Q54 Does the child/young person reside with any of their siblings?

Q55 Does the child/young person have contact with siblings they aren't residing with?

Q56 If no, please explain why not

Extended family

Q57 Does the child/young person have contact with any extended Aboriginal/Torres Strait Islander family members?

Q58 If yes, how often does contact occur?

Q59 If the child/young person is not having contact with any extended Aboriginal/Torres Strait Islander family members, please explain why not

Q60 Does the child/young person have contact with any non-Aboriginal/non-Torres Strait Islander extended family members?

Q61 If yes, how often does contact with non-Aboriginal/non-Torres Strait Islander extended family occur?

Q62 If the child/young person is not having contact with any non-Aboriginal/non-Torres Strait Islander extended family, please explain why not

Cultural connectedness

Q63 Are both parents from the same Aboriginal/Torres Strait Islander community?

Q64 Does the child/young person have contact with their parent/s' Aboriginal/Torres Strait Islander community?

Q65 Does the child/young person regard themselves as being part of the Aboriginal/Torres Strait Islander community?

Q66 Does the child/young person identify with an Aboriginal/Torres Strait Islander community?

Q67 If yes, is it one of their parents' communities?

Q68 In the past 12 months, has the child/young person been provided with opportunities to participate in activities that foster knowledge and appreciation of their culture?

Q69 If yes, what types of activities?

Q70 In the past 12 months, has the child/young person been able to engage socially with someone who is Aboriginal and/or Torres Strait Islander?

Q71 If yes, how many times has this occurred?

Case planning and decision-making

Q72 What is the case plan?

Q73 Has an AFLDM conference occurred?

Q74 If no, please explain why an AFLDM conference has not occurred

Q75 Have one or either of the child/young person's parents formally requested a review of the current case plan?

Q76 If yes, has the review taken place?

Q77 If yes, what was the outcome of the review?

Q78 Has the child/young person formally requested a review of the current case plan?

Q79 If yes, has the review taken place?

Q80 If yes, what was the outcome of the review?

Q81 If there is a reunification case plan, is it anticipated the child/young person will return to their parent's care?

Q82 If there is a long-term out-of-home care case plan, has a permanent care case plan been considered?

Q83 If no, please explain why not

Q84 If permanent care is being recommended, has ACSASS been consulted prior to a referral to VACCA's permanent care program?

Q85 If yes, did ACSASS endorse the decision to proceed to permanent care?

Q86 If there's a permanent care case plan, has a referral been made to VACCA'S permanent care program?

Q87 If the child is placed in foster care, has the carer been assessed for permanent care?

Q88 If there is a long-term out-of-home care case plan and the child/young person is over 15 years of age, has a leaving care case plan been prepared?

Significant decisions

Q89 Did consultation with ACSASS occur at the time of the most recent report being made?

Q90 Was ACSASS consulted during the child/young person's most recent placement change?

Q91 If yes, is the consultation documented on the child/young person's file?

Aboriginal Child Placement Principle

Q92 When making the decision to place the child/young person in out-of-home care, was the Aboriginal Child Placement Principle applied?

Q93 If yes, is this documented on the child/young person's file?

Cultural support plans

Q94 Has a cultural support plan been developed?

Q95 Was the child/young person engaged in the development of the cultural support plan?

Q96 If no, has the purpose of the cultural support plan been explained to the child/young person?

Q97 Was one or both parents involved in the development of the cultural support plan?

Q98 Were any extended family members of the child/young person engaged in the development of the cultural support plan?

Q99 If no to any of questions 95–98, please explain why not

Q100 Was an Aboriginal community controlled organisation engaged in the development of the cultural support plan?

Q101 If no, please explain why not

Q102 When was the cultural support plan last reviewed?

Child/young person's health and wellbeing

Q103 Does the child/young person have a Medicare card or number recorded on their CRIS file?

Q104 Does the child/young person have an up-to-date maternal child health record?

Q105 Is the child/young person up to date with their immunisations/vaccinations?

Q106 When was the child/young person's last health assessment?

Q107 Has the child/young person been prescribed medication for any condition?

Q108 If yes, what condition?

Q109 Has the child/young person been admitted into hospital since entering out-of-home care?

Q110 If yes, please advise reason for admission

Dental

Q111 Has the child visited a dentist in the past 12 months?

Q112 Was follow-up dental treatment required?

Q113 Was a referral to another service made?

Eyes

Q114 Has the child visited an optometrist and/or undergone an eye test in the past 12 months?

Q115 If yes, was a follow-up required?

Q116 If yes, was a referral made?

Ears

Q117 Does the child/young person experience recurrent ear infections?

Q118 Has the child had a hearing check in the past 12 months?

Q119 If yes, was a follow-up required?

Q120 If yes, was a referral made?

Mental health

Q121 Does the child/young person have mental health concerns?

Q122 Is the child or young person receiving support/treatment from a mental health service?

Q123 If no, please explain why not

Q124 Has the child/young person ever been placed in a mental health facility as either a voluntary or involuntary client?

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Behaviour

Q125 Does the child/young person display any of the following challenging behaviours? (verbal aggression, physical aggression, damage to property, disinhibition, absconding, substance abuse, self-harm, suicide attempt/s)

Q126 If yes, is the challenging behaviour associated with any of the following conditions and/or disabilities? (diagnosed ADHD, diagnosed conduct disorder, diagnosed oppositional defiance disorder, diagnosed intellectual disability and/or learning difficulties, any mental health diagnosis, eating disorder, diagnosed Autism spectrum disorder)

Q127 If yes, was the child/young person's behaviour a factor resulting in their entry into out-of-home care?

Q128 Is the child/young person's behaviour impacting on the stability of their current placement?

Q129 Are the child/young person's behaviours currently preventing their placement with kith/kin?

Q130 Is the child/young person's challenging behaviour a factor contributing to them no longer residing with their parents?

Q131 Has the child/young person's behaviour resulted in their contact with the criminal justice system?

Q132 Has the child/young person ever been placed in secure welfare services?

Q133 Has the child/young person ever been remanded?

Q134 Has the child/young person's behaviour ever resulted in the child/young person suffering serious physical injury?

Q135 Does the child or young person abuse substances?

Q136 If so, what types of substances do they use?

Q137 Is the child/young person addicted to any substances?

Q138 Has the child/young person ever accessed a drug treatment/detox facility?

Q139 Is the child/young person referred to/engaged with a drug and alcohol service?

Q140 Has the child/young person been provided with any support in relation to his/her challenging behaviours/diagnosed condition?

Q141 Have the carer/s been provided with support in relation to the child/young person's challenging behaviours/diagnosed condition?

Q142 If no to any of questions 139–141, please explain why not

Disability

Q143 Does the child/young person have a disability?

Q144 If yes, what is the nature of their disability?

Q145 Is the child/young person receiving support from disability services?

Q146 If no, please explain why not

Q147 Is placement support being provided in relation to the child/young person's disability needs?

Q148 If no, please explain why not

Q149 Is the child/young person's disability impacting on the stability of their placement?

Education

Q150 What type of school is the child currently enrolled in?

Q151 What type of educational setting does the child/young person attend?

Q152 Does the child attend school regularly?

Q153 Has the child made 12 months' learning gain in the past 12 months of schooling?

Q154 Does the child/young person have learning difficulties?

Q155 Has a referral to an allied health professional been recommended?

Q156 Does the child/young person have an individual education plan developed?

Q157 Does the child/young person have a student support group?

Q158 If the child/young person is transitioning from early childhood to primary school, has a Transition Plan been prepared?

Q159 If the child/young person is transitioning from primary to secondary school, has a Transition Plan been prepared?

Q160 Have educational professionals been involved in the case planning process for this child/young person?

Q161 If the child/young person is not attending school, what are they doing?

Q162 Has the child/young person ever been suspended?

Q163 If yes, how many times has the child/young person been suspended?

Q164 Has the child/young person ever been expelled?

Q165 If yes, how many times has the child/young person been expelled?

Q166 If the child is older than 15, does the child do any paid work?

Q167 Have you interviewed the child/young person as part of this survey?

Q168 If yes, does the child/young person want to meet with the Aboriginal Commissioner for Children and Young People, Mr Andrew Jackomos?

Appendix 6: Core membership of Taskforce 1000 Steering Committee

Andrew Jackomos PSM
Co-chair
Commissioner
Aboriginal Children and Young People

Judith Abbott
Department of Health and Human Services

Chris Asquini
Deputy Secretary Operations
Department of Health and Human Services

Tracy Beaton
Director
Office of Professional Practice
Department of Health and Human Services

Kylie Belling
Senior Advisor Aboriginal Policy
Commission for Children and Young People

Antoinette Braybrook
CEO
Aboriginal Family Violence Prevention and Legal Service

Amanda Cattermole
Deputy Secretary
Community Services Programs and Design
Department of Health and Human Services

Andrew Crisp
Deputy Commissioner
Victoria Police

Sandie de Wolf AM
CEO
Berry Street Victoria

Carly Edwards
Acting Director
Community Services Programs and Design
Department of Health and Human Services

Kym Peake
Co-chair
Secretary
Department of Health and Human Services

Beth Allen
Assistant Director, Child Protection
Department of Health and Human Services

Muriel Bamblett AM
CEO
Victorian Aboriginal Child Care Agency (VACCA)

Michael Bell
CEO
Windamara

Brenda Boland
CEO
Commission for Children and Young People

Gill Callister
Secretary
Department of Education and Training

Marcus Clarke
CEO
Gunditjmara Aboriginal Cooperative Ltd

Michal De'Ath
Deputy Secretary
South Division
Department of Health and Human Services

Catherine Dixon
Department of Justice and Regulation

Jill Gallagher
CEO
Victorian Aboriginal Community Controlled Health Organisation

Appendices

Jill Gardiner
Acting Deputy Secretary
East Division
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Janette Kennedy
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Aboriginal Strategy and Policy
Commission for Children and Young People

Paul McDonald
CEO
Anglicare Victoria

Shelley O'Connell
Principal Program Officer
Department of Health and Human Services

Debbie Pratt
Senior Advisor Child Protection
Commission for Children and Young People

Colette Rogers
Community Services Programs and Design
Department of Health and Human Services

Joshua Smith
Director, Aboriginal Health and Wellbeing Branch
Department of Health and Human Services

Greg Wilson
Secretary
Department of Justice and Regulation

Ross Hampton
Executive Director Operations
Mallee District Aboriginal Services

Rudolph Kirby
CEO
Mallee District Aboriginal Services

Janette Nagorcka
Department of Education and Training

Christine Owen
Area Director, Western Melbourne
Department of Health and Human Services

Dana Pyne
Secretariat
Victorian Aboriginal Community Controlled
Health Organisation

Angela Singh
Department of Education and Training

Deb Tsorbaris
CEO
Centre of Excellence in Child and Family Welfare

Daphne Yarram
Chairperson
Ramahyuck District Aboriginal Corporation

Appendix 7: Bringing them home Scorecard

The latest NSDC *Bringing them home: Scorecard report 2015*,[167] states that the implementation of the recommendations remains:

> 'fundamental to the resolution of other unfinished business between Aboriginal and Torres Strait Islander peoples and other Australians' [and failing to do so] 'not only fails the Stolen Generations but also the current generations of Aboriginal and Torres Strait Islander children...and the achievement of the long cherished national ideal of equality and opportunity for all'.[168]

The NSDC reports that only partial steps have been taken towards reparation and that there has been a 'failure to implement human rights based frameworks for the protection of Aboriginal and Torres Strait Islander children based on the principle of self-determination'.[169] Specifically, the NSDC recommends that governments and policymakers urgently develop a comprehensive bipartisan national strategy to both implement outstanding *Bringing them home* recommendations and simultaneously devise a framework for monitoring, evaluation and review of the implementation of the recommendations.

Of the recommendations relating to the current generation of Aboriginal children, two have been implemented:

- *Recommendation 44 – The creation of minimum national standards of treatment for all Indigenous children.* This has been achieved through the *National framework for protecting Australia's children 2009–2020*.[170]
- *Recommendation 54 – Amendments to the Family Law Act 1975* introduced in 2006 recognised and specified that Aboriginal and Torres Strait Islander children have the right to enjoy their respective cultures; to maintain their connection to culture in a manner that is promoted, supported and consistent with the child's age and development.

Progress on the other recommendations specific to the current generation of Aboriginal children has been assessed by the NSDC as being poor, with a 'fail' recorded against many of the indicators. Of relevance to this Inquiry are the following *Bringing them home* recommendations that have not been fully implemented:

- *Recommendations 45a and 45b – National standards for Indigenous children under state, territory or shared jurisdiction.* NSDC cites funding cuts by government to key peak advisory bodies and agencies that have input to and oversight of standards as being a threat to the efficacy of this recommendation.
- *Recommendations 46a and 46b – Best interests of the child – factors.* The NSDC found that while there are standards established to maintain Aboriginal children with family, community and culture, that in practice Aboriginal children are still being removed from their Indigenous families and communities, and are more likely to be in out-of-home care than non-Aboriginal children.
- *Recommendation 47 – When best interests are paramount.* The NSDC has assessed poor progress on this indicator as linked to the high rates of Aboriginal children in the child protection system.
- *Recommendation 48 – When other factors apply.* The NSDC has assessed poor progress on this indicator as linked to the high rates of Aboriginal children in the child protection and juvenile justice systems.
- *Recommendation 49 – Involvement of accredited Indigenous organisations in decision-making and consultation.* The NSDC has assessed poor progress on this indicator as linked to the high rates of Aboriginal children in the child protection system.
- *Recommendation 50 – Judicial decision-making.* The NSDC has assessed poor progress on this indicator as linked to the high rates of Aboriginal children in the child protection system.
- *Recommendation 51 – Indigenous child placement principle.* While all jurisdictions recognise this principle, in practice there are concerns that compliance is not measured adequately.
- *Recommendation 52 – Adoption as a last resort.* The NSDC reports that many jurisdictions in Australia provide no legal representation to parents to exercise their legal rights to appeal a proposed adoption or to fully understand the ramifications of making an adoption order.
- *Recommendations 53a and 53b – Juvenile justice.* Australia-wide, Aboriginal children are 31 times more likely to be incarcerated, according to the NSDC.

167 Rule, J and Price, E *Bringing them home: Scorecard report 2015*.

168 Ibid.

169 Ibid.

170 Commonwealth of Australia, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Supporting outcome 6: Indigenous children are supported and safe in their families and communities.

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Relevant Acts

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Children, Youth and Families Act 2005 (Vic)

Commission for Children and Young People Act 2012 (Vic)

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