



ALWAYS WAS, ALWAYS WILL BE KOORI CHILDREN

Extract

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

October 2016



COMMISSION FOR CHILDREN AND YOUNG PEOPLE



**This document has been created to
accompany the full inquiry Report**

**Always was,
always will be
Koori children.**

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

October 2016

This booklet highlights extracts from the report.
In this document the term Aboriginal refers to both
Aboriginal and Torres Strait Islander people.

The full report can be found in PDF format at:

www.ccyp.vic.gov.au

or by contacting the Commission directly

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Warning:

This report contains explicit
material that may cause distress.

Introduction

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

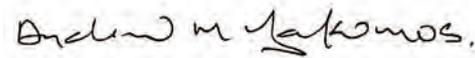
The *Always was, always will be Koori children* report, however, is about the ever-growing number of Victorian Aboriginal children who come to the attention of child protection services and find themselves placed in out-of-home care. Aboriginal children in Victoria are 12.9 times more likely than non-Aboriginal children to be placed in out-of-home care.¹

As at 30 June 2015, there were 8,567 Victorian children in out-of-home care – 1,511 (17.6 per cent) were known to be Aboriginal.² Considering Aboriginal children comprise only 1.6 per cent of all children in Victoria, this rapidly increasing over-representation is cause for grave concern.

The report found that systemic failures and inadequacies have contributed to the vast over-representation of Aboriginal children in the child protection and out-of-home care systems and that practice deficits have led to the degradation of Aboriginal culture for children who are placed in out-of-home care.

The report presents a catalogue of failure and neglect in many areas by the State, including poor attempts to locate and support Koori kin to care for their children; and in keeping children in contact with their brothers and sisters.

'It was quite clear that many parents of the 980 children we saw had been in the care of the state and the state pushed them out of the door ill-prepared. The same thing sadly is happening to the current generation of Koori kids leaving care.'



Andrew Jackomos PSM

Commissioner for Aboriginal Children and Young People

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

2. Ibid.

Taskforce 1000 reviewed

980

Aboriginal children in out-of-home care

88%

of children had experienced family violence

87%

of children were exposed to parental alcohol/substance use

42%

of children were placed away from their extended family

25%

of the children on Guardianship orders had no cultural support plan

86%

of children were case managed by a non-Aboriginal agency

over 40%

of children with siblings were separated from their brothers and sisters

over 60%

of children were placed with a non-Aboriginal carer

Taskforce 1000

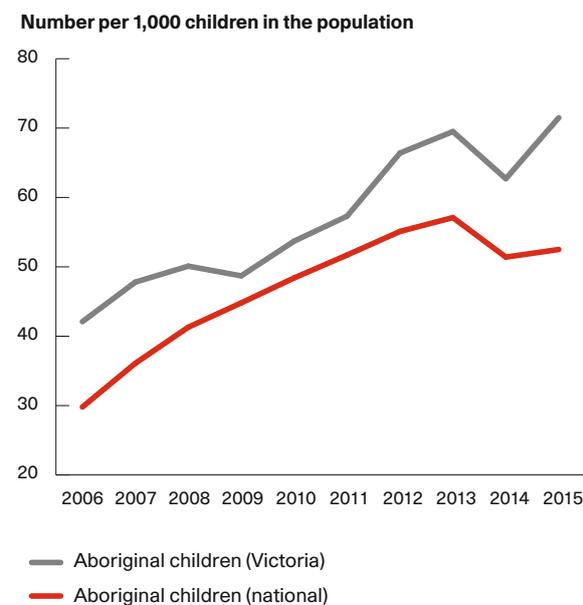
Taskforce 1000 was established in 2014 by the Commission for Children and Young People with the former Department of Human Services.³

Its purpose was to critically review the case plans and circumstances of almost 1,000 Aboriginal children in out-of-home care in Victoria and to look at opportunities to review and improve practice.

Taskforce 1000 is a ground-breaking investigative process involving comprehensive action research that provides a strong evidence base for widespread reform to the way child protection and out-of-home care are delivered to Aboriginal children in Victoria.

If properly implemented and sustained, its findings and recommendations will help to break the intergenerational cycle of children in out-of-home care in Victoria and Australia.

Figure 2: Aboriginal children (0–17 years of age) in out-of-home care in Victoria and nationally, 30 June 2006 to 30 June 2015³



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

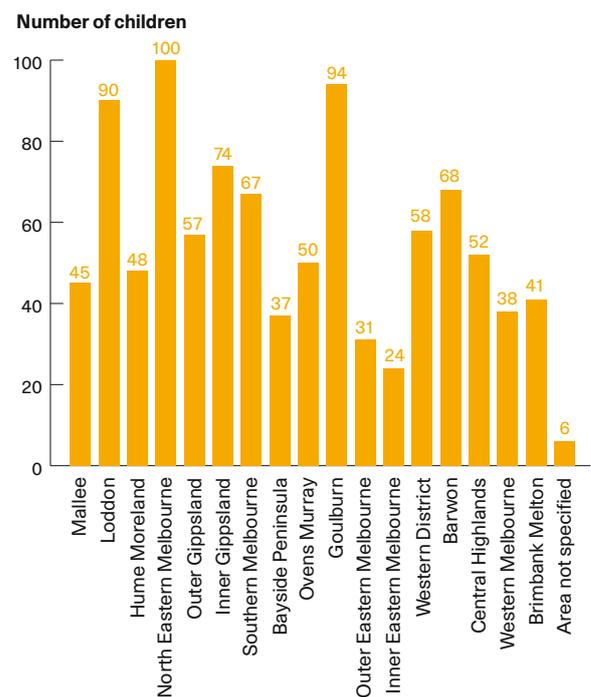
There was a

59% increase

in the number of Aboriginal children in out-of-home care between 2013–2015.

The number of Aboriginal children in care is increasing and the gap with non-Aboriginal children is widening.

Figure 3: Children reviewed during Taskforce 1000, by DHHS area⁴



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

³ On 1 January 2015, the Victorian Government established the Department of Health and Human Services, bringing together the former Department of Health, Department of Human Services and Sport and Recreation Victoria. Source: Appendix 1, Tables A3–A6.

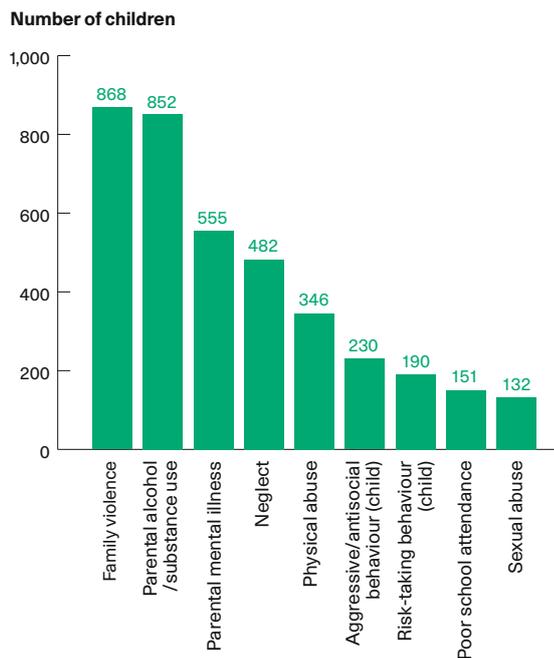
Key Findings

Finding 1:

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

It is now widely understood that as victims of violence and abuse in the home that a child's emotional, physical and mental health are often adversely impacted which in turn effects future choices, education and wellbeing.

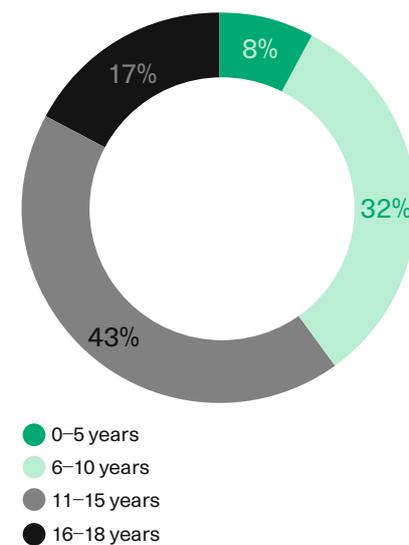
Figure 5: Known risk factors for children reviewed during Taskforce 1000



Known risk factors such as family violence, parental alcohol and substance abuse, parental mental illness, physical and sexual abuse, neglect as well as the child's risk taking behaviour and school attendance were identified in Taskforce 1000.



Figure 18: Ages of children with mental health issues reviewed during Taskforce 1000



n = 216
Source: Appendix 1, Table A26.

This case study details the lack of therapeutic care, counselling and support for a boy who, from the age of five, experienced repeated abuse and trauma, including sexual abuse. The deterioration in the boy's mental health and wellbeing was a familiar theme in many of the children's cases that were heard during Taskforce 1000, as were the failures of those agencies with legal responsibility for the children's care to ensure timely access to counselling and support.

Case study 2: Bert

Bert was five years old when he first came to the attention of child protection. Over the following eight years, there were 10 further reports to child protection about his wellbeing. The majority of these reports were closed without investigation. The concerns reported to child protection involved Bert and his younger siblings being exposed to significant family violence perpetrated by their father.

In 2013, Bert again came to the attention of child protection. He had experienced multiple episodes of harm and his mental health required medication. It was identified that Bert needed treatment to deal with the impact of the abuse and trauma he had experienced.

Before entering out-of-home care, Bert and his two younger siblings disclosed their experiences of sexual abuse to Victoria Police, but charges were not laid against the perpetrator.

Of particular concern to the Commission was that Bert had not received any counselling. His case records revealed that, although he had been referred in late 2013 to a sexual assault counselling service, the service closed the referral because he was not in a stable placement.

When Bert's case was presented at Taskforce 1000, he still had not been provided with counselling. Despite being responsible for the day-to-day care of Bert, DHHS and the CSO that was contracted to care for him had failed to address his trauma.

By this time Bert could no longer live with his family. He had become physically abusive towards his six younger siblings, he was using drugs and he had disengaged from school. Bert had four in-patient placements in a mental health facility in Melbourne, a long way from his family in rural Victoria.

Finding 5:

The Department of Health and Human Services and community sector organisations offer poor cultural safety to Aboriginal children in the out-of-home care system. There is evidence of practice deficits in respecting and establishing children's Aboriginal identity and a lack of compliance with legislative and policy obligations.

This is in direct contravention to the rights guaranteed under the *Charter of Human Rights and Responsibilities Act 2006*.

It was evident to the Commission, during both Taskforce 1000 area panel presentations and through enquiries made to the Commission directly, that there are a number of significant practice challenges and issues relating to respecting and establishing a child's Aboriginal identity.

These issues involve:

- late identification by service providers of children's Aboriginal status, resulting in children's cultural rights and needs not being upheld
- de-identification of children's Aboriginal status by service providers.

Identification

Numerous cases were presented to Taskforce 1000 area panels where there had been years of involvement with DHHS prior to a child's Aboriginal status being known. Often this was because child protection practitioners relied on the advice of the initial report to child protection and failed to re-check at key points, or they simply failed to ask families the question at all.

The impact of failing to ascertain a child's Aboriginal status is significant. It results in key legislative and mandated provisions of the *Child and Youth Families Act 2005* not being considered, particularly the application of the Aboriginal Child Placement Principle in decision-making for the placement of a child and cultural support plan requirements for Aboriginal children in out-of-home care.

Key Findings

A young girl had child protection involvement for

11 years

before her Aboriginality was established

De-identification

An emerging issue of concern has been instances of the de-identification of Aboriginal children, effectively dislocating these children from accessing and engaging with their culture.

Only 38%

of cases reviewed had their Aboriginality confirmed at the first home visit.

This case study, which was presented at Taskforce 1000, is an example of poor attention to a child's need for cultural connection. The Commission was able to intervene and ensure the child could access an Aboriginal playgroup.

Case study 4: Bodhi

Child protection received a report in relation to Bodhi on the day he was born that identified concerns about his mother's capacity to care for him. Bodhi's mother was separated from his non-Aboriginal father, who had a history of substance abuse. After services were linked with his mother, the situation deteriorated and Bodhi was placed in home-based care on a Custody order. Bodhi experienced at least three placement changes before being placed in a kinship placement with Aboriginal carers.

The placement lasted six months; however, Bodhi was removed when he was one year old due to quality of care issues. Bodhi then moved to a placement with non-Aboriginal carers.

When Bodhi's case was presented at Taskforce 1000 in rural Victoria, the Commission was concerned that there was no cultural support plan in place and that no AFLDM (Aboriginal Family Led Decision Making) conference had been held. Although ACCOs (Aboriginal controlled community organisations) had been consulted during decision-making, they were not part of regular meetings. At the urging of the Commission, Bodhi was placed in an Aboriginal playgroup to allow him to socialise with other Aboriginal children and facilitate connection with his culture. The Commission noted that there had been no initiative by DHHS to connect Bodhi to his Aboriginal culture.

Key Quotes

'Because the objective was to absorb the children into white society, Aboriginality was not positively affirmed. Many children experienced contempt and denigration of their Aboriginality and that of their parents or denial of their Aboriginality. In line with the common objective, many children were told either that their families had rejected them or that their families were dead. Most often family members were unable to keep in touch with the child. This cut the child off from his or her roots and meant the child was at the mercy of institution staff or foster parents.'

Commonwealth of Australia,
Bringing them home, p. 154.

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

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

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

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

Findings

Finding 1:

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

Finding 2:

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

Finding 3:

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

Finding 4:

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

Finding 5:

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

Finding 6:

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

Finding 7:

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

Finding 8:

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

Finding 9:

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

Finding 10:

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

Finding 11:

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

Recommendations

The report makes 77 recommendations under the following themes:

- 1. That the Victorian Government accepts the recommendations of this Inquiry report and, in the spirit of self-determination, the Minister for Families and Children authorises the Aboriginal Children's Forum to monitor and provide oversight for their implementation and continuous development.**
- 2. Keep Aboriginal children safe within their family.**
- 3. Strengthen healing-informed interventions to address family violence and intergenerational trauma.**
- 4. Ensure Aboriginal children in out-of-home care have meaningful access to their culture.**
- 5. Build the cultural competency of organisations providing services to Aboriginal children in out-of-home care.**
- 6. Improve child protection responses and service provision for Aboriginal children in out-of-home care.**
- 7. Aboriginal children in out-of-home care need resilient, supported and capable carers.**
- 8. Aboriginal children in out-of-home care deserve optimal health, education and wellbeing outcomes.**
- 9. A stronger, more collaborative service system will benefit Aboriginal children in out-of-home care.**



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