COMMISSIONER FOR ABORIGINAL CHILDREN & YOUNG PEOPLE

TRANSCRIPT OF PROCEEDINGS

April Lawrie, Commissioner for Aboriginal Children and Young People

Denise Rieniets, Counsel Assisting

Hearing for the Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children in South Australia

Monday, 9 October 2023 at 10:00am

Expert Witnesses:

- **Dr Rhiannon Pilkington**
- **Dr Fiona Arney**
- **Karen Glover**

Denise Rieniets, Counsel Assisting:
OK. For the purposes of the transcript, I'll just say that three panel witnesses today are Dr Rhiannon Pilkington, Dr Fiona Arney and Karen Glover. Welcome. Madam Chair, would you like to do a formal welcome?

Commissioner April Lawrie (Chair):
Yes. Before we go into this process, I'd like to acknowledge that we are meeting on Kaurna Country. Pay my respect to elders, past and present, and to those who are emerging. I'd like to acknowledge that while we meet on Kaurna Country that we acknowledge all those children and families who make Kaurna Country their home that we think of them throughout this process. Thank you.

Counsel Assisting:
I'll now have my associate have everyone affirm their evidence before we start.

Carla Ringvall, Assistant to Counsel Assisting:
OK, so starting. So if you could repeat after me, I solemnly affirm the evidence I will give will be the truth, the whole truth, and nothing but the truth.

Karen Glover:
I solemnly affirm that the evidence I will give will be the truth, the whole truth, and nothing but the truth.

Assistant to Counsel Assisting:
And please state your full name, occupation and address.

Karen Glover:
Karen Michelle Glover, Principal Research Fellow, The Women's and Children's Hospital, SAHMRI Women and Kids [Address Provided].

Assistant to Counsel Assisting:
And I'll be you to repeat after me that you solemnly affirm that the evidence you will give will be the truth, the whole truth, and nothing but the truth.

Dr Fiona Arney:
I solemnly affirm that the evidence I will give will be the truth, the whole truth, and nothing but the truth.

Assistant to Counsel Assisting:
And please state your full name, address and occupation.

Dr Fiona Arney:
Fiona Marie Arney [Address Provided] Director of Arney Chong Consulting.

Assistant to Counsel Assisting:
And Dr Pilkington. Please repeat after me. I solemnly affirm that the evidence I will give will be the truth, the whole truth and nothing but the truth.

Dr Rhiannon Pilkington:
I solemnly affirm that the evidence I give will be the truth, the whole truth, and nothing but the truth.

Assistant to Counsel Assisting:
Thank you. And please state your full name, occupation and address.

Dr Rhiannon Pilkington:
Rhiannon Megan Pilkington, Epidemiologist, University of Adelaide [Address Provided].

Assistant to Counsel Assisting:
Thank you.

Counsel Assisting:
Thank you. Dr Pilkington, we might start with you. Can I show you this document? The report that was provided, do you recognise that document?

Dr Rhiannon Pilkington:
Yes, I do.

Counsel Assisting:
Can you tell us what it is please?

Dr Rhiannon Pilkington:
So we were commissioned through the Inquiry to undertake analysis of data that's come from the

Department for Child Protection to understand child protection contact patterns for Aboriginal and Torres Strait Islander children from the very first notifications all the way through to removals into out of home care.

Counsel Assisting:
And I'm going to ask you to speak to what that data indicated but beforehand, can you tell the Inquiry please, whether there are any difficulties with collating that data and where did it come from?

Dr Rhiannon Pilkington:
So the data comes directly from the South Australian Department for Child Protection, and so we receive that data semi regularly and we have it linked into a broader data platform which enables us to then have a view of whether or not children are identified as Aboriginal or Torres Strait Islander from multiple data sources, so spanning health, education and child protection, rather than just relying on child protection alone to identify children as Aboriginal. Now the most recent data we were able to access and use for the purposes of this analysis was for the financial year 2020-21. So the only, I suppose, caveat on this is we've not been able to include more recent data, so the 2021-2022 financial year. However, our historical analysis over a number of years would not give us any reason to suspect that these patterns will have changed.

Counsel Assisting:
Thank you. And in terms of the data being separated so that it was clear to indicate Aboriginal children as distinct from non-Aboriginal children, was there any difficulties with that? Is all of the DCP's data identified?

Dr Rhiannon Pilkington:
Yeah, so there's no, I wouldn't describe it as difficulties. I would say that there's no perfect way in data that's collected through government departments to identify Aboriginal and Torres Strait Islander children, because we know that the practice of identifying children and families and then how that's recorded varies dramatically. So obviously ideally we would be relying on self-identification and actually asking children and families and we know that doesn't always happen. Now we also did not receive data from the department that enabled us to interrogate directly the Aboriginal Child Placement Principle. So we were not able to at a whole of population level understand whether or not that principle was attempted to be addressed or complied with in any way. So we were able to understand patterns and placements. However, there are some challenges as we know in how those things are interpreted and recorded and I imagine we'll get to those when we when we speak to that at some point.

Counsel Assisting:
Was that requested from the Department? That information?

Dr Rhiannon Pilkington:
Yes. So we've requested it previously, but there are challenges in terms of what actually exists in what we call structured fields. So if it doesn't exist in a structured field, it becomes very difficult for them to extract that data.

Counsel Assisting:
So it is what that indicates is that the Department doesn't record the application of the child placement policies in their data.

Dr Rhiannon Pilkington:
So things might have changed since we did this, so we'd want to double check that with the Department, but I think there is an opportunity to think about what's recorded, what's not recorded and possibly just as, if not more importantly, what is reported on transparently. So I think there's an opportunity to think about how we report, how often we report and how we use that to understand what's happening for Aboriginal and Torres Strait Islander children and families.

Counsel Assisting:
So moving on to the data that you did collect and collate, what were the main indicators of that data?

Dr Rhiannon Pilkington:
So in summary, the most striking findings from the analysis we did, and there was, it was, substantial. So we could, we could be here for a while and if anyone else has any thoughts or questions or areas they want to focus on, please do bring them up. But the most striking findings were really in the disparity in child protection contact patterns when we compare the non-indigenous population with Aboriginal children. So if we just looked in one year, what we see is 1 in 12 non-indigenous children have some sort of contact with child protection and that increases to a staggering one in two for Aboriginal children. So simply within one year, we're looking at half our entire population of Aboriginal children and young people being at least notified to the Department for Child Protection.

Counsel Assisting:
And what does that look like with, that's with notifications, in terms of engagement then with the Department. What does that look like?

Dr Rhiannon Pilkington:
Yeah, so within one year, if we think about stepping through the system, what we see is about half of those children then have at least one screened in notification, but for the whole population that translates to one in three Aboriginal children who have a screened in notification and that's compared to one in 12 for the non-indigenous children. Sorry, one in 25 for the non-indigenous children. And then if we see how many are investigated, one in 12 Aboriginal children in one year are subject to at least one child protection investigation and the disparity in that becomes even more striking, because that's one in 125 for the non-indigenous children. And as we continue to go through the system, so if we look at what proportion of all children are substantiated by the Department at least once, it's one in 20 for Aboriginal and Torres Strait Islander children, compared to one in 250 for non-indigenous children. And then when we look at how many children experience out of home care in one year, it's one in 10 for Aboriginal children, verse one in 100 for non-indigenous children. So when we think about these disparities and we think about whole populations and we understand that that is a view of disparity simply within a 12 month period and we understand that those disparities have existed for a long time. But that the proportion of the population coming into contact with child protection keeps increasing now year on year. What we got to in thinking about what those numbers actually mean is that it's very difficult to imagine that there's any one Aboriginal or Torres Islander family who hasn't been impacted by contact with the Department for Child Protection in this state. And so for us, that starts to raise some serious questions about how we think about our broader child family community well-being system where we should be striving to achieve improved well-being, good outcomes for families and children and communities, and we start to think well how have we really gotten to a place where we have one in 10 children in one year not living with their families? And so when we start to think about what that

means for our systems and because we're public health, we think about how could we have prevented this? How could we have prevented those child removals? How could we have prevented substantiations? How could we have prevented the need for for any of this contact? and I think initially thoughts go to, well, how do our intensive family support services fit into this picture? Because they would seem to be closest to that removal point before we might get to or at the same time as we get to family preservation services. But I also really want to think about how we've even set up what we call our universal services and how appropriate resourced and equipped they are to better support Aboriginal families and communities? And that's all the way from antenatal care in our hospitals through to childcare, through to preschool through to schools. Because I think you know what this, what this data says to us is if we are impacting entire communities at this point that we have completely failed as a system in supporting families to be the supports they want to be and need to be for their children. And so we have to start at the start and that means thinking what does that mean for universal services and then what does that mean for our targeted services? And of course, then we think about our targeted services, and we think about our Aboriginal controlled services and in a research project we recently did where we were focused on services in the North, so they were adult services and they were all dealing with things you might consider to be drivers of child protection risk. So there were services in drug and alcohol, domestic family violence, homelessness, general family support. And when we surveyed 28 organisations who delivered over 80 different programs in metropolitan North, we actually found that one in five of those programs had a wait list of longer than four months. So if we are in a space where the resource in the intensive targeted space is not there, and if we consider even if we consider a screening notification or an investigation as an indicator of some need, then you know how are we using this data to understand how we should actually be resourcing our services to meet that need before we get to any point where any statutory service needs to be involved with a family.

Counsel Assisting:
I think Ms Glover will be able to speak in a moment about the service that they're offering at that at that level. But and the difficulties that that you're finding with that too. What are the main indicators that you found through your data Dr Pilkington, in terms of of what brings indigenous people into contact with the the Department?

Dr Rhiannon Pilkington:
I mean, I think that's a that's a difficult question to answer directly. So I'm gonna think about it a little bit differently and you know, when we look at the disparity between the Aboriginal and the non-Aboriginal population, the biggest gap you actually see is at the front end of the system, so it is the proportion of the population being notified and not notified, and so that starts to raise questions around why are so many Aboriginal people being notified. And there's no data out there that tells you that. But you know, there's no study out there that's gone and surveyed thousands and thousands of notifiers and said, why did you notify? However, what we can know from the data is what are the background characteristics that we might consider to be related to child protection risk and from, you know, various research done over the years, we consider those things to include, you know, fundamental structural drivers like poverty. We consider things like domestic and family violence, substance misuse, mental health, as all drivers of child protection related risk. And so we were able to use our broader data platform. So we were able to use data from hospitals, from homelessness services, from public housing and to understand domains of risk. Now one thing that is important to understand about this particular data is it does represent interactions with what I would describe as our acute or our tertiary service system. So you know these are interactions with homelessness services with emergency departments, you know, these are inpatient hospitalisations.

So our assumption is for most of these these are an underestimate. But what we do know is that for Aboriginal and Torres Strait Islander children are much more likely to have a family background with all of those challenges related to what their family's dealing with, and so if we just look at children in out of home care, what we see is that 14% of Aboriginal Torres Strait Islander children in out of home care had an indicator of poverty, mental health, substance misuse, domestic and family violence and also intergenerational child protection contact. So that's compared to 6% of the non-Aboriginal population. So they're around 2 1/2 times more likely to be dealing with all of those. drivers of child protection risk than the non-Aboriginal population, which again I think speaks to, you know, moving back to that idea of how do we think about early support? How do we think about prevention? There's clearly heightened need. Are we resourcing and setting up our system and our funding models in a way that recognises that heightened need? And the historical drivers of those needs also. And one interesting result that I would also like to point out is that there are a large proportion of children in out of home care who only have indicators of poverty and intergenerational child protection contact. So 19%, so that's like one in five children in out of home care have come from backgrounds, where all, where all we're seeing is poverty and intergenerational child protection contact and to me, that begs the question around the role of poverty in both perceived and actual child protection risk and the fact that our system does not seem to be set up to respond to the fact that the parents, the families, the carers are living in the very circumstances that we remove the children from. So while we're focused on child safety, we also need to be focused on improving the well-being and outcomes of the carers of our children too. And I would say it’s very clear that the way our system is currently set up, by and large, does not have the capacity or the mechanisms to do that.

Counsel Assisting:
In terms of of pathways out of the system, what does the data show with respect to Aboriginal children being able to be moved out of the system as distinct from remaining in the system until they're they're adults, until they're 18?

Dr Rhiannon Pilkington:
So following the Nyland Royal Commission, one of the changes that came into the way, the Department triages those notifications is the ability to refer out, so those referrals out of the system are called Refer State Authority or Refer Other Agency and they can occur to notifications that are screened in. So they have to be screened in and I would like to before we go in, raise the question around why we've actually limited that ability to refer out to only screened in notifications. So we know by age 10, 80% of Aboriginal children will have been screened in at least once, but within a year, there's only 30% of those children being screened in. So why are we not taking the earlier opportunity to actually think about what supportive service, what supportive service involvement might look like, and I emphasise supportive because I think that's also key. So that to me would seem to be a missed opportunity within the system, acknowledging that we have to address the mismatch between need and our ability to supply and respond to that need. If we were to think about taking up those opportunities for earlier support. So going back to your original question around ways out of the system. One of the ways out of the system that that have now been used are those referrals out and so what we have actually seen since the Nyland Royal Commission. So if we go back to 2016-17 and we look every year through to 2020-21, so that's over five years, is we went from 5.9% of screened in notifications being referred out of the Department for a supportive service, up to 9.6%, to 15.7% to 23.7% to in our most recent year of data, 41% of all screened in notifications, were getting a referral out to another service. And so that's fairly comparable to the non-indigenous notifications coming in. So on the Department side, there's been an increased referral out, now the

question remains as to whether there has been a matched increase in investment in services that are able to respond to those referrals. So I think you know how we think about how we treat notifications in the child protection system as opportunities for early support is a key question that I don't believe has been dealt with within government in a way in which we truly have a whole system understanding around what the resourcing would need to be to meet that need, and that opportunity for earlier support.

Counsel Assisting:
Is there any information in the data about the success or otherwise of early intervention. Is there any anything in the the Department's data that that looks at that?

Dr Rhiannon Pilkington:
I think that is one of the big system questions that cannot be answered satisfactorily, so we can have some views of that. So what we can do is we can look at those referrals out and say, well, what happens after they've had a referral, you know, do they just come back to child protection and so what we do know from some of our other work is the the the act on its own of being referred out does not substantially change the likelihood of returning to go through the child protection system and process yet again, as opposed to not being referred out. Now the important thing to know with that though, is we can't tell whether those referrals were responded to, so that may simply be a function of the fact that the system can only respond to a very small proportion of those referrals. Now that anecdotally is what we understand, but we haven't been able to connect up the data to show that that is actually the case. But I would, I suppose as a first point of call, be looking to the Department for Human Services to supply the information that says this is the proportion of referrals we're able to respond to, as probably the best indicator or one of our best indicators of unmet need. And I think one of the other points to think about, you know, when you talk about ways out of the system, Denise, I guess I think about reunification and you know, we are able to look at reunification within the data. And.

Counsel Assisting:
What does that?

Dr Rhiannon Pilkington:
Sorry, Denise?

Counsel Assisting:
Sorry, Dr, what does the data tell us about the rates of reunification?

Dr Rhiannon Pilkington:
Well, it does show that in the most recent data we have, if we look at early reunification. So that's sort of is within six months of placement within out of home care. For 2020-2021, what we saw was 19% of non-Aboriginal children were reunified, versus 12.6% of Aboriginal and Torres Strait Islander children. Now when we start moving that time horizon out. So if we look at reunification at 12 months post entry into care. Those numbers start to look more similar, but they're still elevated for the non-Aboriginal compared to the Aboriginal population, with 21.8% being reunified and 24.8% of the non-Aboriginal population being reunified. And again, if we go out even further to 24 months, we are still seeing a disparity, so we're seeing 29% of the Aboriginal population being reunified, compared to 34% of the non-Aboriginal population. So, we see disparities in contact patterns. We see disparities in reunification patterns, and we also see high levels of inequality in the experience of background characteristics that we think might be related to child protection risk.

Counsel Assisting:
Dr Pilkington can you just elaborate on that please?

Dr Rhiannon Pilkington:
Hmm. So I guess I'm really trying to bring the picture together so you know in a. If we think about all of the different indicators we look at to understand what comes in, how they move through the system, what we know about those children and families from the data. What we see is, consistently you know, up to half of Aboriginal Torres Islander children are coming in in one year, compared to one in 12 and then through the system they are more likely to move through every stage of the system. So they're more likely to be screened in, more likely to be investigated, more likely to be substantiated, more likely to be removed. And then once they're in the system, they're less likely to be reunified than their non-indigenous peers. And so, but if we then look to say well, what could we have known before there was statutory system involvement? And I think it's reasonable to say that the system broadly speaking and the child protection system were aware usually of these indicators of risk. They are greatly elevated for the Aboriginal and Torres Strait Islander population and, of course, we need to understand and acknowledge that that's in the context of invasion, systemic racism, continued judgement of people based on the colour of their skin. But nonetheless, those are, that is what we're seeing in the data. So it it really doesn't matter what indicator we look at, there's indicators of disproportionate progression through the child protection system and disproportionate need compared to the non-Aboriginal population.

Counsel Assisting:
You mentioned before the disparities in contact patterns. Can you just speak to that please?

Dr Rhiannon Pilkington:
Yes, yes.

Counsel Assisting:
Is that contact with families?

Dr Rhiannon Pilkington:
Yeah. So there's lots of different parts of the system we can think about that in. So I will start by thinking about earlier contact with child protection and then I'd like to talk about the out of home care patterns that we've seen over the years. So, once children get into the child protection system, and so by that I mean once they're notified, we do still see disparities in the likelihood of them moving to the next stage of the child protection system. So for example, if we just even look in that one year again. So we have about 9000 Aboriginal children who were notified at least once in that one year period. So 62% of those children were screened in at least once. And then if we compare that to the non-Aboriginal population 47.8% of those children were screened in at least once. So you see, they're more likely to be screened in. Then if we go to, OK, well of those screened in how many get investigated? So 28.7%, so nearly a third of all Aboriginal children get investigated, compared to 20%, so one in five of the non-Aboriginal children. And then we say, well, of those investigated, how many end up substantiated and we see that for Aboriginal children, 59% of those who were investigated get substantiated compared to 51.8%. So, it's not just the disparate contact patterns at the front door. It's also that through every step of the child protection system, these children are more likely to progress. Now you could argue that that's related to the higher levels of background complexity disadvantage characteristics that are occurring, but I think our underlying expectation is that the further these children move through the child protection system, the more similar they are to their non-indigenous peers. And even once we reach, if we're just looking within children who are substantiated for maltreatment, so we would assume that those populations are more similar in

terms of child protection risk because they've all been substantiated for maltreatment. Aboriginal children are still more likely to be removed from their families than non-Aboriginal children. So I think that's when we have to start to ask what's driving that.

Counsel Assisting:
And Chair, do you have a question?

Commissioner Lawrie:
I just wanted you to talk more about that Rhiannon in terms of, how it gets to the point, what you see in the data about how the system is responding through what appears through the data for Aboriginal children in terms of…

Dr Rhiannon Pilkington:
The removals, yeah.

Commissioner Lawrie:
Progress through the system and getting to the point of removal. Just, you, talk more about that.

Dr Rhiannon Pilkington:
Yeah, I can. So I guess. Is at every point of the child protection system, decisions are made about what level of risk to the safety of the child, indicates a certain level of response. So that decision, whether to investigate or not, relates to that perceived level of risk. So I've talked about, you know, what are considered common child protection risk related things. So poverty, mental health, substance abuse, intergenerational child protection contact and the assumption is that if all of those things were held equal, then the risk of moving through the child protection system should look the same for Aboriginal and non-Aboriginal children. If there, if those, background characteristics were the same. So sometimes the argument for the disparities we see is that, well, that just reflects higher levels of those background characteristics for the Aboriginal children. But when we've done analysis which has tried to actually make those background characteristics the same from a statistical perspective, what we've found is that there continues to be an increased risk of Aboriginal children being investigated, substantiated or and removed into out of home care once they're within the system, and it's very difficult for us to explain why that difference persists. And so, when we've talked to Aboriginal families, Aboriginal workers, even within the system, they have said to us racism is inherent in the way our systems work all the way from who gets notified to who gets removed. And so that's been the response to that remaining gap even when statistically we have tried to make those background characteristics equivalent between the two populations. And so. April, are you happy for me to talk about the patterns of removal into out of home care to get onto that? Yep.

Commissioner Lawrie:
Yes, yes, thank you.

Dr Rhiannon Pilkington:
So. Just trying to gather my thoughts here. So one of the things we're able to do with the data is go back in time quite a long way to understand the lifetime experiences and risk of being removed into out of home care for Aboriginal and non-Aboriginal children. So we were able to follow children born from 1991 all the way through to children born in 2019-2020 and actually say well, for each year of birth what proportion of children have been removed in out of home care, into out of home care? So this way we've been able to understand the lifetime experiences of out of home care and how that's changing over time. So if we just looked at any type of out of home care, so short term, long term, emergency, it's all included in that. What we actually saw was for children born in 1991 to 92, about 25% of Aboriginal children were removed and placed in out of home care at least once. Now that

was compared to 2% of non-Aboriginal children. And I'm gonna leave non-Aboriginal children to the side now because you can take it as read that the proportion removed always sits between 1.5 to just over 2%, no matter what year of birth you're looking at. So if we just focus on Aboriginal children, so 25% of those born in 91 to 92 were removed. So then if we actually keep following children who are born in more recent years and we fast forward to children born in 1999 to 2000, we actually see that the proportion of children removed was going down and it was going down every year. So for those children born in 99 to 2000, so we just think by the time they turn 17, it was 2017. So that's their lifetime experience of out of home care spanning 1999 to 2017. That went to about, I'm looking at my graph here, it's about 16-17% of those children were removed, so we were actually seeing those rates of removal going down successively every year of birth for those children. Now when we then fast forward and we start to go to more contemporary cohorts, so children born more recently, and we look at children born 2001-2 and 2009-10, what we were seeing was actually it was staying reasonably stable for the ages we could follow. We were getting up to about 20%, so it was going up a bit again of children being removed. But then when we fast forward to children who've been born from, let's say, 2019-20, 2017-18, and we're only able to follow them to as old as they are. And so these are very young children. But what we're actually able to see, so if we even just looked at children born in 2015-16, by the time they were aged 5, so we're talking about 2020. We're now back to 15% of those children being removed by the time they were aged 5. And so for all of these more recently born birth cohorts, each more recent year the more likely they are to be removed and the higher was that likelihood of removal at younger ages. So in the most recent birth cohort we could look at, those born 2019-20, we actually saw over 10% of those children had experienced out of home care at least once by age 2. So I actually don't know how to comment on that figure because it's so devastating. I, I don't even know what to say. I do want to though, move on to any out of home care too. Sorry. Take a deep breath. Alright, so I want move on to focus on long term orders. So, it is commonly accepted that once children are on 18 year orders, it's much harder to reunify with family. So we wanted to focus and understand those same patterns I just talked through, but for those long-term orders. So, if we do the same thing because we can follow children born 1991 all the way through to 2020. The pattern looks really different for long term orders than it looked for overall out of home care. And it looks different in the sense that we didn't have that early period where things looked like they were going in the right direction. But it also looks different in the sense that, umm. I think it is, it's the most staggering indicator of a system set up to remove children. I think it's difficult to come to any other conclusion when you look at these numbers. So for children born in 91-99. So if you remember, when we looked at those, those same Aboriginal children born in that year, we had, we had about 25% of them experiencing any out of home care. But we had only about 5% experiencing a guardianship to 18 years order. So then when we fast forward and we look at more recently born children, the experience of those 18, those orders until they were 18 years of age goes up for each cohort born more recently. So for those born in 2000-2003, that reached one in 10 by age 17. Then if we fast forward to those born in 2007-2009, it reached one in 10 by age 10. And then if we keep going forward and we keep looking at more recent birth cohorts, if we look at those children born 2015 to 2016. We've removed one in 10 of those children onto an order until they are 18 years of age by the time they turn 5. And then if we look at our most recently born children, we're removing about 7% of children born in 2019 onto an order until they are 18 years of age by age 1. So it's not just that more children are experiencing out of home care, it's that there are staggering proportions of our Aboriginal children being removed for the entirety of their childhood and adolescent life. And those patterns are going up quicker in more recent years. So if we just think that by age 1, 1 in 14 infants are being removed onto long term orders and when we know what that means for opportunities for reunification.

Counsel Assisting:
I'm wondering if it might be a good time to take a break. I think your information has been profoundly moving, Dr Pilkington, I'm very grateful to you. I think everybody's surprised.

Dr Rhiannon Pilkington:
Oh sorry, I got upset, I'm normally very good at compartmentalising.

Counsel Assisting:
Please don't apologise. How about we have a 15 minute break? Is there much more you want to speak to Dr Pilkington in terms of your data, when you've given us a very.

Dr Rhiannon Pilkington:
I think I just want to say one last thing, which is and then you know, maybe we can, we can move on if the Commissioner's happy with that but.

Dr Rhiannon Pilkington:
Can I just ask you before we do break those, that specific increase at 2017, is that, that's in line, isn't it, with the, the changes to the Care and Protection Act that came in the the new Act came in in 2017. Is that the indicator of of the increase that Act demanded that the court make, what was referred to, as timely decisions about removals and about permanency. Is that reflected in the in the data? That, that's where the change came?

Dr Rhiannon Pilkington:
It looked like it was going up every year regardless. But the speed of the increases in more recent years and the the speed of the increases to removing greater proportions of children at younger ages in more recent years, would suggest that there might be perverse outcomes related to how the priorities were set out in the legislation. We cannot prove that from this, that's really difficult to do. However, I think, you know, in some ways, I think, it doesn't matter. There's no one solution to this, you know? So we have to look at legislation and we have to look at supportive services and we have to look at how we're matching our resourcing to need and we have to look at how we tackle systemic racism and we have to also think about in our broader society what that means, because the biggest gap is in the proportion of children and families being reported. And we also have to look at a system that we've set up where some people are reporting because they think that's the only way to get a family a service. So, you know, but so I almost think it it doesn't matter, all of those things have to come into consideration. But then I go back to things we have known for years. So you know how many years have we known that Aboriginal and Torres Strait Islander children make up 30 to 40% of all of our child protection business? You know, we've known that for a long time. But are we funding 30 to 40% of our services that are relevant to this space to be culturally safe to be Aboriginal controlled? We've known things like that for more than a decade and what have we done?

Counsel Assisting:
Thank you. We'll have a 15-20 minute break now if that's all right and we'll come back to you. Thanks, Dr Pilkington.

Dr Rhiannon Pilkington:
Thank you.

Counsel Assisting:
Before we break, does anybody have any questions they'd like to ask of you?

Dr Fiona Arney:
I, I just have one.

Dr Rhiannon Pilkington:
You're allowed to have 10.

Dr Fiona Arney:
Rhiannon, I don't know whether you had an opportunity to explore this in the data, but just about the total number of notifications per child that might have been made over time, like the extent of repeat reporting for children and or family units, if you were able to explore that?

Dr Rhiannon Pilkington:
I think we did do both of those things. We just, we did a lot.

Dr Fiona Arney:
I can only imagine.

Dr Rhiannon Pilkington:
I do not have the numbers in my head. I mean, I suppose the other things we didn't touch on are things like the proportion of children who are in kinship care, noting that that is not necessarily a measure of kinship care as we'd like it to be. The other thing I guess we didn't touch on also was the huge disparity in the unborn notifications, but let me find that for you Fiona.

Counsel Assisting:
We'll come back to that when we've had a break because that is something I want you to to speak to because it's particularly relevant Ms Glover’s project.

Dr Rhiannon Pilkington:
Yeah. Let me find that for you, Fiona, while you're breaking.

Dr Fiona Arney:
Thanks, Rhiannon.

[BREAK]

Counsel Assisting:
OK. So Dr Pilkington, if you wouldn't mind now speaking about the unborn child notification data that you've collated and what that's indicated.

Dr Rhiannon Pilkington:
Yes, I will. And Fiona, just to resolve your question, we don't actually have it in the report. So you can back calculate averages from the years and what you do see is that Aboriginal children are consistently subject to more notifications and more screened in notifications, that, Commissioner, if you'd like a breakdown of that we will add that to the report, in probably like the next week, if that works for you and send an updated version through.

Commissioner Lawrie:
Certainly that would be fantastic. Thank you.

Dr Rhiannon Pilkington:
Yeah, because I was thinking surely we did it and the raw numbers are there but not presented in the way I'd like. So we will add that.

Dr Rhiannon Pilkington:
OK, so moving now to focus on unborn notifications. So these are notifications that occur during pregnancy. We know the vast majority of these reports come either from police or the health system. And if we look over time, at what proportion of, it's pregnancies really that get notified for Aboriginal and Torres Strait Islander women. In 2016, 24.7% of all Aboriginal pregnancies were reported with at least one unborn concern, and that's increased every single year to now. If we look in the most recent data in 2020, we see 32.8% or one in three pregnancies being reported to the Department for Child Protection. Now that's compared to 3.3% of non-Aboriginal pregnancies. So we're talking about one in three versus one in 33. So Aboriginal unborn children are 10 times more likely to be reported to the Department for Child Protection then their non-Aboriginal counterparts. So, that makes me think of a few things and one of, I think one of the themes that comes out of everything we've looked at is is a big question around, well, how does the system treat prior child protection involvement as a risk. So how do health workers view mum, dad, or brother or sister or auntie having previous child protection contact and how is that treated. Because our understanding of current screening practices is it's used as a flag to say there is increased risk in this family. And if we take that along with such high levels of child protection contact for Aboriginal children, families and communities, then it starts to ask the question have we built a system whereby every generation we are simply entrenching further statutory intervention and further levels of disadvantage that leads to more mental health problems, more substance use issues, in our future generations. Because there's no other way I can think about it and what when I look at those unborn child concerns. That is, starting in our antenatal health system. Where we're treating the system's response to previous assessments in itself as a risk and if we're treating, you know, what more do we need to know then if, as a system, we are treating prior out of home care experience as a risk for their own children? Because surely that says we have failed as a system. We failed to prevent the removal and then when we removed them we know, we know what that system does in terms of how it is on average unable to provide good environments for children that we would wish them to be in. So we then treat that as a risk, and yet we don't connect those things up and say well, what more evidence do we need of things not working? And I just I didn't want to lose that that point of how, you know, we have in in effect the way we've designed our system and the way we then assess risk intergenerationally means we are embedding a continued growth in essentially assessment of families being at high risk purely related to previous system responses. And you know, I do want to reiterate that is simply my thinking after doing this and reading this and other work, but it it's very difficult to think of how else to understand that and obviously Tamara Mackean's project will be amazing at really hopefully bringing that forward in the antenatal space. But I just didn't want to lose that point. And so when we think about those infants who are notified during pregnancy, then we can go on and track their experience of out of home care once they're born. And, so what we can see is that within the first month of life, 15% of those Aboriginal and Torres Strait Islander infants who were reported during pregnancy are removed from their families, compared to 11.7% of non-Aboriginal infants who were also reported. And that disparity between the Aboriginal and the non-Aboriginal populations continues as you move into the children being older. So if we look at three months, we see 18.8% of Aboriginal infants who reported as unborn child concerns being removed, compared to 13% of the non-Aboriginal infants. What, where, we don't really see a difference or a dramatic difference, is time in care following that first placement. So we do actually see that over the longer term, so two years post that first placement, a very similar proportion of Aboriginal and non-Aboriginal really young children have spent that full two years in care, so 72.3% of Aboriginal children and 72.7% of non-Aboriginal children removed following an unborn child concern will have spent their full that full two years in care. And then acknowledging, how a placement gets recorded as kinship care is not necessarily clear and may not relate to the definition of kinship that would be

appropriate for Aboriginal Torres Strait Islander families compared to non-Aboriginal families. I think even taking those questions into account, what we do see is that following that first placement in out of home care over 50% of Aboriginal and Torres Strait Islander children never spend any time in kinship care in the two years following their first placement. So that's their first two years. So even taking into account the problems with the data, that seems fairly unacceptable. That we have half of all Aboriginal children who are removed never even experiencing a kinship care placement in that first two years of care.

Commissioner Lawrie;
Is that point in time just recently or the pattern?

Dr Rhiannon Pilkington:
So that is, that's going back a couple of years because we have to follow them for two years. So it's 2018-19 through to 2020-21. But the way I look at it is. Yeah, you know, these are very young children too.

Counsel Assisting:
Dr Pilkington, does the, does the data then indicate that those children move to GOM18, at the end of the two years?

Dr Rhiannon Pilkington:
We don't have that here. I don't have the transition of unborn care concerns to GOM18s in front of me, so I can take that question on notice.

Counsel Assisting:
Yes. OK. Thank you.

Dr Rhiannon Pilkington:
So I will take 2 questions on notice. I will do the number of notifications and the transition to GOM18s.

Commissioner Lawrie:
Orders to 18. I don't think, there's no GOM anymore under the act.

Dr Rhiannon Pilkington:
No, that's right. So I still think of them as GOM18 'cause they have the same effect even if we've changed something. And I suppose the only other thing to say is, you know, much of our other findings for children subject to unborn concerns simply mirror what we saw for the broader child protection out of home care population, which is when we looked to understand background characteristics related to poverty, mental health, substance misuse, domestic family violence, 17% of those children, Aboriginal children, reported as an unborn notification had indicators of all five of those occurring in their family, compared to 7% for non-Aboriginal children. But again, we had that 19% who had indicators of only poverty and intergenerational child protection contact.

Counsel Assisting:
Thank you for that. Are there any other questions, Commissioner?

Commissioner Lawrie;
No, I'm fine. Thank you.

Counsel Assisting:
Dr Pilkington, thank you very much for that very disturbing and very enlightening presentation. I'll

now move to Dr Arney if I may, who's going to speak to the basically where the system has come from, the development of the system, how we've got to where we are.

Dr Fiona Arney:
Yeah. So contemporary mainstream child protection systems have effectively evolved since the middle of, were created in the middle of last century, and they've almost remained set and forget in a in a in the broader sense, and don't reflect our contemporary understandings of a whole range of different things, such as complex trauma, intergenerational trauma, the importance and protective function that connection to culture have, they're based on kind of middle mid-century attachment theory. So what happened was, we had this kind of evolution of mainstream child protection systems that were based on findings that were coming out of the US around what they called the battered child syndrome. So you will have heard Dr Henry Kempe and his colleagues who were in paediatric hospital settings who were noticing particular presentations around shaking babies, physical abuse, sexual abuse, those characteristics that were presenting at their kind of tertiary hospital clinics. And while you did have kind of eras of, you know, societies for protection of children that were happening, the kind of government formalised systems evolved from those that mid-century understanding at the same time you've got John Bowlby and his colleagues looking at attachment theory, but again very much, in a, a Eurocentric way, when lifestyles were vastly different, you had nuclear households generally, you know one parent not working. So this these notions of attachment theory were studied in a very context specific way, those contexts for family life have changed greatly since since they were being studied then. What you also had based on you know what Kempe and his colleagues were seeing, was a huge underestimate of the true extent of what was going on within family settings in terms of exposure to abuse and neglect because he was only seeing, like a small number of presentations that were coming to his hospital setting. So if you design a system that says we must, this is only affecting a very small portion of the population, it's really easily identifiable. We just need what they call residual systems. We just need these systems that pick it up when it happens and we have an investigative response and we determine and then we might have criminal sanctions for that. The family support movement kind of came along later, as they said, look, this is happening in context of poverty and and other things, where really we could be putting more supports in for families, but really it was kind of a law and order response. Now while you've got that happening in kind of the mainstream setting, you've still got eras of protectionism happening in Australia. So still children being removed with goals of broad range of goals, presumably protectionism, but also cultural decimation, if we may say, you know, the the objective of removing culture from from families. And so you've kind of these two systems of protectionism and mainstream child welfare they kind of meet at a particular point. And while you have amazing advocacy on the behalf of Aboriginal people who create Aboriginal community controlled organisations, dealing taking matters into their own hands, as we see an era of self-determination happen, the mainstream system is almost in charge of it all in terms of whether people can receive a service, whether action may be taken, that mainstream system kind of continues along as the arbiter of all things child welfare and you have Aboriginal organisations who do absolutely everything they can on kind of the outskirts of that system. What we then develop over time is a is a broader understanding of things that can be damaging to children and can cause them trauma beyond the kind of physical signs and symptoms of of abuse and neglect. We start to learn that repeated exposure to chronic family violence is really damaging to children's development, so we bring in kind of emotional abuse as a category to respond to, and we bring in cumulative harm concepts of, you know, repeated exposure to different things, you know, chronic neglect, those kinds of things start to come into the mix and that's where we actually see the bulk of what people are concerned about. The other, the other elements of sexual abuse and physical abuse

quite like relatively easy to detect that, criminal sanctions. But the bulk of what starts getting reported to child protection services is more, your kind of, as Rhiannon was saying, chronic neglect associated with poverty, umm and family violence, which I would argue is a symptom of intergenerational harm and trauma that's not being responded to. Meanwhile, as a nation, we've failed to respond to the impacts on the stolen generations of the trauma, the grief, the loss that occurred there. An apology only came in 2008. So we we have failed to provide for Aboriginal Australians, a trauma response system and I would argue that's also a violence prevention system you'd be providing there if we were actually adequately responding to trauma. So we we're also, as we're evolving, we're becoming more and more aware of children as rights holders in themselves that's a new development as well. And so we're also starting to for some of these social welfare issues starting to apply what's called the public health approach. We're starting to understand that there's things that you would do at scale, as Rhiannon was saying, there's things you do off of universal or more targeted systems and so Australia starts conceptualising what a public health approach might be in terms of responding to abuse and neglect. And it starts making beautiful triangles and saying this percentage of the population, you know, they just need something, maybe a website or an app or, you know, a parenting class or whatever. And then we kind of what we once again did was woefully, woefully underestimate both the proportion of children in Australia who may be having these exposures to abuse and neglect with and exposure to violence within their families, woefully, woefully underestimated it. We didn't resource any prevention systems. SA remains the only jurisdiction I think from which the prevention system is divorced from the statutory child protection system, so we didn't scale up resources and say adequately so still there's this dearth of preventative and early intervention responses, and because we've had just these successive generations of systemic neglect, which I'll talk about a little bit about, but we've had successive generations of this. So the problem just keeps on growing and because people have their own families, they haven't had their trauma addressed. We just kind of increasing generation by generation. But we arm the statutory child protection system with probably only three tools really. We armed it with the requirement and the ability to receive concerns, the ability to conduct investigations and the ability to remove children. Now some systems have done other things in that time. They may have provided family support services, but they've kind of often been sheared off to the non-government sector or another department these days. So we only have three things in the arsenal that we've given child protection. We haven't, until recently there hasn't been population level modelling of the the needs of families. We haven't gone to just first principles and said who were we hearing about what do they need? do they need our ability to receive notifications? Our ability to conduct investigations, and our ability to remove children? We have? That question has never been asked, and so the systemic neglect I talk about with within a residual system is you kind of go right we've got this much resource for doing something about it. Heavens, people are telling us about all these kids, all these kids they're telling us about. No one stopped and went, could there be that many children that we're we're worried about? And when we talk about that many children and the figures that Rhiannon's presented, we've got to remember these are children within families. So you might have seven children within a family, for example. Those numbers get up pretty quickly once you have larger families. But they kind of go, oh, gosh, we can't get to all of these. We will have to work out a way in which we do what we call the screening that Rhiannon was talking about. We have to work out a way. So what we'll do is we'll kind of compare groups of these kids that are being reported to us we'll work out who the kind of the worst them are. The people making those notifications are thinking, as Rhiannon said, that some form of help will be triggered and it's probably gone beyond the capacity of the what the notifier can do, or there's a legal requirement. We've told you to call us or to e-mail us. So then you go. Well, we've only really got this capacity at the other end. So we'll and we're only really gonna let's make it almost like an emergency department presentation. Let's just look at what you're telling us about in this moment that you're worried about. So we call that incident based screening. What's the presenting issue today with a, you know, rare resource we've got here, is that thing worse than these other things we're hearing about on this particular day? And that incident based screening, so rather than taking a holistic view of the child in the context of their family and understanding what's going on, still, the only thing we're armed with is the investigation and removal tools. So on the basis of that incident based screening, we go, I can't get to 50% of these things that you've rung me up about or I actually don't think they require us to, which is the 50% screen out figure at the front. We just go, no, go away, don't come back. And then of the people we do get to, well, we actually haven't got enough resources to do things for them. So we work out a way to remove them from our view really and SA and NSW are the only two jurisdictions where you can actually literally remove that child from a list on the same day you received that report. So you've decided that meets your threshold for doing some a statutory response and then you've gone, we can actually remove that child off this list and that just disappears. At least as Rhiannon was presenting those figures, we've increased the rate of refer-outs for those children, but before they used to just not receive anything and we get to this very small group of children that we've decided to do something about.

Counsel Assisting:
So Dr Arney, would they, those children be notifier only concern?

Dr Fiona Arney:
Notifier only concern is the 50% at the front door. We say no we can't see you and then of the 50% in then a small proportion would get a, receive an investigation and, as Rhiannon's data was showing, there was a time when they didn't receive anything and those who didn't receive an investigation got nothing else. Recent data analysis, and Rhiannon will provide the figures potentially on just those rates of re-reporting, but figures from 2016 showed in the South Australian jurisdiction in 17 post codes of the children and young people who are notified, 90% of them have been reported before. So 90%, when 90% of your business is repeat business and that was in a, I think that was in a 6 or 12 month period, but it was a very short period of, sorry that was over eight years. But when the bulk of your business is repeat business, as Rhiannon was saying, that's a clear indicator that you are, what you are doing is not fixing the problem and so what you then find is you find a lot of the system capacity becomes about how not to do anything. There's lots of screenings, there's lots of assessments. There may be referrals. We don't know if there's referral uptake. The system isn't great at kind of recording that, so we don't know what might be effective for families. So you have just this continual building of this system, of this business, so much of which is repeat business and so much of which builds escalation into the system, because until you get that investigation there may not be other things that can be done for you, or until you get the referral, but the referrals start bouncing around because the family's needs are so complex and so high they've been so entrenched for such a long time that you just get this repeat patterns of of reporting and then you get new children born into the family and complexity goes up and up up. And that system has been around for a really long time without the level of inquiry into it, that this, this Commission of Inquiry is able to take. So we have repeated repeated royal commissions and inquiries in that continually tinker with the system as it is. There is not the public health system for responding to intergenerational trauma and violence and and chronic harm that we see that would be the preventative system. And so even when we do have an early intervention system, what people envisage when they see early intervention, which versus what is actually required for families are very different things. I almost feel we should get away from the term early intervention because this has been going on for families for such a long time and they're complex family presentations where

you've got to work out what each member of the family needs in terms of, you know, a trauma response as well as, you know, developmental assessment and a whole range of other things that there often can be competing or common interests in the family. But it's really, it's very complex work. It's also an area where the workforce that we have determined to do this work is recent graduates, sometimes it’s students, and it’s some of the most complex work you could ever undertake in your life. I know in a hospital setting where I did my research training you had to specialise and specialise again to be in the field of child abuse and neglect. It was treated as really important, complex work to undertake with families, but instead we we have this kind of one trick pony of a system. The other thing we have is, Rhiannon gave evidence around just how early we are removing children and that they're being placed with non-relative carers. And we then have those concepts I mentioned about the attachment theory that come in, and it's so selectively applied in terms of how is it interpreted around attachment to whom and what. And they call the evidence based around this WEIRD, it's Western, it's educated, it's industrialised, rich and developed. So it's come from a place in time that I think we could all agree we're no longer, you know, heterosexual, nuclear families where one parent is staying home and tending the home, so that's where we get these notions of there will be a single primary attachment figure, etcetera, and once that attachment is formed, you know what we actually know and particularly from the literature is that attachment can look really different across cultural groups. The importance is that there are people who love and care for that child and are responsive, that can be multiple caregivers. And it's a true strength of Aboriginal child rearing that caregiving is shared amongst multiple people and the and children have the ability to attach to multiple people with such critical developmental periods because that actually strengthens the people you've got there as your support and mentors and and and key attachment figures rather than weaken it, it actually strengthens what's there for children. And we also, which is not reflected. And when you get into these situations where children are placed with non-relative caregivers on potentially long-term orders, we're not and and this is you know it's anecdotal evidence from the literature because people haven't studied it that much. But you know there's not high rates of contact necessarily with extended family or parents in those periods and so we then see the primary attachment figure is considered the non-relative carer, opportunities for forming attachments with other within culture and developing cultural attachment as well as bonds have not been provided, and then you get these arguments around well, there's a primary attachment figure here, let's continue that singular relationship. So we, the assessments that are done around child rearing and attachment are Western Eurocentric assessments to this, to this day and attachment theory is very much misunderstood in, even existing attachment theory is very much misunderstood, in terms of when there is transition from, like grief and loss is not incorporated into that theory. So the fact that you might be removing children from their families, the grief and loss that happens at either end of that transaction is not accounted for in child protection systems when we know that it's, it can be devastating for all parties and that grief and loss kind of cycles and spirals may mean people have subsequent pregnancies because of their loss of of older children and it's not treated as it would be treated as the loss of the due to death of a child, when really what people are experiencing is the is the same. And so, as I say, contemporary systems are very they're very procedural. They're very like, the they're just not fit for purpose. There is, I don't know, and I do despair because I don't know what purpose you would create a system like this for. We've got a policing system. If we needed investigations and, you know, criminal sanctions, we've got that system. This system is just not built on the fundamentals of what you would design today for responding to child abuse and neglect. And so I think an immense opportunity, if if it can be resourced adequately, is to create the alternative system that is designed on these knowledge bases. Or utilise existing systems and get this knowledge base and the and the people working together around this because one in two is the scariest stat when you think of other paediatric conditions like I just think of paediatric conditions where what 2% Type 1 Diabetes in juveniles, you've got about 11 or 12% I think it is for asthma like this is just 50%., you can't even, I can't even think. And then you think of the devastating impact that this has on brain development, it has on subsequent relationship formation, it has on your educational achievement like this is as as someone who came out of the paediatric sphere in research I go, this is a stand in the street screaming moment. We can't and we're just going to we're inflicting it on subsequent generations. The other point I just wanted to pick up on that Rhiannon made about, we don't know what our service capacity is out there in terms of our family support services. So the, the typical kind of as we try to prop up this system that got overwhelmed so quickly. We couldn't get to the children. We didn't have the adequate kind of tools and resources to get to the children. We've started creating pockets of family support services everywhere and that those family support services have kind of evolved at the same time, attachment theory was really evolving. We got home builders and we got other things. Now some of them. Actually, I'll speak to many of them, have very limited capacity for for families. So Rhiannon mentioned, we haven't done the modelling to say what is actually the level of need and how should resourcing look. That number will probably be mind blowing when we get to what that is, but we are investing in a like a billion dollars, I believe in a system that is not doing anything really. It's kind of geared up to do lots of nothing. So it's not that resource isn't there, it's just there and being used very ineffectively. So, but many of these services by design have very small caseloads. So you kind of even if we could get to the those families the right supports at the right time. We haven't modelled well what would that actually look like for a population base if we really wanted to address this demand. We also make participation in that system often conditional on a decision that's been made at child protection land. It's not democratised. We can't say all family, all Aboriginal families should have access to this system as we once did with family home visiting, you know, we we haven't said that. We we've said you can have it if child protection decide your concern is enough for us to screen in. But not to do anything about. And then you can have this thing that will, you'll get assessed again by someone and you won't quite know why they're coming to your door and a whole range of different things will happen. But it's a very conditional participation we allow for families to participate in that early intervention prevention system. It's not democratised, it's not you need help, here’s non-judgemental non-stigmatising help, that you just get provided because we have systemically neglected you for such a long time and we're really sorry. So that early intervention prevention piece is very conditional and very limited, and at a population level, we won't see a reduction in demand anytime soon if that's the way we continue to to proceed. The other thing is some of those models that come from the 1970s actually have crisis built into them, so they actually utilise the crisis as the point of change. So by their very nature things have to get so bad in a family that it would be considered a crisis rather than being preventative in any way shape or form. That you know you're you're effectively inflicting trauma on a family by saying you have to wait this long until it's this bad until you can have us do something in relation to that, and then we'll use that crisis and we can turn this around in 12 to 14 weeks when these problems are entrenched. It's not like suddenly life is going smoothly, crisis, everything else in my life was wonderful. There are some families where that happens, but they are not the majority of families that come to the attention of child child protection. So we've got kind of a terrible statutory response and then a kind of a conditional non statutory response that families may or may not be able to participate in, but those that decision making is taken out of their hands and it's in the hands of of child welfare. The other thing you see is absolute bouncing around of assessment and referral. Because you get assessed and referred at the door of child protection when those notifications are made, that's one form of assessment about a particular response. You may get referral if you get screened in and things are special then those referrals go out to non-government platforms for further assessment and referral as to what they have in there, some of them are called child and family assessment and referral networks, it's it's actually in their name but you know they're, they're trying to see if there's something within their system that can match to what you're presenting need is. Now we don't know the uptake rates of that we I don't know that we've got the bounce back rates of that. So kind of where the you send it out to the non-statutory system the non govy system and they go this is too hard for us to deal with. You already screened it into your system as requiring a statutory response we'll send that back to you. We don't know the rates at which family members may feel they can't take up that referral because they're living in context that don't support it like family violence where you're not wanting outside people involved necessarily or you're scared of that involvement. We also don't know the extent to which someone may come to see what's going on in the family because they've been told that the presenting issue is school non-attendance, shall we say, or you know, there's been exposure to violence. We don't know the extent to which the knock on the door or the telephone call. Once a further assessment has been done by the worker who is going to that family goes this is way too complex for us and we now thank you for accepting the referral to our service but our service is not for you or we don't have anything or as Rhiannon was saying, the wait list is four months to for us to refer you to the drug and alcohol. So we don't have any kind of system that comes together around the needs of these families. We have the families who, by dint of whatever decision making, has gone on, have to bounce around the systems that exist. And I think an opportunity exists to build that wraparound and Karen might speak a little bit about, about that in future, but to start to build the capacity of those systems with they're all clients in common, you'll see them at some stage in whatever system it is. It's just you may not be seeing them right now, but they will be clients in common. They will be people who are going to be referred at some stage and we need to work out how we can kind of get that collective effort happening now, without it having to be triggered by child protection without it having to be, you know you said yes to this thing that we work our systems out. How to do that complete wraparound because these families' lives are complex enough to have to kind of navigate NDIS at the same time you're navigating housing at the same time you're navigating your parole hearing, you know all of these things that are just. And and add in to that you know your own trauma, loss, background. It's just we're asking families to do the absolute incredible and impossible, I think. And so working out how you have a system that is responsive rather than coming off of child protection, which is so so much of what we designed.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
I've, I've got a question. You you gave us lots of information about the way in which the child protection system developed, sort of like in parallel to the protectionist era. Are you able to speak about what you know in terms of post the protectionist area, what was actually happening in the Aboriginal community with the whole approach to Aboriginal community controlled services, but this whole thing around the benefit of those, you know, Aboriginal organisations, particularly councils around neighbourhood development and what that actually means for a family in need.

Dr Fiona Arney:
Yeah, I think I'd be speaking beyond my expertise. That might be a question for Auntie Muriel, I would be thinking tomorrow, but or for Karen, or yourself, April.

Karen Glover:
I'm, I'm thinking Muriel.

Dr Fiona Arney:
Yeah.

Karen Glover:
You're talking about Muriel Bamblett?

Dr Fiona Arney:
Yeah. In terms of, I'd be speaking to a very limited exposure to to that in the South Australian context and coming I wasn't part of that movement or but certainly the.

Commissioner Lawrie:
The things that come across in the literature reviews?

Dr Fiona Arney:
Unfortunately, it talks about, so the literature reviews talk about the rise of Aboriginal organisations through periods of self-determination that there were there was dedicated funding, but also just dedicated will to enable Aboriginal organisations to take child welfare matters into Aboriginal hands and to determine the way in which families would be responded to in ways that were flexible, in ways that drew on knowledge within the community, in the family, in ways that were rights based as well as based on an understanding of what we would now be calling the social and cultural determinants of health. You know, that understood that things stemmed from trauma, poverty, etcetera and and were able to build from a much broader knowledge base, I would say than mainstream child protection systems have been built from, but also and I would, I'd be, I may be treading into territory, I'm not sure, I I believe that was facilitated through kind of Commonwealth impetus, if I, as well as state and territory kind of willingness, if you like, as part of not quite reparations but recognition that self-determination that we would get better answers if we put matters into Aboriginal hands to to deal with these responses. You then see kind of the the growth of the behemoth that is child welfare kind of growing up and then sidelining Aboriginal organisations for particular child protection matters and and not funding them. So kind of this marginalisation then, of Aboriginal organisations that was happening and now you see and Auntie Muriel will be will give excellent evidence on the role of ACCOs, Aboriginal community controlled organisations and their continued advocacy to claw back elements of of those responses, and you're also receiving evidence from Cindy Blackstock as well. So how that looks different in different First Nations contexts and what enables that. But it's been a hard fight that the kind of behemoth of child mainstream child welfare became so big and has remained so steady for probably the past 20 years, I would say almost that Aboriginal organisations, to the point that, you know, we've got one gazetted organisation now in the whole of South Australia when there used to be multiple gazetted organisations. That also that single gazetted organisation had a statutory role that they had to fulfil through their own funding for a while until they were actually funded to undertake it. So we we see this kind of sidelining and undermining of Aboriginal capability and and expertise and we also see that as Rhiannon spoke of that disparity in the proportion of funding that's going to Aboriginal community controlled organisations, still, there's still this notion of non-Aboriginal organisations will somehow manage affairs better and it's not been my experience in the least.

Commissioner Lawrie:
Yep. Thank you.

Counsel Assisting:
Thank you.

Karen Glover:
I’m just gonna say, I, I'm agreeing with what you're saying and that that whole thing about the with the Commonwealth through the 67 Referendum having the powers then to create that funding for

that purpose, that was driven by Aboriginal people and so we saw the Aboriginal community control and particularly the Aboriginal childcare agencies that were working in this space and and actually started the reunification kind of 'cause it was coming from the experience of Aboriginal people at the board level and in the staff, about the experience of Aboriginal people around child removal and interference by the Department of Welfare, Child Welfare. So I was not in South Australia at that time when that was happening, I was in Western Australia, but Brian Butler was here and I was working in the WA equivalent, a little bit, and it was probably a couple of years behind. So that, was that didn't start in WA till 82.

Commissioner Lawrie:
Yorganop.

Karen Glover:
The ACCA.

Commissioner Lawrie:
Yeah, Yorganop ACCA in Perth.

Karen Glover:
Yeah, yeah. So and having that Aboriginal perspective about what it was and having a broader kind of view and being sidelined as you say, yeah, by the other thing that's been growing. And and. So underfunding underresourced in every other way around, you know training and not having the ability to look at things from Aboriginal perspectives around policy making and things like that, and the understanding that, so it was interesting your comment about the referrals like you've both talked about referrals, referrals to what and when the funding goes to the non-government sector who the staffing, we don't know who they are and what their kind of expertise is around Aboriginal business and Aboriginal families and and helping and supporting Aboriginal families.

Dr Fiona Arney:
Mm hmm. Yeah. The cultural capability of non-Aboriginal organisations which, there was as part of the work undertaken for the Early Intervention Research Directorate, where there was an examination of kind of what the early intervention prevention investment looked like for SA, although several elements of that were made Cabinet in Confidence, so I can't share them here. However, there was a general finding that non-Aboriginal organisations were very ill equipped to meet minimum standards of cultural proficiency, not even cultural proficiency, just very minimum standards. Which means that Aboriginal families once again, even if they are receiving a service, are not receiving one that's necessarily culturally safe, culturally embedded. The literature is quite clear that connection to culture and cultural strength is a protective factor, that it is associated with reduced rates of, you know, poor mental health and well-being and suicidality and a whole range of other things that cultural connection provides. So if people are being provided a service that's not culturally strong, but also may be undermining aspects of their child rearing and culture that are particularly strong. Or may just be feel unsafe. They may reduce their connection time with that service as well, so or might just not take it up, and word will get around quickly about programs that don't feel safe.

Counsel Assisting:
Thank you for that. Karen, I'll move to you. I understand you are running a program. Would you tell the inquiry about the program you're involved in, please?

Karen Glover:
Yes, so I work at SAHMRI in research, so it's a research, well, we've got a few programs and we've

also got Aboriginal advisory groups or governing groups set up to give us advice and tell us how to do the work as respectfully as we can. So starting right from the priorities, so we're looking at the principles of the accord and doing ethical research that comes from NHMRC, the funding body. So just to kind of foreground that. One of the thing, one of the priorities is about supporting families and we because we work in the maternal and child health sector and families that that's our focus of our research, child protection comes up all the time. It's a real concern of anywhere where we go from services, Aboriginal services to Aboriginal communities. We go to Elders groups and other places like that. So, what we've what we've found over a number of years is talking about the intergenerational trauma and how that becomes a barrier to your parenting. But also so I'm I've got lots of things firing off, so I'm hoping that it'll make sense and it'll all come into place. So one of the things we've found is the number of stresses that women are experiencing during pregnancy, at the time when we did a study of mothers from 2011 to 2013 and what, and what their experiences were in accessing antenatal healthcare. So there is no Aboriginal hospital, birthing hospital. So and there's even though there's moves around birthing on country, which might mean birthing at home or close to your land, but it's it is also about how do you make things culturally respectful in a hospital or other setting. So, looking at looking at the number of stresses, we also asked a question about cannabis use during pregnancy. So so we asked the questions maybe somewhere around 9 or 10 months after baby was born. So women were freely telling us, we had, we had women telling us that they had been using cannabis and we could make a health link between cannabis use and the small gestational age babies. So we've been thinking, well, what kinds of things can we be doing to address that that's in a safe way for families because we've got the trust because the, because there weren't notifications, because we'd said we'd give that information after baby was born, by the time we wrote about it, children were older. So we're still asking questions like that and we've gone to a broader range of substance use now. One of the other things that is clear umm is we don't want to be doing anything in our research to be triggering child protection, like we're trying to take a strengths-based approach and look at what are the strengths that families have, how can we build on that or if families are missing whatever it is they're missing, how can we try to support that better to take care of the children. So so our research is not intended to reduce child removals. However, it might be that by participating in the research that might help families, might help families to not not be drawn to the attention of child protection and.

Counsel Assisting:
Can I just ask? Sorry to interrupt you. How are people referred to you or involved in your research how they become involved in your research?

Karen Glover:
Not through a referral, not child protection. We've, we've not done that. We're we're working with the Aboriginal birthing programs for Corka Bubs, we're working at Women's and Children's Hospital and the Lyell McEwin in their Aboriginal birthing or Aboriginal antenatal care programs. They're both quite different models, and sometimes there's difficulties around workforce. But what, what, what we are wanting is to work together with the health service itself and they give us a consent to make contact with the women. So they actually are, we don't hang around the waiting room and keep the pregnant women with, not allowed, It's not ethical. So we ask the workers to do that for us and they and, and that's what they do through the consent contact process and then we follow the women up who say yes. And we've also found through our research that the dads have felt quite excluded in the whole process around the antenatal care and expecting baby and parenting and all of those things. So the Corka Bubs program is looking at offering, offering a package so Yvonne Clark works with us and what is behind her thinking all the time is around the wellbeing of families and how can

we strengthen that and also, you know, look at strengths. So, what she's talking about. So that's why we developed the package approach and looked at what are, what are the things causing stress and in that package we have three things legal support, counselling and drug and alcohol support. So we even had to go to the extent that, it's a two year feasibility and acceptability study and we knew that it would take a while for people to want to engage because of the risk of child protection and we have, it's took a long time to get the pick up and it's and it will come to an end by around about March. We have got a new grant that is will be starting in March. So we're trying to stretch this, because that's the other issue is stop start nature. Just get the buy in by community and in that one that one will have a bit different. We chose what was in the package, what we knew about, but we didn't have everything and what's happening with this one is a thing called Baby Coming You Ready? It's an app based program that women will answer lots of questions, it's iterative, and it will spit out a client summary at the end, which we then will be connected up and we haven't done this, but it's our intention and it's from the learnings of the Corka Bubs, that there will be a number of things that will come up. You've talked about those five things. So we'll include to those those three things will include housing and family violence. We did have family violence in Corka Bubs but there was a change in the staffing at Nunga Mi:Minar at the time. So we we didn't have it, we couldn't work that out. So so while we're doing that, we're also working on another program called Acorn, and with the so so what I should say first of all, with the Corka Bubs, is what's happening now, is that because we did go to child protection, to the senior Aboriginal staff, and we said this is what we want to do, is there a way that if people are participating in this program, that you could leave them alone so we can get some info, good information so it'll help you develop, you know, health response as well as child protection response and that was when they said that a lot of the reporting was about we're worried about this woman for these reasons but there was nothing about, and women are connected to these things, so what services? So that was when we found that it's a double-edged sword because then what child protection does is looks at, oh, you're attending those things so now they're looking at our research and they're ringing us to say, has this person attended those appointments?

Dr Fiona Arney:
Oh, God.

Karen Glover:
And can you tell us, you know, are they missing?

Commissioner Lawrie:
Are you saying that as in evidence gathering? As part of an investigation.

Karen Glover:
It's a, it's an s150 or an s152.

Commissioner Lawrie:
That's part of the evidence gathering.

Karen Glover:
Yes. And we are really frustrated by that because we're not a child protection agency. We understand that children have to be protected. But this is what's actually happening. So, we're getting our advice too about that, but but what we've done is we've, because we took a risk assessment and thought child protection might get hold of what we're doing and they might start doing this. What we are saying, what what we have said is, is we will all we’ll know is if people are as if people are assessing, accessing different the services and at the end we'll want to know did it

make a difference to women. Did they feel more supported? You know, what was the feasibility of it? But we what we're finding of all of those three things, the counselling is the biggest and most people are accessing.

Counsel Assisting:
What sort of counselling is it?

Karen Glover:
It's narrative therapy or it's general counselling. And the next thing after that before you even get to the legal and the, or anything else, is transport. Women are really struggling to get to their appointments so and I can imagine being bombarded by a number of appointments that might be, you know, getting directed to do that by DCP, if transport's not provided that could be causing an issue because that's how they're getting, we've got a high proportion of people needing that support to get to an appointment. And and the feedback so far, because it's too early, but the feedback is women feel better that they've spoken to somebody about something that's been really worrying them, that they might not have known that it was possible to get that kind of support. And we've had a couple of the partners we've had a couple of nannas and we've also had a couple the partners have come in as well and are accessing those services too, so that, that's kind of where that's up to and we want to go further with it in our I care project that's starting in March next year. So then we were looking at what are some of the things that could be in that package that we're calling the Coolamon because it's different research project. What's the sort of supports and one of them is this thing called in it, there's a thing called Acorn and this is an Aboriginal Acorn and. We had a reference Aboriginal reference group meeting last week and we actually that we actually had to really the the reference group felt very strongly about the DCP being involved because the Aboriginal, the Acorn program had, I mean, you had to have a mental health issue and be connected to some kind of health service to get a referral into Acorn, and we're thinking, well, if there's a mental health issue, women need that and then what's the risk then and what they what they found is that it was in one of the big non-government organisations and there weren't notifications that the DCP just left them alone. And so we're wondering, well why is that? Why is? Because this group they described child protection, as you know, we're trying to do something strengths-based and child protection is like the eagle hovering in the air and the women are the mouse on the ground trying to help themselves and this is the kind of way that they were seeing it. They they were very vocal and very strongly speaking about how we didn't want to be creating something else that is another lever for child protection. So and we're trying to think, well, how are we going to generate research if we can't engage community safely? So, so you know, so then it kind of weakens what we can do with our research and all the things you've spoken about here, both of you, Fiona and Rhiannon, about you know, empowering women to be, you know, driving their own their self-determined kind of, these are my issues because the issues the woman's facing might not be the what the midwife thinks. And if you don't sort this out, whatever it is, you're not going to get to the the other bit. So and that just brings me to this thing about attachment and Aboriginal attachment theory. And we were thinking about investing, investigating and exploring that. And so what what we've come to as our group and through the reference group as well, particularly for the Acorn, is that there isn't a single attachment theory and it's because of that everything you said about the mid-50s but there is the social, emotional wellbeing wheel and those domains in there. And we have used that in, it does get used in a number of settings and we've recently used it in an adolescent dealing with adolescent trauma, so we've called it Strong Culture, Strong Aboriginal Young People and and the connected, so young people and Aboriginal people who look at it can see themselves in it. And then around the outside of it are those determinants that you know whether there's transport issues or if there's been

somebody stolen in the family, or if there's been some kind of breakdown in their connectedness to things. So so, it's and social and emotional wellbeing is about connectedness to those seven domains around your physical, your mind, emotion, culture, family, community, and I'll send the link to it if you like Denise, I can send you that, what it looks like and the explanation about it and also about connection to land or country and to spirit and and ancestors and different people have got different experiences in that. And so that's what we're trying to look at taking that kind of approach. Because the actual and with the child protection and I can imagine those workers over there and including women who work at the hospital when a removal happens at the hospital, that it's so such a stressful impact on for for the mum having baby removed for the staff member who's doing it at the direction of DCP. And and I've, umm just recently found out that that's actually not even counted how often that happens, and yet it's a big workforce issue, for what happens to workforce. But so everyone knows it happens, but I didn't realise that child protection can actually, if they can't get there to do it themselves, they can direct somebody from the hospital to do it and and then that becomes a stressful thing, even if that person was the one who made the notification in the first place, that's which we'd, I don't know.

Commissioner Lawrie:
And what does that direction look like when the Department gives Health as one of the Authorities?

Karen Glover:
I, I haven't seen any instructions like that. I'm get this is not my research, it's it's that it's it, well, it is, but it isn't documented anywhere. We've just started the conversation. I'm not sure whether that's appropriate for here. Yeah, but certainly what we're trying to do is take a strengths-based approach and look at if we strengthen all of those domains in the wheel, then that, from all of the all of the literature that we've read about that in the terms of adolescence really does point to it, there are outcomes, like we've talked about, they're there for suicide. So you've got some kind of stop smoking program that's also looking at suicide prevention, so you've got to kind of do all of these things that have all these fabulous and strength building outcomes. Kids attending school more or being more connected to their relations or broader extended family. Lots of lots of things that have, you know, learning language, lots of things that strengthen identity, particularly in in adolescence, but identity in, you know, I'm thinking about Stolen Generation and all of those that trauma that goes with it and being severed from all of that and trying to rebuild that so, so I don't know whether in any of your data you've got whether people say you've got come to the notice before, but I don't know whether there's any Stolen Gen kind of data in there.

Dr Rhiannon Pilkington:
So we can tell, removals, you know 'cause that's all it's classified as since 1981, 1980. So, but there's nothing you know specific which really clearly calls out Stolen Generation at all. And so, you know, the reason we do intergenerational child protection contact is because how do we get to intergenerational trauma? You know, in data like this and that's the only way we think we have a window into it. But no, there's nothing specific in there that we could use from the quantitative data. But I would be surprised if it wasn't recorded in some of the cases, but it would be ad hoc and it would depend on, you know, the the independent, the, each individual social worker understanding that that should be recognised and recording it. I don't know if you ever saw it, Fiona, in the work you did?

Dr Fiona Arney:
No, we I think child protection in the case files we saw like to reference its own business in the sense of whether they had moved under placed, a parent had been on an order or in out of home care

from their own system. There is research from WA that looks at Stolen Generations people, who, and then kind of their subsequent risks, if you like, in terms of gambling, alcohol use, etcetera. And of course it throws up the context that Rhiannon was speaking on earlier. So there's clearly, but it's not recorded in any systematic fashion. But anecdotally, of course we hear of just multiple generations of removal that have continued on. And and I would back up Rhiannon’s view that we are using previous removal as yourself as a child as the key indicator of risk, yeah.

Karen Glover:
And we and we have people around the table who, who work in that space, who have confirmed that too, yeah.

Commissioner Lawrie:
Karen, can you tell me what Acorn represents in terms, like does it stand for anything?

Karen Glover:
So the A, no, it's not a acronym. What it is is. There's three elements to it, so it's about giving women more confidence and about them because that 'cause my understanding, the attachment theory if you use it what it was intended for was about having a connection, but that it's been misconstrued over time and has become something different. But what it's about is about using dance and play as a way so so for women who might have a mental health issue, who who have got some kind of barrier to their connection to their child for all sorts of reasons, including trauma from all kinds of, could have been from child sexual abuse or some other kind of trauma. And so if they are feeling and they're lacking confidence and skills and experience or or supports whatever it is. So it's about having some play time that includes dancing that so that you can build that trust and between the mother and the child. So again, it's only focused on mums and baby and it's up to three years old. Then, then the second part of it is, is that there's some kind of, what we're doing is we're actually developing what the Aboriginal Acorn might look like so and we've just, we're gonna pilot it next year and we want it to be part of this Coolamon package. So the second bit is what they're calling journaling, so mums can actually journal about what they what they experience and talk about how they felt about it, that's just for themselves, it's not for public consumption or anybody else to see, it's a private thing. And the the third element is that some kind of the mental health worker who's in the group may notice is is actually looking for some positive things, positive interactions between mums and babies, and then what they do is they write a letter to the mother in between because it's about 15 weeks. So in between each week, the mums will receive a letter to say, oh, you know, I noticed the way you were looking at baby or there was whatever the moment was that was, so it’s to give positive feedback to the mothers, and that worked in some situations and it didn't in a previous effort with Aboriginal mums. So we're trying to work out what would that look like and using that social, emotional wellbeing wheel so that it it tackles all of the domains and there might be dancing in it but there might be other kinds of cultural activities as well. So that, that's that's what that Acorn is. So it's not, it's not a fully funded program or anything like that yet, but the the actual discussion that took place in trying to work out what would that look like that was safe for Aboriginal mums.

Counsel Assisting:
If it was to become a fully funded program, where would the funding come from?

Karen Glover:
Well, that's the that's the question. So Department of Human Services. So there's Acorn that there is process now to fund it. So this is a classic, let's have let's do the let's do the Acorn program and then let's do the Aboriginal Acorn program and it's different, right? And it and it and it and it, so it was in

practice and in train, but there wasn't any evaluate well there was an evaluation that's under embargo. So it's been funded through a philanthropic, the Acorn and so similarly with the one that we're doing now as well. And then it's like if there's all that training and everything all in train now then what about the Aboriginal Acorn? So, so these are the sorts of things that happen. And I just wanted to also say, you know, with the lack of skills of mainstream organisations and with child protection becoming a behemoth and over here, we've got ACCAs like that, that, it's a similar thing with Health, the ACCHOs, the Aboriginal community controlled health organisations, are underfunded in comparison. We did the continuity of care and child protection came up there as well and it was looking at, you know, workforce issues and, you know, trying to trying to skill up the workforce and the mainstream workforce, but also about the actual services themselves and designing them. And through that, umm, through that kind of process we found out that there's there's some regions, it's about 10 regions in SA Health regions and some of them they don't, are unaware that there's an Aboriginal community controlled organisation in it. Some of the Aboriginal community controlled health organisations because they they do everything from antenatal to death, they they've got the whole spectrum. And some of them, like they've had, they have no inroads to an LHN or a Primary Health Network either. So it's very hit and miss. And so just sort of thinking about that question around if you've got this giant, so say like Child and Family Health Services, CaFHS, and when they had the family home visiting. Absolutely wonderful opportunity and it was meant to be for, you know, for everybody or well, there was a universal and then there was this targeted thing for two years that would have benefited every family. But the training was only for nurses, so that excluded Aboriginal health workers straight away and also if there were drug and alcohol, family violence or mental health issues, that was used as an exclusion criteria. So it's that same old thing

Dr Fiona Arney:
With child protection services, the system that would pick that up, almost like kind of that residual system almost.

Karen Glover:
Yeah, that was that was at the time when if if you had somebody from CaFHS at the table, child protection would say you're managing it and they would leave and wouldn't attend. So. So that's so we're talking, I don't know what are we talking eight years ago might even be 10 years ago. But it it's really. But they've changed that now. And so when you want to have the integrity of a program, so something like family home visiting is now being dismantled, so they're modules but you might not have all the modules and all, and so they're working all of that out. And this is what happens when you've got these big, big systems that have limited kind of input. One of the things I've just heard that word navigator being used before and that's why we wanted to do a project our research like we are, is if you've got you know, years ago they talked about, oh, you've got, you know, 50 cars pulling up in one week to one house and then up the road, nobody goes there. And so we're trying to be, you know, more targeted to stop that and spread it around a bit and be more targeted. And and so by doing, now I'm just…

Dr Fiona Arney:
The navigator.

The navigator. Yes. So when you think about the woman in that house and her family, and they've got 50 people, even if it's ten people, it's overwhelming. And and that is the way that the woman finds out that there's some, that and letters, that something is happening. So in our research, looking at strong dads looking at umm, even the continuity of care, we wrote that report for Health.

Umm. The the idea of a navigator role and you know they're doing it for the homeless people. This is where the language navigator came from. The homeless adults in Adelaide through the Department of Treasury and that social investment capital we came up with this navigator who would support a woman who is getting overwhelmed so that she can, you know, maintain a diary, can attend appointments if she needs that all those things and and the partner or nanna. And then what happens is it then goes, it gets escalated to another level in health to another level in Health until it becomes a, you know, a big group that's looking at antenatal and then they decide, oh, it's a systems issue, so we won't fund the navigator. And it's like, yes, where while you're fixing the system, you fund the navigator so that women can actually because because that's the other red flag for DCP, oh you're not attending your appointment, you don't care about your baby, you're not a good parent, so you know, and the appointment isn't necessarily the Health one. And the current way that DASSA works at the Women's and Children's, they started with Aboriginal women and it was ok, you've had a referral from your your midwife to come to the DASSA appointment. So the DASSA appointment is at the hospital, which is not easy for everyone to get to, but it's on a different day to the antenatal appointment. So you kind of have to then make 2 trips and and if you miss it three times, then there's a notification. So and then they thought, oh, this is working really well, we're gonna do this for all mums now. So it it's kind of they're driven by the did not attend. So I don't know if I'm going off the track here, but there's all this that happens and I don't know to what extent Child Protection is understanding, you know what's going on because you would think with all these years and as you've said and all this data then why are they not creating some other way of doing it? So and with our research, we're trying to show that by being driven by what women are saying is important to them, to 'cause we know there's lots happening in their lives, the social as well as the clinical health issues then how can we help that? Because if you get a better birthing outcome, you also get a better outcome for the family so that you know, mum and baby, could, some of these mothers who are sick with a clinical issue, so diabetes or hypertension or something like that, during pregnancy, they're the ones that are getting their appointments during pregnancy and then in that six week check late after baby's born, they're the ones that are not getting to their GP, the ones that of all the mums, the ones who need it the most, are the ones not getting the appointment. So this is the the nonsense and that's in the health system and I don't know whether they are the mums that are getting their child, babies removed, but they've been sick during pregnancy so we're not sure yet, we haven't, haven't done that bit.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
Can you tell us a bit about the continuity of care report? Did you produce that?

Karen Glover:
We did, so we were, we were, what's the word, commissioned by the Aboriginal Health Strategy from the Department to develop a protocol that had a systems approach to maternal and child health continuity of care. So the three levels of continuity. I'm I'm hoping I'm going to remember this was at the relational level, so that women have a relationship with whoever is their carer and then you could have, you would have, so so there would be some notes there that you could actually, a clinician could actually make a sensible kind of referral, or in the context of what's happening. Relational, I think one's a institutional, and and the third one is and I can. It's a really, really long report, but there were about 13 recommendations in it, one of which was about we called it child safety and wellbeing. So racism was in there, that was, there was leadership, Aboriginal leadership, racism, family centred approaches not just at the individual. There was a COVID one. We also talked

about establishing some kind of centre of excellence, because if you're going to, if you want to take a systems approach, you have to look at all sorts of things, including and, we use the WHO model of what is a, what is a system, what's in a system right through to the communications that happen, workforce, access to medicines or treatments, all the bits that that impact and what we found was, and we talked about culture as well, and we found if you put the family here in the middle or the mum, pregnant, mum and baby and her family then the next layer out was culture and the next layer out from that was child safety and wellbeing so that and then all of those elements from the WHO and then around that was better outcomes.

Commissioner Lawrie:
Thank you.

Counsel Assisting:
Is that report publicly available?

Karen Glover:
Yeah, I can forward it to you.

Counsel Assisting:
Great. Thank you.

Dr Rhiannon Pilkington:
Commissioner, my apologies. I'm gonna have to run soon if I'm to get to Treasury at one o'clock that.

Commissioner Lawrie:
Yes, you've got roughly 20 minutes to get there.

Dr Rhiannon Pilkington:
Yes. So I don't have to run straight away, but I just wanted to let you know in case there was any last things you wanted from me and I know Karen had to leave a little bit early too, didn’t you Karen.

Counsel Assisting:
Thank you very much for that. I think I don't think there's anything more we need. Is there any? Is there anything else you would like?

Commissioner Lawrie:
I'm good.

Dr Rhiannon Pilkington:
But we're gonna add, I've taken those two questions down, so I'll get someone to start working on that today, tomorrow, so.

Commissioner Lawrie:
Karen will give us the continuity of care report.

Karen Glover:
Yeah. And the and the social emotional wellbeing.

Commissioner Lawrie:
Yeah, the framework itself?

Karen Glover:
Yeah, so.

Commissioner Lawrie:
The National?

Karen Glover:
Yeah. Yeah. Well there's a, yeah. We can.

Commissioner Lawrie:
Thank you.

Karen Glover:
And just to just to to say that, umm, looking at the well-being of parents or parents and carers, the systems are not set up for that at all. That's another program, another. We're just in the middle of the literature search now about carers, parents it, but it's not parents actually, it's actually carers, for carers what is their experience of caring? And what is what is the experience and benefits for the children of carers? So it's probably going to be kinship carers. We'll have some focus groups and we'll be inviting your office to if you've got time or want to see what we're doing. However, you want to communicate, yeah.

Commissioner Lawrie:
Can I ask you just one thing before we look at having a break or finishing this up? It was something that you said in relation to, umm, the continuity of care report. What, what was the Department, hoping out of, like to create change, out of the continuity, continuity of care report. With the recommendation. What, what was hoped?

Karen Glover:
What they, what, what I believe that they were looking for was, there is lots of breaks, there's a lots of discontinuity and one of them, of course, is if there's a child removed, that's a big. But there's also things like if you live in Port Lincoln or if you live in Ceduna and you might have to travel to have baby, so you might get some care and then you travel to Adelaide 'cause there's some kind of, because again there's all that high risk and everything's high risk because your Aboriginal, there's high risk, might be to do with body mass index or other things. All kinds of discontinuity if you, you know, change address and so things the mail gets lost. If there's some kind of health issue for mother or baby, then there's really long wait times. So you know, if you're trying to get children ready because the it was maternal and child health up to maybe three or four years old, it was kind of school ready was one of the things that gets talked about so if you're waiting 18 months to have some kind of assessment done, that's a long time in a baby's life to you know, before that age 3, to go to kindy or age 4 to go to kindy or school. So there's, it was looking at how can that be smoother and sometimes the communications was poor, that was another recommendation, like the way that the referrals are made, so if you come here to the hospital and then there's something happens in the hospital, then the referral is back to the hospital when it could be in the home community. Then workforce is an issue too, about having clinical skills, but also about the kind of, these sorts of cultural safety skills. So clinical and cultural safety for Aboriginal families, particularly if there's been a a baby there, pregnancy or baby. So there's all sorts of things that can break break down, if you change your address. And we found in the Aboriginal family study in that five year period we had a very few women were still in the same address and the one that moved the most was 16 times in that five year period and then there were probably the most were around about between three and five times, so that if you're moving around and there's health issues or letters that then don't find you to follow these things up.

Commissioner Lawrie:
Thank you.

Counsel Assisting:
Thank you very much everybody for for your evidence. It's been a very powerful morning of information sharing.

Commissioner Lawrie:
Definitely.

Dr Rhiannon Pilkington:
Thank you for having me.

Karen Glover:
Thank you.

Dr Fiona Arney:
Thanks Rhiannon.

Commissioner Lawrie:
Oh it’s been marvellous, thank you Rhiannon.

Dr Rhiannon Pilkington:
See you everybody.

END