

# Final Submission to the Commission of Inquiry into the Queensland Child Safety System

## **Strong Families, Safe Children, Valued Carers, Supported Workers**

Partnering to deliver generational change for  
Queensland's children, families and communities

29 March 2026

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## Acknowledgement of Country

We acknowledge the Jagera and Turrbal people as the Traditional Custodians of Meanjin (Brisbane), the lands on which PeakCare is physically located - where we meet, work and learn - and acknowledge the Traditional Custodians of all lands across Queensland. We pay respects to their Elders past and present and extend that respect to emerging leaders.

We acknowledge the strength, wisdom and resilience of Aboriginal and Torres Strait Islander children, young people, families, and communities, who continue to nurture their cultures, share their stories and uphold their knowledge systems.

At PeakCare, we honour the enduring connection First Nations peoples have to land, waters, skies and community. We remain committed to listening deeply, walking alongside, and creating a future where Aboriginal and Torres Strait Islander voices are heard, valued and respected.

## Executive Summary

PeakCare Queensland Incorporated's (**PeakCare**) vision is that Queensland's children, young people, and families, in all their diversity, are thriving with access to support, when and where it is needed. A vision that is shared by the hard working and dedicated people in non-government and community-controlled organisations, the child and family services sector partners and the Department of Families, Seniors, Disability Services and Child Safety (**Child Safety Department**).

Despite our collective vision and efforts, there remains long standing and persistent challenges in the Queensland Child Safety system. Many of these challenges are driven by a discrepancy between what Queensland's children and families need to be safe, healthy, and flourishing, and what our service systems supporting them provide.

Today the prevalence of child maltreatment, which brings children to the attention of the Child Safety system, is significant. Families continue to face multiple challenges – such as housing insecurity, poverty, parental health, and mental health concerns, domestic and family violence – with limited access to services that effectively address these challenges. There is an imbalance in funding towards statutory child protection and care, over early intervention and prevention. There are growing shortages of foster carers, low numbers of kinship carers, and limited supports for home-based carers (kinship and foster carers) to meet the multiple and complex needs of the children in their care. There is an over reliance on residential care and, due to structural issues, residential care struggles to meet the needs of children and support the safety of residential care workers.

The workforce is under constant strain and there is limited funding, availability or time for workers to engage in continuous learning, professional development, peer networks and communities of practice. Workforce shortages, retention and recruitment challenges in the government, non-government and community-controlled workforces impede relationship-based practice that the evidence demonstrates delivers the best outcomes for children and families.

We know that we need to fundamentally shift our service systems away from crisis and statutory services. We know that we need to provide earlier and more effective interventions designed to meet the individual needs of children and families that proactively support their participation to address the root causes of child maltreatment and treat its impacts.

The Child Safety Inquiry's report and recommendations can lay the foundation for generational change and to build a better future for children, families and the broader Queensland community. Systemic reform requires time, planning and resourcing to support ongoing implementation, with the benefits coming to fruition over many years. To achieve lasting and sustained change in the Child Safety system, it is critical that reform initiatives and policy are complemented with implementation and infrastructure supports, over many years, that enable all child and family system partners to perform their respective roles. Supported implementation allows immediate actions to be followed with ongoing, long-term actions to develop consistent leadership, workforce capability, state-wide learning and improvement over many years.

The Child Safety system depends on non-government and community-controlled service providers delivering high quality care, family support and transition services, that support active participation by children and families. In a reform context, supporting peak bodies, such as PeakCare and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (**QATSICPP**), to perform their intermediary functions and provide support to non-government providers and their workforce is essential. Peak bodies assist across multiple organisations with readiness, workforce training and capability uplift, and cross provider and regional communities of practice and peer networks. Non-government and community-controlled organisations and their workers also often speak more candidly

to a peak body, than directly to the Child Safety Department, which allows for earlier identification of systemic issues, implementation risks, and unintended consequences.

PeakCare also has a thorough understanding of the residential care system and its large and largely casualised workforce across Queensland. Due structural issues in the residential care system and an isolated working environment, residential care workers are at significantly higher risk of workplace violence and aggression (**WVA**). From the work of PeakCare and others, we know that priority action is needed to better support Queensland's residential care workforce and the children in their care.

PeakCare is committed to continuing to build and enhance its partnership role with the Child Safety Department and non-government and community-controlled organisations. In performing its role, PeakCare supports and enables sector wide collaboration, consistent workforce development, and the translation and implementation of policy and reforms that support continuous improvement in the Child Safety system.

This Submission outlines proposed reform actions to deliver successful and sustained improvements to the Queensland Child Safety system. Aligned to the Child Safety Inquiry's Terms of Reference in respect of the role and resourcing of peak bodies,<sup>1</sup> this submission also proposes reform actions that PeakCare's role, experience and expertise is best placed to lead and contribute to, with investment from the Child Safety Department, including PeakCare:

- Reforming the residential care system:
  - Establishing and leading an ongoing Queensland Residential Care Workforce Training & Professional Development Centre.
  - Leading the co-design, development and implementation of a Residential Care Workplace Health and Safety Leadership Program that specifically meets the needs of the residential care workforce across Queensland.
- Providing opportunities to young people with a care experience to gain meaningful and remunerated work experience and opportunities to contribute their lived experience to policy development, workforce training, and models of care.
- Establishing, supporting, and facilitating communities of practice for non-government workers, with a focus on cross organisation and cross region learning, collaboration and consistency of practice.
- Supporting sector wide collaboration, consistent data capture and reporting, the translation and the successful implementation of policy and reforms to achieve better outcomes for children and families.

Working in partnership with non-government and community controlled organisations, the Child Safety Department, cultural knowledge holders, independent experts and systematically capturing and embed the voice of children, young people, parents, carers and workers, we can achieve our common vision – that all Queensland's children, young people, and families, in all their diversity, are thriving with access to support, when and where they need it.

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<sup>1</sup> Commission of Inquiry into the Queensland Child Safety Inquiry, Term of Reference 5(b).

## About PeakCare

PeakCare is a not-for-profit peak body for the child and family services sector in Queensland. Its vision is that Queensland's children, young people, and families, in all their diversity, are thriving with access to support, when and where it is needed. PeakCare's purpose is to improve the wellbeing of Queensland's children, young people, and families by championing innovation, creating impactful partnerships, anchoring its actions in evidence, driving forward-thinking advocacy, and amplifying the voice of its members and the sector. PeakCare has five key focus areas: policy and advocacy, innovation and partnerships, capacity building, research, and technology and digital leadership.

PeakCare's members are non-government organisations who deliver child and families services across the continuum of life and need, from early supports through to statutory kinship, foster, and residential care across Queensland. PeakCare's membership includes associate members who are aligned to PeakCare's vision and purpose.

## Supporting self-determination

For Aboriginal and Torres Strait Islander peoples, the child protection system is intertwined with colonisation and the impacts of legislative and executive actions that removed children from their families, communities and culture on racial grounds under the pretext of 'Protection', which continue to this day. Structural factors, system design, legacy data and practices continue to disproportionately expose Aboriginal and Torres Strait Islander children and families to statutory intervention. In Queensland today, there are more Aboriginal and Torres Strait Islander children in state care than at any time in history.<sup>2</sup>

The National Agreement on Closing the Gap (**Closing the Gap**) supports Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians. Closing the Gap has 19 national socio-economic targets across areas that have an impact on life outcomes for Aboriginal and Torres Strait Islander people.<sup>3</sup> Target 12 aims to reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 per cent by 2031. However, in its most recent report, the Productivity Commission found that Target 12 is deteriorating nationally relative to the baseline year of 2019. In 2019, 47.3 per 1,000 Aboriginal and Torres Strait Islander children were in out-of-home care. In 2024, the rate was 50.3 per 1,000 children.<sup>4</sup> For non-Aboriginal and Torres Strait Islander children, the rate is 4.6 per 1,000 children.

In this context, the importance of the Aboriginal and Torres Strait Island Child Placement Principle (**ATSICPP**) is paramount in seeking to address the ongoing over-representation of Aboriginal and Torres Strait Islander children in child protection systems and to prevent further harm being caused by separating children from family, culture and community. The ATSICPP extends beyond care placements to emphasise prevention, partnership, participation, and connection, aiming to keep children safely with their families wherever possible and, where this is not, to ensure they remain connected to their cultural identity.

PeakCare is committed to self-determination and to working in partnership with the QATSICPP, Aboriginal and Torres Strait Islander community-controlled organisations and cultural knowledge holders.

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<sup>2</sup> Family Matters Report 2025, pg 109, [Family Matters Report 2025](#).

<sup>3</sup> See [Closing the Gap targets and outcomes | Closing the Gap](#).

<sup>4</sup> Productivity Commission, Closing the Gap, Information Repository, Child Protection data, <https://www.pc.gov.au/closing-the-gap-data/dashboard/outcome-area/child-protection>.

PeakCare advocates for all recommendations and reforms to the Child Safety system made by the Commission of Inquiry into the Queensland Child Safety Inquiry and accepted by Child Safety Department to be:

- underpinned by a commitment to self-determination for Aboriginal and Torres Strait Islander children, young people, and families;
- supporting and expanding delegated authority<sup>5</sup> aligned to the position of Aboriginal and Torres Strait Islander communities and community-controlled organisations; and
- implementing the ATSI CPP to the standard of ‘active efforts’,<sup>6</sup> to keep children connected to their family, culture, community, and country and to reduce the overrepresentation of Aboriginal and Torres Strait Islander children at all stages of in the Child Safety and care systems in Queensland.

## Background

### The 2013 Carmody Report

In 2012, the Hon Tim Carmody QC, Commissioner, was tasked with “reviewing the entire child protection system root and branch to find out whether it is still failing our children, and, if so, why. More than this, we were asked to deliver a roadmap for the way forward, one that will take us, within a decade, to the best possible system for supporting families and protecting children that our state can afford”.<sup>7</sup>

On 28 June 2013, Commissioner Carmody submitted the final report of the Queensland Child Protection Commission of Inquiry, “Taking Responsibility: A Roadmap for Queensland Child Protection” (**the Carmody Report**). The Carmody Report identified three main causes of systemic failure in the Child Safety system, namely:

1. Too little money spent on early intervention to support vulnerable families.
2. A widespread risk-averse culture that focused too heavily on coercive instead of supportive strategies and overreacted to (or overcompensated for) hostile media and community scrutiny.
3. A tendency from all parts of society to shift responsibility onto Child Safety.<sup>8</sup>

In his Forward, Commissioner Carmody underscored that without preventive strategies the cycle of intergenerational abuse would continue to infect successive generations.<sup>9</sup>

The Carmody Report made 121 recommendations across areas such as early intervention and family support, reducing the over-representation of Aboriginal and Torres Strait Islander children in the Child Safety system, workforce reform and training, a new statutory child protection framework, court and legislative reform, and governance and accountability structures.

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<sup>5</sup> The *Child Protection Act 1999 (Qld)* under section 148BB(1) provides for the Chief Executive of Child Safety to delegate one or more of their function or powers under that Act in relation to an Aboriginal or Torres Strait Islander child who is either in need of protection or likely to become in need of protection.

<sup>6</sup> Active efforts are purposeful, thorough and timely efforts, supported by legislation and policy, that enable the safety and wellbeing of Aboriginal and Torres Strait Island children.

<sup>7</sup> The Carmody Report, pg xi.

<sup>8</sup> The Carmody Report, pg xi.

<sup>9</sup> The Carmody Report, pg xii.

*“There is a critical need for an accessible and adequately resourced family support system in Queensland... to refocus our attention away from coercion and on to early preventive intervention before families reach crisis point.”*

...

*“As well as being more productive, such services [family support services] are also less stigmatising and traumatising than investigative intervention.”*

The Hon Tim Carmody QC, Commissioner Queensland Child Protection Commission of Inquiry, 2013, at pg xi, xiii.

## The 2025 Commission of Inquiry into the Queensland Child Safety System

The Commission of Inquiry into the Queensland Child Safety Inquiry (**Child Safety Inquiry**) was announced by the Queensland Government in May 2025.<sup>10</sup> The Child Safety Inquiry has comprehensive terms of reference, which directed Commissioner Anastassiou KC to make appropriate and feasible recommendations on:

- a. **Reforming the residential care system:** which existing models of residential care best support children who have high complex needs (particularly those with a disability) and Aboriginal and Torres Strait Islander children, and appropriate market structures to best deliver those models.
- b. **Fixing a broken system:** the implementation and appropriateness of child safety practices; Departmental structure, governance and culture; the adequacy and effectiveness of current training programs for child safety staff; the extent to which leadership structures support accountability in the protection of children; Ministerial engagement and accountability; appropriate frontline resourcing; and third parties including peak bodies and oversight bodies.
- c. **Fixing a broken system:** design and implementation plan for a new independent complaints escalation review process to escalate serious concerns about complex cases and restore critical support for families and carers.
- d. **Safer children:** system design to support and facilitate foster care, kinship care and adoption in a modern best practice setting.
- e. **Safer communities:** new models of care ensuring children are provided an opportunity for intervention and rehabilitation and that escalating risk or behaviours are managed in line with community safety expectations.
- f. Any reforms to ensure that Queensland’s child protection system **achieves the best possible outcomes to protect children and support families.**
- g. Any **legislative reforms** required.<sup>11</sup>

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<sup>10</sup> Joint Statement Premier and Minister for Veterans, The Honourable David Crisafulli, Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence, The Honourable Amanda Camm, Commission of Inquiry into Queensland’s broken Child Safety System, 18 May 2025, <https://statements.qld.gov.au/statements/102583>.

<sup>11</sup> The Terms of Reference for the Commission of Inquiry into Queensland’s Child Safety System are published in an Extraordinary Queensland Government Gazette on 23 May 2025, Vol. 399, No.16.

**“...at its core, the Inquiry concerns the children and young people of Queensland, cared for under the child protection system, for whom the State is their notional parent. The paramount aim of this Inquiry, as I see it, is to improve the lives of and outcomes for these children and young people. If that aim is achieved, and I shall do all that I can to see that it is, it will benefit not only those children but all of the community of Queensland.”**

Commissioner Anastassious, Commission of Inquiry into the Queensland Child Safety Inquiry, Brisbane opening public hearing, 23 July 2025.

## The structure of this Submission by PeakCare

PeakCare welcomes the opportunity to continue to assist the Child Safety Inquiry and support its investigations into how to best reform the systems, services and workforce that supports vulnerable families to keep their children safe and meet the needs of children in care.

As part of its role, PeakCare regularly undertakes both formal and informal consultation, engagement and discussions with its members, non-government and community-controlled organisations, workers in the child and family services sector, peak bodies, researchers, cultural knowledge holders and experts. These regular engagements over many years are reflected in this submission. A high-level overview of PeakCare’s recent formal consultations is also summarised in **Attachment 1**. This submission is informed by PeakCare and its members experience, expertise and system-wide insights. It outlines, for the Child Safety Inquiry’s consideration, proposed priority reform actions, to deliver successful and sustained improvements to the Child Safety system.

This submission outlines proposed priority reform actions for the Child Safety Inquiry’s consideration. In doing so, this submission:

- consolidates PeakCare’s work supporting the Child Safety Inquiry since its commencement in July 2025;<sup>12</sup> and
- identifies where PeakCare’s role, experience and expertise make it well best placed to lead or contribute to reform actions, with investment by the Child Safety Department.

To assist the Child Safety Inquiry, the structure of this submission aligns to the areas in its Terms of Reference that the Commissioner has been directed to make appropriate and feasible recommendations in respect of.<sup>13</sup>

PeakCare also defers to the experiences and expertise of Aboriginal and Torres Strait Islander children, families, cultural knowledge holders, community-controlled organisations and QATSICPP, as experts in the reforms needed to reduce the over-representation of Aboriginal and Torres Strait Islander children at every stage of the Child Safety system.

In this submission, when children are referred to it includes young people, with children being under 18 years of age.<sup>14</sup>

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<sup>12</sup> PeakCare’s former Chief Executive Officer gave evidence at the public hearings in Cairns on 15 and 16 September 2025. PeakCare’s CEO’s Outline of Evidence was tendered into evidence by the Child Safety Inquiry on 15 September 2025, his Supplementary Outline of Evidence was provided to the Child Safety Inquiry in November 2025. On 23 January 2026, PeakCare also made a submission in response to the call for submissions on “Corporate parenting and the links between the child safety and youth justice system”.

<sup>13</sup> Queensland Government Gazette Extraordinary, Vol. 399, Friday 23 May 2025, No.16, *Commissions of Inquiry Act 1950*, Commissions of Inquiry Order (No. 1) 2025, at paragraph 5, pg 138.

<sup>14</sup> Consistent with the Convention on the Rights of the Child, Article 1, that defines as child as below the age of 18 years of age.

# Summary of PeakCare’s Observations & Proposed Reform Actions for reform to the Queensland Child Safety System

PeakCare’s observations and proposed reform actions for the Queensland Child Safety system are summarised in the table **below** and considered in the body of this submission.

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare’s proposed role (Lead / Contribute)
<p><b>Child Safety Inquiry Term of Reference 5(a), Reforming the Residential Sector:</b> which existing models of residential care best support children who have high complex needs (particularly those with a disability) and Aboriginal and Torres Strait Islander children, and appropriate market structures to best deliver those models.</p>			
1	<p><b>Over reliance on residential Care</b></p> <ul style="list-style-type: none"> <li>Residential care should be a therapeutic treatment intervention model for a very small cohort of children, aged 12 years and over with complex needs and histories of abuse and trauma.</li> <li>In Queensland, the number of children in residential care and the forecast growth is a significant outlier in Australia.</li> <li>Queensland has the highest rate of Aboriginal and Torres Strait Islander children in residential care in Australia, 18 per cent.</li> <li>The over-reliance on residential care in Queensland reflects a care system out of balance.</li> </ul>	<p><b>1. Reduce the total number of children in residential care by 50 per cent within four years.</b></p> <p>1.1. The <b>Department of Child Safety</b> commence a dedicated program of work, supported by quarantined funding for the forward estimates, to reduce the total number of children in residential care in Queensland by 50 per cent within four years, with a priority focus on:</p> <ol style="list-style-type: none"> <li>children 12 years and under, including with models of care that have been proven to successfully exit children to kinship or foster care, or family reunification; and</li> <li>Aboriginal and Torres Strait Islander children, supported by dedicated and ongoing family mapping and finding work by the community-controlled sector and QATSICCP, and increased financial and non-finance support to kinship carers.</li> </ol>	Contribute
2	<p><b>Therapeutic Residential Care</b></p> <ul style="list-style-type: none"> <li>Therapeutic residential care was recommended in the 2017 final report of the</li> </ul>	<p><b>2. A therapeutic residential care framework for all residential care in Queensland.</b></p> <p>2.1. The <b>Child Safety Department</b> develop and implement a Queensland therapeutic residential care framework, including:</p>	Contribute

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
	<p>national Royal Commission into Institutional Responses to Child Sexual Abuse.</p> <ul style="list-style-type: none"> <li>• Therapeutic residential aims to support children to heal, recover and develop through trauma-informed practice.</li> <li>• Workers are provided with ongoing training in trauma approaches, reflective practice and professional development</li> <li>• Evaluations of therapeutic residential demonstrate improved outcomes for children and reduced staff turnover.</li> </ul>	<ul style="list-style-type: none"> <li>a. a co-design process with non-government and community-controlled organisations, residential care workers, young people with a residential care experience, cultural knowledge holders, academics and experts in trauma-informed care and peak bodies;</li> <li>b. developing an evaluation and monitoring framework and data capture infrastructure; and</li> <li>c. state-wide roll out of training to embed, report, monitor and evaluate the therapeutic residential care framework.</li> </ul>	
3	<p><b>Residential Care Training &amp; Ongoing Support</b></p> <ul style="list-style-type: none"> <li>• Residential care workers minimum training requirements do not reflect their role or unique working environment.</li> <li>• There is limited consistent and available training, professional development and support for residential care workers across providers and regions in Queensland.</li> <li>• The residential care workforce is highly casualised, workforce shortages and retention issues are widespread, and workers report very limited opportunities for training, supports or for professional development.</li> </ul>	<p><b>3. Establish an ongoing 'Queensland Residential Care Workforce Learning &amp; Development Centre' within 12 months.</b></p> <p>3.1. The Child Safety Department commit to and fully fund the establishment and ongoing of a sector led 'Queensland Residential Care Workforce Learning &amp; Development Centre' within 12 months, which:</p> <ul style="list-style-type: none"> <li>a. delivers ongoing on-line and face-to-face training, professional development, forums, seminars, communities of practice, peer networks, scholarships and excellence awards to residential care workers across Queensland; and</li> <li>b. is led by PeakCare - leveraging off its experience and Hope &amp; Healing platform, membership and experience - in collaboration with QATSICCP, residential care providers, young people with a lived experience of residential care, independent experts, cultural knowledge holders and government departments providing services and supports to children and families.</li> </ul>	Lead

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
		A high-level overview of the PeakCare proposed <b>Residential Care Learning &amp; Development Centre</b> is at <b>Attachment 2</b> .	
4	<p><b>Workplace Violence and Aggression in Residential Care</b></p> <ul style="list-style-type: none"> <li>• Workplace violence and aggression (<b>WVA</b>) in residential care is a significant work health and safety issue for residential care workers.</li> <li>• WVA causes physical injury, post-traumatic stress disorder, vicarious trauma, burnout, high turnover, reduced worker confidence, absenteeism and recruitment difficulties.</li> <li>• Addressing WVA in residential care requires understanding and addressing gaps in: awareness, current practices, reporting, trends in the residential care workforce; and developing a bespoke safety leadership program for Queensland's residential care workforce.</li> </ul>	<p><b>4. Develop and implement a sector lead Queensland Residential Care Workplace Health and Safety Leadership Program.</b></p> <p>4.1. The <b>Department of Child Safety</b> commit to and fully fund the co-design, development and implementation of a 'Queensland Residential Care Workplace Health and Safety Leadership Program' led by PeakCare, which includes:</p> <ol style="list-style-type: none"> <li>a co-design of process with residential care workers, providers, WorkSafe, occupational health and safety experts and academics, cultural knowledge holders, and young people with residential care experience of the program and training;</li> <li>a state-wide survey of residential care workers, with a clear baseline year to enable tracking of change over time, combining both quantitative measures (e.g. scaled responses) and qualitative insights (e.g. open-ended responses capturing experience) to provide depth and context;</li> <li>development and implementation of a monitoring and evaluation framework and infrastructure and workforce training to enable it;</li> <li>online and face-to-face engagement, consultation, and ongoing training.</li> </ol> <p><b>Residential Care Safety Leadership Program</b> development, deliverables and funding is at <b>Attachment 3</b>.</p>	Lead
5	<p><b>Residential Care Licensing</b></p> <ul style="list-style-type: none"> <li>• The 2017 final report of the national Royal Commission into Institutional Responses to</li> </ul>	<p><b>5. Establish and implement an independent and modernised licensing scheme for residential care providers in Queensland.</b></p>	Contribute

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
	<p>Child Sexual Abuse recommended that a body independent of child safety is responsible for the accreditation of care providers.<sup>15</sup></p> <ul style="list-style-type: none"> <li>• The Child Safety Department is responsible for the licensing scheme for residential care providers, in addition to its roles as the contractor, funder and care placement decision maker, for residential care.</li> <li>• Unlicensed residential care providers are not required to be audited under the Human Services Quality Framework.<sup>16</sup></li> <li>• Unlicensed residential care providers' workers are not required to complete the minimum training qualifications or have and LCS-2 check.</li> </ul>	<p>5.1. The Queensland Government transfer the licensing scheme for residential care providers to:</p> <ol style="list-style-type: none"> <li>an entity that is independent of the Child Safety Department within 12 months; and</li> <li>review, modernise and centralise the scheme to reflect best practice within two years.</li> </ol> <p>5.2. All providers of residential care must be licensed within three years.</p> <p>5.3. Dedicated transition and implementation planning and support is provided to:</p> <ol style="list-style-type: none"> <li>unlicensed residential care providers to meet the Human Services Quality Framework accreditation requirements;</li> <li>workers in unlicensed residential care are directly supported to meet minimum qualification, training, and worker screening requirements; and</li> <li>licensed providers comply with a modernised licensing scheme.</li> </ol>	
6	<p><b>Residential care Relief Pool</b></p> <ul style="list-style-type: none"> <li>• The Child Safety Department is responsible for finding a suitable care placement for a child. This can be challenging due to limited numbers of available home-based carers and residential workforce shortages, particularly in regional areas.</li> </ul>	<p><b>6. Establishing a pool of accredited emergency and relief residential workers for Queensland.</b></p> <p>6.1. The Child Safety Department investigate and report on the feasibility to establish a pool of relief residential care workers, similar to Queensland Health's QCP model.</p>	Contribute

<sup>15</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, December 2017, Out of Home Care Volume 12, Recommendation 12.5.

<sup>16</sup> Human Services Quality Framework – Overview of the framework, Queensland Government. <https://www.families.qld.gov.au/our-work/human-services-quality-framework/overview-framework>.

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
	<ul style="list-style-type: none"> <li>Queensland Country Practice (<b>QCP</b>) in Queensland Health provides a pool of qualified, credentials and causal workers for deployment across regional, rural and remote Queensland.</li> </ul>		
<p><b>Child Safety Inquiry Term of Reference 5(b), the role and resources of peak bodies:</b> fixing a broken system: the implementation and appropriateness of child safety practices; Departmental structure, governance and culture; the adequacy and effectiveness of current training programs for child safety staff; the extent to which leadership structures support accountability in the protection of children; Ministerial engagement and accountability; appropriate frontline resourcing; and third parties including peak bodies and oversight bodies.</p>			
7	<p><b>The Role and Resourcing of Peak Bodies</b></p> <ul style="list-style-type: none"> <li>Peak bodies play a critical partnership, leadership and intermediary role between government and non-government organisations, workers, carers and individuals with lived experience.</li> <li>Peak bodies deliver consistent, state-wide, capability uplift, engagement and support to workers and providers in the non-government sector.</li> <li>Resourcing peak bodies must reflect the vastness and remoteness of Queensland, and the importance of place-based and face-to-face engagement and training.</li> <li>PeakCare has had demonstrated success in the supporting the residential care sector and its workforce.</li> </ul>	<p><b>7. Establish a sustained, statewide peak body function to support system reform and implementation.</b></p> <p>7.1. The <b>Child Safety Department</b> commit to and fully support and resource peak bodies in the child and family services sector to:</p> <ol style="list-style-type: none"> <li>deliver on-line and place-based, locally responsive implementation support for reforms across Queensland;</li> <li>PeakCare to deliver annual CareCONNECT forums for residential care workers;</li> <li>PeakCare to expand the CareCONNECT model to deliver annual forums for child and family services workers;</li> <li>Partner, fund and implement the August 2025 approved <i>Foundations of the future – building a workforce that carers, connects and evolves, Queensland Workforce Strategy</i>’ (<b>the Residential Care Workforce Strategy</b>).</li> </ol>	Lead
8	<p><b>Supporting Long Term Implementation of Reform Activities</b></p>	<p><b>8. Adopt and resource an implementation science approach to deliver and sustain Child Safety system reforms.</b></p>	Contribute

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	<ul style="list-style-type: none"> <li>Given the size and complexity of the Child Safety system and the entrenched issues to be address, implementation of recommendations and reforms will be over many years.</li> <li>Successful implementation of reforms requires a long-term, multilevel approach, supported by implementation science and with a multiyear commitment and dedicated funding.</li> </ul>	<p>8.1. The <b>Child Safety Department</b> adopt an implementation science approach to deliver the Child Safety Inquiry recommendations and reforms, including:</p> <ol style="list-style-type: none"> <li>working in partnership with and supporting non-government community-controlled organisations, workers, peaks and stakeholders; and</li> <li>providing support to plan, implement, embed and sustain change, including for continual training, supervision, coaching, data collection, reporting and accountability.</li> </ol>	
9	<p><b>Young people with a care and protection experience - work experience, higher education pathways and contributing lived experience</b></p> <ul style="list-style-type: none"> <li>Continued efforts are needed to enliven the voice and experience of young people with a care and protection experience across the child and family services system.</li> <li>Young people with a care and protection experience also continue to face barriers in accessing and succeeding in vocational and higher education.</li> <li>Supporting young people with a care and protection experience contribute to policy and practice, providing meaningfully workforce participation opportunities and pathways can be enabled through workforce placements and work with peak bodies.</li> </ul>	<p><b>9. Provide opportunities for the voice of lived experience to engage with and obtain workforce experience in sector peaks</b></p> <p>9.1. The <b>Child Safety Department</b> commit to and fully support as part of PeakCare's core role and business-as-usual activities to:</p> <ol style="list-style-type: none"> <li>employ a Lived Experience Coordinator and two Lived Experience Advisors (full-time); and</li> <li>establish and implement an education and training pathways support program in partnership with vocational and higher education providers, to support young people with a care experience to succeed in entering the workforce.</li> </ol>	Lead

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
<b>Child Safety Inquiry Term of Reference 5(c), a complaint process independent of the Child Safety Department:</b> fixing a broken system: design and implementation plan for a new independent complaints escalation review process to escalate serious concerns about complex cases and restore critical support for families and carers.			
10	<p><b>Child Safety Complaints Process</b></p> <ul style="list-style-type: none"> <li>• If a parent, carer or child wants to complain about the Child Safety Department it must complain to the Child Safety Department, and the Child Safety Department then investigates itself.</li> <li>• Independent complaints processes are critical for child safeguarding, promoting a safe work environment, and upholding the rights of children to have their views heard and taken seriously.</li> <li>• Independent complaint mechanisms also enable quantitative and qualitative data collection for system learning and continuous improvement, accountability, and promote transparency.</li> </ul>	<p><b>10. Implement a new independent complaints system for the Child Safety Department.</b></p> <p>10.1. The <b>Queensland Government</b> identify a suitable and independent agency for any and all complaints, at any stage, in respect of the Queensland Child Safety system and the Child Safety Department to be made.</p> <p>10.2. This independent agency commences a co-design process with the Child Safety Department, non-government and community-controlled providers, workers, peak bodies, children, families and carers with a lived experience and independent experts, and cultural knowledge holders to develop a new complaints process within 12 months.</p> <p>10.3. The newly designed complaints process is fully implemented within two years by the independent agency, and include annual public reporting on numbers, types, outcomes, and trends in complaints.</p>	Contribute
<b>Home-Based Care (Kinship and Foster Care) Child Safety Inquiry Term of Reference 5(d):</b> Safer children: system design to support and facilitate foster care, kinship care and adoption in a modern best practice setting.			
11	<p><b>Home-based Care (Kinship and Foster Care)</b></p> <ul style="list-style-type: none"> <li>• Home-based carers (kinship and fosters carers) provide an essential community service.</li> <li>• Carers in the workforce have limited access to leave entitlements, including parental leave, despite looking after complex and/or very young children.</li> </ul>	<p><b>11. Increase support (financial and non-financial) in home-based carer (kinship and foster care)</b></p> <p>11.1. The <b>Commonwealth Government</b> provide equitable leave entitlements to statutory kinship and foster carers in the workforce, including:</p> <ol style="list-style-type: none"> <li>a. recognising statutory kinship and fosters as a defined group under the National Employment Standards leave entitlements, such as Community Services Leave,</li> </ol>	Contribute

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	<ul style="list-style-type: none"> <li>Limited financial and non-financial support impedes the ability of home-based carers to provide for the multiple and complex needs of the children in their care.</li> <li>Educational outcomes for children are impeded by school exclusions and limited educational support. Exclusions from school adversely impact carers causing placement instability and carer stress.</li> <li>There is limited comprehensive data capture on the characteristics and needs of home-based carers.</li> </ul>	<p>Parental Leave and to Sick, Carers and Compassionate Leave; and</p> <p>b. extending paid parental leave entitlements to statutory kinship and foster carers.</p> <p>11.2. The <b>Queensland Government</b> and <b>Child Safety Department</b> increase financial and non-financial support to home-based carers (kinship and foster carers), including:</p> <p>a. increasing kinship and foster carer payments to meet the need and complexity of children in care and the costs of raising a child;</p> <p>b. providing support to carers, including financial and non-financial, to establish and sustain a placement (with ability to scale up supports at key transition points – such as increased contact with family, planning and transition from primary to secondary school or to independent adulthood) by engaging non-government and community-controlled organisations to provide support with brokerage available for goods and services assessed to support the outcomes for children in care and stabilise a care placements;</p> <p>c. providing access to educational support children in care, including to teachers and tutors, to assist children to catch up on missed school, support reintegration into schools, and provide assistance when children in care experience difficulties with learning, or are excluded from school.</p> <p>11.3. Commission an annual independent survey and interviews of home-based carers (kinship and foster carers) with a mixed method approach (qualitative and quantitative) focused on hard-to-reach carers to better understand carer</p>	

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		<p>characteristics and needs. This survey is benchmarked in year one and completed annually thereafter. The survey and interview questions are developed with input from cultural knowledge holders, peak bodies and independent experts and independently administered and publicly reported on.</p> <p>a. The Child Safety Department Strengthen data capturing and engagement with sibling kinship carers, including action to define sibling kinship carers, capture and report publicly, and establish a sibling kinship carer lived reference group to support the unique needs of sibling carers. Refer to PeakCare's separately supported Sibling Kinship Carer submission as part of its joint work with the QFCC.</p>	
12	<p><b>The State of Queensland as a 'Corporate Parenting' for children in care</b></p> <ul style="list-style-type: none"> <li>• Children in care experience higher levels of child maltreatment than the general population.</li> <li>• Children in care need coordinated, trauma-informed support to recover from the effects of abuse and cumulative harm. This includes access to integrated government services—such as healthcare, mental health support, and education to help them achieve safety, wellbeing, and the opportunity to thrive.</li> <li>• Children in care struggle to get services available to the broader Queensland</li> </ul>	<p><b>12. Establish the State of Queensland as a corporate parent to children in care, responsible and accountable for providing timely services across portfolio areas and deliver better outcomes.</b></p> <p>12.1. The <b>Queensland Government</b> design, legislate and implement a corporate parenting framework for children in and transitioning from care, which includes:</p> <ol style="list-style-type: none"> <li>a. identification of government entities with corporate parenting responsibilities;</li> <li>b. requiring prioritised and timely access to services for children in care; and</li> <li>c. mandating that these entities publish, plan and report against their responsibilities, which includes identifying specific and evidence-based outcomes for children.</li> </ol>	Contribute

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	<p>community and continue to achieve poorer outcomes than their peers.</p> <ul style="list-style-type: none"> <li>The State of Queensland, that removed the child from their parents due to safety concerns, is responsible for the health, wellbeing and development needs of children in care. A whole-of-government coordinated and accountable approach is needed to meet the needs of children in care and improve their outcomes.</li> </ul>	<p>11.2. The <b>Queensland Government</b> work with the <b>Department of Education</b> to require data capture and reporting of children on alternative arrangements or reduced school hours and implement a mandatory review every two months of any such arrangements. This review must include engagement with the Child Safety Department and the child or young person (in an age-appropriate way), carer or worker, supported by a trusted adult or advocate, including an Aboriginal and Torres Strait Islander Community Controlled Organisation, where appropriate, to uphold their right to education.</p>	
13	<p><b>Health Care for Children in Care</b></p> <ul style="list-style-type: none"> <li>Children in care have multiple and complex health needs, poor physical health, development delays and compromised mental health.</li> <li>Despite the needs, they have limited access to health care compared to the rest of the community.<sup>17</sup></li> </ul>	<p><b>13. Prioritise access for children in care to health services and supports, including through the design and implement a dedicated system, processes, supports, and public reporting to comply with and report on the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i>.</b></p> <p>13.1. The <b>Commonwealth Government</b> provides all children in or with a care experience with a 'Health Access Card', similar to a veterans' Gold Card.</p> <p>13.2. <b>Queensland Health</b>, supported by the Child Safety Department, within 12 months:</p>	Contribute

<sup>17</sup> The “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” recognises that children and young people in statutory care tend to have multiple and complex health needs, poor physical health, development delays and compromised mental health. It also recognises that children and young people in statutory care tend to experience very limited access to health resources that are otherwise routinely available to the rest of the community. Compounding this situation, the large number of placements experienced by some children and young people often leads to reduced availability of information about their past medical history, inconsistent maintenance of accurate information about their current health status and consequently poor continuity of health care.

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		<ul style="list-style-type: none"> <li>a. design, develop and implement a dedicated system, process and supports to comply with the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i> for all children in care;</li> <li>b. capture of state-wide data and publicly report annually against the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i>;</li> <li>c. prioritise access for children in or with a care experience to access health and mental health, and allied health as needed and in accordance with health professional's recommendations and best practice guidance.</li> </ul>	
14	<p><b>Measuring and reporting on the care outcomes framework</b></p> <ul style="list-style-type: none"> <li>• There is no standardised set of essential data elements that are consistently collected across the care system (i.e. no minimum data set to enable consistent and reliable monitoring, comparison and reporting across Queensland.</li> <li>• There is no dedicated or regular public reporting on the Queensland Care Services Outcomes Framework.</li> <li>• A system design to support and facilitate home-based care (foster and kinship care) and support in a modern best practice setting should provide public reporting and information on whether children in care are</li> </ul>	<p><b>14. Report annually against the Queensland Care Services Outcomes Framework.</b></p> <p>14.1. The <b>Child Safety Department</b> report annually against the Queensland Care Services Outcomes Framework within 12 months, including:</p> <ul style="list-style-type: none"> <li>a. develop and report on a minimum data set for the care system;</li> <li>b. mapping the available quantitative and qualitative data and developing mechanisms for reporting on any gaps, to report on the measures for success;</li> <li>c. develop system and processes to capture unavailable data.</li> <li>d. publicly report annually against the Queensland Care Services Outcomes Framework.</li> </ul>	Contribute

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	being supported, and meeting the outcomes the Child Safety Department seeks to achieve for them.		
15	<p><b>Supporting Successful Transition from Care to Adulthood</b></p> <ul style="list-style-type: none"> <li>• Young people leaving care continue to experience challenges and limited support in their transition to independent adulthood.</li> <li>• 30 per cent of young people experience homelessness in the first year after their transition from out-of-home care.<sup>18</sup></li> <li>• Evidence demonstrates that successful transitions from care require a range of financial and non-financial supports, including enduring relational security, housing stability, and access to education and employment opportunities.</li> </ul>	<p><b>15. Expand post-care support to include relational, housing and wellbeing supports.</b></p> <p>15.1. The <b>Department of Child Safety</b> extends post care support to include:</p> <ol style="list-style-type: none"> <li>a. guaranteed access to stable and appropriate housing options for all young people leaving care, including priority access to social housing and supported accommodation pathways;</li> <li>b. flexible, trauma informed mental health and substance use support, including assertive outreach models that respond to young people who may not engage with traditional services;</li> <li>c. embed relational permanency planning as a mandatory component of leaving care plans;</li> <li>d. strengthened and earlier transition planning processes to ensure all young people have access to supports prior to exiting care; and</li> <li>e. develop and undertake a longitudinal study to understand the trajectories and supports accessible to carer leave and how to enhance services and support to improve outcomes.</li> </ol>	Contribute

<sup>18</sup> McDowall, J. J. (2020). Transitioning to adulthood from out-of-home care: Independence or interdependence. Sydney: CREATE Foundation. <https://create.org.au/wp-content/uploads/2021/05/CREATE-Post-Care-Report-2021 LR.pdf>

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<b>Child Safety Inquiry, Term of Reference 5(e) New Models of Care: Safer communities:</b> new models of care ensuring children are provided an opportunity for intervention and rehabilitation and that escalating risk or behaviours are managed in line with community safety expectations.			
16	<p><b>Therapeutic care for children affected by trauma</b></p> <ul style="list-style-type: none"> <li>Children in care have experienced significantly higher and more intensive child maltreatment incidences than the general population.</li> <li>Child maltreatment leads to children experiencing placement instability, disrupted relationships and education, further trauma, poor lifelong outcomes and perpetuating an intergenerational engagement in the Child Safety system. It also causes long-term health costs and lost productivity.</li> <li>Therapeutic care for children affected by trauma and cumulative harm, addresses the impacts of child maltreatment and disrupts the intergenerational engagement in the child safety and care systems.</li> <li>Trauma-informed care is not simply about understanding trauma and its impacts, instead it requires training the workforce to deliver evidence-informed therapeutic and tailored responses to individual children.</li> </ul>	<p><b>16. Require all proposed models of care to be trauma-informed with trained workers and carers.</b></p> <p>16.1. The <b>Department of Child Safety</b> design, develop, and contract specialist providers and experts to embed specialist, practice-based trauma capability across the government, non-government and community-controlled workforce and carer system, including:</p> <ol style="list-style-type: none"> <li>all workers receive best practice training in trauma-informed care, focused on responding to, managing, and treating trauma in practice, beyond foundational trauma awareness.</li> <li>supporting and funding the delivery of trauma capability training for home-based carers (kinship and foster carers) to enable therapeutic responses within home-based care; and</li> <li>investigating the feasibility of training developed by the Australian Centre for Child Protection (such as for the Western Australia workforce to treat the impacts of children) or a like provider for roll out in Queensland.</li> </ol> <p>16.2. The <b>Queensland Government</b> support and fund a pilot of the Framework for Youth Mental Health Maltreatment Healing (development in progress) in out-of-home care and develop a plan for state-wide implementation alongside partners Australian Catholic University (ACU), QFCC and PeakCare.</p>	Contribute
17	<b>The rights of the child</b>	<b>17. Embed the Convention on the Rights of the Child into the Queensland Child Safety System policy and operational processes and practices.</b>	Contribute

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
	<ul style="list-style-type: none"> <li>The United Nations Convention on the Rights of the Child is the principal instrument setting out the human rights of children.</li> <li>Australia has ratified the Convention and child protection legislation and policy must align with its principles.</li> <li>Failing to embed the rights of the child in the Queensland Child Safety System has a tangible impact on the experiences and outcomes of children.</li> </ul>	<p>17.1. The <b>Child Safety Department</b> review its policy, practices, models or care (new and existing) to reflect, enliven and the rights of the child under the Convention on the Rights of the Child, including</p> <ol style="list-style-type: none"> <li>embed and enliven the Convention on the Rights of the Child into its operational policy, practice and day-to-day decision making;</li> <li>develop a framework supported metrics and process for quantitative and qualitative data collection, to measure compliance with the Convention on the Rights of the Child and to identify improvement opportunities to enliven child rights; and</li> <li>publicly report annually on compliance with the Convention on the Rights of the Child against the reporting framework and metrics.</li> </ol>	
<p><b>Better outcomes for Children and Families, Child Safety Inquiry, Term of Reference 5(f):</b> any reforms to ensure that Queensland's child protection system achieves the best possible outcomes to protect children and support families.</p>			
18	<p><b>System Enablers</b></p> <ul style="list-style-type: none"> <li>Queensland's Child Safety system has limited system enablers. This limits its ability to understand what is working (or not), for whom, when, where, and to effectively and efficiently allocate resources and seek new funding, with an evidence base in support.</li> <li>Limited system enablers result in missed opportunities to systematically hear the voice of children and families and incorporate their experiences, trajectories and outcomes to support continuous</li> </ul>	<p><b>18. Establish contemporary system enablers and embed them into business-as-usual to enable continuous improvement.</b></p> <p>18.1. The <b>Child Safety Department</b>, with the support of other government departments, independent experts and researchers, peak bodies, child and family services non-government and community-controlled organisations providers, and cultural knowledge holders, design, establish and embed in its business-as-usual activities and public reporting, a series of system enablers to allow for actionable intelligence to be gathered and inform policy, practice, resources and budget allocation, and public reporting. These enablers should include:</p>	Contribute

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
	<p>improvement, system design and operational work.</p> <ul style="list-style-type: none"> <li>• System enablers: <ul style="list-style-type: none"> <li>○ deliver actionable intelligence to inform policy, practice, resources and budget allocation;</li> <li>○ provide an understanding of what practices and interventions work, for whom, when, and where;</li> <li>○ identify key risk and protective factors;</li> <li>○ enable the effectiveness, trajectories and outcomes for clients from new and existing practices and interventions to be evaluated and measured; and</li> <li>○ provide for the systematic capture of client voice, experience and feedback, through validated regular survey tools and interviews.</li> </ul> </li> </ul>	<ol style="list-style-type: none"> <li>a. A minimum data set for the care system with annually public reporting.</li> <li>b. Annual surveys of children (age appropriate), parents, carers and workers that are designed, undertaken and analysed by independent experts, with a clear baseline year to enable tracking of change over time, combining both quantitative measures and qualitative insights to provide depth and context. Surveys should prioritise inclusive methods to reach hard-to-reach populations.</li> <li>c. Commissioning a longitudinal care study, with a mixed method approach combining quantitative<sup>19</sup> and qualitative<sup>20</sup> data, to better understand the experiences and trajectories of children in care.</li> <li>d. Developing a data linkage map, with datasets such as child protection, health, education, housing, justice, to support the identification and evaluation (for example) of services pathways, early indicators of escalation, effectiveness of interventions.</li> <li>e. Making the data linkage map available, with appropriate protections, to researchers and relevant parties to inform research and analytical work aimed at improving outcomes for children.</li> <li>f. Developing and implementing an ongoing research and evaluation strategy for existing and new practices, interventions, models of care, which includes</li> </ol>	

<sup>19</sup> Quantitative data is measurable numerical information, such as counts, measurements and averages.

<sup>20</sup> Qualitative data is non-numerical information that describes characteristics, opinions and experiences.

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
		<p>independent evaluations and making them publicly available.</p> <p>g. Engaging in the development and incorporating of best practice evidence of what works. Including investigating the feasibility of a collaboration with the Australian Centre for Child Protection on the design and implementation of the Living Evidence Guidelines</p>	
19	<p><b>Demand and Funding for Family Support Services</b></p> <ul style="list-style-type: none"> <li>• Queensland has the second lowest proportion of expenditure on family support and intensive family support services in Australia.<sup>21</sup></li> <li>• Demand modelling (state-wide, regional, and for priority cohorts) is not available to forecast, plan, build workforce capability, or seek additional investment to meet the need for early intervention and prevention services to support families.</li> <li>• Demand indicators (Child Concern Reports, Notifications, care numbers) indicate that early intervention and prevention services to support families are significantly underfunded to operate at a sufficient scale to both meet and reduce the demand in the Child Safety system.</li> </ul>	<p><b>19. Invest in meeting demand for family services to reduce the progression of children into and the demand on the Child Safety system.</b></p> <p>19.1. The <b>Child Safety Department</b>:</p> <ol style="list-style-type: none"> <li>develop a demand model for state-wide and regional Family Support Services demand within 12 months;</li> <li>invest in ongoing support for infrastructure and training to non-government and community-controlled organisational providers of Family Support Services, to enable consistent and contemporaneous data capture;</li> <li>monthly public reporting on demand for state-wide and regional Family Support Services;</li> <li>fund non-government and community-controlled organisations to meet the demand for Family Wellbeing Services; and</li> <li>commission an independent evaluation within 12 months of Family Support Services, with measurements focused on tangible outcomes for children and families and an evaluation process that is consistent with Aboriginal and</li> </ol>	Contribute

<sup>21</sup> Family Matters Report 2025, SNAICC, pg 12.

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
		Torres Strait Islander values and priorities for what is measured.	
20	<p><b>Redesigning the Child Safety System to be efficient, effective and fit for purpose</b></p> <ul style="list-style-type: none"> <li>• Child protection systems were designed in the 1960s to respond to low prevalence and high severity physical abuse.</li> <li>• The definition of child abuse has subsequently expanded to include neglect, sexual and emotional abuse.</li> <li>• 61 per cent of young Australians have experienced one type of abuse or neglect.<sup>22</sup> Community awareness of abuse has increased and mandatory reporting introduced.</li> <li>• The largest cohort of children known to child protection are born into families experiencing multiple challenges and disadvantages.</li> <li>• In the absence of system redesign, the Queensland Child Safety system will continue to experience unrelenting demand, regardless of further resourcing.</li> </ul>	<p><b>20. Redesign the Queensland Child Safety System to be contemporary and fit for purpose.</b></p> <p>20.1. The <b>Queensland Child Safety Department:</b></p> <ol style="list-style-type: none"> <li>a. commence an evidence-based redesign process to develop a contemporary, efficient, and effective child protection system with independent experts, researchers, children and families with lived system experience, non-government and community-controlled organisations, peak bodies, cultural knowledge holders and system partners; and</li> <li>b. investigate the feasibility on an ongoing engagement with Professor Bromfield and Australian Centre for Child Protection, to collaborate on developing a contemporary and a fit for purpose Child Safety system.</li> </ol>	Contribute

<sup>22</sup> Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>.

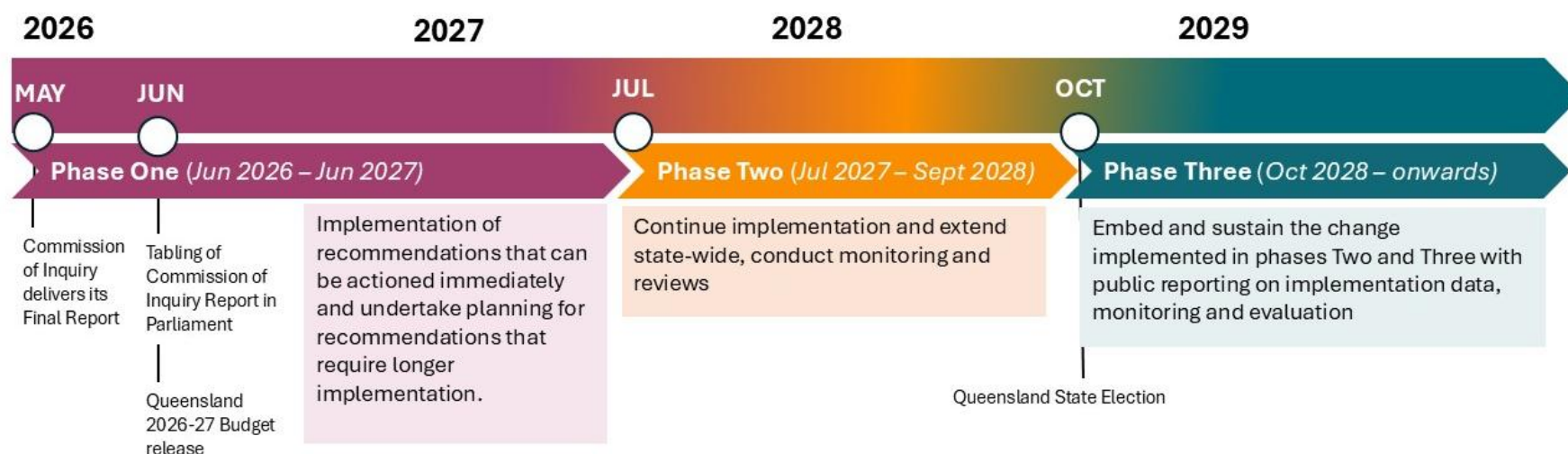
No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
21	<p><b>A whole-of-government approach to child maltreatment and a minister for children</b></p> <ul style="list-style-type: none"> <li>The prevention of child abuse and neglect is a core function of the primary health care and early childhood systems.</li> <li>The Child Safety system's remit and funding is after harm has occurred to children. Services such as health and mental health are critical to prevent and reduce child maltreatment.</li> <li>There is no oversight and accountability across multiple ministerial portfolios and government departments to provide timely and effective services to children and their families with the aim of reducing the risk of child maltreatment or to provide priority services to vulnerable children and families who are over-represented in the Child Safety system.</li> </ul>	<p><b>21. Establish a whole-of-government commitment to reducing child maltreatment and a Minister for Children to oversee and hold accountable all government agencies providing services and interventions to children and their families.</b></p> <p>21.1. The <b>Queensland Government</b> establish a dedicated Ministry for Children with a mandate to:</p> <ol style="list-style-type: none"> <li>develop, implement and hold government portfolios accountable for a whole-of-Queensland Government Child Maltreatment Prevention Framework;</li> <li>have a dedicated focus on improving and holding accountable service delivery and integration for children in families experiencing multiple challenges and intergenerational disadvantage, that are over-represented in the Child Safety system - and other government service systems; and</li> <li>report on whole-of-Queensland government services delivery and outcomes for vulnerable children and families across portfolio areas.</li> </ol>	Contribute
22	<p><b>Independent Implementation Monitor</b></p> <ul style="list-style-type: none"> <li>Independent implementation monitors have been established across multiple jurisdictions to monitor and report on progress in implementing inquiry recommendations.</li> <li>Their roles also include ensuring that the implementation of recommendation is effective and improves the system and outcomes it delivers.</li> </ul>	<p><b>22. Establish an independent statutory implementation monitor.</b></p> <p>22.1. The <b>Queensland Government</b> legislates a new and independent statutory Implementation Monitor to monitor and report annually to parliament on the implementation of the Child Safety Inquiry recommendations and whether they are improving outcomes for children and families.</p>	Contribute

No.	PeakCare Key Observations	PeakCare Proposed Reform Actions for the Child Safety Inquiry	PeakCare's proposed role (Lead / Contribute)
<b>Child Safety Inquiry; Term of Reference 5(g):</b> any legislative reforms required.			
See <b>recommendation 5</b> establish and implement an independent and modernised licensing scheme for residential care providers in Queensland.			
See <b>recommendation 12</b> to establish the State of Queensland as a corporate parent to children in care, responsible and accountable for providing timely services across portfolio areas and deliver better outcomes.			
See <b>recommendation 22</b> to establish an independent statutory implementation monitor.			

## Reform of the Child Safety system required a long term and funded commitment

Supporting families to keep their children safe, thriving and at home, improving outcomes for children in care, and disrupting the intergenerational cycle of engagement in the Queensland Child Safety system requires a long-term commitment by the Queensland Government, non-government and community-controlled organisations, and service system partners such as peak bodies, researchers, cultural knowledge holders, and the broader Queensland community.

Queensland must leverage off the best available evidence and commit to continuous innovation, embedding cultural priorities and outcomes, designing, testing and learning from programs and practices to address services gaps, to build evidence of what services and supports effectively meet the needs of Queensland’s children and families. This systemic approach to reform requires time, planning, funding and resourcing to deliver on *what we want to achieve for Queensland’s children, families and the broader community and supporting how we work together to achieve it*. This means that a dedicated, structured and funded approach to implementation across all partners in the child and family service system is essential for the benefits of reform to come to fruition over many years.



***“There is no greater responsibility of government than protecting vulnerable children. It unquestionably requires constant commitment, vigilance, and agility, and seamless integration and cooperation across government and non-government service providers.”***

Mr Brendan Worrall, Auditor-General, “Family support and child protection system, Report 1: 2020-21” August 2020

# Reforming the Residential Care System: Child Safety Inquiry Term of Reference 5(a):

*“which existing models of residential care best support children who have high complex needs (particularly those with a disability) and Aboriginal and Torres Strait Islander children, and appropriate market structures to best deliver those models.”*

## The Case for Reforming Queensland’s Residential Care System

The Child Safety Inquiry was announced largely due to the exponential growth in Queensland’s residential care residential system, workplace health and safety issues, and concerns that it facilitated a pathway for children into the youth justice system.

Residential care is part of the continuum of placement types in care systems throughout Australia. However, throughout Australia residential care is for a very small number of children over 12 years of age and who cannot be placed in a home-based care placement (kinship or foster care) due to behavioural and emotional issues and very complex needs. The aim of a residential care placement is to provide a time-limited therapeutic treatment intervention, with a highly skilled and supported workforce, and then transition children to a supported home-based care placement or to transition to independent adulthood.

### **Residential care – growth and forecast demand in Queensland**

Residential care in Queensland grew by 85 per cent between 2018 to 2023. During that period, Queensland had 40 per cent of Australia's residential care placements, despite only having 21 per cent of the nation's children in care.<sup>23</sup>

The demand for residential care is forecast to continue to grow. The Queensland Commission for Child and Families (**QFCC**) forecasts that 4,000 children would be in residential care by 2030.<sup>24</sup>

The Demographic Group was engaged by PeakCare to model future residential care demand for the purposes of informing the size of the future residential workforce needed in Queensland.<sup>25</sup> The Demographic Group forecasted between 3,100 – 3,400 children would be in residential care by 2030 (see graph **below**).<sup>26</sup>

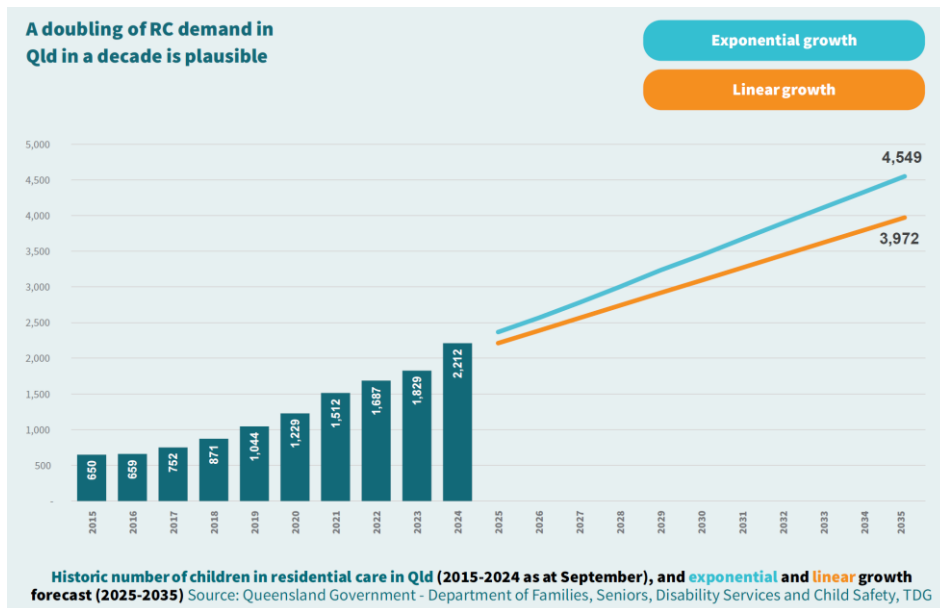
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<sup>23</sup> Child Safety Commission of Inquiry, 23 July 2025, at transcript pg 18.

<sup>24</sup> Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission. August 2025, pg 20.

<sup>25</sup> Queensland’s Residential Care Workforce: Insights and Opportunities – Detailed Report, PeakCare Queensland, 2025.

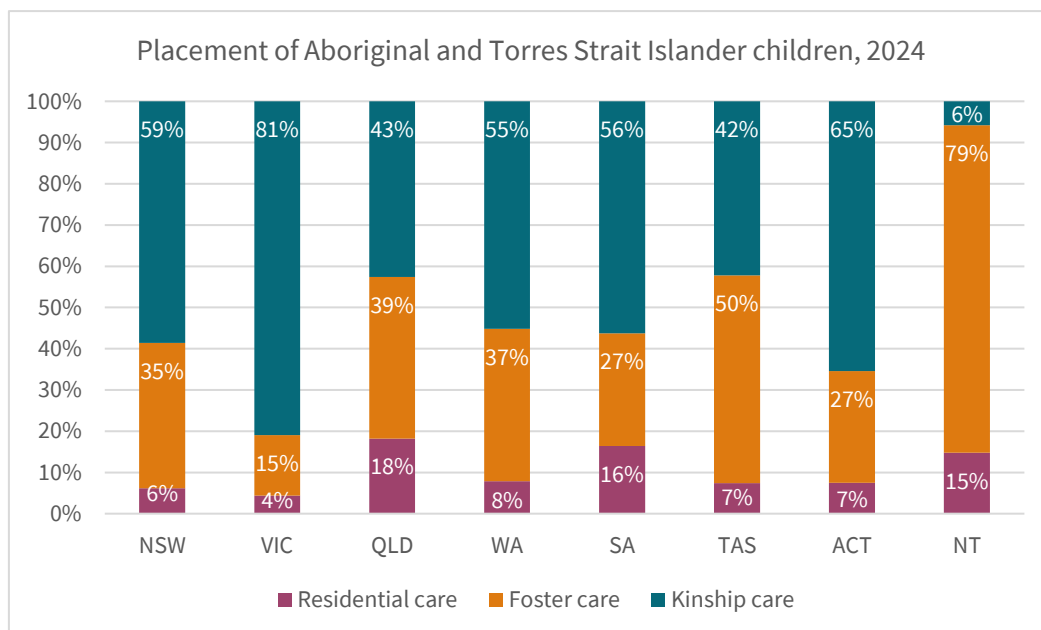
<sup>26</sup> Draft Demographic Group draft consultation report “*The Future Residential Care Workforce – Demographic Analysis*”, September 2025.



The Demographic Group’s forecast shows a number lower than that of the QFCC, but both are similarly significantly higher than all other jurisdictions in Australia.

### Aboriginal and Torres Strait Islander children in residential care

Queensland has the highest rate of Aboriginal and Torres Strait Islander children in residential care, at 18 per cent.<sup>27</sup> The over reliance on residential care in Queensland clearly demonstrates the urgent priority action to invest in financial and non-financial supports to support and grow kinship care. Queensland also one of the lowest rates of Aboriginal and Torres Strait Islander children in kinship carers across Australia.<sup>28</sup> In 2024, only 42 per cent of Aboriginal and Torres Strait Islander children in Queensland in care were in kinship care. In contrast, states with a comparable population size to Queensland, have a much higher rates of Aboriginal and Torres Strait Islander children in kinship care, Victoria at 81 per cent and New South Wales at 56 per cent (see graph **below**).



<sup>27</sup> Report on Government Services (RoGS)

<sup>28</sup> Report on Government Services (RoGS), 2025

## Residential care workforce - data

There is no state-wide data capture or collection on the characteristics of the residential care workforce, such as employment status (part-time, full-time or casual), the number of workers who have achieved the minimum qualifications as opposed to working towards them, age, gender, or region.

The number of residential care workers, and the throughput of workers, is believed to be very substantial. In this respect, since 2018, 27,427 residential workers have completed PeakCare's Hope & Healing online training. This number is very likely to be an underestimation of the total number of residential care workers. In this respect, workers in unlicensed providers are not required to complete the training. Furthermore, a worker in an unlicensed provider can only access the Hope & Healing online training if their unlicensed provider requests access and the Child Safety Department approves it.

Since 2018, **27,427 residential workers** have completed PeakCare's Hope & Healing. This training is only required for workers in licensed providers before they can work unsupervised.

PeakCare has extensively consulted with and surveyed the residential care workforce, including through its 'Catalyst for Care' project. Catalyst for Care received time-limited and now lapsed funding from the Child Safety Department.<sup>29</sup>

From PeakCare's work, characteristics of the residential care workforce include:

- **Employment status:** 57.8 per cent of the frontline workers were casuals, 36 per cent were part-time, and only 4 per cent were full time workers.<sup>30</sup>
- **Experience:** 76 per cent had five years or less experience.<sup>31</sup>
- **Age and gender:** from early 20s to late 50s and is predominantly female.<sup>32</sup>
- **Aboriginal and Torres Strait Islander** workers are significantly underrepresented.
- **Workforce numbers:** conservatives estimate from discussions with medium to large, licensed providers only engaging between 750 to 900 casual workers, suggests that the licensed workforce could be in the vicinity of 5,000.<sup>33</sup>

## Residential care – forecasted future workforce need in Queensland

The Demographic Group analysed the number of workers needed for the future Queensland residential care workforce. This analysis found that:

- A tripling of the number of children in care requires roughly a doubling of the residential care workforce on the ground.
- In the absence of demographic data, linear and exponential growth scenarios suggest a doubling of children in care in the next decade in Queensland (although noting that in the

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<sup>29</sup> PeakCare received funding from the Child Safety Department (\$3,298,781) for the period 1 April 2024 through to 30 September 2025 (extended to 28 February 2026) for activities including: review and revise the Hope & Healing training, develop masterclasses for residential care workers, consult with and survey the residential care workforce, undertake a comprehensive literature review on residential care, develop a Residential Care Workforce Strategy; and deliver CareCONNECT 2025 a one day conference on 21 October 2025.

<sup>30</sup> Catalyst for Care Project, Residential Care Workforce Survey 2024.

<sup>31</sup> Catalyst for Care Project, Residential Care Workforce Survey 2024.

<sup>32</sup> Catalyst for Care Project, Residential Care Workforce Survey 2024.

<sup>33</sup> PeakCare, *Insights and Opportunities, Queensland Residential Care Workforce* report, March 2025, pg 7.

previous seven years, from 2017 and 2024, the number of children in residential care in Queensland tripled).

- The number of children forecast to be in residential care in Queensland in 2030 is 3,100 to 3,400.
- By 2030, the residential care workforce required in Queensland is forecast to be between 7,700 and 8,100.
- Growing the residential care workforce to meet the growth in residential care number by 2030 presents extreme challenges, as Queensland is simply running out of workers.
- Significant challenges recruiting and retaining workers will be compounded by anticipated demand for higher wages.

Without reform, Queensland is unlikely to meet the future demand for residential care workers either operationally or financially.

**Growing the residential care workforce to meet the growth in residential care number by 2030 presents extreme challenges as Queensland is simply running out of workers .... significant challenges recruiting and retaining workers will be compounded by anticipated demand for higher wages. Without reform, Queensland is unlikely to meet the future demand for residential care workers either operationally or financially.**

Demographic Group draft report, *The Future Residential Care Workforce – Demographic Analysis*  
September 2025

The **Demographic Group’s report made recommendations** to improve the recruitment and retention of the residential care workforce to meet growing and forecasted future demand, including:

- establishing a minimum training standards linked to pay and conditions;
- building a career pathway to professionalise the workforce;
- recruiting workers with lived experience and cultural match in mind;
- improved workforce planning and data sharing, including introducing a statewide workforce forecasting model using real time data and requiring reporting of workforce metrics as a contractual condition (such as qualification, turnover and vacancies); and
- creating a centralised pool of trained and vetted relief emergency care workers for deployment across the regions, with associated pay and housing support to enable rural and remote cover.

### **The lifelong and intergenerational outcomes for children with a residential care experience**

Children in residential care have higher rates of mental health difficulties, suicidality, exclusion from school, homelessness, substance use challenges, early pregnancy and parenting, and contact with the criminal justice system as children and adults.<sup>34</sup> Further, the legacy of residential care can be lifelong, children have poorer health and mental health outcomes, higher rates of homelessness, and their children are more likely to be known to child protection.<sup>35</sup>

Research consistently demonstrates that children with a residential care experience have lower school engagement, attendance and achievement, are more likely to be suspended or excluded, are less likely to meet national literacy and numeracy benchmarks, and are more frequently involved in the justice

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<sup>34</sup> Draft Hope & Healing Literature Review – For Residential Care July 2025.

<sup>35</sup> Draft Hope & Healing Literature Review – For Residential Care July 2025.

system (see for example the New South Wales *Pathways of Care Longitudinal Study- Improving the long-term outcomes of children in Out-of-Home Care*<sup>36</sup>).<sup>37</sup>

Placing a child in residential care requires taking account of their individual needs in matching them with other, often unrelated, children in a residential care house. This requires comprehensive assessments and intentional work and planning. Poor placement matching of children can exacerbate their behavioural and emotional issues and adversely impact both other children and workers.

### **A residential care house is a home and a workplace**

The residential care workforce is deeply committed to providing the best support possible to children in their care. Significant efforts are made by providers to make residential care houses as home-like as possible.

Most residential care houses are staffed with a 24/7 roster, with multiple workers filling shifts. This can make achieving relationship-based practice and continuity for children challenging. For example, approximately nine to ten individual workers are required in a week to staff one residential care house with four bedrooms and three children (the fourth bedroom is used for the staff quarters). This is comprised of approximately seven permanent part-time workers and two to three casual workers to fill a 24/7 shift roster. Although, the number of workers is usually much higher due to staff shortages and a highly casualised workforce.

### **The voice of children with a residential care experience**

The experience of children in residential care has been captured across multiple consultations, reports and in evidence to the Child Safety Inquiry. Consistent themes include many different workers coming and going, an institutional setting, limited opportunity to experience normal family routines, being exposed to conflict and unsafe behaviours, and disruption in education, friendships and support networks.

For example, at the Child Safety Inquiry's Toowoomba public hearings in February 2026, Aimee gave evidence that:

*“At the end of the day my home was always someone's workplace. My home had exit signs all over the walls and ceilings... My home had strangers in there almost daily. Sometimes we'd wake up to find that the youth worker that was on shift when we went to bed had left and an agency youth worker, usually male and unknown to us, was in the house when we woke up. My home had shift handovers... Whatever I did or said was documented at the end of their shift. I felt like I was constantly being surveilled, I had no secrets, I had no privacy, and what I said to one youth worker was documented and discussed in team meetings.”<sup>38</sup>*

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<sup>36</sup> <https://dcj.nsw.gov.au/about-us/research-strategy/our-research-projects-and-partners/the-pathways-of-care-longitudinal-study.html>

<sup>37</sup> Consistent with the *Looked After Children Grown Up Project*, a longitudinal research initiative based in the United Kingdom, focused on understanding the long-term outcomes and adult experience of people who were in care as children. It has found children with a residential care experience were three times more likely to have died than children who stayed with their parents, were more likely to have no qualifications, live in rented accommodation, and were less likely to be employed. See, for example, <https://www.nuffieldfoundation.org/project/looked-after-children-grown-up> and Sacker, A., with Murray, E., Lacey, R, and Maughan, B. “*The lifelong health and wellbeing trajectories of people who have been in care, Findings from the Looked-after Children Grown Up Project*”, July 2012, page 12.

<sup>38</sup> Commission of Inquiry into the Queensland Child Safety System, Toowoomba Public Hearings, 16 February 2026, pg 41254.

## The experiences of the residential care workforce

For a residential care worker, their workplace is a house in the community often working alone with the day-to-day care and management of the most complex and vulnerable children in the care system.

PeakCare's extensive consultation with residential care workers has identified consistent challenges, including:

- **Retention issues:** high turnover is attributed to the emotional and physical demands of the work and a highly casualised workforce.
- **Complex and high needs children:** vicarious trauma, workload and managing children with complex needs contributes to burnout.
- **Limited resources:** due to funding constraints.
- **Safety concerns:** regularly encountering complex and potentially volatile situations, insufficient ongoing training and support to manage, de-escalate and respond to challenging behaviours that can be amplified by other children in the residential care house with similar trauma backgrounds. Workers reported experiencing workplace violence and aggression (**WVA**) directly and/or as witnesses, particularly from children with behavioural, emotional, mental health and substance abuse issues that can escalate into physical assaults.<sup>39</sup>

### Exposure to Workplace Violence and Aggression (WVA)

WVA in residential can cause physical, psychological and emotional harm and injuries to workers. It contributes to absenteeism, high staff turnover and Workcover claims. WVA also contributes to placement breakdowns and increased criminalisation of children in care.

WVA can have profound impacts on workers, including never returning to work following an injury. Data from WorkSafe Queensland found that 25 per cent of claimant from the residential care sector (including disability, youth care, and aged care) never returned to work following an injury.<sup>40</sup>

Workplace Health and Safety Queensland also found that from 2016 to June 2021, there was an 81 per cent increase in WVA claims in Queensland and a 93 per cent increase in WVA claims in the residential care sector. However, these figures are likely to be under-reported. Approximately two-thirds (62 per cent) of all claims lodged were for anxiety or stress disorders and time lost claims were lodged at a rate of 29.6 per 1,000 employees for workers that fall under the 'Other Residential Care Services' category. This is higher than the rates of claims lodged across the state and within the health care and social assistance sector at 15.0 and 19.7 respectively.<sup>41</sup> Prioritising consistent and improved residential workplace health and safety is a key priority area.

### A therapeutic framework for residential care

In 2017, the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse recommended that residential care be a therapeutic model for children with histories of abuse and trauma, specifically:

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<sup>39</sup> PeakCare, *Insights and Opportunities, Queensland Residential Care Workforce* report, March 2025.

<sup>40</sup> Workplace Health and Safety Queensland. (2021). Work-related violence and aggression in residential aged, disability and youth care. Queensland Government at [Work-related violence and aggression in residential youth disability care](#).

<sup>41</sup> [Work-related violence and aggression in residential youth disability care](#).

“[t]he key focus of residential care for children should be based on an intensive therapeutic model of care framework designed to meet the complex needs of children with histories of abuse and trauma.” (Recommendation 12.18).<sup>42</sup>

There is consensus that Queensland needs a new model (or models) of residential care. PeakCare’s position is that there must be a therapeutic framework for all residential care, which provides for cultural safety, trauma informed care, and meets the needs of each child. To achieve this, the residential care workforce must be highly skilled and supported.

In developing a new model (or models) of residential care, caution must be exercised. Designing multiple models of residential care, which may have new classifications and counting rules, may obscure underlying systemic issues. In this respect, there are no exigencies that uniquely bear upon the State of Queensland driving the number of children in, or the forecast growth of, residential care.<sup>43</sup> The over reliance on residential care in Queensland appears to be a structural problem for examination, driven by a combination of care system design, policy, operational processes, governance, legislative and/or funding arrangements.

### **The residential care workforce - minimum qualifications and ongoing learning and support**

Residential care workers in licensed providers<sup>44</sup> are required to:

- complete PeakCare’s Hope & Healing online training before working unsupervised (approximately five hours); and
- hold, or be working towards, a minimum qualification requirement of a Certificate IV in Child, Youth and Family Intervention (Residential Care) or another relevant recognised qualification (such as Youth Work).

Ongoing training, professional development and support is largely dependent on the residential care provider. Very limited cross provider or regional ongoing professional development or communities of practice are provided to support the workforce and drive consistency. A consistent and targeted model of ongoing learning, development, and support both online and face-to-face is needed for residential care workers in Queensland.

### **Models of ongoing residential care worker training, development and support**

The peak body in Victoria and Tasmania, the Centre for Excellence in Child and Family Welfare (**CFECFW**), has a residential care learning and development centre. Its role is to meet the specific needs of the residential care workforce. Since 2016, the CFECFW has provided the *Residential Care Learning and Development Strategy (RCLDS)*<sup>45</sup> and has delivered training (in person and online) for all Victorian residential care workers. RCLDS leadership, administration, training and associated costs are fully funded by the child protection department in Victoria.

RCLDS is a learning and development strategy, with training as a key component. It includes other support mechanisms to assist in developing the residential care workforce, including forums, conferences, seminars, scholarships and excellence awards. RCLDS promotes:

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<sup>42</sup> *Royal Commission into Institutional Responses to Child Sexual Abuse*, Final Report, Out of Home Care, Volume 12, December 2017, Recommendation 12.18.

<sup>43</sup> For example, Queensland’s geography and remoteness is similar to that in Western Australia or the Northern Territory, its budget position is arguably stronger than South Australia, Victoria and New South Wales, the impact of COVID-19 was arguably much greater in Victoria.

<sup>44</sup> See *Child Protection Act 1999* (Qld), Chapter 4, Part 2, Division 2.

<sup>45</sup> [Residential Care Learning and Development Strategy \(RCLDS\) - Centre for Excellence in Child and Family Welfare](#).

- ongoing development of a skilled and stable residential care workforce;
- provision of high-quality training, supervision and support to workers;
- development and delivery of appropriate pre-service and in-service qualifications relevant to the field;
- a commitment to, and development of, a lifelong learning culture in the residential care workplace; and
- responding to current trends/issues in residential care through evidence-informed learning and development activities.

PeakCare recommends a similar model to RCLDS is established in Queensland. The model should be developed, delivered and funded for a significantly larger, geographically dispersed, and diverse Queensland residential care workforce than in Victoria. Like RCLDS, it should be supported to deliver both face-to-face and online training, supervision, support and communities of practice for the residential care workforce.

### **The cost of residential care**

Queensland spends \$1.1 billion annually (51 per cent of total Child Protection expenditure) on residential care services.<sup>46</sup> The average cost to the Queensland taxpayer per day of residential care is approximately \$2.8 million.<sup>47</sup>

However, the high numbers of Queensland children in a residential care placement causes the total cost of residential care to obscure the average funding per child being less than other states and territories. In 2022-23, the annual costs of residential care per child in Australia ranged between \$561,246 to \$1.1 million.<sup>48</sup> However, the average reported cost per child per year for residential care in Queensland was \$420,548.<sup>49</sup>

## **Reforming the Residential Care System – Proposed Actions**

### **‘Right-sizing’ residential care in Queensland**

In Queensland, the number of children in residential care reflects a care system that is not achieving optimal, or even preferred, placement outcomes for children.

As at 31 March 2025, 2,257 children were in residential care in Queensland. Of these children, 752 were under 12 years of age and 78 were under 5 years of age.<sup>50</sup>

Residential care is not suitable for children under 12 years old, except in very limited circumstances and with appropriate supports and safeguards. No child under 4 years of age should be placed in residential care, other than in very exceptional circumstances, and in such cases great care and thought must be given to their wellbeing and the ability of the direct care workers to be committed, consistent and

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<sup>46</sup> Buyer Beware, How economic forces are shaping Queensland’s residential care market, Queensland Family & Child Commission, August 2025, pg 1.

<sup>47</sup> Child Safety Commission of Inquiry, 23 July 2025, at transcript page 18.

<sup>48</sup> Report on Government Services 2024, Steering Committee for the Review of Government Service Provision, Productivity Commission, January 2024, pg 147.

<sup>49</sup> Question on Notice No. 784, Queensland Parliament, asked 14 June 2023, pg 1.

<sup>50</sup> Child Safety Commission of Inquiry, Proactive Statement No.5, Statement of Bernadette Harvey, Acting Deputy Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraph 130.

available for attachment relationships. This is even more important when those infants are placed in residential care in the first year of life.<sup>51</sup>

Residential care is inconsistent with ATSI CPP.<sup>52</sup> It can dislocate Aboriginal and Torres Strait Islander children from their families, communities, and culture.

A proposed priority reform action for the Child Safety Inquiry, is the reduction in the number of children in residential care and the prevention of further entries. This action will require planning, implementation and quarantined investment over the forward estimates. The aim being to effectively *right size* the number of residential care placements in Queensland to reflect its place in the continuum of care and align it with national benchmarks. Over time, this would create capacity in the Child Safety system from the reduction in residential care placement numbers and the associated long and intergenerational impacts.

PeakCare proposes a cohort priority focus to exit, and prevent further entries, from residential care from:

- children 12 year of age and under; and
- Aboriginal and Torres Strait Islander children.

Reducing the number of children in residential care will require concurrent workstreams, such as:

- Roll out of models of care proven to exit children from residential care and prevent further entries. These models provide a behavioural and treatment intervention that address issues preventing a child being placed in home-based care (kinship and foster) or reunified with family. They also provide therapy and capability uplift to parents where reunification is the case plan goal.<sup>53</sup>
- Increased financial and non-financial supports for home-based carers (kinship and foster) that directly support and manage children transition from residential care and ongoing needs to stabilise the home-based placement (such as access to a child therapist, educational assistance).
- Community-controlled organisations supported by partners such as QATSI CPP, being engaged in ongoing and supported family finding and family mapping work. This work would need to be supported by Child Safety Department to develop policies and guidance to operationalise consistent, early, and ongoing engagement with community-controlled organisations to find kinship placement options state-wide. This work could be modelled on the prior time-limited project – What Will It Take - to transition Aboriginal and Torres Strait Islander children out of residential care.

Given the number of children currently in residential care, and the reported limited or timely access to supports such as health, mental health, and education, exiting children from residential care in Queensland will require a dedicated workstream and quarantined investment over the forward

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<sup>51</sup> Hope & Healing Literature Review – For Residential Care July 2025.

<sup>52</sup> The Child Protection Act, section 5C formally recognises the Aboriginal and Torres Strait Islander Child Placement Principle. It requires that when making decisions about Aboriginal or Torres Strait Islander children, the department must consider: the importance of the child maintaining a connection with family, community and culture; the importance of the child’s Aboriginal or Torres Strait Islander identity; the role of Aboriginal and Torres Strait Islander people in decision-making. Section 83 sets out the placement hierarchy for Aboriginal and Torres Strait Islander children when they must live away from their parents. It prioritises placement in the following order: with a member of the child’s family; with a member of the child’s community or kinship group; with another Aboriginal or Torres Strait Islander person; with another person who is supportive of the child’s culture and identity. This hierarchy aims to ensure children remain connected to family, culture and community.

<sup>53</sup> For example, Treatment Foster Care Australia – Queensland (TFCA-QLD).

estimates. In effect there needs to be new *balloon investment* from the Queensland Government to reduce placements in residential care and prevent further entries. Funding is needed for the forward estimates, to realise the longer-term savings of a smaller residential care system and reduced generational engagement in the child protection and care systems. It will also deliver a significant return on investment for the children and reduce intergenerational demand, most particularly if the pipeline into residential care is concurrently significantly reduced.

<b>1. Reduce the total number of children in residential care by 50 per cent within four years.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>Residential care should be a therapeutic treatment intervention model for a very small cohort of children, aged 12 years and over with complex needs and histories of abuse and trauma.</li> <li>In Queensland, the number of children in residential care and the forecast growth is a significant outlier in Australia.</li> <li>Queensland has the highest rate of Aboriginal and Torres Strait Islander children in residential care in Australia, 18 per cent.</li> <li>The over-reliance on residential care in Queensland reflects a care system out of balance.</li> </ul>
<b>Proposed Reform Actions</b>	<p><b>1. Reduce the total number of children in residential care by 50 per cent within four years.</b></p> <p>1.1 The Department of Child Safety commence a dedicated program of work, supported by quarantined funding for the forward estimates, to reduce the total number of children in residential care in Queensland by 50 per cent within four years, with a priority focus on:</p> <ol style="list-style-type: none"> <li>children 12 years and under, including with models of care that have been proven to successfully exit children to kinship or foster care, or family reunification; and</li> <li>Aboriginal and Torres Strait Islander children, supported by dedicated and ongoing family mapping and finding work by the community-controlled sector and QATSICCP, and increased financial and non-finance support to kinship carers.</li> </ol>

## Designing a therapeutic framework for all residential care in Queensland

A therapeutic residential care framework is essential to support children to heal through trauma-informed practice. It should focus on understanding the child’s trauma, attachment difficulties and development needs. Clinicians and/or therapeutic specialists will be required to provide support and guidance to workers under the therapeutic residential care framework.

A therapeutic residential care framework should focus on enabling a safe and structured environment where children can heal and develop. Key components include:

- Embedding therapeutic specialists in residential care houses, who guide therapeutic practices and support workers. They work primarily with workers rather than directly with children.
- Providing specialised training for workers in trauma-informed approaches, enabling them to use everyday interactions with children as therapeutic opportunities. This promotes healing and behavioural change in young people.

- Lower worker to child ratios to allow for individualised care, flexibility and responsiveness to children’s needs.
- Providing time for workers to engage in structured and supported reflective practice and care team meetings, to enable the continual adaptation of care strategies and facilitated professional development.

Evaluations of therapeutic residential care models demonstrate that they increase children’s engagement with school and their community and reduced risk-taking behaviours. Additionally, it reduces worker turnover.

All residential care services working within a therapeutic framework is also consistent with the recommendations in the Carmody report.

<b>2. Co-design and implement a therapeutic framework in all residential care placements in Queensland.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Therapeutic residential care was recommended in the 2017 final report of the National Royal Commission into Institutional Responses to Child Sexual Abuse.</li> <li>• Therapeutic residential aims to support children to heal, recover and develop through trauma-informed practice.</li> <li>• Workers are provided with ongoing training in trauma approaches, reflective practice and professional development</li> <li>• Evaluations of therapeutic residential demonstrate improved outcomes for children and reduced staff turnover.</li> </ul>
<b>Proposed Reform Actions</b>	<p>2. The Child Safety Department led develop and implement a therapeutic residential care framework, which includes:</p> <ol style="list-style-type: none"> <li>a co-design process with non-government and community-controlled organisations, residential care workers, young people with a residential care experience, cultural knowledge holders, academics and experts in trauma-informed care and peak bodies;</li> <li>developing an evaluation and monitoring framework and data capture infrastructure; and</li> <li>state-wide roll out of training to embed, report, monitor and evaluate the therapeutic residential care framework.</li> </ol>

## Supporting the residential care workforce – establish a sector led Residential Care Learning & Development Centre

For residential care workers in Queensland, the required minimum qualification they must hold or be working towards<sup>54</sup> and around five hours of Hope & Healing online training, does not reflect the requirements and working environment of their role.

The Carmody Report identified that successful implementation of its recommendations depended “*in large measure on the capacity of the government and non-government child protection workforces to*

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<sup>54</sup> Since 1 January 2019, residential care workers in licensed providers must have or be enrolled in a Certificate IV in Child, Youth and Family Intervention (Residential Care) or another relevant recognised qualification (such as Youth Work

*deliver services to children and families.*<sup>55</sup> Further, that the workforce could not support families or protect children without the necessary skills, ability, knowledge and aptitude for the task.<sup>56</sup>

The Carmody Report recommended the development of a workforce plan and a strategy across the government and non-government sectors. However, its recommendations did not extend to the development, implementation and ongoing support for a targeted and consistent residential care learning centre to support workforce capability uplift, professional pathways, communities of practice, coaching and supervision (across providers and regions).

A decisive factor in translating reforms into sustained change is investing in the frontline workforce ongoing capability uplift, training, and professional support.

Leveraging off its expertise and experience in delivering the Catalyst for Care program, PeakCare recommends the establishment and ongoing funding for a dedicated **Residential Care Learning & Development Centre in Queensland** to meet the specific needs and specialised role of the workforce. This centre would provide critical and ongoing learning and professional support, through the ongoing online and face-to-face mechanisms. PeakCare is best placed to establish and lead a Residential Care Learning & Development Centre, with QATSICCP and residential care providers, given its multiple year delivery of the Catalyst for Care project and many of its members being residential care providers. This dedicated Residential Care Learning & Development Centre in Queensland would deliver to the residential care workforce:

- **Ongoing training and development:** specific training and support tailored to the workforce and Queensland environment, through online and face-to-face training.
- **Knowledge exchange and communities of practice:** facilitate connections and communities of practice, to share insights, experiences, and opportunities for improvement to new and experienced workers and providers.
- **Support and resources:** through sharing resources, webinars and events that focus on current good practices, issues and challenges, and emerging developments and evidence to support quality improvement and consistent good practice.

In Queensland, both face-to-face and online support is needed to support the substantial and geographically dispersed residential care workforce. The proposed Residential Care Learning & Development Centre in Queensland would require significant investment to be established and to meet the ongoing support needs of the workforce. However, supporting the workforce will promote stability, professional pathways, improved outcomes for children and reduce workforce retention issues.

<b>3. Establish an ongoing Queensland Residential Care Workforce Learning &amp; Development Centre within 12 months.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Residential care workers’ minimum training requirements do not reflect their role or unique working environment.</li> <li>• There is limited consistent and available training, professional development and support for residential care workers across providers and regions in Queensland.</li> <li>• The residential care workforce is highly casualised, workforce shortages and retention issues are widespread, and workers report very limited opportunities training, supports or for professional development.</li> </ul>

<sup>55</sup> Carmody Report pg xxii.

<sup>56</sup> Carmody Report pg xxii.

<p><b>Proposed Reform Actions</b></p>	<p>3.1 The Child Safety Department commit to and fully fund the establishment and ongoing delivery of a sector led ‘Queensland Residential Care Workforce Learning &amp; Development Centre’ within 12 months, which:</p> <ul style="list-style-type: none"> <li>a. delivers ongoing on-line and face-to-face training, professional development, forums, seminars, communities of practice, peer networks, scholarships and excellence awards to residential care workers across Queensland; and</li> <li>b. is led by PeakCare - leveraging off its experience and Hope &amp; Healing platform, membership and experience - in collaboration with QATSICCP, residential care providers, young people with a lived experience of residential care, independent experts, cultural knowledge holders and government departments providing services and supports to children and families.</li> </ul> <p>See details of the proposed <b>Residential Care Learning &amp; Development Centre</b> in <b>Attachment 2</b>.</p>
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## Prioritising a safe and supported residential care workforce – develop and implement a Queensland Residential Care Workplace Health and Safety Leadership Program

WVA in residential can cause physical, psychological and emotional harm and injuries to workers. It contributes to absenteeism, high staff turnover and Workcover claims. WVA also contributes to placement breakdowns and increased criminalisation of children in care.

PeakCare has undertaken numerous consultations with residential care providers and workers in Queensland that have consistently reported serious concerns with WVA in the workplace.<sup>57</sup> Residential care workers encounter complex and potentially volatile situations in residential care homes, and experience WVA directly and/or as witnesses, particularly from children with behavioural, emotional, mental health and substance abuse issues that can escalate into physical assaults.

Residential care workers deserve a working environment and training to support their safety and wellbeing and provide the best possible care to children.

WorkSafe Queensland’s publicly available data for WVA in the residential care workforce is not disaggregated from the broader care workforce (aged care and disability workers).<sup>58</sup> From data available in other states, such as in Victoria, residential care workers experience the highest levels of WVA in the social services sector. This results in absenteeism from work, workers compensation claims, and drives up liability insurance premiums for residential care providers.

### Other jurisdictional approaches to WVA

Other jurisdictions have identified WVA in residential care as a significant issue to address. For example, in Victoria in 2021, the CFECFW, residential care providers, workers, the child protection department, WorkSafe, and independent experts worked together to better understand and reduce WVA. The

<sup>57</sup> For example, PeakCare’s June 2023 workshop with residential care providers and its PeakCare Report “Insights and Opportunities – Queensland Residential Care Workforce”, March 2025.

<sup>58</sup> See Workplace Health and Safety Queensland (2021). [Work-related violence and aggression in residential aged, disability and youth care.](#)

program aimed to improve the health and safety of residential care workers through building leadership capability and understanding strategies to prevent WVA across all levels of the system, from Chief Executive Officers through to frontline workers. This program developed a co-designed Safety Leadership Framework with academic expertise, an evaluation framework, data collection and reporting. From this work and a trial, test and learn approach in the Victorian environment, bespoke actions and trainings for the residential care sector and its workforce were developed. This tailored training has transitioned to being delivered by the CFECFW in its Residential Care Learning and Development program available to all residential care workers and funded by the child protection department.

PeakCare recommends a **Queensland Residential Care Safety Leadership Program** that meets the needs of the workforce and geography of Queensland, is developed through a co-designed process with residential care providers, sector peaks, workers, Child Safety and WorkSafe representatives, occupational health and safety experts and academics, cultural experts, and young people with a residential care experience.

Given PeakCare’s expertise and experience in engaging and supporting the residential care workforce, its membership including several residential care providers, and proven record in delivering Catalyst for Care, it believes it is well placed to lead the development of a Residential Care Safety Leadership Program tailored to meet the needs of the Queensland workforce and environment.

The design and development of such a **Residential Care Safety Leadership Program** for Queensland is proposed to:

- understand and develop consistent reporting and data capture to gain a greater understanding of reporting practices, outcomes, prevalence, impacts, and trends over time;
- build awareness of WVA and promote consistent reporting by the residential care workforce;
- develop a Safety Leadership Framework for the residential care workforce and leaders; and
- develop tailored WVA training modules for frontline workers through to provider CEO/board members that build awareness of WVA, encourage reporting of WVA, capturing report and data on WVA incidents, provide training to prevent and deescalate WVA, the responses and supports available to the workforce; and
- transition training modules into the PeakCare proposed Residential Care Learning & Development Centre (outlined above).

A co-designed, supported, and embedded in business-as-usual activity, a Residential Care Safety Leadership Program will build workforce capacity, contribute to the reduction in WVA, improve the experiences for workers and children of residential care, and in turn reduce workplace incidents, injury and illness to workers, workplace compensation claims and insurance premiums.

<b>4. Develop and implement a sector lead Queensland Residential Care Workplace Health and Safety Leadership Program.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Workplace violence and aggression (<b>WVA</b>) in residential care is a significant work health and safety issue for residential care workers.</li> <li>• WVA causes physical injury, posttraumatic stress disorder, vicarious trauma, burnout, high turnover, reduced worker confidence, absenteeism and recruitment difficulties.</li> <li>• Addressing WVA in residential care requires understanding and addressing gaps in: awareness, current practices, reporting, trends in the residential care workforce; and developing a bespoke safety leadership program for Queensland’s residential care workforce.</li> </ul>

<b>Proposed Reform Actions</b>	<p>4.1. The <b>Department of Child Safety</b> commit to and fully fund the co-design, development and implementation of a ‘Queensland Residential Care Workplace Health and Safety Leadership Program’ led by PeakCare, which includes:</p> <ol style="list-style-type: none"> <li>a. a co-design with residential care workers, providers, WorkSafe, occupational health and safety experts and academics, cultural knowledge holders, and young people with residential care experience of the program and training;</li> <li>b. a state-wide survey of residential care workers, with a clear baseline year to enable tracking of change over time, combining both quantitative measures (e.g. scaled responses) and qualitative insights (e.g. open-ended responses capturing experience) to provide depth and context;</li> <li>c. development and implementation of a monitoring and evaluation framework and infrastructure and workforce training to enable it;</li> <li>d. online and face-to-face engagement, consultation, and ongoing training.</li> </ol> <p>Please see details of the proposed <b>Residential Care Safety Leadership Program</b> development, deliverables and funding required in <b>Attachment 3</b>.</p>
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## Licensing all residential care and supporting transition

In 2017, the final report of the national *Royal Commission into Institutional Responses to Child Sexual Abuse*, Out of Home Care, Volume 12 report, recommended:

*“12.5 In each state and territory, an existing statutory body or office that is independent of the relevant child protection agency and out-of-home care service providers, for example a children’s guardian, should have responsibility for:*

- a. receiving, assessing and processing applications for accreditation of out-of-home care service providers*
- b. conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.”<sup>59</sup>*

In Queensland, residential care is outsourced by the Child Safety Department to non-government organisations, both not-for-profit and for profit. The *Child Protection Act 1999* (Qld) (**the Child Protection Act**) governs the licensing of residential care providers.<sup>60</sup> A licensing team in the Child Safety Department oversees and monitors the residential care licencing scheme and compliance.

There are two types of residential care providers:

- Outsourced Service Delivery, which has recurrent funding and can only be provided by a licensed provider; and
- Individual Placement Support, which can be provided by licensed and unlicensed providers.

<sup>59</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, December 2017, Out of Home Care Volume 12, Recommendation 12.5.

<sup>60</sup> Child Protection Act, Chapter 4, Part 2, Division 2

Licensed providers are audited against the Human Services Quality Framework.<sup>61</sup> The Human Services Quality Framework sets out the minimum requirements service providers need to adhere to in providing safe and effective care that is responsive to the needs of children. The Human Services Quality Framework focuses on governance and management; client rights and responsibilities; service delivery; safety; and continuous improvement. Unlicensed providers self-assess their compliance with the Human Services Quality Framework.

The QFCC has reported on the significant growth of Individual Placement Support providers. In 2022-23, there were 5,816 places provided under Individual Placement Support agreements, and 893 places contracted through Outsourced Service Delivery providers. Total expenditures were \$531.9 million for Individual Placement Support contracts and \$241.5 million for Outsourced Service Delivery.

The process for become a licensed provider delivering Individual Placement Support is complex and varies in application across Child Safety Department regions. It involves:

- the licensing team in the Child Safety Department determines if an unlicensed provider is suitable for a licensing assessment, which includes a requirement that they have continually provided placement services with no breaks for over 12 months;
- the region (or main region) of the Child Safety Department where the Individual Placement Support provider delivers services exercise their discretion to proceed with a licensing assessment;
- if the assessment is successful and the unlicensed provider meets the legislative requirements,<sup>62</sup> the Child safety Department's delegate can issue a license.

Workers in unlicensed providers are not required to:

- hold or be enrolled in a Certificate IV in Child, Youth and Family Intervention (Residential Care) or another relevant recognised qualification;
- undertake the mandatory Hope & Healing training, either before working unsupervised in a residential care house or at all; or
- undergo an LCS-2 screening checks, a suitability assessment for working with children, considering child protection, domestic violence and driving history.

PeakCare's position is:

- All providers of residential care should be licensed.
- The licensing requirements and renewal process should be modernised.
- The licensing scheme be transferred to a statutory body or office. The Child Safety Department currently undertakes multiple functions, including contracting and funding residential care providers, placing children in residential care, and regulating the residential care system. Independent oversight of the licensing process would provide for greater transparency.
- Support and investment for all residential care providers to meet the licensing requirements and transition to a new licensing scheme.
- Support and investment for training and minimum qualifications for workers.

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<sup>61</sup> Human Services Quality Framework – Overview of the framework, Queensland Government.  
<https://www.families.qld.gov.au/our-work/human-services-quality-framework/overview-framework>.

<sup>62</sup> See section 126 of the Child Protection Act.

<b>5. Establish and implement an independent and modernised licensing scheme for residential care providers in Queensland.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• The 2017 final report of the national Royal Commission into Institutional Responses to Child Sexual Abuse recommended that a body independent of child safety is responsible for the accreditation of care providers.<sup>63</sup></li> <li>• The Child Safety Department is responsible for the licensing scheme for residential care providers, in addition to its roles as the contractor, funder and care placement decision maker, for residential care.</li> <li>• Unlicensed residential care providers are not required to be audited under the Human Services Quality Framework.<sup>64</sup></li> <li>• Unlicensed residential care providers' workers are not required to complete the minimum training qualifications or have and LCS-2 check.</li> </ul>
<b>Proposed Reform Actions</b>	<p>5.1. The Queensland Government transfer the licensing scheme for residential care providers to:</p> <ol style="list-style-type: none"> <li>a. an entity that is independent of the Child Safety Department within 12 months; and</li> <li>b. review, modernise and centralise the scheme to reflect best practice within two years.</li> </ol> <p>5.2 All providers of residential care must be licensed within three years.</p> <p>5.3 Dedicated transition and implementation planning and support is provided to:</p> <ol style="list-style-type: none"> <li>a. unlicensed residential care providers to meet the Human Services Quality Framework accreditation requirements;</li> <li>b. workers in unlicensed residential care are directly supported to meet minimum qualification, training, and worker screening requirements; and</li> <li>c. licensed providers comply with a modernised licensing scheme.</li> </ol>

## Investigate the feasibility of a pool of relief residential care workers

The Demographics Report on the future of the residential care workforce recommended the creation of a centralised pool of trained and vetted emergency relief residential carers workers for deployment across the Queensland.

The Child Safety Department should investigate the feasibility of developing a model similar to Queensland Country Practice (**QCP**), a division in Queensland Health focused on short- and medium-term relief placements of health professionals in regional and remote areas. QCP advertises regularly for relief needs to a pool of already credentialed casual employees. Relief can be for a matter of days to months and for immediate needs or to cover planned staff leave. There is no minimum hour's requirement and workers can also work for agencies.

<sup>63</sup> Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, December 2017, Out of Home Care Volume 12, Recommendation 12.5.

<sup>64</sup> Human Services Quality Framework – Overview of the framework, Queensland Government.

<https://www.families.qld.gov.au/our-work/human-services-quality-framework/overview-framework>.

Learning from Queensland Health’s successful implementation of QCP, the Child Safety Department could consider a similar model for relief residential care workers across Queensland.

This could enable the deployment at short notice or coverage for planned leave, by qualified and credentialed residential care workers in areas with workforce shortages.

<b>6. Consider creating a readily available pool of accredited emergency and relief residential workers for Queensland.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• The Child Safety Department is responsible for finding a suitable care placement for a child. This can be challenging due to limited numbers of available home-based carers and residential workforce shortages, particularly in regional areas.</li> <li>• Queensland Country Practice (<b>QCP</b>) in Queensland Health provides a pool of qualified, credentials and causal workers for deployment across regional, rural and remote Queensland.</li> </ul>
<b>Proposed Reform Actions</b>	6.1 The Child Safety Department investigate and report on the feasibility to establish a pool of relief residential care workers, similar to Queensland Health’s QCP model.

## Fixing a Broken System: Child Safety Inquiry, Term of Reference 5(b):

*“the implementation and appropriateness of child safety practices; Departmental structure, governance and culture; the adequacy and effectiveness of current training programs for child safety staff; the extent to which leadership structures support accountability in the protection of children; Ministerial engagement and accountability; appropriate frontline resourcing; and third parties including peak bodies and oversight bodies.”*

### PeakCare’s areas of expertise

PeakCare’s observations and proposed recommendations in respect of Term of Reference 5(b) are relevant to its area of experience, expertise, role and resourcing needs as a peak body for the child and family services system in Queensland.

PeakCare considers the Child Safety Department is best placed to respond to Term of Reference 5(b) in respect of the departmental structure, governance, culture and practices.

This section builds on the proposed role and investment in PeakCare to lead reforms to the Residential Care system outlined above.

### The role of peak bodies

Peak bodies represent the collective voice of a sector and support quality services and outcomes for the people they serve. The core functions of peak bodies generally include:

- Sector leadership, collaboration and coordination.
- Workforce development, support and capability uplift.
- Information and research.
- Representing and raising awareness of the sector and the outcomes for the people they serve.
- Insights and inputs to policy development and reform.
- Supporting sustained and successful implementation of reforms and new policies.

Peak bodies play a critical partnership intermediary role for policy makers, government, and the sector they represent in driving and accelerating implementation of best practices and reforms, strengthening workforce capability, and improving the experiences and outcomes of the people served by the sector they represent.

To be effective, peak bodies need core long-term and stable funding. This enables core functions to be established, maintained, and corporate knowledge retained. Peak bodies can also be tasked by governments to undertake specific project work with time-limited funding.

### Peak bodies for child and family services in Queensland

The Child Safety Department partners with peak bodies and provides funding to provide capability, research, advice and dissemination of information. The peak bodies and networks for child and family services who receive funding from the Child Safety Department are listed on their website as follows:<sup>65</sup>

- [PeakCare](#): promotes excellence in the development and delivery of non-government services for the protection and care of children and young people and the support of their families. PeakCare is managed by a Board of Governance. Members of PeakCare are service providers across the child protection continuum from family support to child placement.

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<sup>65</sup> See [Networks and peak bodies | Department of Families, Seniors, Disability Services and Child Safety](#).

- [CREATE Foundation](#): a national organisation with offices in every state, established to advocate for children and young people in care. CREATE Foundation connects with and empowers children and young people in care and seeks to improve the care system through activities, programs, training and policy advice.

CREATE Foundation provides an avenue for feedback from children and young people regarding their care experiences and recommendations for change.

- [Queensland Foster and Kinship Care](#): to support foster and kinship carers with knowledge and skills in their role as carers to better support children and young people in their care.
- [Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited](#): represents the Aboriginal and Torres Strait Islander community-controlled child protection and family support services sector in Queensland. Its principal purpose is to promote and advocate for the rights, safety and wellbeing of Aboriginal and Torres Strait Islander children, young people and their families.
- [Family Inclusion Network](#): a network of parents and Brisbane based non-government organisations who facilitate opportunities for parents and kin to be advocates for children and themselves on issues that affect their lives.

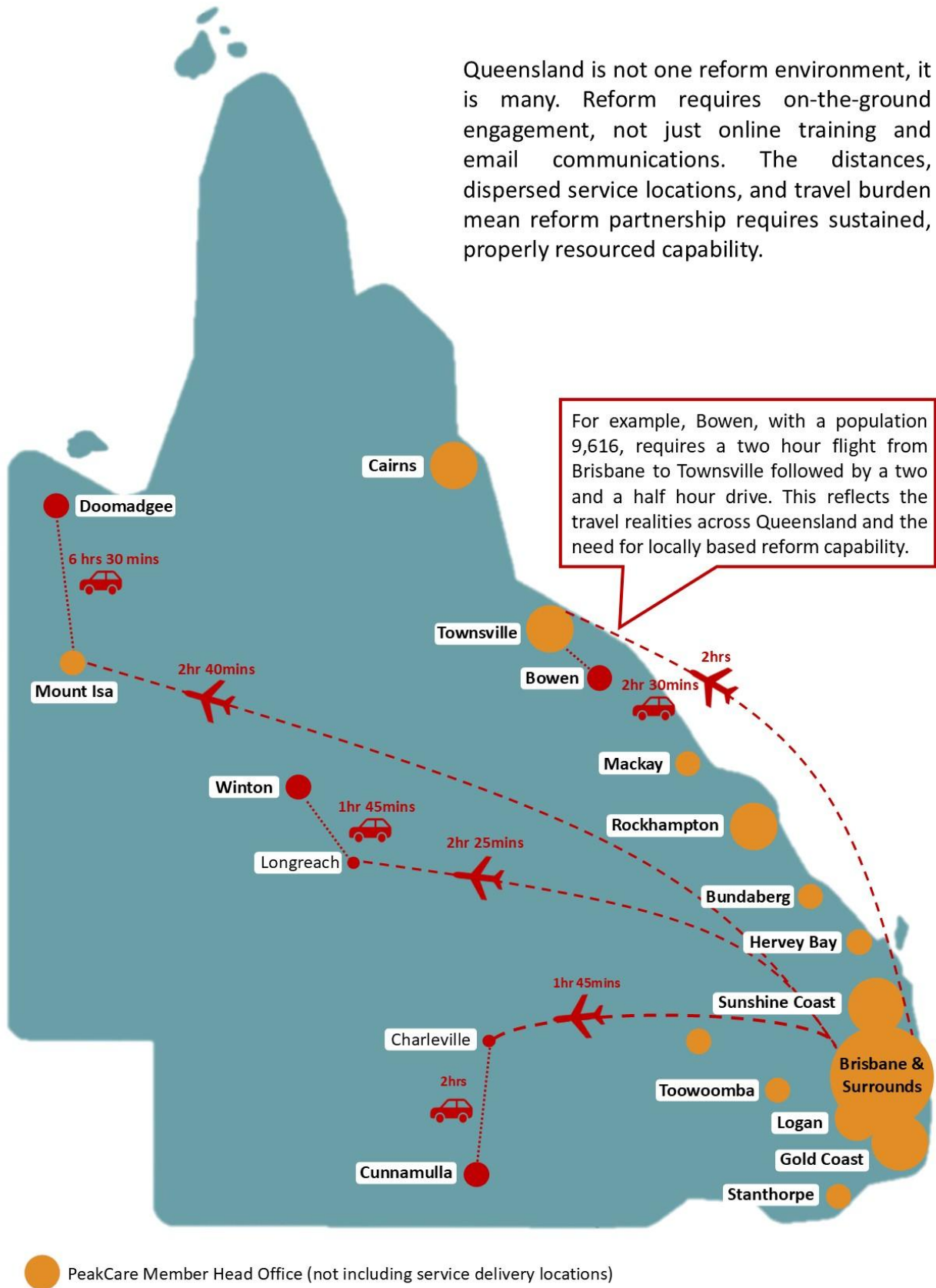
## An extensive footprint to cover

The State of Queensland is vast with the Child Safety system and the non-government child and family services sector providing services across metropolitan, regional and remote areas. Each area has differing cultural and environmental factors, different needs and challenges faced by children, families, and communities, varying service availability, workforce availability and capability.

To operate successfully, capture feedback and learning and provide training and support, peak bodies (like the Child Safety Department), need to be properly funded and supported. This enables engagement, consultation and delivery of face-to-face and place-based training across Queensland. This is an extensive undertaking but one that enables comprehensive engagement, placed-based capability uplift and supports, feedback and learning about the needs and circumstances of individual children, families and communities across Queensland, and integration and learnings between services providers and regions.

The **following graphic** is a pictorial representation of the distances and challenges operating across the vastness of Queensland that peaks are navigating in the child and family services sector, and the associated need to be considered in supporting their operations.

Queensland is not one reform environment, it is many. Reform requires on-the-ground engagement, not just online training and email communications. The distances, dispersed service locations, and travel burden mean reform partnership requires sustained, properly resourced capability.



## PeakCare has an integral system partner role

PeakCare works in partnership with the Child Safety Department and non-government child and family services providers, QATSICCP, academics and experts. PeakCare plays an important intermediary role, connecting, supporting and facilitating interaction between the Child Safety Department and non-government organisations.

PeakCare's role includes:

- **Knowledge sharing** and translation of policy into practice.
- **Workforce training, capability uplift** across non-government organisations workforce and geographical dispersed locations, including the Hope & Healing training specifically designed for residential carers and foster carers.
- **Coordination and information sharing:** bringing together non-government organisations service providers and the Child Safety Department.
- **Aggregating system level insights:** workers are more likely to provide feedback to a peak body than directly to government. PeakCare regularly engages and consults with providers and workers, and is able to synthesise pressures, emerging issues and opportunities for improvement, and support implementation of reforms that otherwise may not be visible or timely to the Child Safety Department.
- **Collaboration across service systems** and peaks in areas that provide services to children, such as health, housing, domestic, family and sexual violence and education. For example, PeakCare's collaboration and sector capability building work in the Preventative Peaks Alliance<sup>66</sup> and the Catalyst for Care program.

### Place-based implementation at scale

Effective system reform in Queensland requires implementation approaches that are place-based, culturally informed and grounded in the reality of service delivery within the community. Delivery of system reform in this way, will support that strategic policy objective's translation to on the ground outcomes for children.

PeakCare is well positioned to provide cost-efficient, place-based implementation support at scale, leveraging established networks, trusted relationships and deep engagement across Queensland. Building on this, PeakCare can act as a locally embedded implementation partner, supporting reform rollout and implementation in a way that is responsive to regional contexts and the unique needs of children and families. Funding is needed to undertake face-to-face engagement, consultation, training and support to non-government providers and workers throughout Queensland. This would improve PeakCare's capacity to engage in place, facilitate real-time feedback loops and support on the ground approaches to reform implementation.

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<sup>66</sup> Preventative Peaks: PeakCare collaborates with human sector peak to drive more effective funding and better outcomes for children and families across human services. For example, PeakCare is a partner in the 'Preventive Peak' project, a partnership with the Child Safety Department, PeakCare, QATSICCP, Shelter, Neighbourhood Centre Queensland and QDN Queenslanders with Disability Network. The Preventive Peaks Project is focused on successful early interventions and programs that provide holistic supports vulnerable families and children across human services programs. The Preventive Peaks partners undertake joint engage in place in across Queensland to support knowledge sharing, identify opportunities for services to better integrate to support vulnerable families and children engage at the earliest opportunity and break the cycle of disadvantage.

This approach would enable more effective, coordinated and sustainable reform implementation, reducing duplication, strengthening system coherence and ensuring reforms translate into improved outcomes for children, families and the workforce.

**Catalyst for Care – supporting the residential care workforce**

A key program of work delivered by PeakCare has been Catalyst for Care, which involved developing and providing training, capability uplift, and support to the frontline residential care workforce.

The extent of the mandatory Hope & Healing training delivered by PeakCare since 2018, is demonstrated by 27,427 residential workers completing the training.

As part of the now concluded Catalyst for Care time limited project, PeakCare delivered a CareCONNECT forum in 2025. CareCONNECT brought together residential care workers and sector leaders to acknowledge the dedication of residential care workers throughout Queensland and to promote and cultivate a culture of learning, innovation, knowledge sharing and practice excellence. CareCONNECT brought together 300 residential care workers and leaders for a day of connection, shared learning, and strengthening relationships across the sector.

PeakCare finalised the ‘Foundations of the future – building a workforce that cares, connects and evolves, Queensland Workforce Strategy’ (the **Residential Care Workforce Strategy**) as part of the Catalyst for Care program of work.

The Residential Care Workforce Strategy is publicly available.<sup>67</sup> It is a shared plan to strengthen Queensland’s residential care workforce. PeakCare led the development with the support of the residential care sector and its workers, QATSICCP and the Child Safety Department. The strategy focuses on creating meaningful career pathways, building respectful and collaborative cultures, and ensuring every worker feels empowered to make a lasting difference in the lives of children. The priority action areas in the Residential Care Workforce Strategy are:

- investing in developing system enablers to empower the workforce;
- creating meaningful career pathways and development opportunities;
- building a collaborative and respectful workplace culture; and
- strengthening community understanding and support.

The Residential Care Workforce Strategy has been approved by the Child Safety Department. It now requires a commitment and funding for coordinated state-wide implementation.

PeakCare’s sector leadership role and its understanding of and extensive engagement with the residential care sector and its workforce makes it well placed to support and lead actions in the implementation planning and state-wide implement of the Residential Care Workforce Strategy in partnership with QATSICCP.

<b>7. Establish a sustained, statewide peak body function to support system reform and implementation.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Peak bodies play a critical partnership, leadership and intermediary role between government and non-government organisations, workers, carers and individuals with lived experience.</li> <li>• Peak bodies deliver consistent, state-wide, capability uplift, engagement and support to workers and providers in the non-government sector.</li> </ul>

<sup>67</sup> At [Foundations-of-the-Future.pdf](#).

	<ul style="list-style-type: none"> <li>• Resourcing peak bodies must reflect the vastness and remoteness of Queensland, and the importance of place-based and face-to-face engagement and training.</li> <li>• PeakCare has had demonstrated success in the supporting the residential care sector and its workforce.</li> </ul>
<b>Proposed Reform Actions</b>	<p>7.1 The Child Safety Department commit to and fully support and resource peak bodies in the child and family services sector to:</p> <ol style="list-style-type: none"> <li>a. deliver on-line and place-based, locally responsive implementation support for reforms across Queensland;</li> <li>b. PeakCare to deliver annual CareCONNECT forums for residential care workers;</li> <li>c. PeakCare to expand the CareCONNECT model to deliver annual forums for child and family services workers;</li> <li>d. Partner, fund and implement the August 2025 approved <i>Foundations of the future – building a workforce that carers, connects and evolves, Queensland Workforce Strategy</i>’ (<b>the Residential Care Workforce Strategy</b>).</li> </ol>

## Supporting implementation

Reform and system change is not a single event. Instead for systems such as Child Safety, it is a complex and long process and may take many years and then longer still for the impact to be seen.

The Child Safety Inquiry’s recommendations require complementary systematic implementation and funding recommendations. This will support purposeful implementation that is understood across government, non-government and community-controlled providers and their workers; and that can be described in sufficient detail such that an independent observer can detect the presence and strength of the ‘specific set of activities’ related to implementation.<sup>68</sup>

There is good evidence that successful implementation efforts designed to achieve beneficial outcomes for children and families in human services systems require a longer-term multilevel approach. Information dissemination and training alone are ineffective in human services as implementation methods.<sup>69</sup> Implementation requires a suite of activities including:

- Raising awareness and understanding of the desired change to a level that enables preplanning, preparation and action.
- Alignment of policies, procedures, and practices.
- Investment in implementation strategies and methods.
- Funding for:
  - establishment costs associated with new practices and programs, to enable planning, concurrent running of existing services while change and new programs are established, and for equipment and infrastructure;
  - intensive activities such as community forums and core implementation meetings, planning and assessments and organisational change;

<sup>68</sup> Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231), pg 5.

<sup>69</sup> Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231), pg 70.

- continued and sustained change, including continual training, supervision, coaching, data collection, reporting and accountability.

Long-term and dedicated implementation planning and support in complex systems with multiple providers and systems partners is also crucial to reducing and addressing change resistance, fatigue and weariness.

For the Child Safety Inquiry’s recommendations to achieve their intended outcomes, an implementation science approach, supported by dedicated planning and long-term investment, is recommended. Implementation science focuses not on *what works* but on *how to make what works happen* at scale in service delivery. It is the study of methods and strategies to promote the best evidence-informed practices and interventions into 'business as usual', with the aim of improving service quality.<sup>70</sup>

To achieve sustained reform of the Child Safety system, the implementation will require dedicated planning, commitment and funding for:

- **Workforce capability uplift:** including ongoing training, professional development support, supervision and coaching to develop competencies and new ways of working, and embed ongoing continuous improvement and learning
- **Organisational support:** leadership and infrastructure that sustain delivery of reforms and programs, enable data collection (qualitative and quantitative) and reporting.
- **Evaluation and feedback:** to guide continuous improvement.<sup>71</sup>

An example of this approach can be seen in Scotland’s implementation of the Getting it Right for Every Child (**GIRFEC**) framework and related children’s services reforms. The Scottish Government funded Children in Scotland to support implementation across the non-government sector (referred to as the third sector). This included the Third Sector Project, led by Children in Scotland and funded by the Scottish Government since 2014, to strengthen the role of the non-government sector in the planning and delivery of children’s services across Scotland. The project provides structured implementation support by facilitating training, information sharing, guidance and peer networks that enable third sector organisations to engage more effectively in national and local decision making related to children, young people and families.<sup>72</sup>

<b>8. Adopt and resource an implementation science approach to deliver and sustain Child Safety system reforms.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Given the size and complexity of the Child Safety system and the entrenched issues to be address, implementation of recommendations and reforms will be over many years.</li> <li>• Successful implementation of reforms requires a long-term, multilevel approach, supported by implementation science and with a multiyear commitment and dedicated funding.</li> </ul>

<sup>70</sup> See Australian Institute of Families Studies, “A guide to implementing evidence-informed programs and practices, <https://aifs.gov.au/resources/practice-guides/implementation-action>.

<sup>71</sup> Fixsen, D. L., Naoom, S. F. Blasé, K.A. Friedman, R. M. & Wallace, F. (2005), “Implementation Research: A Synthesis of Literature”, Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National implementation Research Network (FMHI Publication #231).

<sup>72</sup> [Supporting the Third Sector Project | Projects | Children in Scotland](#)

<b>Proposed Reform Actions</b>	<p>8.1. The Child Safety Department adopt an implementation science approach to deliver of the Child Safety Inquiry recommendations and reforms, including:</p> <ul style="list-style-type: none"> <li>a. working in partnership with and supporting non-government community-controlled organisations, workers, peaks and stakeholders; and</li> <li>b. provide support to plan, implement, embed and sustain change, including for continual training, supervision, coaching, data collection, reporting and accountability.</li> </ul>
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## Supporting participation by children in the decisions impacting their lives

Realising the rights and improving participation of children in decisions that affect their lives is critical.

The 2017 Royal Commission into Institutional Responses to Child Sexual Abuse<sup>73</sup> fundamentally shifted the national conversation about safeguarding children. Its recommendations led to the development of the National Principles for Child Safe Organisations, establishing a clear expectation that children’s voices must be central to organisational culture, governance, and decision making.

However, it was not until 2024 that Queensland legislated the requirement for organisations to embed the Child Safe Organisations Principles into practice.<sup>74</sup> This legislative shift is significant and welcome. Though legislation alone does not deliver cultural change. Embedding children’s rights, participation, and voice into the daily operation of organisations and the broader child and family services system requires sustained leadership, capability uplift, and structural reform.

A child centred system ensures that the rights, entitlements, needs and aspirations of children are central to policy design, funding decisions, workforce development and service delivery. It requires that children are actively engaged in shaping the services and systems intended to support them.

Meaningful participation improves policy design, strengthens implementation outcomes and enhances accountability. It reduces the risk of unintended consequences and increases trust in the system. For government, it improves the effectiveness of investment and reform efforts. For the sector, it strengthens practice and service outcomes. For children it affirms dignity, agency and rights.

PeakCare is uniquely positioned to support collaboration between young people with lived experience, service providers and government. However, to deliver on this ambition, this function cannot continue to be delivered informally or opportunistically, it must be embedded as a core and funded function within PeakCare’s business model.

PeakCare currently makes every effort to embed the voices of children and young people into its advocacy and reform work. We leverage trusted relationships held by member organisations and sector partners to seek input from young people wherever appropriate. While this approach reflects our commitment, it lacks the structural foundation required for sustained system impact.

To address this, PeakCare proposes the establishment of a dedicated Lived Experience Advocacy function as a core element of our reform role funded by the Department of Child Safety.

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<sup>73</sup> [Final report | Royal Commission into Institutional Responses to Child Sexual Abuse](#)

<sup>74</sup> [Child Safe Organisations Act 2024 - Queensland Legislation - Queensland Government](#)

Two full time Lived Experience Advisor roles would be established within PeakCare. These roles would:

- Provide direct input into all PeakCare advocacy, policy development, submissions, and reform initiatives.
- Ensure that children and young people’s perspectives are incorporated early in policy design processes, not retrospectively.
- Develop and oversee safe, ethical, and trauma-informed engagement mechanisms.
- Work with organisations to build feedback loops so young people can see how their contributions influence change.
- Participate in consultations and challenge systemic perceptions of care and protection experienced young people.

These roles would operate at a systems level. They would not provide individual advocacy. Instead, they would focus on structural reform, participation and sector capability. These roles would work alongside PeakCare staff and would be embedded into core business. These roles would complement lived experienced opportunities throughout a range of organisations within the child and family services sector.

### **Sector leadership and capability uplift**

The Lived Experience Advocacy function would work directly with member organisations and partners to strengthen the embedding of children and young people’s voices in practice. This would include:

- Sharing best practice models for participation and co-design.
- Facilitating communities of practice focused on child voice and rights.
- Leveraging learning across organisations to scale effective approaches.
- Partnering with government to support the cultural shift required under the Child Safe Principles.

In doing so, PeakCare would support organisations to embed consistent and developmentally appropriate approaches to participation across metropolitan, regional and remote Queensland.

### **Education and pathway partnerships**

Young people with a care experience continue to face significant barriers in accessing and succeeding in vocational and higher education. If Queensland is to build a child centred and rights-based system, it must also invest in pathways that enable young people with care experiences to participate as leaders, professionals, and decision makers.

The dedicated Lived Experience Advocacy function would work with vocational and higher education partners to establish a structured program to support young people with an out-of-home care experience to access and succeed in education and training pathways. This would include:

- Developing partnerships with TAFE and universities
- Supporting mentoring and peer networks
- Advocating for tailored supports and flexibility within education institutions.

This could include a similar program to the CFECFW successful Raising Expectations Program, which is coordinated and delivered by the CFECFW with TAFE, university partners and the Victorian Government to support young people in care or with a care experience to access and thrive in higher education.<sup>75</sup>

All participation mechanisms established under this Lived Experience Advocacy function would be paid and structured. Young people would be engaged as contributors and advisors, not as volunteers. Participation would be trauma-informed, culturally safe, inclusive of First Nations young people and

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<sup>75</sup> See <https://cfecfw.org.au/our-work/raising-expectations> and <https://www.raisingexpectations.com.au>.

young people from diverse backgrounds, and accessible to those living in regional and remote communities.

<b>9. Provide opportunities for the voice of lived experience to engage with and obtain workforce experience in sector peaks.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Continued efforts are needed to enliven the voice and experience of young people with a care and protection experience across the child and family services system.</li> <li>• Young people with a care and protection experience also continue to face barriers in accessing and succeeding in vocational and higher education.</li> <li>• Supporting young people with a care and protection experience contribute to policy and practice, providing meaningfully workforce participation opportunities and pathways can be enabled through workforce placements and work with peak bodies.</li> </ul>
<b>Proposed Reform Actions</b>	<p>9.1. The Child Safety Department commit to and fully support as part of PeakCare’s core role and business-as-usual activities to:</p> <ol style="list-style-type: none"> <li>a. employ a Lived Experience Coordinator and two Lived Experience Advisors (full-time); and</li> <li>b. establish and implement an education and training pathways support program in partnership with vocational and higher education providers, to support young people with a care experience to succeed in entering the workforce.</li> </ol>

## Fixing a Broken System: Child Safety Inquiry, Term of Reference 5(c):

*“design and implementation plan for a new independent complaints escalation review process to escalate serious concerns about complex cases and restore critical support for families and carers.”*

### Independent complaints processes support continuous improvement and accountability

Services and systems committed to continuous learning and accountability have mechanisms for independent, regular, and structured feedback and complaints. These mechanisms enable quantitative and qualitative data collection that allow trends to be identified, concerns addressed early and for the continuous improvements of policies and their implementation. Independent complaints process also promote accountability, transparency and public trust in government service systems.

In child safety systems, independent complaints processes from the outset (not only an independent escalation review process) are critical for child safeguarding, promoting a safe work environment, and upholding the rights of a child to have their views heard and be taken seriously (Article 12, Convention on the Rights of the Child).

### The Child Safety Department complaints process

The current complaints process in the Queensland Child Safety system is almost exclusively within the Child Safety Department.<sup>76</sup> This process directs a child, family or carer who wishes to make a complaint to their Child Safety Officer, failing that to the Team Leader of their Child Safety Officer; and if they remain unhappy to the Child Safety Department’s Complaints Team.

At the February 2026, Child Safety Inquiry public hearings Ms Clair Martin, Principal Legal Officer, Office of the Child and Family Official Solicitors, in the Child Safety Department, gave evidence in respect to the current complaint process. In her evidence, Ms Martin stated:

*“I think one of the consistent complaints I've heard over the last 15 years is that if a parent or anyone wants to complain about the department they have to complain to the department about the department and then the department investigates it themselves. I do think potentially having an external complaints mechanism might assist with some of those administrative decisions being reviewed in an actually independent way.”<sup>77</sup>*

The Queensland Child Safety system complaints process being managed almost entirely by the Child Safety Department causes structural issues that can limit transparency, accountability and system improvement. For example:

- the Child Safety Department is reviewing its own decisions and conduct;
- a reluctance to complain out of concern that it may adversely impact decisions being made in respect of the child, family or carer;
- undermining trust in the Child Safety system, given limited transparency and public reporting;

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<sup>76</sup> In limited circumstances review of a Child Safety Officer’s decision can be requested by the Queensland Civil and Administrative Tribunal be asked to review these decision (within 28 days of receiving notice). For decisions about where a child should live, whether Child Safety will tell a parent where a child is living, or the amount of parental contact.

<sup>77</sup> Commission of Inquiry into the Queensland Child Safety System, Brisbane Public Hearing, 2 February 2026, pg 3838,

- missed opportunities for reflective practice, learning and improvement, as complaints can highlight systemic issues; and
- limited complaints data restricting the ability to identify and address systemic issue.

Complaints process should extend beyond complaints at an individual level and provide a mechanism for systemic feedback to be identified and addressed through policy and process changes. In this respect, complaints processes are integral for identifying and addressing issues and trends, driving accountability, transparency and promoting continuous improvement.

<b>10. Implement a new independent complaints system for the Child Safety Department.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• If a parent, carer or child wants to complain about the Child Safety Department it must complain to the Child Safety Department, and the Child Safety Department then investigates itself.</li> <li>• Independent complaints processes are critical for child safeguarding, promoting a safe work environment, and upholding the rights of children to have their views heard and taken seriously.</li> <li>• Independent complaint mechanisms also enable quantitative and qualitative data collection for system learning and continuous improvement, accountability, and promote transparency.</li> </ul>
<b>Proposed Reform Actions</b>	<p>10.1. The <b>Queensland Government</b> identify a suitable and independent agency for any and all complaints, at any stage, in respect of the Queensland Child Safety system and the Child Safety Department to be made.</p> <p>10.2. This independent agency commences a co-design process with the Child Safety Department, non-government and community-controlled providers, workers, peak bodies, children, families and carers with a lived experience and independent experts, and cultural experts to develop a new complaints process within 12 months.</p> <p>10.3. The newly designed complaints process is fully implemented within two years by the independent agency, and include annual public reporting on numbers, types, outcomes, and trends in complaints.</p>

# Safer Children: Child Safety Inquiry, Term of Reference 5(d):

“system design to support and facilitate foster care, kinship care and adoption in a modern best practice setting.”

## Home-based care – kinship care and foster care

### Home-based care (kinship care and foster care) in Queensland

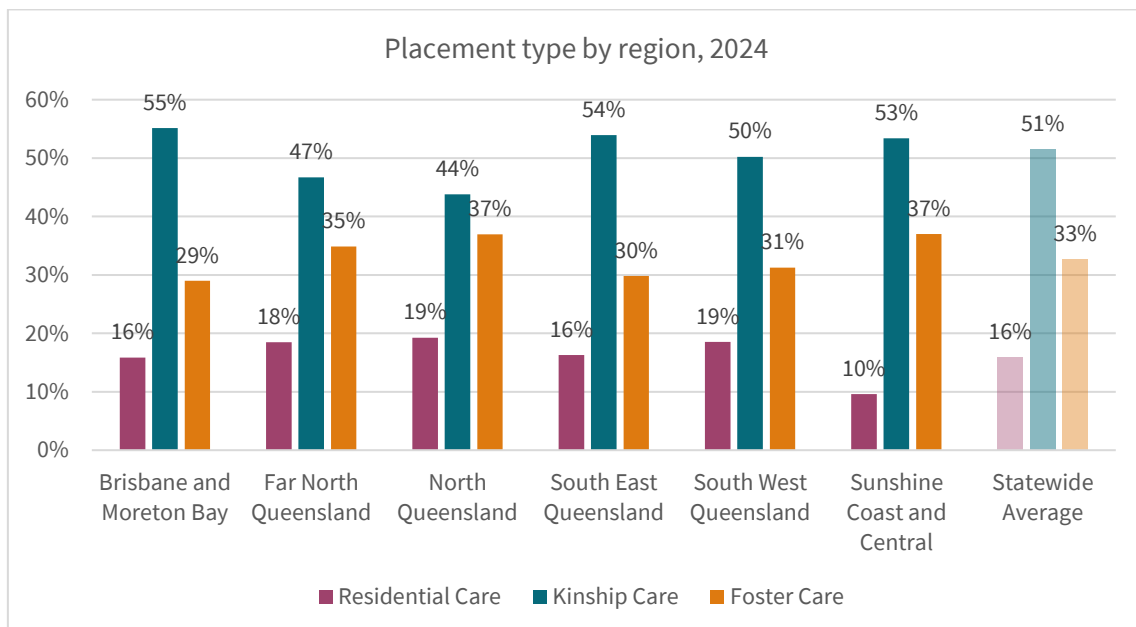
Home-based carers (kinship and foster carers) have the day-to-day care and responsibility for children removed from their biological parents by the Child Safety Department under the Child Protection Act and Court Orders and placed into care.

A child in Queensland can be placed in home-based care with a kinship or foster carer.

- Kinship carers are either a family member or person known to the child.
- Foster carers are approved by the Child Safety Department. A foster carer does not know the child before their removal and entry into statutory care. Foster carers also undergo an assessment and approval process and complete the mandatory online Foster Care Hope & Healing training, approved by the Child Safety Department and provided by PeakCare.<sup>78</sup>

### Children in home-based care in Queensland

Queensland has one of the lowest percentage of children placed in kinship care across Australia.<sup>79</sup> Queensland’s care types by region are set out in the **following graph**.<sup>80</sup>



As shown in the Residential Care Reform section of this submission, as residential care continues to grow Queensland has among the lowest percentage of children placed with kinship carers across Australia.<sup>81</sup>

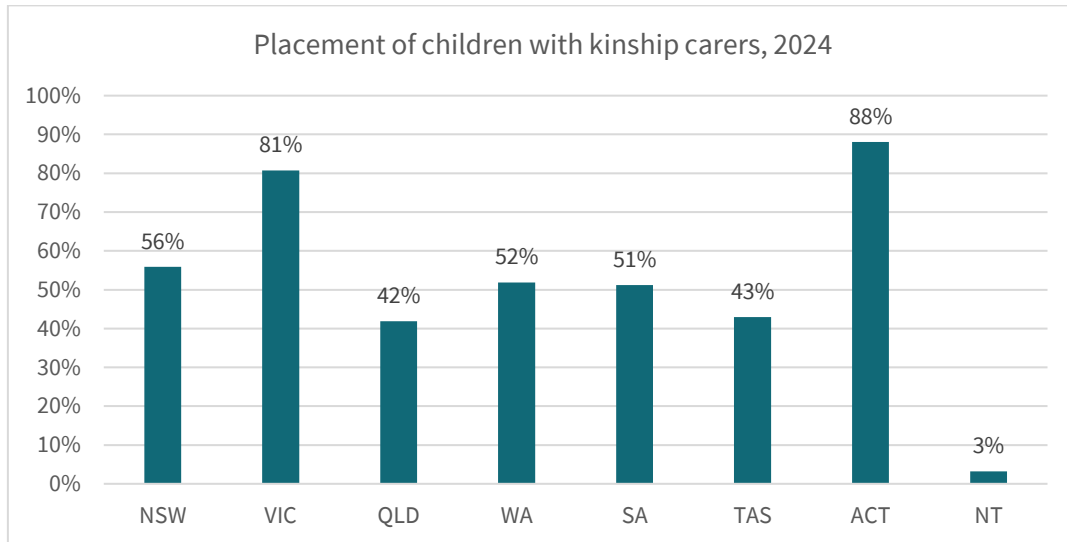
<sup>78</sup> PeakCare’s Foster Carer Hope & Healing training see <https://peakcare.org.au/training/foster-care/>.

<sup>79</sup> Report on Government Services (RoGS), 2025

<sup>80</sup> Report on Government Services (RoGS), 2025

<sup>81</sup> Report on Government Services (RoGS), 2025

In Queensland in 2024, only 42 per cent of children in care were in kinship care. In contrast, the percentage of children in kinship care in state with a comparable population to Queensland are Victoria at 81 per cent, and New South Wales at 56 per cent in 2024 (see **following graph** below). A key action to address the over reliance of residential care in Queensland is a dedicated and supported investment in growing and better supporting kinship care.



### The role of home-based carers

Home-based carers (kinship and foster carers) open their homes to children who have suffered from child maltreatment, disruption caused by removal from their parents and placement in care, are suffering from trauma and cumulative harm, and who have high rates of developmental, physical and mental health issues.<sup>82</sup>

Home-based care (kinship care and foster care) aims to provide children with a safe and supportive home environment where they can heal from trauma, have meaningful relationships with the adults who are raising them, receive timely and responsive health and mental health care, have continuity in their schooling, and maintain connections to community, family and culture.

To achieve the aims of home-based care, home-based carers (foster and kinship carers) require ongoing supports and assistance to:

- Access to timely, effective health, mental health and allied health services and learning and education supports to address the multiple and complex needs of children in their care.
- Training and support to understand and manage the impacts of trauma - which can manifest in behavioural challenges, learning difficulties and school exclusions – and support children to heal.
- Support and enable children to engage with family, community and culture.
- Intensive supports at key transition points and life stages, for example: commencing and establishing a home-based care placement over the first 12 month; transitioning from primary to secondary school; supporting reunification and family contact; and transition planning for independent adulthood.

<sup>82</sup> Borenstein, J., Frederico M, Mc Namara P, “Kinship care in the welfare system: The lived experience and the case for reform”, Children and Youth Services Review 168 (2025) 108026.

## Home-based carer (kinship and foster care) allowance

Home-based carers (kinship and foster carers) receive a fortnightly carer allowance that *contributes* to the day-to-day costs of caring for a child - food, clothing, schooling, travel, recreation, personal care, safety equipment costs (such as baby capsules or car seat), energy, and other expenses.<sup>83</sup> The allowance does not represent *cost recovery* for home-based carers (kinship and fosters) or the costs incurred for being the carer of a children in care.

The expectation is that health, mental health and dental services and any associated costs are ordinarily expected to be met through the public health system. Further, that any out-of-pocket expenses are paid up front by the home-based carer (kinship and foster carers) and a reimbursement subsequently arranged by Child Safety on completion of the required forms and evidence that the costs were incurred.

For home-based carers (kinship and foster carers) in Queensland, as at 1 January 2025, the standard fortnight allowances are:

- \$623.00 for children agreed 0 to 5 years;
- \$671.30 for child agreed 6 to 10 years; and
- \$729.68 for children aged 11 to 17 years.<sup>84</sup>

There is a regional and remote loading on the fortnightly carer allowance of 10 per cent of the fortnightly allowance.<sup>85</sup> There is an establishment payment of \$671.30 to the carer provided by the Child Safety Department when a child enters statutory care or returns after an unsuccessful reunification.<sup>86</sup>

A high support needs allowance may be provided to a carer to assist with the direct care costs of a child assessed as having a high level of support needs, but only where the needs consistently lead to expenses exceeding the fortnightly allowance. It is approved for a specified period or on an ongoing basis for children in care with ongoing medical or psychological needs.<sup>87</sup> A complex support needs allowance may be provided if the child is assessed as having complex or extreme support needs.

In 2025, an annual payment of \$1,500 was also introduced in Queensland to cover the extracurricular activities for children in care.<sup>88</sup>

## Characteristics of home-based carers (kinship and foster carers)

There is limited data on the characteristics of home-based carers (kinship or foster carers).

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<sup>83</sup> *Child Safety Department's Child, Safety Policy, Expenses – Fortnightly caring allowance and interstate foster payments, Policy No. 356-17.*

<sup>84</sup> Child Safety Commission of Inquiry, Proactive Statement No.5, Statement of Bernadette Harvey, Acting Deputy Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraph 45.

<sup>85</sup> Child Safety Commission of Inquiry, Proactive Statement No.5, Statement of Bernadette Harvey, Acting Deputy Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraph 59.

<sup>86</sup> Child Safety Commission of Inquiry, Proactive Statement No.5, Statement of Bernadette Harvey, Acting Deputy Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraph 46.

<sup>87</sup> Child Safety Commission of Inquiry, Proactive Statement No.5, Statement of Bernadette Harvey, Acting Deputy Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraphs 50 to 53.

<sup>88</sup> \$1,500 Extracurricular Activities Boost Payment, Frequently Asked Questions for Family-Based Care, Department of Families, Seniors, Disability Services and Child Safety, Queensland Government, [https://www.families.qld.gov.au/\\_media/documents/foster-kinship-care/faq-boost-fbc.pdf](https://www.families.qld.gov.au/_media/documents/foster-kinship-care/faq-boost-fbc.pdf)

An Australian Institute of Families Studies research report respect of statutory kinship and foster carers found that:

- 88 per cent of foster carers and 87 per cent of kinship carers were female.
- The median age of kinship and foster carers was 53 years and aging over time.
- 25 per cent were in part-time employment.
- 19 per cent were in full-time employment.
- Most carers had an annual gross household income of less than \$60,000, with one-fifth of carers relying on less than \$30,000.
- One third reported that the child in their care had a developmental condition (intellectual disability, physical disability, diagnosed behavioural problem or diagnosed mental illness).<sup>89</sup>

Research and surveys of kinship carers across Australia have shown that:

- kinship carers experience greater disadvantage relating to age, gender, health, education, and finances than foster carers;
- a disproportionate burden falls on women performing kinship caring roles, especially Aboriginal and Torres Strait Islander grandmothers and aunts who are already subject to disadvantage and contextual constraints; and
- some kinship carers feel that child protection and other services available to parents and foster carers believe that kinship carers have an obligation to assume the care of young kin and were responsible for misdeeds of the child's parents and were more difficult than foster carers.<sup>90</sup>

### **Challenges for home-based carers (kinship and foster carers)**

Home-based carers (kinship and foster carers) share a desire to support the children in their care to live happy, healthy lives. However, they routinely face common challenges in achieving this outcome including barriers to health and mental health services and support (for both child and carer), education support, transportation assistance, and general housing and home keeping assistance. Financial pressures and cost-of-living challenges that are felt nationally are compounded for these carers. Consistent challenges reported by home-based carers (kinship and foster carers) include:

- Insufficient health and other information provided on placement, which hinders the carer's ability to support a child to receive timely and effective services and supports.
- Difficulties accessing assessments, treatments and supports for children to heal from trauma, receive health and mental health care, and educational supports to reengage and/or catch up with learning.
- Difficulties obtaining documentation and support from Child Safety to, for example, apply for Medicare cards, NDIS supports, for a child in their care.
- Difficulties navigating multiple services systems – health, early childhood, education – and obtaining support and information from Child Safety.
- Struggling to maintain employment and to meet the needs of the child in their care, particularly for very young children. This can result in carers reducing their working hours or leaving the

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<sup>89</sup> Australia Institute of Families Studies, "Working Together to Care for Kids, A survey of foster and relative/kinship carers", Research Report" 2018.

<sup>90</sup> Borenstein, J., Frederico M, Mc Namara P, "Kinship care in the welfare system: The lived experience and the case for reform", Children and Youth Services Review 168 (2025) 108026.

workforce altogether and having to rely on Centrelink payment.<sup>91</sup> For example, a recent kinship carer study called for urgent reform given Aboriginal kinship carers reported having to leave the workforce to continue to provide care.<sup>92</sup>

- Financial pressures driven by rising costs of living, housing pressures, the shift towards dual income families, insufficient financial and other supports that cause in carer burnout. This trend is especially pronounced amongst younger lower middle-class families who have been the baseline of the foster care system.<sup>93</sup>
- Limited leave entitlements. Home-based carers (kinship and foster carers) are omitted or not specifically identified in some National Employment Standards (NES)<sup>94</sup> leave entitlements, including Community Service Leave, Parental Leave, Sick, Carers and Compassionate Leave. They are also ineligible for paid parental leave.

### **National and jurisdictional efforts and programs to better support home-based carers (kinship and foster carers)**

#### **National Foster Care Sustainability Group – a health access card for all children in care and other initiatives**

The National Foster Care Sustainability Group is an initiative of Families Australia to address the shortage of foster carers. The group is made of leaders from the child and family services sector across Australia and foster carers who are investing their time, resources and efforts in the immediate term to drive positive change in the foster care system. The National Foster Care Sustainability Group initiatives are also advocated for kinship carers.<sup>95</sup>

National Foster Care Sustainability Group is calling on the Commonwealth Government to:

- **Provide a ‘Health Access Card’ for all children in care:** to prioritise access to medical, therapeutic and developmental support to all children and young people in care (kinship, foster and residential care) and with a care experience to ensure their acute health needs are prioritised and met. A ‘Health Access Card’ is likened to the veterans’ federal Gold Card system providing a whole-of-person lifetime health entitlement.
- **Increased carer allowances:** to reduce the financial burden on home-based carers (kinship and foster), give clearer ATO guidance so tax-free care allowances can be increased;

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<sup>91</sup> See Williams, R., & Badry, D. E. (2023). Aboriginal kinship carers and carers of children with Fetal Alcohol Spectrum Disorder in Western Australia: Advancing knowledge from an Indigenous and disability lens. *First Peoples Child & Family Review*, 18(1), 60-80. <https://fpcfr.com/index.php/FPCFR/article/view/603>; DiGiacomo, M., Green, A., Delaney, P., Delaney, J., Patradoon-Ho, P., Davidson, P. M., & Abbott, P. (2017). Experiences and needs of carers of Aboriginal children with a disability: a qualitative study. *BMC Family Practice*, 18(1), 96. <https://doi.org/10.1186/s12875-017-0668-3>; and Kiraly, M. (2023). In loco parentis: Informal kinship care in Australia—social benefit and material poverty. *Societies*, 13(11), 227. <https://www.mdpi.com/2075-4698/13/11/227>.

<sup>92</sup> J. Jones, S. Moodie, R. Chenhall, J. Brook, R. Williams, K. Davis, C. Garlett, A. Gibberd, E. Banks, B. Harrap, M. O’Donnell, B. McNamara, S. Eades, ‘Our babies are our gold’: The experiences of aboriginal kinship carers in Western Australia, *Children and Youth Services Review* (2026), doi: <https://doi.org/10.1016/j.chilyouth.2026.108827>.

<sup>93</sup> “*The Future Residential Care Workforce – Demographic Analysis*”, September 2025

<sup>94</sup> The National Employment Standards (NES) are minimum employment entitlements that must be provided to all employees in the national workplace relationships system.

<sup>95</sup> [Families-Australia-Submission-on-the-National-Employment-Standards-For-Statutory-Out-of-Home-Carers-February-2026.pdf](#)

- **Equitable leave entitlements for carers:** providing equitable leave entitlements, so that home-based carers (kinship and foster) in paid employment can start or continue caring for children in out-of-home care.

### **Families Australia – improving access to leave entitlement for home-based carers**

Families Australia has recently made a submission to the Commonwealth Parliament House of Representatives Standing Committee on Employment, Workplace Relations, Skills and Training - Inquiry into the operational and adequacy of the National Employment Standards (NES), at **Attachment 4**. This submission highlights that home-based carers (kinship and foster carers) are omitted or not entitled to leave to care for children in statutory care – an essential service that state care systems rely on. This also being despite these leave entitlements being available to the child’s parents had they not been removed by the state.

Leave entitlements, such as paid and unpaid parental leave, are particularly needed to support home-based carers (kinship and foster carers) to care for very young children without having to reduce their working hours or exit the workforce and rely on Centrelink benefits. It also would mean children could be placed with home-based carers instead of in residential care.

In their submission, Families Australia has recommended that the NES:

1. Recognise statutory kinship and fosters as a defined group under the NES Community Services Leave entitlement. This would recognise the unplanned, time-critical and essential community service that they provide and that states and territories are reliant on for their out-of-home care systems to function.
2. That the all NES leave entitlements specifically identify statutory kinship and foster carers as a recognised class of people entitled to leave - such as in the entitlement to Parental Leave and to Sick, Carers and Compassionate Leave.
3. Commission national data collection of statutory kinship and foster carers such as their employment status (full-time, part-time or casual); industry or occupation; employer size; age; gender; Aboriginal or Torres Strait Islander; and their reduced hours, income loss or workforce exits due to caring for children in out-of-home care.

Families Australia has also recommended that statutory kinship and foster carers are included in the entitlement to paid parental leave.

Recognising statutory kinship and fosters as a defined group under the NES and to paid parental leave will support home-based carers meet the needs of children in their care and to care for very young children, who otherwise could be placed in residential care, which is *“widely acknowledged as the most expensive and least preferable form of placement, especially for younger children or those requiring more stable environments.”*<sup>96</sup>

### **Supporting kinship carers establish and stabilise care placements**

Kinship carers often have very limited time to plan and prepare for becoming a carer. Workers have noted that kinship care can be more complex than related foster care. For example, one worker described:

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<sup>96</sup> Queensland Family & Child Commission, *“Buyer Beware, How economic forces are shaping Queensland’s residential care market, Queensland Family & Child Commission”*, August 2025. pg 13.

*Kinship carers are dealing with complex family dynamics... being asked to play the role of a statutory carer – they are required to be grandparents, mothers/fathers, uncles/aunts, play a parenting role whilst adhering to Court Conditions and processes involved with child protection.*<sup>97</sup>

In recognition of the economic disadvantage and complexities faced by kinship carers, in Victoria for example, a new model of kinship care was introduced in 2018. One component of this new model was a ‘First Support Program’, contracted by the child protection department to be provided by non-government and community-controlled organisations for the first 12-months of a kinship care placement. The First Supports Program supports kinship placements to start well and be stable and includes:

- The non-government or community-controlled organisation undertaking the comprehensive kinship carer assessment, to understand the needs of the kinship placement (known in Victoria as the Part B assessment).
- Family support services of up to 110 hours (quarantined funding only for kinship carers), to build the caregivers capability and help stabilise the kinship care placement.
- Flexible brokerage<sup>98</sup> to be used based on the needs of the carer to purchase items or services that help establish or maintain the kinship care placement.

### **Priority focus and targeted supports required for kinship carers in Far North Queensland**

Better supporting and growing kinship care in Queensland is a priority action. This support should be tailored to regions that face unique challenges. A priority focus should be given to:

- Far North and North Queensland regions, where the proportion of kinship care is low (47 per cent and 44 per cent) and residential care high (18 per cent and 19 per cent).<sup>99</sup>
- Rural and remote areas where tailored supports and placement arrangements are required to address and overcome barriers which are often compounded in these communities.
- Areas where Aboriginal and Torres Strait Islander children and young people make up a high percentage of placements in residential care, such as Far North Queensland (77 per cent) and South East (62 per cent) and North Queensland (62 per cent), as these spaces require tailored solutions that are community driven and culturally appropriate.

These priority groups should be targeted with tailored supports to enable them to provide stable and secure placements for children. The supports should also recognise the unique challenges faced by kinship carers in comparison to other care types, as these carers often remain a part of the family unit of the birth parent/s, kinship carers often require a higher intensity of family support services. Priority should be given to directing funding towards supports to kinship carers to reduce the number of children and young people placed in residential care. These supports could include:

- Support to kinship carers from community-controlled organisations.
- Dedicated flexible funding to support carers to help establish or maintain the placement.

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<sup>97</sup> Borenstein, J., Frederico M, Mc Namara P, “*Kinship care in the welfare system: The lived experience and the case for reform*”, Children and Youth Services Review 168 (2025) 108026.

<sup>98</sup> Targeted, short term financial assistance is referred to as ‘brokerage’ as a government or non-government organisation ‘brokers’ a good or service for an at-risk child, young person or family, instead of providing or delivering it directly.

<sup>99</sup> Report on Government Services (RoGS), 2025

- Family support services to assist in the management of the family unit throughout the duration of the placement.
- In-home support workers for kinship carers to assist with tasks such tutoring, health and medical appointment access, supporting kinship carers at transition times (e.g. getting ready for school, or a dinner/bed/bath times) and general day-to-day supports (sporting and community group involvement)

### Sibling kinship carers recognition and support

Kinship carers can also include siblings of a child in care. Sibling carers are often significantly younger than the majority of kinship carers and at a different stage in their lives. They are often transitioning themselves to independent adulthood, for example they may be studying, or recent entrants to the workforce.

PeakCare, in collaboration with the QFCC, is leading the Sibling Carer Initiative that aims to reform policies and practices for kinship sibling carers within the care system.<sup>100</sup> The first step in better supporting sibling kinship carers is for the Child Safety Department to establish a definition of sibling carers and institute mechanisms to identify, capture and report on their prevalence. A targeted support package for sibling kinship carers that reflects their unique life stage, responsibilities and support needs can then be co-designed and developed. Further information on the Sibling Carers Initiative and PeakCare’s associated recommendations can be found in the supported submission to the Commission of Inquiry – Sibling Kinship Carers.<sup>101</sup>

<b>11. Increase investment in home-based carers (kinship and foster carers) through both financial and non-financial supports to ensure the sustainability of Queensland’s child protection system.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Home-based carers (kinship and fosters carers) provide an essential community service.</li> <li>• Carers in the workforce have limited access to leave entitlements, including parental leave, despite looking after complex and/or very young children.</li> <li>• Limited financial and non-financial support impedes the ability of home-based carers to provide for the multiple and complex needs of the children in their care.</li> <li>• Educational outcomes for children are impeded by school exclusions and limited educational support. Exclusions from school adversely impact carers causing placement instability and carer stress.</li> </ul>
<b>Proposed Reform Actions</b>	<p>11.1. The <b>Commonwealth Government</b> provide equitable leave entitlements to statutory kinship and foster carers in the workforce, including:</p> <ol style="list-style-type: none"> <li>a. recognising statutory kinship and fosters as a defined group under the National Employment Standards leave entitlements, such as Community Services Leave, Parental Leave and to Sick, Carers and Compassionate Leave; and</li> <li>b. extending paid parental leave entitlements to statutory kinship and foster carers</li> </ol>

<sup>100</sup> Sibling Kinship Carer Initiative, PeakCare Queensland, webpage, accessed 11 March 2026.

<sup>101</sup> Submission to the Commission of Inquiry into Child Safety System – Better Supporting Sibling Kinship Carers, 29 March 2026

	<p>11.2 The <b>Queensland Government</b> and <b>Child Safety Department</b> increase financial and non-financial support to home-based carers (kinship and foster carers), including:</p> <ol style="list-style-type: none"> <li>a. increasing kinship and foster carer payments to meet the need and complexity of children in care and the costs of raising a child;</li> <li>b. providing support to carers, including financial and non-financial, to establish and sustain a placement (with ability to scale up supports at key transition points – such as increase contact with family, planning and transition from primary to secondary school or to independent adulthood) by engaging non-government and community-controlled organisations to provide support with brokerage available for goods and services assessed to support the outcomes for children in care and stabilise a care placements;</li> <li>c. providing access to educational support children in care, including to teachers and tutors, to assist children to catch up on missed school, support reintegration into schools, and provide assistance when children in care experience difficulties with learning, or are excluded from school.</li> <li>d. commission an annual independent survey and interviews of home-based carers (kinship and foster carers) with a mixed method approach (qualitative and quantitative) focused on hard-to-reach carers to better understand carer characteristics and needs. This survey is benchmarked in year one and completed annually thereafter. The survey and interview questions are developed with input from cultural knowledge holders, peak bodies and independent experts and independently administered and publicly reported on;</li> <li>e. the Child Safety Department Strengthen data capturing and engagement with sibling kinship carers and establish a sibling kinship carer lived reference group to support the unique needs of sibling carers. Refer to PeakCare’s separately supported Sibling Kinship Carer submission as part of its joint work with the QFCC.</li> </ol>
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## A legislated and accountable Corporate Parenting Model for children in care

Carers and residential care workers report repeated and prolonged difficulties in accessing government services to meet the complex and multiple needs of the children in their care.

- supports to heal from the impacts of maltreatment prior to their entry into care<sup>102</sup>; and
- services and supports to be healthy, well, meet developmental milestones, meaningfully engage in education, and reach their potential in and transitioning from care.

A system designed to support and facilitate home-based care should arguably require the State of Queensland, that removed the child due to significant safety concerns, to coordinate and prioritise the state’s provision of services needed by the child, which are provided across government agencies.

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<sup>102</sup> The prevalence of child maltreatment is higher and more intense for children in care than for the general population. Harris LG, Higgins DJ, Willis ML, Lawrence D, Meinck F, Thomas HJ, Malacova E, Scott JG, Pacella R, Haslam DM, “Dimensions of child maltreatment in Australians with a history of out-of-home care. *Child Maltreatment*” 2025 August, 30(3):525-39.

This can be achieved through a new Corporate Parenting Model which could impose on the State of Queensland, and all its Ministers and departments heads, responsibilities, and accountabilities to uphold the rights of children in care across their specific portfolio areas to promote the health and wellbeing of children in care. Leveraging off the recommendations in the All-Party Parliamentary Group for Care-Experienced Children and Young People 2024 report<sup>103</sup> for an effective corporate parenting model, elements for a new Corporate Parenting Model could include:

- **Legislation:** Defining a corporate parenting model that extends parenting obligations and responsibilities beyond the Child Safety Department to include departments and agencies that impact the wellbeing and development of children in care, such as health and mental health, education and housing.
- **Specific and measurable outcomes:** Identification of outcomes that are concrete and measurable, such as compliance with the Clinical Assessment Framework, NDIS plans for all children in care with a disability, specific and evidence-based educational participation and attainment metrics etc.
- **Monitoring and evaluation:** Mandating that every child in care must have a care plan and regular reporting by all government departments and agencies providers on progress in achieving the plan's objectives. Independent oversight of each plan and global public reporting obligations for the cohort of children in care would further strengthen this approach.
- **Data and reporting:** Improved data sharing, monitoring, reporting and independent evaluation, to be a more effective corporate parent, understand and act on opportunities for ongoing improvement, and monitor outcomes.
- **Funding and service access:** New, dedicated, and quarantined funding coupled with mandatory prioritisation of children in care to access services and supports, such as health care and mental health care and education.
- **Voice of the child:** The right for children and families to be heard and to meaningfully participate in decisions that affect their lives.
- **Implementation** of the Aboriginal and Torres Strait Island Child Placement Principle to the standard of 'active efforts'<sup>104</sup>, to keep children connected to their family, culture, community, and country.

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<sup>103</sup> What makes an effective corporate parenting model was considered in the United Kingdom by the All-Party Parliamentary Group for Care-Experienced Children and Young People (**APPG Care Group**). This is an informal group of Members of Parliament and Peers who share a common interest in promoting the voice of care-experienced children and young people and better informing or influencing government policy for the care system. The APPG Care Group, "*Inquiry on Extending Corporate Parenting Responsibility across the Public Sector Final Report*", March 2024 report, made 14 recommendations to improve the effectiveness of a corporate parenting model.

<sup>104</sup> Active efforts meaning purposeful, thorough, proactive steps to keep children connected to their families, culture, community and country, rather than simply defaulting to removal.

<b>12. Establish the State of Queensland as a corporate parent to children in care, responsible and accountable for providing timely services across portfolio areas and deliver better outcomes.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Children in care experience higher levels of child maltreatment than the general Queensland community.</li> <li>• Children in care struggle to get services available to the broader Queensland community and continue to achieve poorer outcomes than their peers.</li> <li>• The State of Queensland, that removed the child from their parent/s due to safety concerns, is responsible for the health, wellbeing and development needs of children in care. A whole-of-government coordinated and accountable approach is needed to meet the needs of children in care and improve their outcomes.</li> </ul>
<b>Proposed Reform Actions</b>	<p>12.1. The <b>Queensland Government</b> design, legislative and implement a corporate parenting framework for children in and transitioning from care, which includes:</p> <ol style="list-style-type: none"> <li>a. identification of government entities with corporate parenting responsibilities;</li> <li>b. requiring prioritised and timely access to services for children in care; and</li> <li>c. mandating that these entities publish, plan and report against their responsibilities, which includes identifying specific and evidence-based outcomes for children.</li> </ol> <p>12.2. The <b>Queensland Government</b> work with the <b>Department of Education</b> to require data capture and reporting of children on alternative arrangements or reduced school hours and implement a mandatory review every two months of any such arrangements. This review must include engagement with the Child Safety Department and the child or young person (in an age-appropriate way), carer or workers, supported by a trusted adult or advocate, including an Aboriginal and Torres Strait Islander Community Controlled Organisation, where appropriate, to uphold their right to education.</p>

## Ensuring children in care have access to health care

Children in care have multiple and complex health needs, poor physical health, developmental delays and compromised mental health. However, they have limited access to health resources that are otherwise routinely available to the rest of the community i.e. their health and medical history records, and poor continuity of health care.<sup>105</sup>

The *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* sets out core elements that cover physical, developmental and mental health. These core elements recommendations include that children in out-of-home care have:

<sup>105</sup> “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” March 2011, [national-clinical-assessment-framework-for-children-and-young-people-in-out-of-home-care.pdf](#).

- A Preliminary Health Check as soon as possible and no later than 30 days after entry into out-of-home care to determine areas of immediate concern.
- A Comprehensive Health and Developmental Assessment (physical, developmental, psycho-social, mental health, dental, optometry and audiology) within three months after entry into out-of-home care.
- A Health Management Plan is developed and integrated with other management plans (e.g. education plans) into a single management plan for the child.
- Follow up monitoring in accordance with the clinical needs of the child.

Compliance with the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* is poor. For example, the evidence given to the Child Safety Inquiry by carers and health professionals, such as Dr Marnie Fraser, Staff Specialist, Paediatrics (Cairns and Hinterland Hospital and Health Service) on 26 September 2025.<sup>106</sup>

Failure to assess and attend to the health and development needs of children care at all or in a timely manner can result in children having challenging behaviours, carers and workers being unable to manage and address their needs and results in placement breakdowns.

The failure to address, and in a timely manner, persistent and recurring health issues for a child in care was examined in hearings in the Child Safety Inquiry in a case study of a very young child with persistent and recurring scabies.<sup>107</sup> This resulted in the first foster carer relinquishing care as they could not manage the child’s medical needs.<sup>108</sup> This child ultimately received medical treatment when a subsequent medically trained foster carer arranged and paid for private specialist medical treatment.<sup>109</sup>

Compliance with the *National Clinical Assessment Framework* is essential for children in out-of-home care to receive the care that they had missed out on and is essential to meet their multiple and complex needs.

<b>13. Comply with and report on the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i>.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Children in care have multiple and complex health needs, poor physical health, development delays and compromised mental health.</li> <li>• Despite the needs, they have limited access to health care compared to the rest of the community.<sup>110</sup></li> </ul>
<b>Proposed Reform Actions</b>	13.1. The <b>Commonwealth Government</b> provides all children in care with a Health Access Card, similar to a Veterans’ Gold Card.

<sup>106</sup> Queensland Commission of Inquiry into the Child Safety System, at [www.childsafetyinquiry.qld.gov.au](http://www.childsafetyinquiry.qld.gov.au).

<sup>107</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3868.

<sup>108</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3874.

<sup>109</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3878.

<sup>110</sup> The “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” recognises that children and young people in statutory care tend to have multiple and complex health needs, poor physical health, development delays and compromised mental health. It also recognises that children and young people in statutory care tend to experience very limited access to health resources that are otherwise routinely available to the rest of the community. Compounding this situation, the large number of placements experienced by some children and young people often leads to reduced availability of information about their past medical history, inconsistent maintenance of accurate information about their current health status and consequently poor continuity of health care.

	<p>13.2. <b>Queensland Health</b>, supported by the Child Safety Department, within 12 months:</p> <ol style="list-style-type: none"> <li>a. design, develop and implement a dedicated system, process and supports to comply with the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i> for all children in care;</li> <li>b. capture of state-wide data and publicly report annually against the <i>National Clinical Assessment Framework for Children and Young People in Out-of-Home Care</i>;</li> <li>c. priorities access for children in or with a care experience to access health and mental health, and allied health as needed and in accordance with health professional’s recommendations and best practice guidance.</li> </ol>
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## Measuring and reporting on outcomes for children in care

A system design to support and carers in a modern best practice setting should provide public reporting and information on whether children in care are meeting the outcomes the Child Safety Department seeks to achieve for them.

### A minimum data set for the care system

A minimum data set should be developed as a priority for the care system to enable consistent data capture and public reporting of key outcomes for children in care. A minimum data set is a standardised set of essential data elements that are consistently collected to enable reliable monitoring, comparison and reporting. Minimum data sets define the core information that must be gathered - such as demographics, service use, outcomes and key indicators - ensuring consistency in how data is recorded and interpreted across different providers or regions. By focusing on a concise but meaningful set of variables, a minimum data set reduces reporting burden while still providing sufficient information to track performance, identify trends, support evaluation, and inform policy and service improvement.

### Reporting on the Queensland Care Services Outcomes Framework

The Queensland Care Services Outcomes Framework<sup>111</sup> (**the Care Outcomes Framework**) sets out the outcomes that the Child Safety Department aims to achieve for children in care, at **Attachment 5**. The Care Outcomes Framework aligns with the Convention on the Rights of the Child and the Child Protection Act. It is structured around five domains to improve the life outcomes of children in care, namely:

- **Safe and nurtured:** children and young people feel cared for and nurtured in stable environments, safe from abuse, neglect, violence, and harm.
- **Connected:** children and young people feel a strong sense of identity and belonging, have stable and long-lasting relationships with family and friends and are connected to culture and community.
- **Achieving:** children and young people learn and develop to their full potential.
- **Healthy:** children and young people make healthy lifestyle choices and access health care services.

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<sup>111</sup> [Queensland Care Services Outcomes Framework](#)

- **Resilient:** children and young people have strong social and interpersonal skills and feel confident to pursue life goals and manage challenges.

The Care Outcomes Framework identifies indicators and measures of success for children in care, which are aligned to the five domains. However, there is no dedicated public reporting by Child Safety Department directly against the Care Outcomes Framework.

Whilst reporting on indicators and measures of success may occur in other reports and activities, such as by the QFCC or through surveys of children in care, dedicated data captures and public reporting is needed. This will provide a holistic and single report to determine process in achieving the outcomes identified by the Child Safety Department that it seeks to achieve for children in care in the Queensland Care Services Outcomes Framework.

<b>14. Report annually against the Queensland Care Services Outcomes Framework.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• There is no standardised set of essential data elements that are consistently collected across the care system (i.e. no minimum data set to enable consistent and reliable monitoring, comparison and reporting across Queensland.</li> <li>• There is no dedicated or regular public reporting on the Queensland Care Services Outcomes Framework.</li> <li>• A system designed to support and facilitate home-based care (foster and kinship care) and support in a modern best practice setting should provide public reporting and information on whether children in care are being supported, and meeting the outcomes the Child Safety Department seeks to achieve for them.</li> </ul>
<b>Proposed Reform Actions</b>	<p>14.1 The <b>Child Safety Department</b> report annually against the Queensland Care Services Outcomes Framework within 12 months, including:</p> <ol style="list-style-type: none"> <li>a. develop and report on a minimum data set for the care system.</li> <li>b. mapping the available quantitative and qualitative data and developing mechanisms for reporting on any gaps, to report on the measures for success;</li> <li>c. develop system and processes to capture unavailable data;</li> <li>d. publicly report annually against the Queensland Care Services Outcomes Framework.</li> </ol>

## Support for care leavers and transition to independence

Improving safety for children in Queensland requires us to look beyond simply minimising the likelihood of further harm to young people through removal from birth parent/s. It requires a sustained effort to address the ongoing impacts of experiences during childhood, including trauma associated with removal. If we want to improve the safety of children and young people, including addressing the impacts of intergenerational trauma, support to young people exiting care cannot end when they turn 18.

Evidence consistently demonstrates that safe and successful transitions to adulthood are underpinned not only by financial support, but by range of supports that lay the foundation for a successful transition from early in a child’s placement. This includes the presence of stable, enduring relationships, housing stability, education and employment opportunities, recognition of individual strengths of young people

and access to post-care support.<sup>112</sup> Young people leaving care often experience accelerated transitions into independence, without the relational safety nets that their peers rely on well into their 20's. They also experience significant risks of homelessness, with some evidence reporting 30 per cent of young people experience homelessness in the first year after their transition from out-of-home care.<sup>113</sup>

The Queensland Government's introduction of extended post care support is a positive step. The indexing of these payments annually has also been received positively by the sector, but some concerns have been raised of the eligibility requirements to having to be on a current order. This creates a concern that some young people may miss access to support without proactive and timely transition planning, including the renewal of orders where appropriate.

Financial support alone is insufficient to ensure safe and stable transitions to adulthood. Young people also require consistent support to access safe and stable housing, ongoing physical and mental health care, and strong relational supports to navigate early adulthood. Without a trusted adult or a reliable support network, young people are significantly more likely to experience housing instability, disengagement from education and employment, and poor mental health outcomes.

<b>15. Expand post-care support to include relational, housing and wellbeing supports.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Young people leaving care continue to experience challenges and limited support in their transition to independent adulthood.</li> <li>• 30 per cent of young people experience homelessness in the first year after their transition from out-of-home care.<sup>114</sup></li> <li>• Evidence demonstrates that successful transitions from care require a range of financial and non-financial supports, including enduring relational security, housing stability, and access to education and employment opportunities.</li> </ul>
<b>Proposed Reform Actions</b>	<p>15.1 The <b>Department of Child Safety</b> extends post care support to include:</p> <ol style="list-style-type: none"> <li>a. guaranteed access to stable and appropriate housing options for all young people leaving care, including priority access to social housing and supported accommodation pathways;</li> <li>b. flexible, trauma informed mental health and substance use support, including assertive outreach models that respond to young people who may not engage with traditional services;</li> <li>c. embed relational permanency planning as a mandatory component of leaving care plans; and</li> <li>d. strengthened and earlier transition planning processes to ensure all young people have access to supports prior to exiting care; and</li> <li>e. develop and undertake a longitudinal study to understand the trajectories and supports accessible to carer leave and how to enhance services and support to improve outcomes.</li> </ol>

<sup>112</sup> Grage-Moore, S., Wainwright, H., Newton, D., Mendes, P., & Skouteris, H. (2025). Factors enabling smooth transitions from out-of-home care: A scoping review. *Children Australia*, 47(1), 3026. doi.org/10.61605/cha\_3026

<sup>113</sup> McDowall, J. J. (2020). *Transitioning to adulthood from out-of-home care: Independence or interdependence*. Sydney: CREATE Foundation. <https://create.org.au/wp-content/uploads/2021/05/CREATE-Post-Care-Report-2021-LR.pdf>

<sup>114</sup> McDowall, J. J. (2020). *Transitioning to adulthood from out-of-home care: Independence or interdependence*. Sydney: CREATE Foundation. <https://create.org.au/wp-content/uploads/2021/05/CREATE-Post-Care-Report-2021-LR.pdf>

## Safer communities: Child Safety System, Term of Reference 5(e)

“new models of care ensuring children are provided an opportunity for intervention and rehabilitation and that escalating risk or behaviours are managed in line with community safety expectations.” Terms of Reference 5(e).

### Delivering therapeutic care for children affected by trauma and up skilling the workforce

The Australian Child Maltreatment Study found that the prevalence of child maltreatment for children in care is significantly higher and more intense than in the general population. Children in care reported more types of maltreatment, more frequent exposure, earlier onset, longer duration, and more perpetrators than their peers.<sup>115</sup> Child maltreatment contributes to mental health conditions,<sup>116</sup> causes cumulative harm<sup>117</sup> and a substantial economic burden annually from increased health costs and lost productivity.<sup>118</sup>

Cumulative harm is the result of the compounding impact of ongoing and multiple experiences of child maltreatment. It can significantly impair a child’s wellbeing and development. Children who enter care with cumulative harm may experience additional challenges in care due to their impaired emotional, behavioural, relational and development functioning.

When we fail to provide therapeutic care for children affected by trauma and cumulative harm, we fail to address the impacts of abuse and neglect. This can lead to children experiencing placement instability, disrupted relationships and education, further trauma, poor lifelong outcomes and perpetuating an intergenerational engagement in the Child Safety system.<sup>119</sup>

Therapeutic and trauma informed services and trained and skilled staff, are critical to respond to the impacts of abuse and neglect, and to reduce intergenerational engagement in the Child Safety system. Treating the impacts of trauma is important for all children who experience child maltreatment. For children in care, particularly residential care, it is essential to meet their health and wellbeing needs.

Therapeutic care requires workers to be trained and skilled in addressing the impacts of trauma and cumulative harm for children. It requires workers and service providers to:

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<sup>115</sup> Harris LG, Higgins DJ, Willis ML, Lawrence D, Meinck F, Thomas HJ, Malacova E, Scott JG, Pacella R, Haslam DM, “Dimensions of child maltreatment in Australians with a history of out-of-home care. *Child Maltreatment*” 2025 August, 30(3):525-39.

<sup>116</sup> Grummitt, L., Baldwin, J. R., Lafoa’l J., Keyes, K. M., Barrett, E, “Burden of Mental Disorders and Suicide Attributable to Childhood Maltreatment”, *JAMA Psychiatry*, 2024;81(8):782-788. doi:10.1001/jamapsychiatry.2024.0804, published online May 8, 2024.

<sup>117</sup> Harris LG, Rattambige D, Hunt GR, Higgins DJ, “Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters”, *Current Opinion in Psychology*, <https://doi.org/10.1016/j.copsyc.2025.102260>.

<sup>118</sup> Dai Quy Le, Long Khanh-Dao Le, Marie Bee Hui Yap, Divna M. Haslam, Daryl J. Higgin, Eva Malacova, James G. Scott, David Lawrence, Ben Mathews, Cathrine Mihalopoulos, “Impact of child maltreatment on the costs of health service use and productivity loss: Findings from the Australian child maltreatment study”, *Child Abuse & Neglect* 171 (2026) 107818.

<sup>119</sup> Harris, L.G., et al., *Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters*. *Current Opinion in Psychology*, 2026: p. 102260. See also [Trauma-informed care in child/family welfare services | Australian Institute of Family Studies](#).

- recognise that a child’s behaviours, emotions, relationships, and development may be a response to trauma;
- understand and implement evidence-informed, therapeutic, and tailored responses to support children;
- provide a care environment that is safe; and
- integrate an understanding of trauma beyond care services to all services a child receives, such as education and health care, to promote safety, trust, empowerment, avoid re-traumatisation and build protective factors and resilience.<sup>120</sup>

A priority proposed action is providing training for workers to be highly skilled in therapeutic care. Particularly, for workers engaging with:

- children in care, particularly in residential care;
- children under 12 years of age with trauma histories to prevent problems becoming entrenched and escalating during adolescence; and
- interventions for first time parents with trauma histories and multiple and complex needs, particularly parents 20 years old or younger.

Through the Australian Centre for Child Protection, Western Australia, which has similar geographical challenges as Queensland, supported the development of training to respond, assess and provide trauma-informed care to children. This training includes:

- **A Professional Certificate in Understanding Childhood Trauma:** This certificate is designed to support non-specialist professionals currently working with children impacted by abuse and neglect to develop a trauma-informed understanding of child abuse and neglect. It contains five topics, which should take up to 30 hours to complete, and is flexible and designed for students to work through the content at their own pace within a six-week period.
- **A Graduate Certificate in Child Trauma:** An online qualification to help frontline workers to recognise the signs of abuse, understand the impacts and develop evidence-informed and tailored responses.<sup>121</sup>

The training developed by the Australian Centre for Child Protection for the Western Australia workforce to treat the impacts of children should be investigated for its compatibility in Queensland and consideration given to its roll out.

In 2025, PeakCare in partnership with the QFCC funded the Australian Catholic University Institute of Child Protection Studies to develop a framework for youth mental health maltreatment healing. The two-year research project is in progress and will focus on identifying practical tools to address the impacts on mental health from complex multi-type maltreatment in young people.<sup>122</sup> The development of the framework will lay the foundation for shared tools and resources to support young people exposed to multi-type, high-intensity maltreatment. Given young people in residential care experience disproportionate multi-type, high-intensity maltreatment when compared to the general population, they should be a priority group in the implementation and roll out of an evidence-based framework to support their healing.

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<sup>120</sup> Wall, L., Higgins, D., & Hunter, C. (2016). “*Trauma-informed care in child/family welfare services.*” Child Family Community Australia information exchange, Australian Institute of Family Studies, Melbourne

<sup>121</sup> <https://accp.adelaide.edu.au/our-courses>.

<sup>122</sup> Youth mental health: a framework for maltreatment healing, Institute of Child Protection Studies, Australian Catholic University, webpage, <https://www.acu.edu.au/about-acu/institutes-academies-and-centres/institute-of-child-protection-studies/our-research/current-projects/youth-mental-health-a-framework-for-maltreatment-healing>, accessed 9 March 2026.

<b>16. Require all proposed models of care to be trauma-informed with trained workers and carers.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Children in care have experienced significantly higher and more intensive child maltreatment incidences than the general population.</li> <li>• Child maltreatment leads to children experiencing placement instability, disrupted relationships and education, further trauma, poor lifelong outcomes and perpetuating an intergenerational engagement in the Child Safety system. It also causes long-term health costs and lost productivity.</li> <li>• Therapeutic care for children affected by trauma and cumulative harm, addresses the impacts of child maltreatment and disrupts the intergenerational engagement in the child safety and care systems.</li> <li>• Trauma-informed care is not simply about understanding trauma and its impacts, instead it requires training the workforce to deliver evidence-informed therapeutic and tailored responses to individual children.</li> </ul>
<b>Proposed Reform Actions</b>	<p>16.1 The <b>Department of Child Safety</b> design, develop, and contract specialist providers and experts to embed specialist, practice-based trauma capability across the government, non-government and community-controlled workforce and carer system, including:</p> <ol style="list-style-type: none"> <li>a. all workers receive best practice training in trauma-informed care, focused on responding to, managing, and treating trauma in practice, beyond foundational trauma awareness.</li> <li>b. supporting and funding the delivery of trauma capability training for home-based carers (kinship and foster carers) to enable therapeutic responses within home-based care; and</li> <li>c. investigating the feasibility of training developed by the Australian Centre for Child Protection (such as for the Western Australia workforce to treat the impacts of children) or a like provider for roll out in Queensland.</li> </ol> <p>16.2 The <b>Queensland Government</b> support and fund a pilot of the Framework for Youth Mental Health Maltreatment Healing (development in progress) in out-of-home care and develop a plan for state-wide implementation alongside partners Australian Catholic University (ACU), QFCC and PeakCare.</p>

## A foundational child rights base for models of care

The United Nations Convention on the Rights of the Child is the principal instrument setting out the human rights of children. It was ratified by Australia on 17 December 1990 and became legally binding on 16 January 1991. This means the Queensland Government, responsible for child protection, is obligated to follow the Convention on the Rights of the Child and ensure domestic laws and policies align with its principles.

The preamble of the Convention on the Rights of the Child states that children, by reason of their physical and mental immaturity, need “*special safeguards and care, including appropriate legal protection, before as well as after birth.*”<sup>123</sup> A ‘child’ is defined as below the age of 18 years of age.<sup>124</sup>

<sup>123</sup> Convention on the Rights of the Child, Preamble.

<sup>124</sup> Convention on the Rights of the Child, Article 1.

The Convention on the Rights of the Child has four guiding principles:

1. The best interest of the child must be a primary consideration for all decisions affecting them (Article 3).
2. All children have the same rights (Article 2).
3. Children must be supported to develop physically, emotionally, socially, and mentally (Article 6).
4. Children have the right to express their views and have those views taken seriously (Article 12).

The rights of the child include:

- protection from abuse, neglect, exploitation, inhuman or degrading treatment;
- to health care, education, and disability support;
- to express views, access information, and have freedom of thought;
- for detention only as a last resort and for the shortest appropriate time; and
- to legal assistance, treatment that promotes dignity, rehabilitation and reintegration when engaged in youth justice.

The Child Protection Act and *Youth Justice Act 1992* (Qld) (**Youth Justice Act**) reflect the Convention on the Rights of the Child core principles by prioritising the best interests of the child<sup>125</sup>, emphasising family involvement,<sup>126</sup> promoting cultural connection<sup>127</sup>, promoting rehabilitative responses, limiting the statutory removal of children<sup>128</sup>, the role of child detention as a last resort<sup>129</sup> and the right to self-determination of Aboriginal and Torres Strait Islander children.

Despite the alignment of the Child Protection Act with the Convention on the Rights of the Child, the realisation of the rights of the child in the Queensland Child Safety system is inconsistent and often dependent on factors including a regional office's operational practices, geographical location, service availability, and/or care placement type of a child.

Failing to embed and enliven the rights of the child in the Queensland Child Safety System has a tangible impact on the experiences and outcomes of children.

For example, children in care have limited access to health care otherwise routinely available to the rest of the community,<sup>130</sup> are more likely to be excluded from school and have limited support to continue

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<sup>125</sup> Convention on the Rights of the Child Article 3; *Child Protection Act 1999* (Qld) s. 5A; and *Youth Justice Act 1992* (Qld) general principles.

<sup>126</sup> Convention on the Rights of the Child Article 5, 18; *Child Protection Act 1999* (Qld) s. 4; and *Youth Justice Act 1992* (Qld) s. 5B.

<sup>127</sup> Convention on the Rights of the Child Article 8, 30; *Child Protection Act 1999* (Qld) s. 4; and *Youth Justice Act 1992* (Qld) s. 5C.

<sup>128</sup> *Child Protection Act 1999* (Qld) s. 10, a child is in needs of protection due to having suffered harm, or being at an unacceptable risk of suffering harm, and without a parent who is willing or able to protect the child from such harm.

<sup>129</sup> *Youth Justice Act 1992* (Qld) s. 150(a).

<sup>130</sup> Research, data, and evidence given to the Commission of Inquiry into the Queensland Child Safety System shows that only a minority of children received health assessments and planning in accordance with “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*”, and very few in a timely manner. For example, see evidence of Dr Marnie Fraser, Staff Specialist, Paediatrics (Cairns and Hinterland Hospital and Health Service) at the Far North Queensland Public Hearings on 26 September 2025; and McLean, K., Hiscock, H., and Goldfeld, Timeliness and extent of health service use by Victorian (Australian) children within first year after entry to out-of-home care: Retrospective data linkage cohort study, *Child and Youth Services Review* 134 (2022) 106359.

their education, and operational and decision-making processes do not consistently support children to both express their views and have them taken seriously.

Embedding a rights-based approach in the policy and day-to-day operational practices in Queensland Child Safety System will improve outcomes for children and promote stronger participation in decisions that affect their lives.

**Child rights must be realised in practice, not confined to legislation. Embedding and enlivening child rights in the operational processes and practices of the Queensland Child Safety System will improve outcomes for children.**

<b>17. Embed the Convention on the Rights of the Child into the Queensland Child Safety System policy and operational processes and practices.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• The United Nations Convention on the Rights of the Child is the principal instrument setting out the human rights of children.</li> <li>• Australia has ratified the Convention and child protection legislation and policy must align with its principles.</li> <li>• Failing to embed the rights of the child in the Queensland Child Safety System has a tangible impact on the experiences and outcomes for children.</li> </ul>
<b>Proposed Reform Actions</b>	<p>17.1 The <b>Child Safety Department</b> review its policy, practices, models or care (new and existing) to reflect, enliven and the rights of the child embed and enliven the Convention on the Rights of the Child into its operational policy, practice and day-to-day decision making;</p> <ol style="list-style-type: none"> <li>a. embed and enliven the Convention on the Rights of the Child into its operational policy, practice and day-to-day decision making;</li> <li>b. develop a framework supported metrics and process for quantitative and qualitative data collection, to measure compliance with the Convention on the Rights of the Child and to identify improvement opportunities to enliven child rights; and</li> <li>c. publicly report annually on compliance with the Convention on the Rights of the Child against the reporting framework and metrics.</li> </ol>

## Any reforms to ensure that Queensland’s child protection system achieves the best possible outcomes to protect children and support families: Child Safety Inquiry, Term of Reference 5(f):

*Any reforms to ensure that Queensland’s child protection system achieves the best possible outcomes to protect children and support families. Reform outlined in this section include addressing critical gaps in the Carmody Inquiry Report recommendations*

## Child Safety System Enablers

The Carmody Inquiry recommendations focused heavily on structural redesign of the Child Safety system and associated accountability and governance mechanisms. However, a broader suite of Child Safety system enablers is critical.

System enablers provide actionable intelligence. They enable a comprehensive understanding of system demand, what practices and interventions work, where, when and for whom. In their absence, the Child Safety Department cannot know if it is efficiently allocating its resources, whether its resources are sufficient, whether outcomes are being achieved, or provide an evidence base to seek increased funding.

Good quantitative and qualitative data, evidence, research and evaluation are essential to provide insights into the needs, experiences and outcomes of children and families. It enables high-quality decision making about what works for children and families, the quality of practice, and which services are most effective.

A key pillar of child protection reform agendas across Australian jurisdictions have included, as a priority focus and investment pillar, building contemporary system enablers and embedding them into business-as-usual work to enable continuous improvement.<sup>131</sup>

The suite of critical system enablers that the Queensland Child Safety system would significantly benefit from include:

- **Minimum data set for the care system:** a minimum data set is a standardised set of essential data elements to consistently collect across the care system to enable reliable monitoring, comparison and reporting. Minimum data sets define the core information that must be gathered - such as demographics, service use, outcomes and key indicators - ensuring consistency in how data is recorded and interpreted across different providers or regions. By focusing on a concise but meaningful set of variables, a minimum data set reduces reporting burden while still providing sufficient information to track performance, identify trends, support evaluation, and inform policy and service improvement.
- **Surveys of children (age appropriate), parents, carers and workers:** independent experts engaged to create and undertake surveys, with a clear baseline year to enable tracking of change over time, combining both quantitative measures (scaled responses, outcome indicators) and qualitative insights (open-ended responses capturing lived experience) to provide depth and

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<sup>131</sup> For example. The Victorian [“Roadmap for Reform: strong families, safe children”](#) 2016 and [“Road for Before: children and families, Progress and directions 2018”](#); New South Wales [“Reform plan: transforming the out-of-home care system in NSW”](#) February 2025, and in South Australia [“Roadmap for Reforming the Child and Family Support System”](#) (2021-2023). The New South Wales [“Reform plan: transforming the out-of-home care system in NSW”](#), three of the eight reform directions are *“increasing service quality”* including through rigorous program evaluations; *“improving oversight and accountability”* and *“delivering value for money”*.

The South Australia [“Roadmap for Reforming the Child and Family Support System \(2021-2023\)”](#), which outlines priorities and actions to create a connected, evidence-informed service system that is able to work earlier and more effectively with families, for improved outcomes. To ensure the best possible outcomes for children and families, South Australia continually collects and analyses data, engages with people with lived experience, monitors progress and effectiveness and builds capacity, see [dhs.sa.gov/how-we-help/child-family-support-system-cfss/roadmap-for-reform](https://dhs.sa.gov/how-we-help/child-family-support-system-cfss/roadmap-for-reform). Further, South Australia’s Roadmap for Reforming the Child and Family Support System, Priority 4: Building Evidence, identifies: voice and data for system improvement and service outcomes; outcomes hierarchy; Aboriginal outcomes tool; voices of the workforce and leaders; enhanced data capture, evaluation; and data linkage, information sharing and reporting.

context. Surveys should prioritise inclusive methods to reach hard-to-reach populations -such as culturally appropriate engagement, multiple delivery modes (online, face-to-face, outreach), and partnerships with trusted community organisations - to ensure the data reflects those most affected. Surveys should incorporate validated measures<sup>132</sup> to strengthen reliability and comparability, while remaining accessible and relevant to the target group. This approach ensures the data is credible, representative and capable of informing meaningful system improvement.

- **Longitudinal studies:** For example, in 2009 New South Wales commissioned the Pathways of Care Longitudinal Study (**POCLS**) of the trajectories of children in care that explicitly link administrative data with surveys and assessment data enabling for a cross-system analysis and generating an evidence base to inform policy, system, practice and resources allocation.<sup>133</sup> The POCLS is funded by the Department of Communities and Justice with research partners including the University of New South Wales. The POLCS continues to this day.
- **Data linkage mapping:** For example, Victoria<sup>134</sup>, New South Wales<sup>135</sup>, South Australia<sup>136</sup>, and the Northern Territory<sup>137</sup> have securely matched multiple administrative datasets, such as child protection, health, education, housing, justice, so that outcomes and services interactions can be analysed across government service system while protecting privacy. Linked data enables identification and evaluation of services pathways, early indicators of escalation, effectiveness of interventions.
- **Research and evaluation strategies:** For example, in Victoria as part of the Roadmap for Reform, the “Children and Families Research Strategy 2017-2019”<sup>138</sup> supported the reform agenda to enable a learning system where outcomes are measured and services are continually re-evaluated, refined and improved. This included the development and publicly available Menu of Evidence<sup>139</sup> that provides searcher and independent information on evidence-based practices and programs that have been demonstrated to improve outcomes for children, young people and families experiencing vulnerability.
- **Systematically capture and report on leading indicators:** For example, leading indicators could include: the percentage of families who received a family support services prior to a child entering care (a predictor of preventing entries into care); the time between a referral and the

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<sup>132</sup> A validated measure is a survey tool or instrument that has been rigorously tested to ensure it accurately and consistently and reliability measures what it is intended to measure (i.e. it has demonstrated validity as it captures the concept, such as wellbeing or satisfaction). Validated measures are typically developed through research, tested with target populations, and often peer-reviewed, allowing results to be compared across programs, regions or time. Using validated measures strengthens confidence in the data and enables findings to be used to inform policy, evaluation and system improvement.

<sup>133</sup> In New South Wales, the Pathways of Care Longitudinal Study (**POCLS**) of children and young people in care was commissioned by the Department of Communities and Justice to examine the development, health, education and wellbeing trajectories of children entering care, identify risk and protective factors associated with placement stability, permanency, reunification and long term-outcomes, provide evidence to guide system reform, early intervention investment and corporate parenting responsibilities. The POCLS was commenced

<sup>134</sup> Victorian Centre for Data Linkages [vahi.vic.gov.au/ourwork/data-linkage](http://vahi.vic.gov.au/ourwork/data-linkage).

<sup>135</sup> “*Forecasting Future Outcomes, Stronger Communities Investment – Unit 2018 Insights Report*”

<sup>136</sup> Australia’s “BEBOLD”, BetterStart Group ([health.Adelaide.edu.au/betterstart/bebold](http://health.Adelaide.edu.au/betterstart/bebold)),

<sup>137</sup> SA NT DataLink <https://www.santdatalink.org.au/>

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[https://www.dffh.vic.gov.au/sites/default/files/documents/202109/Children\\_and\\_families\\_research\\_strategy\\_2017\\_to\\_2019.pdf](https://www.dffh.vic.gov.au/sites/default/files/documents/202109/Children_and_families_research_strategy_2017_to_2019.pdf)

<sup>139</sup> <https://menu.dffh.vic.gov.au/>

commencement of a service/intervention (demonstrating system responsiveness and prevention before families escalate into crisis); the percentage of voluntary participation by families in support services (an indicator of accessibility, cultural safety and/or level of trust, which allows for a deeper dive into why families are not participating instead of labelling them as failing to engage in services).

- **Engaging in the development and using Living Evidence Guidelines:** Professor Bromfield and the Australian Centre for Child Protection are working to develop Living Evidence Guidance. The Living Evidence Guidance is intended to provide concrete practical guidance for policymakers and practitioners on foundational evidence, inclusive of key statistics, plain language evidence summaries, and strategically identify gaps in evidence and services. The Living Evidence Guidance will be updated as new evidence and data become available and is proposed to be available through an open-access web-based resource. Jurisdictional implementation support will be made available on a fee-for-service basis.

Investing in Child Safety system enablers will facilitate greater and more timely public reporting aligned to the intent of Professor Coaldrake AO report *“Let the sunshine in, Review of culture and accountability in the Queensland Public Sector, Final Report”*, 28 June 2022 (the **Coaldrake Report**).<sup>140</sup>

The Coaldrake Report aspired to influence a cultural shift in the Queensland public sector to encourage openness from the top, and a resulting shared focus on identifying and dealing with challenges facing the State of Queensland.<sup>141</sup> Many of the recommendations in the Coaldrake Report focused on the need for the public to have a *“better line of sight of how government works, how decisions are made, how agencies and indeed ministerial offices perform, as a basis for both trust in government, and for the improvement of systems of accountability and integrity, as well as service delivery”*.<sup>142</sup>

<b>18. Establish contemporary system enablers and embed them into business-as-usual work to enable continuous improvement.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Queensland’s Child Safety system has limited system enablers. This limits its ability to understand what is working (or not), for whom, when, where, and to effectively and efficiently allocate resources and seek new funding, with an evidence base in support.</li> <li>• Limited system enablers result in missed opportunities to systematically hear the voice of children and families and incorporate their experiences, trajectories and outcomes to support continuous improvement, system design and operational work.</li> <li>• System enablers:               <ul style="list-style-type: none"> <li>○ deliver actionable intelligence to inform policy, practice, resources and budget allocation;</li> <li>○ provide an understanding of what practices and interventions work, for whom, when, and where;</li> <li>○ identify key risk and protective factors;</li> <li>○ enable the effectiveness, trajectories and outcomes for clients from new and existing practices and interventions to be evaluated and measured; and</li> </ul> </li> </ul>

<sup>140</sup> Professor Peter Coaldrake AO, *“Let the sunshine in, Review of culture and accountability in the Queensland Public Sector Final Report”*, 28 June 2022.

<sup>141</sup> Professor Peter Coaldrake AO, *“Let the sunshine in, Review of culture and accountability in the Queensland Public Sector Final Report”*, 28 June 2022, page 2.

<sup>142</sup> Page 89.

	<ul style="list-style-type: none"> <li>○ provide for the systematic capture of client voice, experience and feedback, through validated regular survey tools and interviews.</li> </ul>
<p><b>Proposed Reform Actions</b></p>	<p>18.1 The <b>Child Safety Department</b>, with the support of other government departments, independent experts and researchers, peak bodies, child and family services non-government and community-controlled organisations providers, and cultural knowledge holders, design, establish and embed in its business-as-usual activities and public reporting, a series of system enablers to allow for actionable intelligence to be gathered and inform policy, practice, resources and budget allocation, and public reporting. These enablers should include:</p> <ol style="list-style-type: none"> <li>a. A minimum data set for the care system with annually public reporting.</li> <li>b. Annual surveys of children (age appropriate), parents, carers and workers that are designed, undertaken and analysed by independent experts, with a clear baseline year to enable tracking of change over time, combining both quantitative measures and qualitative insights to provide depth and context. Surveys should priorities inclusive methods to reach hard-to-reach populations.</li> <li>c. Commissioning a longitudinal care study, with a mixed method approach combining quantitative<sup>143</sup> and qualitative<sup>144</sup> data, to better understand the experiences and trajectories of children in care.</li> <li>d. Developing a data linkage map, with datasets such as child protection, health, education, housing, justice, to support the identification and evaluation (for example) of services pathways, early indicators of escalation, effectiveness of interventions.</li> <li>e. Making the data linkage map available, with appropriate protections, to researchers and relevant parties to inform research and analytical work aimed at improving outcomes for children.</li> <li>f. Developing and implementing an ongoing research and evaluation strategy for existing and new practices, interventions, models of care, which includes independent evaluations and making them publicly available.</li> <li>g. Engaging in the development and incorporating of best practice evidence of what works. Including investigating the feasibility of a collaboration with the Australian Centre for Child Protection on the design and implementation of the Living Evidence Guidelines.</li> </ol>

<sup>143</sup> Quantitative data is measurable numerical information, such as counts, measurements and averages.

<sup>144</sup> Qualitative data is non-numerical information that describes characteristics, opinions and experiences.

## Funding family services to meet demand and focus on outcomes to reduce Child Safety system demand

One of the three main causes of systemic failure in the Child Safety system identified in the Carmody Inquiry was too little money was spent on early intervention to support vulnerable families.

The Carmody report identified that family services were more productive and less stigmatising and traumatising than investigative intervention.<sup>145</sup> Further that family support services were not only critically needed, but that they must be **accessible** and **adequately resourced**.<sup>146</sup>

Consistent with the Carmody Inquiry recommendations, programs to support families earlier have been introduced or expanded including:

- Aboriginal and Torres Strait Islander Family Wellbeing Services (**FWS**): to support families experiencing vulnerability and challenges, with the aim of strengthening families, improving child safety and reducing involvement in the Child Safety system.
- Intensive Family Support (**IFS**): providing tailored, case-management support for families with complex needs to prevent children from entering the child protection system.
- Family Participation Program (**FPP**): supporting Aboriginal and Torres Strait Islander family-led decision-making, about the safety, care and wellbeing of their children when the Child Safety system becomes involved.
- Family and Child Connect (**FaCC**): connecting families to a support service that suits their needs.
- Extended Post Care Support: for young adults transitioning from care until 25 years of age.

Child Safety can refer Child Concern Reports to a family support service when a child is not in need of protection, and the family could benefit from additional supports. Child Safety does not require the consent of the family to make the referral. Families can self-refer. Referrals can also be made by government, non-government organisations and community members with the family's consent.

The effectiveness of family services in reducing the progression of children to the statutory children protection system is evident in the available evaluations, data and evidence<sup>147</sup> provided in the Child Safety Inquiry public hearings, for example:

- An evaluation of 33 FWS services across Queensland found that program contributed to reducing children progress into statutory child protection and foster cultural connection and healing.<sup>148</sup>
- QATSI CCP's August 2025 submission to the Child Safety Inquiry reported that the 35 community-controlled organisations delivering FWS, 55 per cent of families had all or most of their needs met and over 90 percent of children avoided reinvestigation by Child Safety within six months of service exit.<sup>149</sup>

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<sup>145</sup> Carmody report, pg xiii.

<sup>146</sup> Carmody Report, pg xi.

<sup>147</sup> For example, see Commission of Inquiry into the Queensland Child Safety System, Toowoomba Public Hearings, 26 February 2026, evidence of Mr Trent Adams, Deputy CEO, Goolburri Aboriginal Health Advancement, at transcript pg 4655

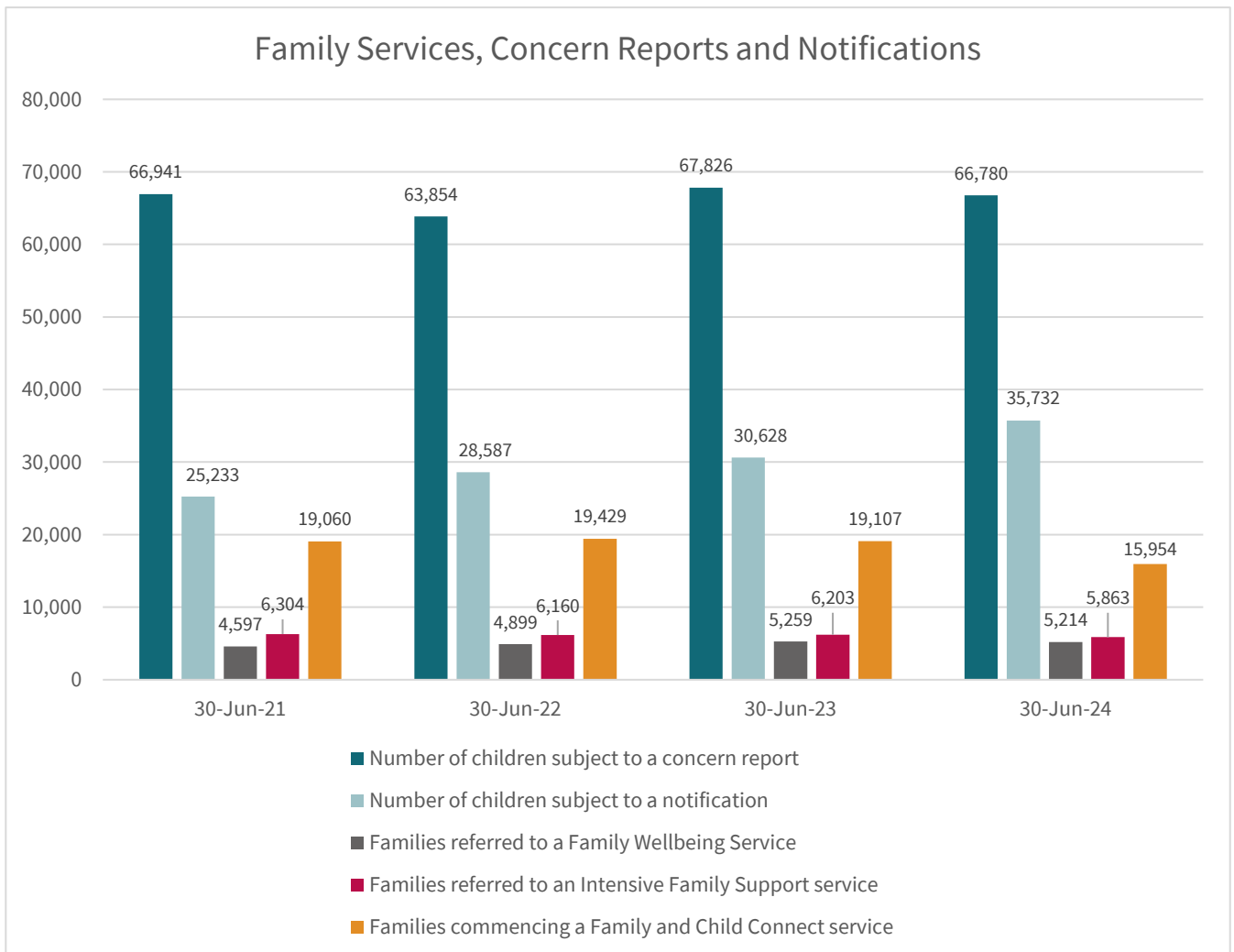
<sup>148</sup> See Abt, Evaluation of Indigenous Family Wellbeing Services, <https://www.abtglobal.com/projects/evaluation-of-indigenous-family-wellbeing-services>; and Queensland Aboriginal and Torres Strait Island Peak, Response to call for submissions re: Far North Queensland (Child Safety Commission of Inquiry), August 2025, pg 5, [20250811-CPCOI\\_FNQ-FINAL.pdf](#).

<sup>149</sup> Queensland Aboriginal and Torres Strait Island Peak, Response to call for submissions re: Far North Queensland (Child Safety Commission of Inquiry), August 2025, pg 5, [20250811-CPCOI\\_FNQ-FINAL.pdf](#).

- The Child Safety Department’s Our Performance Dashboard reporting show 88 per cent of families who received a FWS were not the subject of a notification in the six months after the case was closed.
- In 2023-24, FWS supported 5,135 families to build their own parenting capacity.<sup>150</sup>

However, the number of families needing family services is exceeding the service capacity and funding. This results in family services being rationed, problems escalate and become more entrenched, and the optimal window for effective and early interventions is lost.

In the absence of demand modelling, demand indicators suggest that the scale of investment in family services is significantly lower than these signals indicate. Between 1 April 2024 and 31 March 2025, the Child Safety Department received 142,826 intakes (a 24 percent increase since March 2015). Of these 98,643 were Child Concern Reports and 44,183 Child Protection Notifications.<sup>151</sup>



The Child Safety Department’s Our Performance Dashboard reporting shows that in 2024 102,512 children were subject to either a concern report or a notification. However just 27,031 families (approximately 26 per cent) were referred to a FWS, IFS or commenced a FaCC service. Queensland has

<sup>150</sup> Family Matters Report 2025, SNAICC, pg 107.

<sup>151</sup> Child Safety Inquiry, Proactive Statement, No. 1, Belinda Drew, Director-General, Department of Families, Seniors, Disability Services and Child Safety, 3 September 2025, paragraph 27.

the second lowest proportion of expenditure on family support and intensive family support services in Australia.<sup>152</sup>

In respect of FWS and FPP, community-controlled organisations report:

- under-resourcing to manage the demands;
- struggling to meet the rising referrals; and
- inconsistent practices across Child Safety Departmental regions, with some regions having strong partnership while other regions fail to provide critical information.<sup>153</sup>

Service providers report missed opportunities to provide support or in a timely way when Child Safety fails to refer families, or families are either not referred in a timely way or limited information is provided to assist with understanding the reported concerns or family challenges.<sup>154</sup>

Improving the number of families engaging in early intervention and prevention services would strengthen communities and reduce the demand on the Child Safety system.

<b>19. Invest in meeting demand for family services to reduce the progression of children into and the demand on the Child Safety system.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Queensland has the second lowest proportion of expenditure on family support and intensive family support services in Australia.<sup>155</sup></li> <li>• Demand modelling (state-wide, regional, or for priority cohorts) is not available to forecast, plan, build workforce capability, or seek additional investment to meet the need for early intervention and prevention services to support families.</li> <li>• Demand indicators (Child Concern Reports, Notifications, care numbers) indicate that early intervention and prevention services to support families are significantly underfunded to operate at a sufficient scale to both meet and reduce the demand in the Child Safety system.</li> </ul>
<b>Proposed Reform Actions</b>	<p>19.1 The <b>Child Safety Department:</b></p> <ol style="list-style-type: none"> <li>develop a demand model for state-wide and regional Family Support Services demand within 12 months;</li> <li>invest in ongoing support for infrastructure and training to non-government and community-controlled organisational providers of Family Support Services, to enable consistent and contemporaneous data capture;</li> <li>monthly public reporting on demand for state-wide and regional Family Support Services;</li> <li>fund non-government and community-controlled organisations to meet the demand for Family Wellbeing Services; and</li> <li>commission an independent evaluation within 12 months of Family Support Services, with measurements focused on tangible outcomes for</li> </ol>

<sup>152</sup> Family Matters Report 2025, SNAICC, pg 12.

<sup>153</sup> Family Matters Report 2025, SNAICC, pg 107.

<sup>154</sup> For example: Queensland Aboriginal and Torres Strait Island Peak, Response to call for submissions re: Far North Queensland (Child Safety Commission of Inquiry), August 2025, pg 5, [20250811-CPCOI\\_FNQ-FINAL.pdf](#); Commission of Inquiry into the Queensland Child Safety System, Toowoomba Public Hearings, evidence of Mr Trent Adams, Deputy CEO, Goolburri Aboriginal Health Advancement, at transcript pages 4655, 4673

<sup>155</sup> Family Matters Report 2025, SNAICC, pg 12.

	children and families and an evaluation process that is consistent with Aboriginal and Torres Strait Islander values and priorities for what is measured.
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## Designing a fit for purpose and contemporary Child Safety system

The purposes of the Child Protection Act is to provide for the protection of children, to promote the safety of children, and to the extent that it is appropriate, support families caring for children.

However, the evidence is extensive and unequivocal, the more a child or family is known to the Child Safety system the worse their outcomes are.<sup>156</sup>

Demand in Child Safety systems across Australia and internationally is unrelenting, regardless of increases in resources (qualified by the unique over reliance on residential care in Queensland). The growth in Child Safety in Queensland is a systemic failure, not the failure on any one part of the system.

Child Safety systems were designed in the 1960s to respond to low prevalence and high severity physical abuse by a parent, known as ‘battered child syndrome’.<sup>157</sup> Child Safety systems are tertiary service systems, providing for reporting, investigation of harm that has been perpetrated, and management of the risk of future harm to children. However, since the 1960s:

- the definition of child abuse has significantly expanded to include neglect, sexual and emotional abuse;
- mandatory reporting has been introduced;
- public awareness of child abuse and neglect has increased;
- the landmark Australia Child Maltreatment Study found that prevalence of abuse is high, with 61 per cent of young Australians experiencing one type of abuse or neglect (physical, sexual, or emotional abuse, neglect, or domestic violence). Moreover, one in four young Australians have experienced three to four types of abuse or neglect;<sup>158</sup>
- challenges experienced by families, such as domestic and family violence, substance misuse, mental health concerns, housing insecurity, and poverty, increase the risk of child maltreatment and harm.<sup>159</sup>

Child safety statutory interventions have become intertwined with families struggling with multiple challenges, intergenerational trauma, and disadvantage. The Child Safety system responds to these families by acting as designed, as a tertiary service system with statutory powers. However, it does so for a population and a level of demand it was never designed for. Consequently, Child Safety systems continue to experience unrelenting demand and concurrently fail to:

- reduce the prevalence of child maltreatment;
- encourage families to seek help before they escalate in crisis, often due fears of their children being removed and/or because of their own childhood experiences of Child Safety;

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<sup>156</sup> Prof. Leah Bromfield.

<sup>157</sup> A clinical condition in children where a carer gives inflicted serious physical harm.

<sup>158</sup> Australian Child Maltreatment Study.

<sup>159</sup> Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., “*Advancing a prevention-oriented support system for the health and safety of children*”, Children and Youth Services Review 159 (2024) 107521, pg 1.

- provide warm referrals and facilitate holistic responses to timely, available, effective, and culturally safe early interventions services and support;
- disrupt intergenerational disadvantage;
- address the over-representation of Aboriginal and Torres Strait Islander children and families at every stage of the system; or
- treat cumulative harm and trauma experienced by children prior to entry to care.

Nationally and internationally, there is a growing consensus of the need for genuine transformation of the approach of Child Safety systems. In Australia, work to develop an alternative approach to Child Safety is being led by Professor Leah Bromfield, the Director of the Australian Centre for Child Protection at the University of South Australia. Professor Bromfield is developing a “Blueprint for Child Protection Transformation” comprising of:

- A clearly articulated vision for a transformed approach to child protection, documenting system design, service responses, pathways into and between services, and practice in key areas of health and human service delivery critical to transformation.
- Evidence-based guidance on best practice and change levers in priority areas needed to drive transformation, including “Living Evidence Guidance” that provides clear and concrete guidance, in an implementable form, and is updated as new evidence and data become available.
- Foundational evidence. For example, key statistics, plain language evidence summaries.
- Strategically identifying gaps in evidence and services.

The Queensland Child Safety Department could establish an ongoing engagement with Professor Bromfield and the Australian Centre for Child Protection to benefit and tailor the development of the Living Evidence Guidelines and to progressively develop a contemporary and fit for purposes Child Safety system.

<b>20. Redesign the Queensland Child Safety System to be contemporary and fit for purpose.</b>	
<b>Key Observations</b>	<ul style="list-style-type: none"> <li>• Child protection systems were designed in the 1960s to respond to low prevalence and high severity physical abuse.</li> <li>• The definition of child abuse has subsequently expanded to include neglect, sexual and emotional abuse.</li> <li>• 61 per cent of young Australians have experienced one type of abuse or neglect.<sup>160</sup> Community awareness of abuse has increased and mandatory reporting introduced.</li> <li>• The largest cohort of children known to child protection are born into families experiencing multiple challenges and disadvantages.</li> <li>• In the absence of system redesign, the Queensland Child Safety system will continue to experience unrelenting demand, regardless of further resourcing.</li> </ul>
<b>Proposed Reform Actions</b>	<p>20.1The <b>Queensland Child Safety Department:</b></p> <ol style="list-style-type: none"> <li>a. commence an evidence-based redesign process to develop a contemporary, effective and efficient, child protection system with</li> </ol>

<sup>160</sup> Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>.

	<p>independent experts, researchers, children and families with lived system experience, non-government and community-controlled organisations, peak bodies, cultural knowledge holders and system partners; and</p> <p>b. investigate the feasibility on an ongoing engagement with Professor Bromfield and Australian Centre for Child Protection, to collaborate on developing a contemporary and a fit for purpose Child Safety system.</p>
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## A whole-of-Queensland Government commitment and approach to prevent child maltreatment overseen by a new Minister for Children

The demand in the Queensland Child Safety system is driven by the prevalence of child maltreatment. However, the prevention of child maltreatment, addressing its impacts and preventing intergenerational transmission, is within the remit and expertise of the health, mental health, education, alcohol and other drug, housing and other government services that alleviate disadvantage and support children and families to heal and be resilient, healthy and well.

**“The social, economic and health conditions that underline child maltreatment are powerful, multi-dimensional and often chronic – domestic violence, poverty, mental illness.”**

Jeanne Brooks-Gunn, *Do You Believe in Magic? What we Can Expect from Early Childhood Intervention Programs*

### The definition of Child Maltreatment

Child maltreatment refers to acts or omissions by a parent, care giver or person with parental responsibility for a child that results in harm or the risk of harm to a child. The Australian Child Maltreatment Study defines child maltreatment as physical abuse, sexual abuse, emotional abuse, neglect, and exposure to family and domestic violence.<sup>161</sup>

Child maltreatment includes single events, multiple events and chronic patterns. It can cause significant lifelong impacts on the health and wellbeing of a child or young person and entrench intergenerational experiences of maltreatment.

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<sup>161</sup> Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>

## The prevalence of child maltreatment in Australia

The prevalence of childhood maltreatment is known from the Australian Child Maltreatment Study.<sup>162</sup> It found that 61 per cent of Australians had experienced one type of child maltreatment and one in four had experienced three to four types.<sup>163</sup>

For children and young people in care, the Australian Child Maltreatment Study found the prevalence of child maltreatment was significantly higher and more intense than in the general population. Children and young people in care reported more types of maltreatment, more frequent exposure, earlier onset, longer duration, and more perpetrators than their peers.<sup>164</sup>

## The impact of child maltreatment

Child maltreatment contributes to mental health conditions and <sup>165</sup> causes cumulative harm<sup>166</sup> to children. Cumulative harm is caused by the compounding impact of ongoing and/or multiple experiences of child maltreatment.

The impacts of child maltreatment are long-term, intergenerational and result in increased health costs and lost productivity to the broader Queensland community.<sup>167</sup>

## The experiences of children and families experiencing multiple challenges

Parental mental ill-health, alcohol and other drug issues, housing insecurity and poverty do not cause child maltreatment, but they do increase the risk.<sup>168</sup>

Child maltreatment is the driver of demand in the Child Safety system.<sup>169</sup> However, the Child Safety system's remit is to investigate discrete events of harm that have already been perpetrated, intervene after harm has occurred and manage the risk of future harm. Moreover, the Child Safety Department's

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<sup>162</sup> The Australian Child Maltreatment Study found prevalence rates of maltreatment among people aged 16 to 24 included: 28.2 per cent experienced physical abuse; 25.7 per cent experienced sexual abuse; 34.6 per cent experienced emotional abuse; 10.3 per cent experienced neglect; and 43.8 per cent experienced exposure to domestic violence.

<sup>163</sup> Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>, pg 3.

<sup>164</sup> Harris LG, Higgins DJ, Willis ML, Lawrence D, Meinck F, Thomas HJ, Malacova E, Scott JG, Pacella R, Haslam DM, "Dimensions of child maltreatment in Australians with a history of out-of-home care. *Child Maltreatment*" 2025 August, 30(3):525-39.

<sup>165</sup> Grummitt, L., Baldwin, J. R., Lafoa'l J., Keyes, K. M., Barrett, E, "Burden of Mental Disorders and Suicide Attributable to Childhood Maltreatment", *JAMA Psychiatry*, 2024;81(8):782-788. doi:10.1001/jamapsychiatry.2024.0804, published online May 8, 2024.

<sup>166</sup> Harris LG, Rattambige D, Hunt GR, Higgins DJ, "Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters", *Current Opinion in Psychology*, <https://doi.org/10.1016/j.copsyc.2025.102260>.

<sup>167</sup> Dai Quy Le, Long Khanh-Dao Le, Marie Bee Hui Yap, Divna M. Haslam, Daryl J. Higgin, Eva Malacova, James G. Scott, David Lawrence, Ben Mathews, Cathrine Mihalopoulos, "Impact of child maltreatment on the costs of health service use and productivity loss: Findings from the Australian child maltreatment study", *Child Abuse & Neglect* 171 (2026) 107818.

<sup>168</sup> Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., "Advancing a prevention-oriented support system for the health and safety of children", *Children and Youth Services Review* 159 (2024) 107521, pages 1-2.

<sup>169</sup> Jones, L., Harris, J., Abdelgawad, M., Booth-Rosamond, A., Smith, E., McCoy, E., Ashworth, E., Quigg, Z, "A mixed-method systemic review. Parenting and whole-of-family interventions for families with multiple & complex needs with children & young people 11 to 19", *Foundations*, What Works Centre for Children and Families, December 2025, [foundations.org.uk](https://foundations.org.uk), pg 14.

mandate and funding does not extend to preventing child maltreatment; nor to ensuring that a parent receives a timely and effective mental health or alcohol or other drug intervention and/or housing to reduce the risk of child maltreatment.<sup>170</sup>

Families need a range of services across multiple government agencies to address their challenges and reduce the risks of child maltreatment. However, families experiencing multiple challenges can struggle to access and navigate multiple services systems and can find themselves on *referral roundabouts*.

This situation is exacerbated when services retreat as families are seen as *unwilling or failing to engage*, without services seeking to understand or address barriers to engagement - such as transport, culture safety, fear and financial difficulties.

### **A whole-of-Queensland Government approach to child maltreatment prevention**

The prevention of child abuse and neglect is a core function of the primary health care and early childhood systems. These systems provide primary health care and universal community supports and services in non-stigmatising infrastructure. The primary health care and early childhood systems can identify and provide supports and referrals to interventions that address the root causes of child maltreatment – such as mental health and substance use treatments, secure housing, and addressing the impacts of poverty. In contrast, the Child Safety system directs resources in the opposite direction – to statutory interventions and care, and readily funds increasing care placements while directing limited funding towards the prevention of child maltreatment.

### **A Minister for Children to drive coordination and accountability**

The services and supports for children and families that effectively prevent and respond to child maltreatment are provided across a range of portfolios and service systems. To drive coordination and accountability, a new portfolio area and Minister for Children could lead a whole-of-Queensland Government approach to prevent child maltreatment and treat its impacts.

To ensure coordination and accountability a dedicated Minister for Children in Queensland is recommended. A Minister for Children could have oversight and hold accountable all government agencies that provide services to children and families, ensure that they receive early and effective services and intervention, and in turn prevent and reduce child maltreatment.

Moreover, a Minister for Children could be given a mandate to focus on priority populations, cohorts of children and families who are over-represented in the Child Safety system, such as:

- parents with unborn child harm reports;
- young parents (under 20 years of age);
- parents with a care experience; and
- children transitioning from care or youth detention to independent adulthood.

**21. Establish a whole-of-government commitment to reducing child maltreatment and a Minister for Children to oversee and hold accountable all government agencies providing services and interventions to children and their families.**

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<sup>170</sup> Collier, S. and I. Bryce, *Addressing cumulative harm: responding to chronic child maltreatment in the context of an intensive family support service*. Journal of Children's Services, 2021. **16**(3): p. 249–266. Harris LG, Rattambige D, Hunt GR, Higgins DJ, “*Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters*”, Current Opinion in Psychology, <https://doi.org/10.1016/j.copsyc.2025.102260>.

<p><b>Key Observations</b></p>	<ul style="list-style-type: none"> <li>• The prevention of child abuse and neglect is a core function of the primary health care and early childhood systems.</li> <li>• The Child Safety system’s remit and funding is after harm has occurred to children. Services such as health and mental health are critical to prevent and reduce child maltreatment.</li> <li>• There is no oversight and accountability across multiple ministerial portfolios and government departments to provide timely and effective services to children and their families with the aim of reducing the risk of child maltreatment or to provide priority services to vulnerable children and families who are over represented in the Child Safety system.</li> </ul>
<p><b>Proposed Reform Actions</b></p>	<p>21.1 The <b>Queensland Government</b> establish a dedicated Ministry for Children with a mandate to:</p> <ol style="list-style-type: none"> <li>a. develop, implement and hold government portfolios accountable for a whole-of-Queensland Government Child Maltreatment Prevention Framework;</li> <li>b. have a dedicated focus on improving and holding accountable service delivery and integration for children in families experiencing multiple challenges and intergenerational disadvantage, that are over-represented in the Child Safety system - and other government service systems; and</li> <li>c. report on whole-of-Queensland government services delivery and outcomes for vulnerable children and families across portfolio areas.</li> </ol>

## Monitoring implementation and the effectiveness of reform

Arguably many of the Carmody Report recommendations were not fully implemented or their intent realised.

Jurisdictions in Australia have established statutory implementation monitors, who report directly to parliament on implementation progress of major reforms. The role has no other system function or interest outside of monitoring and reporting. An implementation monitor’s role is to track, evaluate and publicly report on progress, not simply whether recommendations are completed, but whether they are genuinely improving outcomes for children.

For example, following the Commission of Inquiry into the Tasmanian Government’s Response to Child Sexual Abuse in Institutional Settings, a statutory oversight role known as the *Child Safety Reform Implementation Monitor* was established by the *Child Safety Reform Implementation Monitor Act (2024)* (Tas).

<p><b>22. Establish an independent statutory implementation monitor</b></p>	
<p><b>Key Observations</b></p>	<ul style="list-style-type: none"> <li>• Independent implementation monitors have been established across multiple jurisdictions to monitor and report on progress in implementing inquiry recommendations.</li> </ul>

	<ul style="list-style-type: none"> <li>• Their roles also include ensuring that the implementation of recommendation is effective and improves the system and outcomes it delivers.</li> </ul>
<b>Proposed Reform Actions</b>	22.1 The <b>Queensland Government</b> legislates a new and independent statutory Implementation Monitor to monitor and report annually to parliament on the implementation of the Child Safety Inquiry recommendations and whether they are improving outcomes for children and families.

**“The 2025–26 Anastassiou Inquiry offers a renewed opportunity to strengthen the system so it truly works for children and young people. It is a chance to build on what we know, address persistent challenges, and drive the structural reform needed to ensure every child is safe, supported, and able to thrive. With the right commitment, we can create a system that consistently upholds children’s rights, empowers those who care for them, and delivers the outcomes every child deserves.”**

- *Estelle Abela, PeakCare Chief Executive Officer*

# Attachment 1 – PeakCare Consultation Summary 2024-2026

As part of its role, PeakCare regularly undertakes both formal and informal consultation, engagement and discussions with its members, non-government and community-controlled organisations, workers in the child and family services sector, peak bodies, researchers, cultural knowledge holders and experts. These regular engagements over many years are reflected in this Submission. A high-level overview of PeakCare’s recent formal consultations is summarised below. Key findings and insights of this consultation effort can be found on Peak Care’s website publications page.<sup>171</sup>

## Catalyst for Care Program 2024–2026

### Workforce Strategy consultation:

- 153 Queensland providers contacted (statewide outreach; every provider invited)
- 115+ stakeholder engagements
- 350 residential care workers surveyed
- 80 attendees at the Shaping the Future of the Residential Care Workforce workshop in Brisbane
- 11 regional workshop locations
- 120 regional workshop attendees

### CareCONNECT workforce event:

- 280+ attendees from across Queensland’s residential care sector

### Hope & Healing Modernisation:

- 7 workshops
- 4 testing group meetings and 6 1:1 test meetings

### Masterclass Development:

- 2 workshops
- 7 testing group meetings

## Preventative Peaks Alliance 2025–26

- 5 Queensland workshops (Townsville, Toowoomba, Logan, Mackay, Brisbane)
- 225+ stakeholders engaged across child protection, youth justice, disability, homelessness and housing
- 21 stakeholders engaged in critical friends workshop

## Sector Voices 2024

- 10 Queensland workshops
- 6 individual site visits
- 250+ workshop participants

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<sup>171</sup> Publications, PeakCare Queensland, webpage, accessed 16 March 2026.

# Attachment 2 – PeakCare’s Proposed Queensland Residential Care Workforce Learning & Development Centre

A Queensland **Residential Care Workforce Learning & Development Centre** is proposed to be a PeakCare led initiative in collaboration with the sector and the Child Safety Department.

## Background

Queensland’s residential care workforce is tasked with supporting children and young people displaying the most complex needs in the out-of-home care system. However, the sector currently lacks a coordinated, fit-for-purpose training and development infrastructure to support this role.

Unlike other roles with a high degree of interaction with young people, such as teachers and healthcare professionals, residential care workers often enter the role with minimal training and are expected to manage crisis, trauma, mental health, and behavioural issues from day one.

While some providers offer robust internal programs, access to high-quality, consistent learning is patchy and dependent on organisational resources. This can contribute to workforce instability, low morale, and difficulty attracting and retaining skilled staff. It also limits the capacity of the sector to build a shared practice identity or to incorporate evidence-informed approaches to care.

At a system level, the current approach to learning is minimal, reactive, disjointed and under resourced. Without a central point of leadership or accountability, efforts to lift workforce capability risk being ineffective.

## Aim

The aim is to improve the consistency of quality care to young people in residential care through a central hub for developing, coordinating and delivering workforce learning across Queensland’s residential care system, guided by the voices of young people, practitioners, and cultural leaders.

## Proposed outcomes

The successful outcomes for the Residential Care Workforce Learning & Development Centre:

- Improved quality and consistency of care with an evidence-informed approach to residential care practice embedded across the sector, with workers demonstrating capability in trauma-informed and culturally responsive care.
- Increased workforce retention and stability through structured and accessible learning and development pathways, supported by supervision, coaching, and qualifications. Contributing to higher workforce satisfaction, reduced burnout, and improved staff retention across residential care services.
- Strengthened professional identity and workforce culture through residential care being recognised and valued as a skilled, professional workforce, with workers feeling equipped, supported, and connected to a clear practice identity. This contributes to a shift from a reactive workforce model to a sustainable, career-oriented profession.
- Greater sector cohesion and shared practice through a unified framework for capability, values and practice adopted across government and non-government providers, enabling stronger collaboration and alignment across the residential care system.

## The proposed solution is a sector-owned L&D centre

The Residential Care Workforce Learning & Development Centre is proposed to be designed to deliver the following:

- a. Establish a partnership governance group including representatives from service providers, government, Aboriginal and Torres Strait Islander organisations, young people with lived experience, and workforce educators.
- b. Co-design a sector-wide Learning and Development Framework and Capability Model tailored to the Queensland residential care sector.
  - o Co-design a Residential Care Capability Framework aligned with trauma-informed and culturally safe standards.
  - o Define role-specific capability expectations and progression pathways across the workforce.
  - o Align with existing frameworks including Hope & Healing, the Child Safe Standards and the Human Services Quality Framework.
- c. Design and pilot a structured Learning and Development Pathway for the residential care workforce.
  - o Design a modular Learning and Development Pathway, including induction, foundational, intermediate, and advanced learning streams.
  - o Pilot the Learning and Development Pathway across a representative sample of providers and regions.
  - o Conduct a review of the pilot, including participant feedback and revise the pathway.
- d. Roll out the Learning and Development Pathway across the sector, supported by a combination of online, face-to-face, and place-based delivery models.
  - o Develop and implement a statewide rollout strategy that reflects the scale and diversity of the residential care workforce, including coordination for 500+ learners across metropolitan, regional and remote locations.
  - o Undertake regional needs analysis to identify workforce capability gaps, priority cohorts, delivery preferences, and access barriers (including digital access, travel constraints, and workforce availability).
  - o Work in partnership with local stakeholders, including service providers, Aboriginal and Torres Strait Islander organisations, peak bodies, and regional networks, to tailor delivery approaches to local context and ensure cultural safety and relevance.
  - o Partner with TAFEs, RTOs, universities, and existing providers to accredit and deliver training, avoiding duplication and leveraging existing expertise.
  - o Develop and implement a change management strategy to support sector readiness, including leadership engagement, organisational onboarding, and alignment with existing training requirements.
  - o Deliver a targeted communications and engagement plan to promote the pathway, articulate its value, and support uptake across all levels of the workforce.
  - o Monitor participation, completion rates, and learner feedback in real time to identify gaps in access or engagement and adjust rollout strategies accordingly.

- e. Establish communities of practice, supervision and peer learning structures.
  - o Design and facilitate Communities of Practice across regions and roles.
  - o Develop supervision resources, guidelines, and capability-building tools for supervisors and managers.
  - o Pilot reflective practice groups and peer learning forums.
  - o Embed mentoring and coaching opportunities to support workforce development and retention.
- f. Develop and implement a workforce recognition and credentialing approach
  - o Co-design a credentialing and recognition framework aligned to the capability model and with minimum training requirements.
  - o Partner with education providers to ensure credentials are stackable, transferable, and nationally recognised where possible.
  - o Design and deliver a Residential Care Excellence Awards program to formally recognise outstanding practice, leadership, cultural capability, and innovation across the sector.
  - o Establish a targeted Scholarships and Workforce Development Fund to support learning progression and retention, providing priority access to workers in areas with capability gaps such as Aboriginal and Torres Strait Islander workers.
- g. Establish a monitoring, evaluation and continuous improvement framework.
  - o Develop a monitoring and evaluation framework aligned to workforce and child focused outcome indicators.
  - o Develop tools to assess capability uplift, workforce satisfaction, retention, and practice consistency.
  - o Establish baseline measures of workforce capability, training access, and outcomes.
  - o Use findings to continuously refine learning content and delivery models.

<b>Proposed Deliverable</b>	<b>Description</b>
Learning and Development Framework	A sector-wide framework that defines the core capabilities, practice standards, and progression pathways for the residential care workforce, aligned with trauma-informed, culturally safe, and child-safe approaches.
Learning and Development Pathway	A structured, modular learning pathway covering induction through to advanced practice, tested through pilot delivery and refined based on evaluation and workforce feedback.
Regional Implementation Model	A documented and scalable model for delivering learning across metropolitan, regional and remote contexts, informed by regional needs analysis and local stakeholder engagement.
Delivery on ongoing learning, develop, and facilitation of profession supports to the residential care workforce	Delivery on ongoing learning, develop, and facilitation of professional supports and communities of practice to the residential care workforce across Queensland through online and face-to-face delivery methods.

Proposed Deliverable	Description
Monitoring and Evaluation Framework	Monitoring and Evaluation Framework
Annual Reporting and Insights	An annual report that communicates implementation progress, workforce insights, and system-level impact to stakeholders.

## The proposed solution is a sector-owned L&D centre

A high-level overview of the requirements and resources required for PeakCare to establish, coordinate and deliver the Centre would include:

- Centre Director
- Project Manager
- Workforce Development and Practice Experts (i.e. trauma-informed and cultural capability)
- Aboriginal and Torres Strait Islander cultural advisors and partnerships
- Instructional design and curriculum development expertise
- Partnerships with TAFEs, RTOs and universities for accredited learning delivery
- Development of Learning and Development Framework
- Design and production of training materials, facilitator guides, workbooks, and digital resources
- Establishment of Communities of Practice, supervision resources, and mentoring supports
- Workforce recognition and credentialing system, including scholarships and awards program
- Monitoring and evaluation (baseline, process, and outcome evaluation)
- Data collection, analysis, and reporting on workforce capability, retention, and outcomes
- Communications and engagement strategy, including sector-wide rollout and stakeholder engagement
- Delivery and implementation of training (online, face-to-face, and place-based)
- Administration and coordination support
- Travel and associated expenses, particularly for regional and remote delivery.

# Attachment 3 – PeakCare’s Proposed Residential Care Safety Leadership Program

## Proposed Residential Care Safety Leadership Program

A **Residential Care Safety Leadership Program** is proposed to be a PeakCare led collaboration between the Child Safety Department, WorkSafe Queensland, residential care providers, QATSICPP, residential care workers, young people with a residential care experience, QCFF, and independent experts.

### Background

Residential care workers deserve a working environment and training to support their safety and wellbeing and provide the best possible care to children

Residential care workers encounter complex and volatile situations in residential care houses, and experience WVA directly and as witnesses. Children with behavioural, emotional, mental health and substance abuse issues can escalate into physical assaults on residential care workers and other children. Residential workers in Queensland that have consistently reported serious concerns with WVA in the workplace.<sup>172</sup>

WVA in residential can cause physical, psychological and emotional harm and injuries to workers. It contributes to absenteeism, high staff turnover and Workcover claims. WVA also contributes to placement breakdowns and increased criminalisation of children in care.

WorkSafe Queensland’s publicly available data for WVA in the residential care workforce is not disaggregated from the broader care workforce (aged care and disability workers).<sup>173</sup> From data available in other states, residential care workers experience some of the highest levels of WVA in the social services sector. This results in absenteeism from work, workers compensation claims, and drives up premiums for residential care providers.

### Aim

The aim is to improve the health and safety outcomes of residential care workers by building leadership capability and understanding of strategies to prevent workplace violence and aggression (**WVA**) across the levels of the system and changing cultural attitudes towards WVA.

### Proposed outcomes

The successful outcomes for the Residential Care Safety Leadership Program and how they will be evaluated are:

- Improvement in safety leadership capability and knowledge on WVA prevention across CEOs, Boards, middle management, supervisors and frontline workers. Through surveys – baseline then and annually for three years.
- Improvement in workforce stability in residential care sector. Through employer data – baseline and then and annually for three years.

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<sup>172</sup> For example, PeakCare’s June 2023 workshop with residential care providers and its PeakCare Report “Insights and Opportunities – Queensland Residential Care Workforce”, March 2025.

<sup>173</sup> See Workplace Health and Safety Queensland (2021). [\*Work-related violence and aggression in residential aged, disability and youth care.\*](#)

- Decreases in high severity reported WVA incidents. Through employer data – baseline and then and annually for three years.
- Decreases in WorkSafe response visits and WVA related claims. Employer and WorkSafe baseline and then and annually for three years.

## Co-designed for the Queensland Residential Care Sector with Safety Leadership Expertise

The Residential Care Safety Leadership Program is proposed to be co-designed with an independently engaged Safety Leadership Expert to deliver the following:

- Co-design a multi-level leadership capability and WVA prevention framework tailored to the Queensland residential care sector. This framework will identify the capabilities and strategies that are required to create a psychologically safe workplace and prevent WVA at each level of the system, including CEOs, Executive Leadership Teams (ELT), Boards, Managers, Supervisors.
- Design, pilot and rollout a Leadership Program to build safety leadership capability and WVA knowledge across the levels of the system. The program will include tailored modules for: CEOs, ELT, Boards; and Middle Management, Supervisors. This will involve:
  - Design a Safety Leadership Program with tailored modules for CEOs, ELT, Boards; and management, supervisors.
  - Pilot the Safety Leadership Program with CEOs, ELT, Boards; and management, supervisors. The program will be revised based on the findings from a process evaluation.
  - Roll out the Safety Leadership Program across the sector with CEOs, ELT, Boards; management, supervisors.
- Design, pilot and roll out an WVA Prevention Program for frontline workers to change cultural attitudes towards WVA and build practical strategies and skills.
  - Design WVA Prevention Program.
  - Pilot the WVA Prevention Program with frontline workers (cross provider and region representation).
  - Revised based on the findings from a process evaluation.
  - Roll out the WVA Prevention Program to frontline workers across the residential sector. Combination of on-line training and face-to-face practical application.
  - A process evaluation will be conducted.
- Evaluate the impact of the program on leading (perceptions of safety culture and leadership capabilities, workforce stability) and lagging indicators of safety (reported WVA incidents, WorkSafe Queensland response visits).
  - Development of tailored safety leadership capability surveys based on the framework;
  - Develop a plan to monitor and evaluate the impact of the program on leading and lagging indicators of safety;
  - Baseline evaluation of current state of leading and lagging indicators;
  - Annual evaluation of current state of leading and lagging indicators (immediately post roll out, and 1-year post roll out).

## Key Outputs and Deliverables

The key outputs and deliverables of the Residential Care Safety Leadership Program program are set out below:

Proposed Deliverable	Description
Summary report	Baseline and annual reports evaluating the impact
Full report	A multi-level safety leadership capability and WVA prevention framework tailored to the residential care sector. Final report summarising the outputs and impact.
Evaluation framework	A plan to monitor and evaluate the impact of the program on leading and lagging indicators of safety.
Presentation	Presentations on framework and evaluation findings.
Training modules tailed to the Queensland Residential Care System	<ul style="list-style-type: none"> <li>• Safety Leadership Program, with tailored modules for CEOs, Boards, Managers, Supervisors and HSRs</li> <li>• An WVA Prevention Program for frontline workers in the residential out-of-home care sector.</li> <li>• Tailored safety leadership capability surveys</li> </ul>

## Resourcing

The **Residential Care Safety Leadership Program is proposed to be over 4 years** and be funded by the Child Safety Department / Queensland Government. A fully costed proposal is proposed.

A high-level overview of requirements and resources required for PeakCare to lead, engage independent Safety Leadership, survey and evaluation expertise and deliver the program through a hybrid on-line and place based approach over 4 years would include:

- Director.
- Project manager.
- Safety Leadership Expert.
- Multiple trainers.
- Evaluation (pilot and rollout, process and impact).
- Safety Leadership Survey (baseline and annually x 3).
- Safety Leadership Survey results collated and analysed
- Communication and program collateral for the workshop series as part of a co-design workshop process to input into the design of the Safety Leadership
- Instructional design of Safety Leadership Training materials, video production, workbook, guidance and resources development tailored for the residential care sector.
- Delivery and implementation of training (on-line and face-to-face).

- Administration support.
- Travel and associated expenses.

Subject to a fully costed proposal, program and delivery of training to the residential care workforce is estimated at between \$4-\$5 million over 4 years.

# Attachment 4 – Families Australia Submission to the House of Representatives Standing Committee on Employment, Workplace Relations, Skills & Training



## Submission to the House of Representatives Standing Committee on Employment, Workplace Relations, Skills & Training

Submission to the Inquiry into the operational and adequacy of the National Employment Standards

### Submission Details

**Inquiry:** House of Representatives Standing Committee on Employment, Workplace Relations, Skills and Training into the operational and adequacy of the National Employment Standards (NES) under the *Fair Work Act*

**Organisation Name:** Families Australia, ABN 21 830 960 225  
In partnership with the National Foster Care Sustainability Group  
[futureoffostercare.org.au](http://futureoffostercare.org.au)

**Date of submission:** 27 February 2026  
**Contact details:** Jamie Crosby  
Chief Executive Officer  
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PO Box 4386 Kingston ACT 2640  
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**Submission type:** Public submission





## Executive Summary

The National Employment Standards (NES) are minimum employment entitlements that must be provided to all employees in the national workplace relations system. However, the eligibility criteria for some NES leave entitlements are limited to defined activities or specific classes of people.

Statutory kinship and fosters carers provide an essential community service, often with minimal notice, that state and territories are reliant on for their out-of-home care systems to function. Statutory kinship and fosters carers have the day-to-day care and responsibility for children, often for many years, who have been removed by the state under Child Protection legislation and Court Orders. However, they are omitted or not specifically identified in some NES leave entitlements, including Community Service Leave, and Parental Leave. This situation is particularly anomalous when had the child not been removed due to significant safety concerns, the child's parent would have been entitled to these NES leave entitlements.

Statutory kinship and foster carers are overwhelmingly women over the age of 50. Kinship carers are overwhelming Aboriginal and Torres Strait Islanders. Estimates suggest 20 per cent work full-time and a further 20 per cent work part-time or casually. There are approximately 16,000 statutory carer households across Australia. Foster carer numbers continue to decline year-on-year, with foster carer numbers declining over the last 15 years.

Child removals by a state or territory are not optional, planned, predictable, and many times multiple. These removals are emergency, unpredictable responses to a child being in unacceptable risk and requiring an immediate care placement. Statutory kinship and foster carers open their homes and care for children with minimal notice, often within hours of a child being removed from their parents.

Carers often receive children with minimal notice and must immediately manage acute trauma responses, heightened stress responses, emotional dysregulation, attachment insecurity and previously unmet health and mental health needs - when compared to the general population.

Carers coordinate urgent health and development assessments and implement treatment plans. Yet the omission from NES leave provisions undermines carers' workforce participation and economic security, forcing some, predominantly older women and Aboriginal and Torres Strait Islander peoples, to reduce hours, leave jobs, or ultimately rely on Centrelink payments. The omission of statutory kinship and foster carers in NES leave entitlements is a structural gap in the safety net and it adversely impacts women over the age of 50 and Aboriginal and Torres Strait Islander peoples.

The NES are designed to ensure that basic life events and civic responsibilities are supported through employment. This is achieved by providing or protecting leave for circumstances that would otherwise force people out of work and onto government benefits. Consistent with the purpose of the NES, statutory kinship and foster carers should not have to resign, exit the workforce and claim Centrelink benefits to:

- support a child's response to the trauma of being removed from their parents;
- ensure children who enter care and have unaddressed multiple and complex health needs and developmental concerns are assessed and treated by relevant professionals; or
- provide day-to-day care over long periods to very young children.

## About Families Australia

Families Australia is a not-for-profit national peak body that strives to improve the wellbeing of Australian families, especially those experiencing the greatest vulnerability and marginalisation.

Families Australia represents more than 600 members and stakeholders around Australia, all of whom work to advance family wellbeing and participation.

A key focus area for Families Australia is advocating for better support for foster and kinship carers. This includes supporting foster carers and kinship carers' continued participation in the workforce and timely access to health care for all children and young people in their care. This submission has been developed in direct consultation with, and is formally endorsed by, all member organisations and foster carers of the [National Foster Care Sustainability Group](#).



## Families Australia's Recommendations

Families Australia recommends that the House of Representatives Standing Committee on Employment, Workplace Relations, Skills and Training's Inquiry into the operational and adequacy of the National Employment Standards (NES) under the *Fair Work Act* make recommendations to:

1. **Recognise statutory kinship and fosters as a defined group under the NES Community Services Leave entitlement.** This would recognise the unplanned, time-critical and essential community service that they provide and that states and territories are reliant on for their out-of-home care systems to function.
2. Noting the interaction between the NES leave entitlements, that **all NES leave entitlements specifically identify statutory kinship and foster carers as a recognised class of people entitled to leave** - such as in the entitlement to Parental Leave and to Personal, Carers and Compassionate Leave.
3. **Commission national data collection of statutory kinship and foster carers** such as their employment status; occupation; employer size; age; gender; Aboriginal or Torres Strait Islander; and their reduced hours, income loss or workforce exits due to caring for children in out-of-home care.

Families Australia's recommendations align with the objectives of the *Fair Work Act* to promote increased workforce participation and social inclusion, particularly affecting women, women aged 50 and over, and Aboriginal and Torres Strait Islander peoples.

## Detailed Submission

The National Employment Standards

The National Employment Standards (NES) are minimum employment entitlements that must be provided to all employees in the national workplace relations system. However, the eligibility criteria for some NES entitlements are limited to defined activities or to a defined class of people. These eligibility requirements either exclude statutory kinship and foster carers from some types of leave entitlements under the NES or leave it unclear, creating issues for carers with their employers.

## Case Studies – the adverse impact on workforce participation and finances for statutory kinship and foster carers providing care to children

In providing an essential and time critical community service, and supporting the most vulnerable children in our community, statutory kinship and foster carers workforce participation and financial security is significantly adversely affected. This adverse impact is demonstrated in the experience of two carers outlined below.

### Statutory Kinship Carer - Alice<sup>1</sup>

Alice is single, a grandmother and a proud Aboriginal woman. Alice worked full time in the Public Service. When Alice was contacted by Child Protection in another state and asked to become a statutory kinship carer for her 3-year-old grandson, who had just been removed from his mum, Alice didn't hesitate. She immediately took personal leave from work and travelled interstate to collect her grandson. Despite efforts by Child Protection to support Alice, a childcare vacancy for her grandson was not immediately available. Alice exhausted her personal leave to care for her grandson while she waited for a childcare place. Alice also took her grandson to medical and development assessments, which identified serious concerns that needed further specialist assessment and a management plan to address them. Alice had run out of leave and requested unpaid leave; her grandson was attending several lengthy assessments at different locations.

Six months later, Alice was asked by Child Protection to be the statutory kinship carer for another younger grandson. Alice again travelled interstate immediately. She had no leave available and had to again ask her employer to approve unpaid leave, without any notice or planning. Alice's second son was diagnosed with Foetal Alcohol Spectrum Disorder (FASD) among other medical and development delays.

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<sup>1</sup> Name has been changed.



Alice's two grandchildren in her care were under 3 years of age, and both had complex medical needs, which limited their access to suitable childcare. With no more leave available, Alice ultimately had to resign. She then became reliant on Centrelink payments as her only income stream. Leaving full time employment reduced Alice's income. She no longer contributes to superannuation and can no longer afford her mortgage. Alice is currently arranging to sell her house.

#### **Statutory Foster Carer - Susan<sup>2</sup>**

Susan and Michael are middle-aged married statutory foster carers. While they were both working full time, they undertook emergency and respite care for several children. This included caring for Sarah age 12 when her previous foster carers gave her up due to being unable to cope with her behaviours arising from complex trauma and manage their work responsibilities and own health issues.

When Sarah was 16, she was again given up by a foster family who were struggling to cope with the care of multiple children. The agency responsible, knowing that it is virtually impossible to find a foster care placement for adolescents and almost always go into residential care, contacted Susan and Michael and asked whether they would consider taking Sarah long term.

Susan and Michael agreed, deciding that Susan would be the primary carer. In the first 12 months of placement Susan worked part time. However, Sarah had complex medical and developmental needs which had not been adequately diagnosed or treated. She also had emotional, behavioural, relational and developmental needs that created challenging behaviours as a trauma response.

Susan decided she needed to give up paid work to properly support Sarah in addressing these needs. While financially challenging, Sarah is doing better and is the only one of the eight children of her biological parents to have completed year 12.

#### **The case for recognising statutory kinship and foster care as an eligible Community Service under the NES leave entitlement**

States and territories cannot control demand for out-of-home care systems. Child protection legislation requires states and territories to remove a child when there is an unacceptable risk of significant harm to the child because the child cannot live safely at home. Removal is not optional, planned, or predictable, it responds to an acute situation that requires immediate care for the child.

On removal of a child, jurisdictions have very limited options available. Without statutory kinship and foster carers offering homes, the option is to place the child in residential out-of-home care (or even a motel or caravan park) with supervision provided by a paid workforce on a 24/7 roster. This institutional care is hugely different to a foster home with a carer providing a parental figure, love and support and has very poor outcomes for the child, especially younger children. It is also very costly to the taxpayer.

Residential out-of-home care is *"widely acknowledged as the most expensive and least preferable form of placement, especially for younger children or those requiring more stable environments."*<sup>3</sup> The evidence is unequivocal, children with a residential out-of-home care experience have significantly poorer outcomes than those placed in foster or kinship care and are more likely to be engaged in the Youth Justice system.<sup>4</sup> The impact is also lifelong and inter-generational. It results in a substantial annual economic burden due to increased health care costs and lost productivity.<sup>5</sup>

<sup>2</sup> Names have been changed.

<sup>3</sup> Queensland Family & Child Commission, *"Buyer Beware, How economic forces are shaping Queensland's residential care market, Queensland Family & Child Commission,"* August 2025. pg. 13.

<sup>4</sup> See for example, The New South Wales Government funded *"Pathways of Care Longitudinal Study – Improving the long-term outcomes of children in Out-of-Home Care"*. It commenced in 2011 and is a large-scale longitudinal study of children and young people care and focuses on child development domains of physical health, socio-economic wellbeing and cognitive/learning ability. This study shows that children and young people with a residential care experience have lower school engagement, attendance and achievement, are more likely to be suspended or excluded, are less likely to meet national literacy and numeracy benchmarks and are more frequently involved in the justice system.

<sup>5</sup> Dai Quy Le, Long Khanh-Dao Le, Marie Bee Hui Yap, Divna M. Haslam, Daryl J. Higgin, Eva Malacova, James G. Scott, David Lawrence, Ben Mathews, Cathrine Mihalopoulos, *"Impact of child maltreatment on the costs of health service use and productivity loss: Findings from the Australian child maltreatment study"*, *Child Abuse & Neglect* 171 (2026) 107818.



Although only about 12 per cent of Australian children in statutory out-of-home care are in residential settings each night, residential out-of-home care is a multibillion-dollar system that accounts for a large proportion of Child Protection budgets in all states and territories. For example, over half of Queensland's \$1.1 billion Child Protection budget is spent on residential out-of-home care, at an average cost of \$2.8 million dollars a day.<sup>6</sup>

By contrast, statutory kinship and foster carers provide immediate, voluntary, family-based placements that support stabilising children, manage acute trauma responses (heightened stress, emotional dysregulation, attachment insecurity, regression), address urgent health and development needs and undertake normal parenting functions, all in a family home.

States and territories are reliant on statutory kinship and foster carers for their out-of-home care systems to function. Statutory kinship and foster carers provide immediate, voluntary, timely and socially critical care and homes to children removed from their parents and placed in out-of-home care. They are treated as volunteers and paid only a partial subsidy that contributes to meeting the needs of the child in their care (between \$11,942 and \$20,462 per annum<sup>7</sup>).

Statutory kinship and foster carers make themselves available to provide time critical voluntary care and support to children placed in care with minimal notice. However, due to the minimal notice and immediate support children need on placement into out-of-home care, statutory kinship and foster carers are reliant on the discretion of their employers to approve leave with minimal notice and planning (assuming they have leave available) or negotiate a flexible work arrangement with alacrity. Consequently, statutory kinship and foster carers often have to reduce their work hours or leave the workforce and claim Centrelink benefits to support children in their care.

In the absence of statutory kinship and foster carers being immediately available to fulfil a critical civic duty, out-of-home care systems nationwide could not function. Statutory kinship and foster carers provide a critical, unplanned and essential community services that state and territories rely on for their out-of-home care systems to function. In these circumstances, the NES entitlement to Community Service Leave should be amended to explicitly recognise statutory kinship and foster carers as a defined group.

### **The case for extending NES leave entitlements to statutory kinship and foster carers**

The NES leave entitlements interact with each other. Given the essential role and to ensure clarity and consistency, all NES leave entitlements should be amended to specifically include statutory kinship and foster carers as an identified entitled class. This includes the NES entitlements to Parental Leave and to Personal, Carers and Compassionate Leave.

### **Statutory kinship and foster carers need time to support children to address their prior trauma and multiple and complex health and development issues**

Statutory kinship and foster carers need time to help children address prior trauma and access professional support for complex health and developmental needs. Children in out-of-home care have experienced significantly higher and more intensive rates of child maltreatment (physical, sexual and emotional abuse, neglect, and/or exposure to family and domestic violence) than in the general population.<sup>8</sup> This maltreatment causes cumulative harm that impairs their safety, wellbeing and development, often resulting in long-term emotional, behavioural, relational and developmental functioning difficulties if left untreated.<sup>9</sup>

<sup>6</sup> Commission of Inquiry into the Queensland Child Safety System, hearing on 23 July 2025, at transcript page 18.

<sup>7</sup> State and territory websites, published carer base rates 2025-26

<sup>8</sup> Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>. Harris LG, Higgins DJ, Willis ML, Lawrence D, Meinck F, Thomas HJ, Malacova E, Scott JG, Pacella R, Haslam DM, "Dimensions of child maltreatment in Australians with a history of out-of-home care. *Child Maltreatment*" 2025 August, 30(3):525-39.

<sup>9</sup> Cumulative harm is caused by the compounding impact of ongoing and/or multiple experiences of child maltreatment. Harris LG, Rattambige D, Hunt GR, Higgins DJ, "Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters", *Current Opinion in Psychology*, <https://doi.org/10.1016/j.copsyc.2025.102260>.



Children in out-of-home care have multiple and complex physical, mental and development health needs.<sup>10</sup> Yet they often face limited access to health services, have incomplete medical histories, poor record-keeping and inconsistent continuity of care.<sup>11 12</sup>

Disability rates are also high. AIHW data shows 22% of children in out-of-home care have disability, compared to around 11–12% of children and young people in the general population (ABS). This means children in care experience disability at approximately twice the rate of their peers. The over-representation remains clear even when compared specifically to children under 15 years (11%), underscoring the strong intersection between disability and out-of-home care systems.

The “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” sets out core elements that cover physical, developmental and mental health. These core elements recommendations include that children in out-of-home care have:

- A Preliminary Health Check as soon as possible and no later than 30 days after entering care to out-of-home care to determine areas of immediate concern.
- A Comprehensive Health and Developmental Assessment (physical, developmental, psycho-social, mental health, dental, optometry and audiology) within three months days after entry to out-of-home care.
- A Health Management Plan developed and integrated with other management plans (e.g. education plans) into a single management plan for the child.
- Follow-up monitoring in accordance with the clinical needs of the child.

Despite these requirements, only a minority of children receive timely assessments in accordance with this national framework. In Victoria, between April 2010 and December 2015, less than 1 per cent (41 of 5,676) of children aged 0–12 complied with the Framework’s recommendations.<sup>13</sup> Children in foster care were the most likely to meet them.<sup>14</sup> This is consistent with evidence given at the Commission of Inquiry into Queensland Child Safety by carers and health professionals, such as Dr Marnie Fraser, Staff Specialist, Paediatrics (Cairns and Hinterland Hospital and Health Service) on 26 September 2025.<sup>15</sup>

Failure to assess and address health and development needs of children in out-of-home care has multiple adverse consequences to the child and their foster or kinship carers. It can lead to challenging behaviours, carer strain, placement breakdown and the child entering residential care.

Evidence before the Commission of Inquiry into the Queensland Child Safety System highlighted a case in which a child under one in foster care had persistent scabies. The Manager gave evidence that scabies was *seen a bit* by Child Safety in children,<sup>16</sup> and that a child under one year old in foster care had a diagnosis of persistent and recurring scabies, requiring antibiotics four times a day. However, the Manager’s evidence was that the diagnosis was not recorded in the information provided to her new foster carer.<sup>17</sup> Further, the foster carer had to relinquish care as they could not manage the child’s medical needs.<sup>18</sup> The child did not receive appropriate specialist treatment until seven or eight months later, when a medically trained foster carer arranged private care.<sup>19</sup>

Compliance with the National Clinical Assessment Framework requires carers to attend multiple medical and therapeutic appointments within 30–90 days of a care placement, creating unavoidable employment disruption. However, timely

<sup>10</sup> “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” March 2011, [national-clinical-assessment-framework-for-children-and-young-people-in-out-of-home-care.pdf](#).

<sup>11</sup> “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” March 2011, [national-clinical-assessment-framework-for-children-and-young-people-in-out-of-home-care.pdf](#).

<sup>12</sup> “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*” March 2011, [national-clinical-assessment-framework-for-children-and-young-people-in-out-of-home-care.pdf](#).

<sup>13</sup> McLean, K., Hiscock, H., and Goldfeld, “Timeliness and extent of health service use by Victorian (Australian) children within first year after entry to out-of-home care: Retrospective data linkage cohort study,” *Child and Youth Services Review* 134 (2022) 106359.

<sup>14</sup> McLean, K., Hiscock, H., and Goldfeld, “Timeliness and extent of health service use by Victorian (Australian) children within first year after entry to out-of-home care: Retrospective data linkage cohort study,” *Child and Youth Services Review* 134 (2022) 106359.

<sup>15</sup> Queensland Commission of Inquiry into the Child Safety System, at [www.childsafetyinquiry.qld.gov.au](#).

<sup>16</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3868.

<sup>17</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3870.

<sup>18</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3874.

<sup>19</sup> Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pg 3878.



access to care is essential to address children's multiple and complex unmet health needs and to start their recovery from trauma.

### Data on children in out-of-home care

The latest data in respect of children in out-of-home care is from the Australian Institute of Health and Welfare's (AIHW), the "Child Protection Australia 2023-24" report.<sup>20</sup> The Productivity Commission reports on the Closing the Gap Targets, which are relevant Aboriginal and Torres Strait Islander children in out-of-home care. The salient points from these data sets are below:

- **The total number of children in out-of-home care is decreasing:** On 30 June 2024, 44,900 Australian children were in out-of-home care. Between 30 June 2020 and 30 June 2024, the number of children in out-of-home care decreased from 8.2 to 7.7 per 1,000.<sup>21</sup>
- **Aboriginal or Torres Strait Islander are significantly overrepresented in out-of-home care:** Of the 44,900 children in out-of-home care on 30 June 2024, 20,000 were Aboriginal or Torres Strait Islander. Aboriginal or Torres Strait Islander Children are 9.6 times more likely to be in out-of-home care.<sup>22</sup>
- **The Closing the Gap target to reduce the overrepresentation of Aboriginal and Torres Strait Islander children in out-of-home care is worsening.** By 2031, Closing the Gap Target 12 seeks to reduce the rate of overrepresentation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 per cent. The Productivity Commission reports that, nationally, this target is deteriorating. In 2019, 47.3 per 1,000 Aboriginal and Torres Strait Islander children were in out-of-home care. In 2024, the rate was 50.3 per 1,000 children.<sup>23</sup> For non-Indigenous children, the rate is 4.6 per 1,000 children.

### Data on Statutory Kinship and Foster Carers

Data on the number, characteristics and employment status of statutory kinship and foster carers is outlined below.

#### Households

On 30 June 2024 in Australia:

- **Foster Carer Households:** there were about 8,000 foster care households with a child in their care. Of these households, 47.1 per cent had two or more children in their care.<sup>24</sup>
- **Kinship Care Households:** there were about 16,000 kinship care households with a child in their care. Of these households, 35.1 per cent had two or more children in their care.<sup>25</sup>

Foster and kinship carers often have more than one child in their care with precedence given to placing siblings together. There is strong evidence that placing siblings together improves their outcomes,<sup>26</sup> and it supports Aboriginal and Torres Strait Islander children in maintaining connections to family and culture.<sup>27</sup>

<sup>20</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023–24, Report editions - Australian Institute of Health and Welfare](#).

<sup>21</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023–24, Report editions - Australian Institute of Health and Welfare](#).

<sup>22</sup> SNAICC National Voice for our Children, "Family Matters Report 2025, Strong, loved and full of potential", 2025, page 2. [Family Matters Report 2025](#).

<sup>23</sup> Productivity Commission, Closing the Gap, Information Repository, Child Protection data, <https://www.pc.gov.au/closing-the-gap-data/dashboard/outcome-area/child-protection>.

<sup>24</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023–24, Report editions - Australian Institute of Health and Welfare](#).

<sup>25</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023–24, Report editions - Australian Institute of Health and Welfare](#).

<sup>26</sup> NSW Government Communities and Justice - Pathways of Care Longitudinal Study (POCLS)

<sup>27</sup> SNAICC – National Voice for our Children (2017), Understanding and applying the Aboriginal and Torres Strait Islander Child Placement Principle.



## Characteristics

The NES review specifically requires consideration of the experiences of women and workers aged 55 and over. Statutory kinship and foster carers fall squarely within this cohort.

### Data

Data and research on statutory kinship and foster carers is largely collected through surveys, usually at a state or territory level.

An Australian Institute of Families Studies research report<sup>28</sup> found that in respect of statutory kinship and foster carers:

- 88 per cent of foster carers and 87 per cent of kinship carers were female.
- The median age of kinship and foster carers was 53 years and aging over time.
- 25 per cent were in part-time employment, 19 per cent were in full-time employment.
- Most carers had an annual gross household income of less than \$60,000, with one-fifth of carers relying on less than \$30,000.
- One third report that the child in their care had a developmental condition (intellectual disability, physical disability, diagnosed behavioural problem or diagnosed mental illness).

In Victoria in 2024, a foster carer survey<sup>29</sup> found:

- 78 per cent were female.
- 35 per cent worked full-time, 18 per cent worked part-time, 6 per cent worked casually or in contract work and 14 per cent were retired.
- 18 per cent report that the loss of income and superannuation was the most challenging aspect of being a foster carer.

In the 2024-25 South Australian annual survey of foster and kinship carers:<sup>30</sup>

- 87.4 per cent identified as female.
- 4.7 per cent identified as First Nations.
- 81 per cent had reduced or ended their employment to provide care.
- 19.9 per cent were employed on a part-time or casual basis. 17.3 per cent were employed full-time, 17.3 per cent were retired.
- 67 per cent reported that their superannuation had reduced because they were a carer.

### Research

Research shows that foster carers engaged in work are more likely to be in part-time employment.<sup>31</sup>

Research studies of kinship carers have reported that becoming a carer affected their employment. Kinship carers reported struggling to manage their workloads and reducing their working hours to meet the needs of children in their care.<sup>32</sup> A recent study called for urgent reform to account for the needs of Aboriginal kinship carers in Western Australia to enable them to continue to provide care.<sup>33</sup>

<sup>28</sup> Australia Institute of Families Studies, "Working Together to Care for Kids, A survey of foster and relative/kinship carers. Research Report" 2018.

<sup>29</sup> [Foster Care Association of Victoria, Carer Survey 2024 Report.](#)

<sup>30</sup> Connecting Foster & Kinship Carers – SA, Annual Foster & Kinship Carer Survey Summary 2024-24, [Annual Foster & Kinship Carer Survey 2024-25.](#)

<sup>31</sup> McHugh, M. and Valentine, K., "Financial and Non-Financial Support to Formal and Informal Out of Home Carers" Final Report, Social Policy Research Centre, University of New South Wales, January 2011, pg 6.

<sup>32</sup> See Williams, R., & Badry, D. E. (2023). Aboriginal kinship carers and carers of children with Fetal Alcohol Spectrum Disorder in Western Australia: Advancing knowledge from an Indigenous and disability lens. *First Peoples Child & Family Review*, 18(1), 60-80.

<sup>33</sup> <https://fpfcr.com/index.php/FPCFR/article/view/603>; DiGiacomo, M., Green, A., Delaney, P., Delaney, J., Patradon-Ho, P., Davidson, P. M., & Abbott, P. (2017). Experiences and needs of carers of Aboriginal children with a disability: a qualitative study. *BMC Family Practice*, 18(1), 96.



This demonstrates that foster and kinship care has a measurable workforce participation impact that is not currently recognised in the NES leave entitlements.

### **Aboriginal and Torres Strait Islander statutory carers**

As of 30 June 2024, 63.2 per cent of Aboriginal and Torres Strait Islander children in out-of-home care were living with kin (family) or Aboriginal and Torres Strait Islander carers.<sup>34</sup>

Aboriginal and Torres Strait Islander children remain significantly overrepresented in out-of-home care despite Closing the Gap Targets. Statutory kinship and foster carers provide long-term care but largely do not assume legal parenting responsibility or adopt Aboriginal and Torres Strait Islander children. Instead, they play an important role in supporting reunification with their birth parents, communities and culture. This is consistent with the Aboriginal and Torres Strait Islander Child Placement Principles, which are enshrined in child protection legislation in all states and territories.<sup>35</sup>

### **Statutory kinship and foster carer allowances are a small contribution to cover the costs or the needs of the child**

Statutory kinship and foster carers receive a subsidy or allowance to partially cover the support needs of the children in their care from the state or territory government. It is not a full reimbursement of the costs associated with caring. The average carer allowance in Australia varies between \$457 and \$787 per fortnight (\$11,942 and \$20,462 per annum) depending on the age of the child and the jurisdiction responsible for providing the payment to the carer.<sup>36</sup> There is no contribution to the carer's superannuation.

Statutory kinship and foster carers manage complex medical assessments and management plans. Often, they also pay very significant costs for treatment. This should be reimbursed by the state or territory department responsible for child protection, although such reimbursements are often not timely and/or received at all.<sup>37</sup>

### **Who is the parent and is responsible for a child in out-of-home care?**

Statutory kinship and foster carers have the care of a child in out-of-home care but not the legal responsibility, which remains with the state and/or their birth parent. While legal rights and responsibility may remain with the state or birth parents, the day-to-day parenting responsibilities fall entirely to statutory kinship and foster carers. The NES framework does not reflect this reality.

### **How long are children in out-of-home care?**

Statutory kinship and foster care placements for children in out-of-home care are incorrectly assumed to be 'temporary' or 'short-term' or 'emergency placements', but most last several years. In 2023-24, 69 per cent of children in out-of-home care had been in care for two or more years.<sup>38</sup>

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<https://doi.org/10.1186/s12875-017-0668-3>; and Kiraly, M. (2023). In loco parentis: Informal kinship care in Australia—social benefit and material poverty. *Societies*, 13(11), 227. <https://www.mdpi.com/2075-4698/13/11/227>.

<sup>33</sup> J. Jones, S. Moodie, R. Chenhall, J. Brook, R. Williams, K. Davis, C. Garlett, A. Gibberd, E. Banks, B. Harrap, M. O'Donnell, B. McNamara, S. Eades, 'Our babies are our gold': The experiences of aboriginal kinship carers in Western Australia, *Children and Youth Services Review* (2026), doi: <https://doi.org/10.1016/j.childyouth.2026.108827>.

<sup>34</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023-24, Report editions - Australian Institute of Health and Welfare](#).

<sup>35</sup> The Aboriginal and Torres Strait Islander Child Placement Principle has been shaped by Aboriginal and Torres Strait Islander leaders and community-controlled child welfare organisations, emerging from grassroots advocacy in the 1970s in response to the profound harms caused by child removal policies, including those that led to the Stolen Generations, and was formally recognised in Australian child welfare legislation in the early 1980s. Across all Australian jurisdictions, the Aboriginal and Torres Strait Islander Child Placement Principle is embedded in legislation, policy and practice and is foundational to building a culturally safe national child protection system that upholds the rights of Aboriginal and Torres Strait Islander children, families and communities. The Aboriginal and Torres Strait Islander Child Placement Principles include "support family-led decision-making, prevent unnecessary entry into care and promote family reunification where separation occurs", see [Child Placement Principle | National Framework | SNAICC](#).

<sup>36</sup> State and territory websites, published carer base rates 2025-26

<sup>37</sup> For example, see Queensland Commission of Inquiry into the Child Safety, Day 33, 3 February 2026, transcript pages 3880.

<sup>38</sup> Australian Institute of Health and Welfare, Child Protection Australia 2023-24, [Child protection Australia 2023-24, Report editions - Australian Institute of Health and Welfare](#).



Although placements in foster families are lengthy, case plans commonly prioritise reunification with the child's birth family. This means foster and kinship carers are unlikely to become the child's legal parents, adopt them or even have a long-term care order for them—particularly for Aboriginal and Torres Strait Islander children, where maintaining family and cultural connections is paramount. As a result, statutory kinship and foster carers are generally ineligible for parental leave under the National Employment Standards, despite providing full-time, day-to-day parenting and meeting children's medical, educational and developmental needs over many years.

Long-term placements in foster or kinship care reflect the complex challenges many birth families face, including family and domestic violence, mental health concerns, substance misuse, housing insecurity, and poverty. These family challenges increase the risk of child harm and must be addressed before a child can safely return to their birth family.<sup>39</sup> Many children age out of out-of-home care without reunification with birth parents being possible.

Reunification work with birth parents is often highly intensive and long-term, and if assessed as safe, reunification usually involves a gradual increase in supervised contact over time. Given this reality, it is important to note that statutory kinship and foster carers cannot reasonably be characterised as short-term volunteer activity for the purposes of the NES Parental Leave entitlement. The position is anomalous: had the child remained safely with their birth parents, those parents would have been entitled to parental leave, yet the carer who assumes full parental responsibility receives none.

### Fit for Purpose in a Changing Labour Market

The NES was designed in a labour market characterised by single-income households and lower female workforce participation. Contemporary Australia is defined by dual-income households, high female participation, and cost-of-living pressures.






Without formal recognition of statutory and kinship carers caring responsibilities, workforce participation is compromised, carers exit the workforce and then rely on Centrelink benefits. The NES, as currently structured, does not reflect the current labour market realities. The absence of establishment leave disproportionately impacts women in mid-to-late career stages, exacerbating superannuation inequity and workforce exit.

### Recommended Additional Data Collection

Child protection is a state-based responsibility. States and territories survey accredited foster carers and kinship carers. However, introducing state or national data collection for accredited foster carers and kinship carers would assist to better understand the population and the risk of workforce attrition due to inadequate leave protections under the NES. Data collection could include employment status (full-time, part-time or casual); industry or occupation; employer size; age; gender; Aboriginal or Torres Strait Islander; and reduced hours, income loss or workforce exits.



# Attachment 5 – Queensland Care Services Outcomes Framework

Queensland Care Services Outcomes Framework					
Vision : Children and young people in care are safe and healthy, have a sense of belonging and wellbeing, and achieve to their potential					
Domains	 <p>Safe &amp; Nurtured</p>	 <p>Connected</p>	 <p>Achieving</p>	 <p>Healthy</p>	 <p>Resilient</p>
Aspirations	<p>Children and young people feel cared for and nurtured in stable environments, safe from abuse, neglect, violence and threat</p>	<p>Children and young people feel a strong sense of identity and belonging, have stable and long lasting relationships with family and friends and are connected to culture and community</p>	<p>Children and young people learn and develop to their full potential</p>	<p>Children and young people make healthy lifestyle choices and access health care services</p>	<p>Children and young people have strong social and interpersonal skills and feel confident to pursue life goals and manage challenges</p>
Principle of cultural integrity in care					
Culturally responsive and safe care is about being part of a family, community and extended network and knowing where you belong. Culture and identity as a concept is dynamic and to be prioritised as part of every child's day to day life (SNAICC 2011)					
Outcomes	<ul style="list-style-type: none"> <li>Protected from abuse, neglect and exposure to violence</li> <li>Nurtured and cared for</li> <li>Living in stable and predictable environments</li> </ul>	<ul style="list-style-type: none"> <li>Positively connected to family, culture and community</li> <li>Feel a sense of identity and belonging</li> </ul>	<ul style="list-style-type: none"> <li>Attend and engage in education</li> <li>Meeting developmental milestones</li> <li>Engage in, and benefit from, recreational activities</li> <li>Developing independence and life skills</li> </ul>	<ul style="list-style-type: none"> <li>Physically healthy</li> <li>Emotionally and mentally healthy</li> <li>Leading an active and healthy lifestyle</li> </ul>	<ul style="list-style-type: none"> <li>Feel confident and have social skills</li> <li>Possess coping skills and an ability to manage adversity</li> <li>Display positive and appropriate behaviour</li> </ul>
Critical Success Indicators	<p>Children and young people will live in homes where:</p> <ul style="list-style-type: none"> <li>They are not being harmed and they are physically safe</li> <li>Their material needs are met</li> <li>They feel cared for, nurtured and valued</li> <li>Their dignity and rights are respected</li> <li>They lead a violence free life</li> </ul>	<p>Children and young people will:</p> <ul style="list-style-type: none"> <li>Have quality relationships with family, friends and other significant people</li> <li>Know their life history and have a sense of identity</li> <li>Feel connected and have a sense of cultural and spiritual belonging to their community</li> <li>Have opportunities to engage in social, cultural and community events and activities</li> </ul>	<p>Children and young people:</p> <ul style="list-style-type: none"> <li>Are ready for school at entry age</li> <li>Attend and engage in schooling</li> <li>Achieve national educational standards</li> <li>Have age and developmentally appropriate life skills</li> <li>Develop and progress personally, socially and educationally</li> <li>Have career aspirations</li> </ul>	<p>Children and young people:</p> <ul style="list-style-type: none"> <li>Access services and treatment that meet their physical, dental, sexual and mental health needs</li> <li>Access services and treatment that meet needs related to a disability or their development</li> <li>Experience improvements to their health and wellbeing</li> <li>Do not misuse drugs and alcohol</li> <li>Learn to independently make healthy lifestyle choices</li> </ul>	<p>Children and young people:</p> <ul style="list-style-type: none"> <li>Access services and treatment that meet their therapeutic needs</li> <li>Have positive relationships and treat other people with respect</li> <li>Pursue recreational and extra-curricular activities</li> <li>Engage in decision-making about their lives</li> <li>Contribute to and support the community and others</li> <li>Engage in positive and law-abiding behaviour</li> <li>Have confidence and are able to successfully deal with life challenges</li> <li>Have goals and feel optimistic about their future</li> </ul>

## MEASURES OF SUCCESS

Domains	Safe & Nurtured 	Connected 	Achieving 	Healthy 	Resilient 
Child Measures	<ul style="list-style-type: none"> <li>✓ Length of time in placement</li> <li>✓ Permanent placement</li> <li>✓ Number of placements to date</li> <li>✓ Substantiated standards of care matters</li> <li>✓ Do not experience violence or trauma</li> </ul>	<ul style="list-style-type: none"> <li>✓ Positive and supportive relationships</li> <li>✓ Lives with their siblings</li> <li>✓ Lives with kinship carer</li> <li>✓ Regular family contact</li> <li>✓ Regular engagement in community activity</li> <li>✓ Regular visit to community</li> <li>✓ Has a cultural support plan including information from the individual, family and community perspective</li> <li>✓ Lives with a carer from the same cultural background</li> <li>✓ Has a comprehensive record of their family through genogram and ecomap including parents, mob, ancestors, family, community, and country</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attachment to school</li> <li>✓ Attends school, Kindergarten or early childhood education regularly or is engaged in training or employment</li> <li>✓ Most recent overall NAPLAN score at or above national minimum standard</li> <li>✓ Academic performance steady or improving</li> <li>✓ Transition to independence planning</li> <li>✓ Identifies possible career or future hopes and the necessary steps to achieve these</li> <li>✓ Has access to resources for adulthood, including safe accommodation</li> </ul>	<ul style="list-style-type: none"> <li>✓ Overall health</li> <li>✓ Immunisation schedule up to date and in accordance with the National Immunisation Program</li> <li>✓ Has a comprehensive health and development assessment</li> <li>✓ Has a child health passport</li> <li>✓ Physical activity and nutritional consumption meets national recommendations</li> <li>✓ Has had a dental check-up within 12 months</li> <li>✓ Has access to health care including general, mental, dental, sexual and allied health care</li> <li>✓ Alcohol and drug use has minor impact</li> </ul>	<ul style="list-style-type: none"> <li>✓ Self-regulation and prosocial behaviour</li> <li>✓ Social and emotional confidence</li> <li>✓ Has access to therapeutic services</li> <li>✓ Participated in the development/review of their current case plan</li> <li>✓ Regular social/recreation activities</li> <li>✓ No escalation in behavioural issues at school or child care</li> <li>✓ Participated in transition to independence planning and have plans for adulthood</li> <li>✓ No or reduced involvement in illegal activities</li> </ul>
Service Measures	<ul style="list-style-type: none"> <li>✓ Children are stable in placements</li> <li>✓ Children in permanent homes</li> <li>✓ Number of placements to date</li> <li>✓ Substantiated standards of care matters</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children have positive and supportive relationships</li> <li>✓ Children living with siblings</li> <li>✓ Children living with kinship carers</li> <li>✓ Children having regular family contact</li> <li>✓ Children living with carer from same cultural background</li> <li>✓ Children engaged in community activities</li> <li>✓ Children with cultural support plan including information from the individual, family and community perspective</li> <li>✓ Children visiting their community</li> <li>✓ Children who have information about land, totem, language, history, stories and custom</li> <li>✓ Length of time in placements</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children have attachment to school</li> <li>✓ Children are attending school</li> <li>✓ Kindergarten or early childhood education regularly or is engaged in training or employment</li> <li>✓ Children are at or above the NAPLAN minimum standard</li> <li>✓ School exclusions</li> <li>✓ Transition to independence planning</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children fully immunised</li> <li>✓ Children with comprehensive health and development assessments</li> <li>✓ Children with a child health passport</li> <li>✓ Children meeting recommended physical activity and nutritional consumption</li> <li>✓ Children are engaging in sport regularly</li> <li>✓ Children with a dental check-up within 12 months</li> <li>✓ Children have access to health care including general, mental, dental, sexual and allied health</li> <li>✓ Young people using alcohol and drugs with minor impact</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children's social and emotional confidence</li> <li>✓ Children accessing therapeutic services</li> <li>✓ Children's participation in the development and review of their case plan</li> <li>✓ Children engaged in social and recreational activities</li> <li>✓ Young people's participation in their transition to independence planning</li> <li>✓ No or reduced involvement in illegal activities</li> </ul>
Organisational Measures	<ul style="list-style-type: none"> <li>✓ Children are stable in their placement</li> <li>✓ Children in permanent homes</li> <li>✓ Substantiated standards of care matters</li> <li>✓ Length of time in placements</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children have positive and supportive relationships</li> <li>✓ Children living with siblings</li> <li>✓ Children living with kinship carers</li> <li>✓ Children having regular family contact</li> <li>✓ Children living with carer from same cultural background</li> <li>✓ Children engaged in community activities</li> <li>✓ Children with cultural support plan including information from the individual, family and community perspective</li> <li>✓ Children visiting their community</li> <li>✓ Children who have information about land, totem, language, history, stories and custom</li> <li>✓ Length of time in placements</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children have attachment to school</li> <li>✓ Children are attending school</li> <li>✓ Kindergarten or early childhood education regularly or is engaged in training or employment</li> <li>✓ Children are at or above the NAPLAN minimum standard</li> <li>✓ School exclusions</li> <li>✓ Transition to independence planning</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children are fully immunised</li> <li>✓ Children have comprehensive health and development assessments</li> <li>✓ Children with a child health passport</li> <li>✓ Children meeting recommended physical activity and nutritional consumption</li> <li>✓ Children with a dental check-up within 12 months</li> <li>✓ Children have access to health care including general, mental, dental, sexual, allied health</li> <li>✓ Young people using alcohol and drugs with minor impact</li> </ul>	<ul style="list-style-type: none"> <li>✓ Children's social and emotional confidence</li> <li>✓ Children accessing therapeutic services</li> <li>✓ Children's participation in development and review of case plan</li> <li>✓ Children engaged in social and recreational activities</li> <li>✓ Young people's participation in their transition to independence planning</li> <li>✓ No or reduced involvement in illegal activities</li> </ul>

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