Supporting parents with cognitive disability in Queensland

The need for reform

May 2025

The Public Advocate
Influencing change to empower lives

Acknowledgement of Country

The Public Advocate and staff acknowledge the traditional custodians of the lands across the State of Queensland and pay our respects to the Elders past, present, and emerging. We value the culture, traditions and contributions that Aboriginal and Torres Strait Islander people have made to our communities, and recognise our collective responsibility as government, communities and individuals to ensure equality, recognition and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Acknowledgement of Lived Experience

The Public Advocate acknowledges the lived and living experience of people with disability and their family members, carers and supporters.

We acknowledge that each person's journey is unique and valued. We recognise their adverse experience of stigma, but also their strength and resilience.

We recognise the contribution people with lived and living experience make to the Public Advocate's work and disability advocacy in general.

Content warning

Aboriginal and Torres Strait Islander readers should be aware that some information in this report may have been provided by, or refer to, Aboriginal or Torres Strait Islander people who have passed away.

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The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice
Minister for Integrity
1 William Street
BRISBANE 4000

21 May 2025

Dear Attorney-General,

Pursuant to Section 209A of the *Guardianship and Administration Act 2000* (Qld), I present to you my report *Supporting Parents with Cognitive Disability in Queensland: The need for reform.*

Yours sincerely,

John Chesterman (Dr)
Public Advocate

Foreword

The ability of children to grow up with their parents is a basic hallmark of a functioning society. Sometimes, however, the well-being of children is so at risk that the state, through the child protection system, becomes involved, with the most serious intervention being the removal of at-risk children from their parents.

All parents need some support in raising their children; some require more support than others. When parents are affected by drug or alcohol dependence, and this puts the safety of their children at risk, our inclination, and indeed our practice, is to work with the parents to help them recover from dependency.

But when a parent has a cognitive disability, do we do enough to support them in their parenting? Or is the existence of a parent's cognitive disability primarily viewed as a risk to the wellbeing of their child?

These questions are at the centre of this report, the writing of which has been led by Kelly Motley, who has been ably assisted by Tracey Martell and other staff members in my office (including Jacinta Colley and Yuu Matsuyama). I thank them all for their excellent work.

My thanks also go to the various stakeholders who have contributed to this report, including advocacy organisations, disability service providers and people with lived experience of disability, including some parents with cognitive disability who have been involved with the child protection system.

I have also greatly appreciated the collaborative approach taken by the Government agencies with which I have discussed the report and its recommendations, including the Department of Families, Seniors, Disability Services and Child Safety, the Department of Health, and the Office of the Director of Child Protection Litigation.

The report has been substantially improved because of the considered feedback on earlier drafts that has been provided by various departmental representatives.

My role is to be a systemic advocate to promote and protect the rights of adults with impaired decision-making ability. Through the course of my work on other reports – particularly those on adult safeguarding, supported accommodation and the acute mental health system – I have consistently heard that we don't do enough to support parents with cognitive disability in their parenting. And indeed, I am yet to hear anyone disagree with this proposition.

This report seeks to address this. This is not about prioritising the interests of parents over those of children. On the contrary, the aim behind this report and its recommendations is to ensure the best possible upbringing of children in Queensland, by supporting parents in their exercise of one of the most fundamental roles a person can play.

John Chesterman (Dr)
Public Advocate

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ASC	Assessment and Service Connect
CAO	Care Assessment Order
CCR	Child Concern Report
CID	Council for Intellectual Disability
CMC	Crime and Misconduct Commission
CSO	Child Safety Officer
CSSC	Child Safety Service Centre
DCPL	Director of Child Protection Litigation
DFSDSCS	Department of Families, Seniors, Disability Services and Child Safety
Disability Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
EIAA	Enhanced Intake and Assessment Approach
FIS	Family Intervention Service
FPNSW	Family Planning New South Wales
FPP	Family Participation Program
GAA	*Guardianship and Administration Act 2000* (Qld)
IAC	Independent Advisory Council
IPA	Intervention with parental agreement
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual+
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
OCFOS	Office of the Child and Family Official Solicitor
OPG	Office of the Public Guardian
PCA	Parenting Capacity Assessment
PCO	Permanent Care Order
Practice manual	Child Safety Practice Manual
PSNA	Parental Strengths and Needs Assessment
QAI	Queensland Advocacy for Inclusion
QCAT	Queensland Civil and Administrative Tribunal
QFCC	Queensland Family and Child Commission
RIS	Regional Intake Service
SDM manual	Structured Decision-Making Policy and Procedures manual
TAO	Temporary Assessment Order
TBI	Traumatic Brain Injury
TCO	Temporary Custody Order
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNPF	United Nations Population Fund
WHO	World Health Organization
WWDA	Women with Disabilities Australia
WWILD	WWILD-Sexual Violence Prevention Association Inc

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Executive Summary

The right of a person with disability to participate in all aspects of life is an established principle enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Australia was one of the first countries to ratify the UNCRPD, which it did on 17 July 2008. Relevantly, Article 23 of the UNCRPD makes specific provision for the elimination of discrimination against persons with disability in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. The *Queensland Human Rights Act 2019* also guarantees equality before the law and the protection of families and children.[1]

However, there is evidence to suggest that some parents with disability, particularly those with cognitive disability, are being prevented from parenting, or restricted in their parenting, because of misconceptions about the impact their disability may have on their capacity to care for a child. It has been reported that in Australia, as in most of the Western world, the rate of removal of children at, or close to, the date of their birth from parents with disability 'has increased substantially' in recent years.[2] While the actual number of parents with disability whose children are removed by the state is unknown, the discrimination and surveillance of parents with disability in the lead-up to and immediate aftermath is evident.[3]

The removal of children from parents with cognitive disability has been a focus of advocacy for a number of government and non-government bodies in Queensland and across Australia throughout the years.

The issue was explored at length in a research report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission), with 27 recommendations made for reform.[4] The Disability Royal Commission also heard from witnesses about the experiences of parents with cognitive disability, and formal submissions described the obstacles faced by parents who had interactions with Child Safety bodies.

The gaps in support provided to parents with cognitive disability was further raised by stakeholders who contributed to the National Disability Insurance Scheme (NDIS) Review,[5] with a series of reforms also put forward by the Independent Advisory Council (IAC) to the NDIS.[6]

This report initially examines issues surrounding the right of a person with cognitive disability to parent a child, including:

- The legal impediments to a sexual relationship for adults with cognitive impairment that are currently in place in Queensland.
- Access to sexual and reproductive health services for people with cognitive disability.
- The obstacles experienced by people with cognitive disability when seeking to form romantic relationships.
- Current societal perspectives regarding adults with cognitive disability as parents.
- The cross-section of disadvantage experienced by parents with cognitive disability, including Aboriginal Torres Strait Islander parents.

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[1] *Human Rights Act 2019* (Qld) s 26.

[2] S Wise and T Corrales, 'Discussion of the knowns and unknowns of child protection during pregnancy in Australia', *Australian Social Work*, vol. 76, no. 2, 2021, p. 174.

[3] T Libesman, P Gray, E Chandler, L Briskman, A Didi and S Avery, *Research report: Parents with disability and their experiences of child protection systems*, report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Jumbunna Institute for Indigenous Education and Research, UTS Law and Western Sydney University, Sydney, 2023, p. 40.

[4] Ibid., pp. 273-306.

[5] See National Advocacy Collective, 'Submission to the NDIS Independent Review Panel', *Supporting the rights of parents with intellectual disability*, August 2023.

[6] Independent Advisory Council (IAC) to the NDIS, *NDIS support for participants who are parents*, 2019, pp. 14-15, 18 –22.

The report goes on to explore issues relating to the support provided to parents with cognitive disability in Queensland, drawing on existing literature and consultations with stakeholders from 13 organisations, including government agencies, advocacy organisations, and people with lived experience. A focus group of parents with lived experience was included in the consultation process, convened to provide input into the report's content and final reform recommendations.

A number of issues were identified that can contribute to parents with cognitive disability not being provided the level of support they need to care for their children, leading to intervention by the government's Child Safety arm.

These issues are summarised below, under three key themes.

The accessibility of mainstream services

- A lack of reasonable adjustments to pre-natal support programs (provided by health and other service systems) to facilitate access for adults with cognitive disability. The availability of these supports in a format suitable to learning needs would enhance the knowledge and ability of parents with cognitive disability to provide a safe environment for their child.

The interface between pregnancy, parenting and the NDIS

- A participant becoming pregnant does not automatically trigger an NDIS plan review. An immediate plan review could allow for the capacity building supports necessary to prepare for parenting to be put in place.
- The delineation of supports provided in NDIS plans to parents (e.g. house cleaning and laundry services not extending to items including baby bottles and infant clothing).
- Interactions between NDIS support and service providers and Child Safety without agreed upon information sharing protocols being in place.

The child protection system

- A reluctance by adults with cognitive disability to report a pregnancy and access prenatal care based on a fear that their child will be removed. A late presentation at health services due to this fear is often interpreted as an inability to protect a child from harm, triggering a report to Child Safety.
- Gaps in the availability of pre-birth advocacy services that could assist with arranging the necessary supports to be put in place for prospective parents that could prevent a Child Safety notification and consequent assessment and investigation.
- Mandatory reporting procedures, primarily at health services, that can lead to pre-emptive intervention by Child Safety.
- A need for additional specialised training for Child Safety Officers on disability, and how to support a parent with cognitive disability (or the creation of specialist roles), accompanied by a review of policies and procedures to accommodate the reasonable adjustments and inclusivity necessary to increase parent participation in the process.
- The limited availability of accessible parenting support programs throughout a parent's engagement with Child Safety, which can limit opportunities to demonstrate their ability to provide a safe environment for a child.
- The trauma experienced by a parent when a child is removed and the impact this can have on a parent's ability to engage with Child Safety.
- Parents with cognitive disability not being provided with a full understanding of their rights as parents and what actions they need to take to address the concerns of Child Safety.
- The inaccessibility, power imbalance and complexity of child protection proceedings that can lead to parents disengaging from the process.
- Concerns around parenting capacity assessments not being conducive to parental demonstration of their ability to care for their child.
- Decisions around family contact arrangements that can disadvantage a parent seeking to regain custody of their child.
- A reluctance of parents to apply for NDIS funding for fear that becoming an NDIS participant will be perceived negatively by Child Safety.

- Survivors of domestic and family violence with cognitive disability having their children removed based on a perception that they cannot protect their child from harm.

The insights shared by stakeholders highlight the urgent need for government bodies to work together to develop and implement policy and practice reforms that provide targeted support to parents with cognitive disability.

The Public Advocate recognises that children are also removed from the care of parents with cognitive disability through the family law system in Australia under the Commonwealth *Family Law Act 1975*. However, this report focuses on the formal removal of children through the child protection system with a specific focus on the operation of the *Child Protection Act 1999* in Queensland.

Recommendations

Recommendation 1: The Queensland Government should establish a Ministerial Advisory Committee with the responsibility to review the policies and procedures that apply, and the current practices that occur, when parents with cognitive disability interact with the child protection system.

The Committee could potentially be established under section 222 of the *Disability Services Act 2006*, which provides that the Minister may establish 'committees to advise on disability issues, disability services and NDIS supports or services'.

Ideally, the Committee would operate for a set period (up to two years) and report periodically (six-monthly) to the Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence.

The Committee could consist of:

- the Directors-General (or their delegates) from the Department of Families, Seniors, Disability Services and Child Safety and Queensland Health;
- the Chief Practitioner (Child Safety);
- the Chief Midwifery Officer (Queensland Health);
- the Public Advocate;
- the Director of Child Protection Litigation (or their delegate);
- up to three lived experience representatives (including an Aboriginal or Torres Strait Islander person); and
- up to two representatives from non-government advocacy organisations.

Other parties with an interest in the work of the Committee could also be invited to participate on an as-required basis.

In undertaking the proposed review, the Committee would likely need to be supported by one or more internal, cross-departmental working groups (in addition to those already established by the Chief Practitioner, Child Safety), which could be responsible for developing and actioning specific initiatives required by the Committee.

The proposed core business of the Committee would be to review:

a. early intervention policies, procedures and practices;
b. the adequacy of the support given to parents with cognitive disability; and
c. the accessibility of the child protection litigation process.

In reviewing **early intervention policies, procedures and practices**, the Committee could consider:

- mandatory reporting procedures;
- requirements around the provision of support persons;
- unborn child notifications;
- the potential creation of specialist disability Child Safety officer positions;
- parenting capacity assessments;
- the suitability of Child Safety Service Centres as venues for child-parent visits;
- the in-practice efficacy of Child Safety's new (2025) Enhanced Intake and Assessment Approach; and
- the need for greater coordination between pre-birth and post-birth intervention and support services (in the health, child protection, NDIS, independent advocacy, domestic, family and sexual violence, and legal services fields).

In reviewing the **adequacy of support given to parents with cognitive disability**, the Committee could consider:

- the extent to which reasonable adjustments are being made, and need to be made, in the provision of existing ante-natal and post-natal services;
- whether increased NDIS support needs to be available to parents with cognitive disability;
- whether there is a need for a program of therapeutic supports to be provided to parents as part of the services provided to parents when children are in care;
- whether other NDIS reforms are warranted (for instance, whether a participant's pregnancy should automatically trigger an NDIS plan review); and
- the availability of culturally appropriate support for Aboriginal and Torres Strait Islander parents with cognitive disability.

The Committee could also consider proposing new and innovative practices and initiatives, such as:

- the establishment of one or more 'mother and baby' units to provide intensive assistance to pregnant persons with cognitive disability who are in crisis;
- the funding of peer support groups for parents with cognitive disability; and
- the development of family fostering and capacity building programs, in which parents with cognitive disability are provided with in-home assistance to build their parental capacity.

In reviewing the **accessibility of the child protection litigation process**, the Committee could consider:

- the accessibility of existing procedures and information materials;
- the use that is made of litigation guardians;
- the adequacy of parenting capacity assessments; and
- whether, and how, parents with cognitive disability might be better supported during their involvement in child protection litigation.

Current and future working groups established by the Chief Practitioner (Child Safety) that are exploring ways to better support parents with an intellectual disability could also report to the Committee on key developments and any trials of new initiatives.

In concluding its work, the Committee would ideally identify clear reform priorities. It would also outline the timeframe and proposed outcome measures associated with its recommended reforms.

Recommendation 2. The Queensland Government should fund, as part of the Queensland Disability Advocacy Program, a specific program of advocacy support for parents and soon-to-be parents with cognitive disability.

The aim of this advocacy support would be to assist people with cognitive disability before, and following, the birth of their children, in navigating the variety of systems with which they must deal to receive the services and supports to which they are entitled.

The program should include the option for an advocate to be engaged on a one-off basis (single issue), or over a longer term, where they are available to assist at multiple points during a parent's pregnancy journey and the first few years of a child's life.

A key objective of the program would be capacity building among parents with cognitive disability, and in particular ensuring that the voice of parents with cognitive disability is heard during any interactions they have with the child protection system, in keeping with the Queensland *Charter of Rights for parents involved with the child protection system in Queensland*.

Introduction

The Public Advocate

The Public Advocate is a position established under chapter 9 of the *Guardianship and Administration Act 2000* (Qld) to promote and protect the rights and interests of Queensland adults with impaired decision-making ability through systemic advocacy.

Section 209 of the *Guardianship and Administration Act* states that the functions of the Public Advocate are:

> (a) promoting and protecting the rights of adults with impaired capacity for a matter;
> (b) promoting the protection of the adults from neglect, exploitation, or abuse;
> (c) encouraging the development of programs to help the adults to reach the greatest practicable degree of autonomy;
> (d) promoting the provision of services and facilities for the adults;
> (e) monitoring and reviewing the delivery of services and facilities to the adults.[7]

Impaired decision-making ability

A person has capacity to make a decision if they can understand the nature and effect of the decision, can freely and voluntarily make a decision, and can communicate their decision in some way.[8] If a person is unable to do one or more of these things, they may have impaired decision-making ability.

There are several conditions that may affect a person's decision-making ability. These include intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or alcohol and drug misuse. While not all people with these conditions will experience impaired decision-making ability, many will at some point in their lives. For some, impaired decision-making ability may be episodic or temporary, requiring intensive supports at specific times, while others may require lifelong support with decision-making and communicating their choices and decisions.

People with impaired decision-making ability are a broad and diverse group. They can be from all age groups, cultures, and demographics.

Terminology

While the Public Advocate is responsible for promoting and protecting the rights of all adult Queenslanders with impaired decision-making ability, this report focusses on a particular cohort, namely, people with cognitive disability who become parents.

Cognitive disability, as the Disability Royal Commission has noted, 'arises from the interaction between a person with cognitive impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.'[9] People with cognitive disability may include, but are not limited to, people with intellectual disability, learning disability, dementia or acquired brain injuries, and some people with autism.[10]

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[7] *Guardianship and Administration Act 2000* (Qld) s 209.
[8] *Guardianship and Administration Act 2000* (Qld) sch 4.
[9] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Executive summary: Our vision for an inclusive Australia and recommendations', *Final report*, 2023, p. 316.
[10] Ibid., p. 315.

This report uses different terms when referring to adults with cognitive disability, depending on the source from which information is taken. For example, when discussing section 216 of the *Criminal Code Act 1899* (Qld) (*Criminal* Code) the terms 'impairment of the mind' and 'mental impairment' are used because these are the expressions used in the *Criminal Code*. The legislation defines a 'person with an impairment of the mind' as 'a person with a disability that is attributable to an intellectual, psychiatric, cognitive, or neurological impairment or a combination of these'.[11] The terms 'people with disability', 'people with an intellectual impairment', and 'people with a cognitive impairment' are also used in this report when referring to official documents (such as the UNCRPD), legislation, policies, research, or general commentary about the rights of people with disability or studies that involve people with a specific disability. People with cognitive disability are an important cohort of people with disability, however when the term 'disability' is used in this report, it is not suggested that people with disability generally have cognitive disability.

Methodology

To assist in identifying issues surrounding the experiences of parents with cognitive disability, consultation was undertaken with a broad range of stakeholders, each with professional and experiential expertise (see Appendix). This included representatives from the guardianship and administration, advocacy, disability, health care, mental health, and legal sectors.

This report also draws on information and data from a range of other published sources including research papers, annual reports, statistical data, and other project and policy papers.

Consultation with stakeholders was conducted via a series of group and individual discussions, as well as via written information and feedback provided to the Public Advocate. During the consultation, stakeholders identified a range of issues affecting parents with cognitive disability, discussed how they are currently addressed, and identified opportunities to improve responses.

The findings and draft recommendations were also discussed with a focus group of parents with lived experience, hosted by QDeNgage, on 25 February 2025. Their observations have informed this report's content and final reform recommendations.

While stakeholder feedback was considered in the development of the recommendations, the views and opinions expressed in this report are those of the Public Advocate, and do not necessarily reflect the views of all stakeholders consulted.

The context for reform

The rights of parents with cognitive disability cannot be examined without discussing the broader rights of adults with disability to form intimate relationships and start their own families.

This section discusses an important area requiring reform; being section 216 of the *Criminal Code*, which currently restricts the rights of people with disability to engage in sexual relationships.

Under section 216 of the *Criminal Code* it is a crime to engage in sexual activity with a person who has an 'impairment of the mind'. This section effectively criminalises any sexual contact with that person, even if they have the capacity to consent to and understand the nature of such activities.

The Queensland Court of Appeal has expressed concern that the definition of 'impairment of the mind' is so broad that it potentially includes people who do not have 'any diminution in the capacity to acquire knowledge', and simply requires some level of neurological impairment that affects the power to communicate.[12] In effect, 'impairment of the mind' has been interpreted to have such broad application in the *Criminal Code* that it includes not only people who have

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[11] *Criminal Code 1899* (Qld) s 1.

[12] *R v Mrzljak* [2004] QCA 420 at [68].

impaired decision-making ability, but those with disabilities with no impact on decision-making ability.

Section 216 of the Queensland Criminal Code

The principal offence provisions of section 216 state:

> **216 – Abuse of Persons with an Impairment of the Mind**
>
> (1) Any person who engages or attempts to engage in unlawful penile intercourse with a person with an impairment of the mind is, subject to subsection (3) (a) and (b), guilty of a crime, and is liable to imprisonment for 14 years.
>
> (2) Any person who—
>
> (a) unlawfully and indecently deals with a person with an impairment of the mind; or
>
> (b) unlawfully procures a person with an impairment of the mind to commit an indecent act; or
>
> (c) unlawfully permits himself or herself to be indecently dealt with by a person with an impairment of the mind; or
>
> (d) wilfully and unlawfully exposes a person with an impairment of the mind to an indecent act by the offender or any other person; or
>
> (e) without legitimate reason, wilfully exposes a person with an impairment of the mind to any indecent object or any indecent film, videotape, audiotape, picture, photograph or printed or written matter; or
>
> (f) without legitimate reason, takes any indecent photograph or records, by means of any device, any indecent visual image of a person with an impairment of the mind;
>
> is, subject to subsections (3) (c) and (3A), guilty of a crime, and is liable to imprisonment for 10 years.

In addition to the general criminal law defences, such as mistake of fact[13] and insanity,[14] section 216 provides two specific defences:

> (3) It is a defence to a charge of an offence defined in this section to prove -
>
> (a) that the accused person believed on reasonable grounds that the person was not a person with an impairment of the mind; or
>
> (b) that the doing of the act or the making of the omission which, in either case, constitutes the offence did not in the circumstances constitute sexual exploitation of the person with an impairment of the mind.

The current law means it is possible for a consensual relationship involving a person with disability or cognitive impairment to be made the subject of criminal charges and court proceedings, with a requirement that the defendant prove a lack of sexual exploitation. This will necessarily see the person with disability involved in the criminal justice system as a victim or witness, which brings with it existing concerns about their ability to obtain access to justice. While a defence may ultimately be proved, this will come at a cost to all parties involved.

One of the implications associated with the breadth of section 216 is the risk that service providers, support workers and professionals will be reluctant to provide or support access to sexual and reproductive health education and services for clients for fear of placing clients – or themselves – at risk of criminal prosecution.

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[13] *Criminal Code 1899* (Qld) s 24.
[14] *Criminal Code 1899* (Qld) s 27.

The *Criminal Code* holds not only principal offenders liable for offences, but also any other persons who may be a 'party' to the offending. Any person deemed to be a party to the offence can be charged with committing it. For example, a person is deemed to be a party if they do anything that enables or aids another person to commit an offence, or if they counsel or procure another person to commit the offence.

If a person with an 'impairment of the mind' has a sexual encounter with another person, the elements of section 216 are satisfied. Due to the party provisions of the *Criminal Code*, if someone supporting the person with disability has helped to facilitate the sexual encounter, then that could be considered as enabling or aiding that offence. The supporter would be considered a party and could be charged with committing the offence.

These party provisions could also extend to other assistance that supporters may provide, including:

- assisting a person with disability to be transported to a location where they have a sexual encounter with another person;
- facilitating social encounters between people with disability to find and establish relationships;
- arranging for legal sex work to be provided to a person with disability who has requested and is seeking such services; and
- providing contraceptive medication or condoms to people with disability.[15]

The Public Advocate is aware, anecdotally, that section 216 has prevented some service providers and disability support workers from providing sexual and reproductive health education to clients with cognitive disability and other conditions that may impact on their decision-making ability. This is because service providers have been concerned that such actions may be interpreted as encouraging or aiding the commission of an offence.

Denying access to knowledge that may help people with cognitive disability to better understand their bodies and sexuality, to learn what amounts to consent, and to understand the fundamentals of healthy sexual relationships, exposes them to the risk of abuse and exploitation. Withholding this knowledge also denies them the right to develop a normal understanding of their own sexuality and to learn what is socially appropriate in terms of expressing their sexual feelings.

Section 216 was explored extensively in the Public Advocate's 2022 discussion paper, *A discussion of section 216 of the Queensland Criminal Code: A call to review the criminalisation of sexual relationships involving people with 'an impairment of the mind'*.

In this paper, the Public Advocate identified that the creation of an offence that is presumed to have occurred on the basis that a person with 'an impairment of the mind' is incapable of engaging consensually in any sexual activity is inconsistent with the rights of persons with disability in international human rights conventions and other Queensland laws.[16]

Based on the findings in the discussion paper, the Public Advocate recommended that section 216 be referred to the Queensland Law Reform Commission for review.[17] The Public Advocate is optimistic that reconsideration of the need for section 216 will occur, and the human rights implications of section 216 will be addressed to protect the right of people with disability to engage in this aspect of an intimate relationship.

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[15] Office of the Public Advocate (Queensland), *A discussion of section 216 of the Queensland Criminal Code: A call to review the criminalisation of sexual relationships involving people with 'an impairment of the mind'*, 2022, p. 19.

[16] Ibid., p. 7.

[17] Ibid., p. 20.

Sexual and Reproductive Health Services

A review of the impact of section 216 would be an important step toward removing the barriers to the provision of sexual education to people with cognitive disability.

Beyond the legal restrictions around section 216, there are prevailing misconceptions, prejudices, and stereotypes surrounding the sexual and reproductive rights of people with cognitive disability that impede the provision of sexual and reproductive health services.

It is commonly assumed that people with cognitive disability don't or can't have sex, or that they don't have diverse gender or sexual identities.[18] Research shows, however, that people with cognitive disabilities are as sexually active as people without disabilities.[19] Despite this, too often their sexuality has been ignored.[20] There is also a myth that educating people with cognitive disability about sexuality will only make them want to have sex.[21] These assumptions can lead to a lack of access to sexuality education and reproductive and sexual health care and the denial of the basic human right of people with cognitive disability to make decisions about their own body.

Contrary to these societal beliefs, the UNCRPD recognises the rights of people with disability to have access to age-appropriate information, reproductive and family planning education, and to be provided with the means necessary to enable them to exercise these rights.[22]

Article 25 of the UNCRPD also discusses the right to health, highlighting the need for:

- equitable and accessible access to sexual and reproductive health programs;
- health services that facilitate early identification and intervention; and
- raising awareness about the rights of persons with disabilities amongst health care professionals.[23]

Unfortunately, sexual and reproductive health information is not always offered in the flexible and accessible formats required under the UNCRPD. The World Health Organisation (WHO) and the United Nations Population Fund (UNPF) have noted that sexual and reproductive health services are often inaccessible to people with disabilities for many reasons.[24]

Barriers to health services include:

- lack of physical access, including transportation and/or proximity to clinics and, within clinics, a lack of ramps, adapted examination tables;
- lack of information and communication materials (e.g. lack of materials in Braille, large print, simple language, and pictures; lack of sign language interpreters);
- health-care providers' negative attitudes;
- providers' lack of knowledge and skills about persons with disabilities;
- lack of coordination among health care providers; and
- lack of funding, including lack of health-care insurance.[25]

Despite this, there are examples within Australia and internationally of effective sex education programs that have been designed to meet the specific needs of people with disabilities.

For example, Family Planning New South Wales (FPNSW) has made significant efforts to address accessibility by developing a suite of sexuality and reproductive health materials designed specifically for people with intellectual disability and their supporters.

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[18] Play Safe NSW, *Sexual health promotion with young people with disability*, fact sheet, 2023, p. 1.

[19] World Health Organization, *Promoting sexual and reproductive health for persons with disabilities*, WHO/UNFPA guidance note, 2009, pp. 6-7.

[20] Ibid.

[21] Family Planning NSW, *Love and Kisses: Taking acting on the reproductive and sexual health and rights of people with disability*, 2013, p. 13.

[22] UNCRPD, Article 23 (1)(b) - Respect for home and the family.

[23] UNCRPD, Article 25 - Health.

[24] World Health Organization, p. 7.

[25] Ibid.

The FPNSW resource, *Supporting decision making in RSH for PWID: A tool to assist clinicians in supporting the decision making of clients with intellectual disability*, is another example of a resource that health professionals can use to assist people with intellectual disability to make health decisions.

FPNSW has also prepared easy to read fact sheets on a range of sexual and reproductive health issues that have been developed with the accessibility needs of people with cognitive disability in mind.

It is relevant to note that the laws in New South Wales in relation to sexual activity with a person who has a cognitive impairment are less restrictive than those under section 216 of the *Criminal Code* in Queensland. The legislative environment in New South Wales better facilitates such resources being developed and being widely distributed.

Family Planning Queensland has developed the *Everybody Needs to Know* program which is designed to support people with intellectual disability to access information and to gain an understanding of sexuality, sexual health and reproduction. The program is offered to special schools and students in special education programs and is adapted to the specific needs of each group.

Children by Choice Association Inc and WWILD-Sexual Violence Prevention Association Inc (WWILD) have also co-designed Easy English booklets and videos on consent, contraception, pregnancy options and reproductive coercion.

Internationally, in Jamaica, a coalition comprising the Government, the UNPF, and the European Commission have worked with local organisations of persons with disabilities to prepare a set of three manuals on sexual and reproductive health targeted at the specific needs of young persons with intellectual disabilities. The manuals are designed for health-care providers and counsellors, parents, and adolescents with intellectual disabilities.[26]

Right to form relationships

It is clearly articulated in the UNCRPD that people with cognitive disability are entitled to be involved in romantic and sexual relationships, including companionship, partnerships, sex, marriage and having children.[27] However, institutional and attitudinal barriers may prevent many people with cognitive disability from exercising these rights.[28]

The Disability Royal Commission noted, in its final report, that people with disability have described being denied choice about their romantic and sexual relationships.[29] The Disability Royal Commission also reported evidence of support workers ‘blocking’ intimate relationships between people with disability, and the lack of freedom people with disability have to pursue sexual relationships.[30] Evidence was also recorded of violence and abuse against lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual (LGBTIQA+) people with disability based on their sexual orientation. Witnesses who appeared before the Disability Royal Commission reported that the idea of people with disability having a relationship, let alone having a queer relationship or being gender diverse, is often discredited, or not accepted.[31]

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[26] Ibid., p. 12.

[27] UNCRPD, Articles 23 - Respect for home and the family and 25 – Health.

[28] National Development Team for Inclusion, *The Right to a Relationship: Addressing the barriers that people with learning disabilities face in developing and sustaining intimate and sexual relationships*, 2019, p. 5.

[29] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, ‘Volume 3: Nature and extent of violence, abuse, neglect and exploitation of people with disability’, *Final Report,* 2023, p. 269.

[30] Ibid., p. 269.

[31] Ibid., p. 152.

Women with Disabilities Australia (WWDA) noted that women and girls with disability express a desire for romantic, sexual, and intimate relationships but report limited opportunities and difficulty negotiating relationships, often due to a lack of support and paternalistic attitudes.[32]

A review published in the *International Journal of Environmental Research and Public Health* reported that up to 50 per cent of people with intellectual disability are chronically lonely, identifying love as an essential element for their wellbeing and a prerequisite for a good life.[33]

There is also evidence to suggest that the relationship support provided to people with disability tends to focus on risk and vulnerability to abuse, especially for women. There is a dilemma that exists among staff, who may want people to have relationships but fear for a woman's safety.[34] The very nature of living environments designed for people with disability, such as group homes and supported accommodation facilities, are also not conducive to the forming of intimate relationships between residents. The lack of privacy, restrictive house rules imposed by accommodation providers, and the inherent limitations of a co-habitation environment may not provide the foundations for two people to develop a lasting relationship.

Researchers have identified that many group homes either prohibit all sexual activity or require adult residents to pass sexual consent capacity evaluations before they can engage in sexual activity.[35] Justified by concerns about health and safety, provider regulation of the sexual lives of adults with intellectual disability may also reflect paternalistic attitudes that having a disability excludes someone from the right to have intimate relationships.[36]

People with cognitive disability residing in private residences with family or friends, outside of Supported Independent Living (SIL) or Specialist Disability Accommodation (SDA), can also be discouraged from pursuing romantic relationships. This can be due to a desire to protect a person with cognitive disability from potential harm based on a perception of vulnerability and an inability to make good decisions about the relationships they pursue.

The ongoing legal and societal obstacles to the development of loving and intimate relationships for people with cognitive disability act as an impediment to their building of a family. This not only conflicts with obligations under international law,[37] but also goes against a strong domestic and international evidence base which indicates that cognitive disability does not necessarily equate to an impaired capacity to parent.

Parents with cognitive disability

Article 23 of the UNCRPD states that persons with disability have the right to become parents and to found a family. This includes being able to 'retain their fertility on an equal basis with others'[38] and 'to decide freely and responsibly on the number and spacing of their children'.[39] Article 23(4) of the UNCRPD unequivocally states that children should not be separated from their parents based on their or their parents' disability. The UNCRPD also asserts that assistance should be provided to persons with disabilities in the exercise of their family and reproductive rights and responsibilities.[40]

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[32] Women with Disabilities Australia (WWDA), *WWDA Position statement 4: Sexual and Reproductive Rights*, WWDA, Hobart, Tasmania, 2016, p. 9.

[33] P Pérez-Curiel, E Vicente, M L Morán, and L E Gómez, 'The right to sexuality, reproductive, health, and found a family for people with intellectual disability: A systematic review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 2, 2023, p. 9.

[34] Ibid., p. 17.

[35] M Smith, T Allison and M Stein, 'Sexual agency as a rights-based imperative for persons with intellectual disabilities', in G Cohen, C Shachar, A Silvers and M A Stein (eds), *Disability, Health, Law, and Bioethics*, Cambridge University Press, 2020, p. 171.

[36] Ibid.

[37] UNCRPD, Article 23 - Respect for home and the family.

[38] UNCRPD, Article 23(1)(b) - Respect for home and the family.

[39] UNCRPD, Article 23(1)(c) - Respect for home and the family.

[40] UNCRPD, Article 23(2) - Respect for home and the family.

Pre-natal support

As discussed above, anecdotally there is a reluctance to provide sexual and reproductive health services to Queensland adults with cognitive disability. The WHO has noted that most existing policies and programmes concentrate on the prevention of pregnancy but ignore the fact that many persons with disability will eventually have children of their own.[41] There is evidence to suggest that those with power, authority, and influence over women with intellectual disability usually consider it their responsibility to try to prevent them from having children.[42] Research has also revealed that women with intellectual disability feel they cannot take motherhood for granted, having to prove to the authorities and to some family members that they will be suitable parents.[43]

In relation to pregnancy, adults with cognitive disability are often classified as an at-risk group. Should they become pregnant, they are also less likely than their non-disabled peers to have access to prenatal, labour and delivery and post-natal services.[44] They can be turned away from such services should they seek help, being told that they should not be pregnant, or chastised because they have decided to have a child.[45]

Studies have indicated a lack of knowledge and awareness among healthcare professionals, with midwives reporting to have insufficient training or time during appointments to provide adequate support to women with cognitive disability.[46] Often community level midwifery staff will not see women with disabilities, arguing that their birthing process will need the help of a specialist or will require a caesarean section.[47]

Women with disability have also reported experiencing discrimination in accessing assisted reproductive technologies, such as in-vitro fertilisation and assisted insemination.[48]

The Council for Intellectual Disability (CID) recognised the barriers faced by women with disability and provided funding to Northcott Innovation and disAbility Maternity Care to develop several fact sheets to assist people during pregnancy.[49] These resources have been designed to be accessible and focus on the importance of informing and supporting adults with intellectual disability to make their own decisions during pregnancy.

Reluctance to report

A stakeholder interviewed for this project observed that adults with cognitive disability can also be reluctant to report their pregnancy to a doctor for fear that it will bring them to the attention of Child Safety authorities, which may heighten the risk of removal of their child. Conversely, delayed reporting of a pregnancy can also be detrimental for an adult with cognitive disability and used as a sign of potential neglect, effectively evidence that they do not have the ability to provide the appropriate level of care to a child.

Assumptions about the behaviours and support needs of parents with cognitive disability may also preclude a new parent from the opportunity to bond with their child. For example, when a child is removed after birth a mother may not be offered skin contact or breastfeeding support.

In one example provided by a stakeholder, a new mother with cognitive disability expressed a degree of frustration when she struggled with breastfeeding, an experience felt by many women

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[41] World Health Organization, p. 7.
[42] P Pérez-Curiel et al., p. 17.
[43] Ibid., p. 18.
[44] World Health Organization, p. 10.
[45] Ibid.
[46] P Pérez-Curiel et al., p. 18.
[47] World Health Organization, p. 10.
[48] Women With Disabilities Australia (WWDA), *WWDA Position Statement 2: The Right to Decision-Making*, WWDA, Hobart, Tasmania, 2016, p. 10.
[49] Northcott Innovation, *Your Pregnancy, Your Choices*, <https://northcottinnovation.com.au/project/supportingwomenwithidduringpregnancy/>, accessed 28 March 2025.

with a newborn baby. When the mother exhibited behaviours related to frustration, however, no additional supports were offered. Instead, the adult's emotional response was attributed to her disability and used as an indication that she did not have sufficiently developed parenting skills. The mother was then denied an important opportunity to bond with her newborn baby through the skin-to-skin contact provided by breastfeeding.

This reluctance to provide support and education may be indicative of a misplaced assumption that people with cognitive disability are incapable of absorbing information and acquiring new skills. This kind of assumption can potentially result in few efforts being made to provide the targeted parenting supports that may assist a parent with cognitive disability to build their capacity to parent, and may see the involvement of child protection services.

NDIS support during pregnancy

A key aim of the NDIS is to provide Australians who live with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life.[50]

As discussed above, it is an accepted expectation that an ordinary life includes being a parent.

The National Disability Insurance Agency (NDIA) recognises pregnancy as a change of circumstance which would warrant a review of supports provided under a participant's plan. NDIA guides also inform participants to use existing funded supports as intended in an approved plan and, if circumstances change, to lodge a request for a plan review.[51]

A stakeholder consulted for this project confirmed that, if the participant agrees, the NDIA can add pregnancy information to the 'About me' section of the participant's plan. If the participant chooses not to consent to this option, the NDIA will not mention the pregnancy or child/children on the participant's plan.

However, pregnancy, in and of itself, is not an automatic flag for an NDIA initiated plan review. If a participant does inform the NDIA of a pregnancy, becoming a parent is a factor taken into consideration in the planning process to ensure the plan includes any disability specific support the participant may require, as a direct result of their disability, to assist them to undertake their caring responsibilities.

However, stakeholders have advised that navigating the NDIS, for many adults with cognitive disability, can be a daunting and lengthy process. This may act as a disincentive to requesting a new plan and delays in obtaining the supports required prior to their child being born. Delays experienced in securing a plan review can limit the opportunity to gain timely access to mainstream and community supports, including targeted parenting training programs specifically designed for the participant's needs, as well as additional core supports related to any change in functional needs associated with pregnancy.[52]

A stakeholder also advised that Support Coordinators are required to understand NDIS legislation, rules, and how funding can be used flexibly to achieve the most effective range of disability relevant supports for a participant. However, there is no specific guidance provided to Support Coordinators on disability supports that can be funded via a participant's NDIS plan for pregnant participants or parents.

The NDIS interface principles can add another layer of complexity for pregnant participants who would benefit from capacity building supports to prepare for parenting. The interface principles state that the NDIS will fund 'personalised supports related to people's disability support needs, unless those supports are part of another service system's universal service obligation.'[53]

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[50] Australian National Audit Office, *Decision-making Controls for NDIS Participant Plans*, 2020, p. 7.
[51] IAC to the NDIS, *NDIS support for participants who are parents*, 2019, p. 1.
[52] Ibid., p. 15.
[53] Department of Social Services, *Principles to determine the responsibilities of the NDIS and other service systems*, Principle 2, 2015, p. 1.

While skill building for parenting is deemed to be the responsibility of mainstream services, specific parenting training programs designed to meet the needs of a prospective parent with cognitive disability are not available as a mainstream service.

According to a report prepared by the IAC for the NDIS, people who work with parents with intellectual disability report that pregnant women with intellectual disability are unable to secure NDIS supports to facilitate access to mainstream services.[54]

They are also generally not offered the options of:

- a transfer to a participant pathway that offers more intensive or specialised assistance in negotiating with mainstream services; or
- a plan review that will provide increased capacity building and core supports.[55]

NDIS support for parents with cognitive disability

The Disability Royal Commission also identified that the current way in which the NDIS is administered makes it difficult for parents with disability to access the supports they need once their children are born.[56]

Under the NDIS, parents with cognitive disability can access supports and services to help them in their caregiving role. A stakeholder interviewed for this project advised that allied health professionals can complete detailed reports on how a support worker should support specific participants in accordance with their disability needs, with a view to supporting, promoting and building capacity and independence.

However, as the National Advocacy Collective commented:

> A parent with disability may receive support with living skills which might fund a support worker to buy and prepare food for the parents but will not allow the support worker to extend this to include the child or children. The support worker may wash up dishes but will not be allowed to sterilise baby bottles. That same worker may do laundry for the parent but be instructed not to wash the children's clothes.[57]

It was confirmed by a stakeholder included in the Public Advocate's consultation that any additional supports that may be required because a participant becomes a parent need to relate to the disability that enabled the participant to access the NDIS. These additional supports must also be value for money, effective, and beneficial.

The NDIS *Operational Guidelines* do refer to assistance being available to parents with disability, such as parenting programs provided by non-government organisations (NGOs). However, stakeholders have noted that such programs are not always provided in a manner appropriate to the learning needs of people with cognitive disability.

This problem is compounded for parents living in regional, rural or remote areas, who often need to travel long distances to participate in an appropriate parenting program. This reflects an oft-cited criticism of the NDIS in that its effectiveness relies on a service market model, creating challenges for already marginalised groups – Aboriginal and Torres Strait Islander people with disability, culturally and linguistically diverse people with disability, people with disability who identify as being LGBTQIA+, and those living in rural and remote communities.[58]

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[54] IAC to the NDIS, p. 13.
[55] Ibid., pp. 13-14.
[56] T Libesman et al., p. 96.
[57] National Advocacy Collective, Submission to the NDIS Independent Review Panel, *Supporting the rights of parents with intellectual disability*, August 2023, p. 16.
[58] T Libesman et al., p. 97.

An approach often taken by the NDIA is to refer participants to mainstream parenting programs before additional specific supports are provided. NDIA staff note that any role for the NDIS must wait until it is demonstrated that the mainstream option is not working.[59]

It is only when a parent participant continues to have challenges following participation in a mainstream parenting program that reasonable and necessary capacity building supports of a time limited nature can be provided. Examples include daily in-home skill building support to assist the participant parent to implement skills and strategies developed in a mainstream program.[60]

Reasonable adjustments to mainstream parenting classes are generally not made to enable participants with cognitive disability to gain core parenting competencies. Evidence from advocates working with parents with cognitive disability suggests that information about reasonable and necessary daily, in-home skill building options is not widespread, and that the child has often been removed prior to additional NDIS supports being put in place.[61]

Complications with the NDIS interface principles can also create uncertainty around whether parenting programs are the responsibility of the NDIA or that of state or territory disability or health services.[62] There appears to be an assumption that NDIS programs are responsive and accessible to parents involved in child protection systems, when this may not always be the case in practice.[63]

The 2023 review of the NDIS could also see changes to the supports provided to parents with cognitive disability under the scheme, however this has yet to be finalised (some anecdotal information is available which is referred to in a later section of this report).

Removal of children from parents with cognitive disability

Despite Australia's obligations under the UNCRPD, it may well be that a disproportionate number of parents with cognitive disability are having their children removed from their care by child protection authorities, as occurs in other countries around the world.

Numerous international studies have established the prevalence of parents with disability having their children removed by protection authorities. However, data collection systems utilised by child protection services in Australia have not routinely recorded or published the number of parents with disability under their purview.[64] This prevents the true extent of the problem being captured, regarding both the number of people with disabilities who are parents, and, consequently, the proportion of those who have their children removed from their care.

A further obstacle to fully capturing data on parents with disability is the underreporting of cognitive disability that follows a traumatic brain injury (TBI). For example, research indicates that the incidence of mild cognitive impairment from a TBI is significantly underreported, likely due to under-screening, diagnosis, and treatment. This is particularly the case in women who have acquired a TBI following domestic and family violence they have experienced.[65] Mild TBI symptoms can also resemble the effects of alcohol and other substances leading to under recognition and diagnosis.

A lack of data collection generally (despite any barriers that may be present in fully capturing data) is inconsistent with Article 31 of the UNCRPD, which requires state parties to '…collect

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[59] IAC to the NDIS, p. 17.
[60] Ibid., p. 16.
[61] Ibid., p. 17.
[62] T Libesman et al., p. 97.
[63] Ibid., p. 97.
[64] Ibid., p. 1.
[65] K Costello and B D Greenwald, 'Update on domestic violence and traumatic brain injury: A narrative review', *Brain sciences*, vol .12, no. 1, 2022, p. 122.

appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention'.[66]

The very limited data that is available does indicate that a high proportion of parents with disability do not have custody of their children. A survey conducted by the Australian Bureau of Statistics (ABS) in 2015 estimated that only 15 per cent (669,000) of children aged 0–14 lived with one or both parents with disability.[67]

A research report prepared for the Disability Royal Commission identified that mothers with intellectual or cognitive disability are six times more likely to have their children taken into out-of-home care than mothers without intellectual or cognitive disability.[68]

Narratives from the Disability Royal Commission also detail the personal stories of people with an intellectual or cognitive disability who have had their children removed from their care by government departments.[69]

In the final report from the Disability Royal Commission, it was noted:

> A First Nations parent with disability whose children had been removed told us child protection authorities were incapable of seeing parents with disability as 'people with strengths'. Another parent with disability felt she was treated differently and looked at as though she was 'dumb and knew nothing'.[70]

Research indicates that parents with cognitive disability also experience differential treatment with respect to where, how long, and with whom their children are placed following their removal.[71]

Further to this, stakeholders interviewed for this project advised that child protection authorities are less likely to work towards reunifying parents with disability and their children, or to refer parents with disability to parenting support services.

In a literature review conducted for the Disability Royal Commission it was identified that, for many parents with disability, the removal of their children is permanent, and often extends to subsequent children.[72] Stakeholders consulted for this project have confirmed this trend in Queensland, in which parents with cognitive disability who initially have a child removed by Child Safety on a temporary basis, subsequently have their child removed permanently. Further, it was reported by some stakeholders that these parents will often have successive children removed by Child Safety.

Cross section of disadvantage

Despite parents with cognitive disability having children removed from their care at notably high rates, cognitive disability, in and of itself, is not a strong indicator of impaired parental capacity.[73]

Research indicates that it is the disadvantage that often accompanies a person having cognitive disability that can be viewed by child protection authorities as confirmatory evidence of a parent with disability's incapacity to ensure the safety of their children.[74]

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[66] UNCRPD, Article 31- Statistics and data collection.
[67] Australian Institute of Health and Welfare (AIHW), *Australia's children*, cat. no. CWS 69, AIHW, Canberra, 2020, p. 6.
[68] J Vincent, D McCarthy, H Miller, K Armstrong, S Lacey, G Lian, D Qi, N Richards, T Berry, *Research report: The economic cost of violence, abuse, neglect, and exploitation of people with disability*, report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Taylor Fry, Sydney, 2022, p. 359.
[69] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Volume 1: Voices of people with disability - Book 1', *Final Report*, 2023, pp. 292, 444 and 643.
[70] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Volume 9: First nations people with disability', *Final report*, 2023, p. 124.
[71] T Libesman et al., p. 2.
[72] Ibid.
[73] A Lamont and L Bromfield, 'Parental intellectual disability and child protection: Key issues', *National Child Protection Clearing House*, no 31, 2009, p. 11; C Tilbury, P Walsh, and J Osmond, Child Aware Approaches Project literature review, Micah Projects, South Brisbane, Queensland, 2013, p. 17.
[74] F Lima, et al., 'Child protection involvement of children of mothers with intellectual disability', *Child Abuse and Neglect*, vol. 126, 2022, 105515.

A research report prepared for the Disability Royal Commission, *Economic cost of violence, abuse, neglect and exploitation of people with disability,* noted that it is likely that the poorer outcomes faced by mothers with disability are, at least in part, driven by systemic neglect or failures to promote an inclusive, equal society.[75]

A lack of inclusive, accessible, or specialised support services, social isolation, low socio-economic status, and health or mental health problems are all elements of disadvantage disproportionately experienced by parents with cognitive disability that can lead to a belief that a child would not be safe in their care. Many parents without cognitive disability may experience the same disadvantages, however may not be subject to the same level of scrutiny.

Some of the disadvantages experienced by people with cognitive disability are explored below.

Social isolation

Research has identified that parents with cognitive disability experience stronger feelings of social isolation from their local communities, with a marked absence of friends or neighbours willing and able to provide parenting support.[76]

Social isolation can be exacerbated by the obstacles parents with cognitive disability face in accessing transport. Obtaining a driver's licence can be challenging and public transport may not meet an individual's accessibility needs.

Low socio-economic status

Evidence indicates that parents with cognitive disability are more likely to experience socio-economic hardships.[77] Challenges finding employment and a shortage of accessible housing can contribute to the lower socio-economic status of many parents with cognitive disability.

Stakeholders consulted during this research noted that the current shortage of accessible public housing in Queensland, particularly in regional and remote areas, is having a significant impact on parents with cognitive disability who want to demonstrate to Child Safety that they can provide a safe environment for their children.

Health problems

Mothers with cognitive disability may experience significant health problems that have the potential to interfere with their parenting ability. Much like parents without disability, providing sufficient care may prove difficult when the health of a primary caregiver is poor. [78]

Mental health problems

Several research studies have identified a high prevalence of mental illness in adults with cognitive disability.[79] These parents may need mental health support to enable them to care for their child or children.

Child protection experiences

Many women with cognitive disability who have experiences of out-of-home care and become parents will carry histories of trauma, violence, and extreme mistrust and fear of child protection services that they identify as having failed them as children.[80] This trauma could act as a deterrent to seeking parenting support for fear their own children will enter that same system. This was

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[75] J Vincent et al., 2022, p. 359.
[76] A Lamont et al., 2009. p. 11.
[77] Ibid., p. 12.
[78] Ibid., p. 13.
[79] A Lamont et al., 2009, p. 13.
[80] WWILD Sexual Violence Prevention Association Inc., Submission no. 001.00577 to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Violence and Abuse of People with Disability at Home*, 3 January 2020, p. 13.

confirmed by the Disability Royal Commission which heard instances of parents with disability not seeking support when they needed it for fear of triggering a Child Safety intervention.[81]

Stakeholders consulted during this research observed that, in their experience, the impact of this trauma may not receive a sufficient response from child protection authorities. Parents with post-traumatic stress disorder linked to their out-of-home care experiences may not receive the mental health support they need, and so may struggle to parent their own children without access to mental health services. This is a particular concern for Aboriginal and Torres Strait Islander parents who may be experiencing intergenerational trauma.

Aboriginal and Torres Strait Islander parents

Child Safety authorities may require a parenting capacity assessment to guide a decision about an adult's capacity to parent. These assessments are conducted by an occupational therapist and a psychologist and assess a parent's functional cognitive abilities. Further detail regarding these reports is provided on page 61 of this report.

Aboriginal and Torres Strait Islander parents with cognitive disabilities may experience additional disadvantage associated with the nature of these assessments.

This was acknowledged by the Disability Royal Commission, which found that parenting capacity assessments based on Western concepts of parenting are not culturally appropriate, and do not consider the cultural strengths of First Nations peoples, their families, and communities.[82]

Recommendation 9.1 of the Disability Royal Commission's final report stated the following:

> State and territory governments should work with First Nations child protection services, peak bodies and First Nations people with disability to co-design clear principles and guidelines for parenting capacity assessments for First Nations parents with disability in their jurisdiction, to ensure assessments are culturally appropriate. The principles and guidelines should include:
>
> - best practice standards of cultural competence for practitioners conducting parenting capacity assessments of First Nations parents with disability;
> - guidance to assist practitioners conducting parenting capacity assessments of First Nations parents with disability to identify and address assessment test errors that may result from an insufficient understanding of how cultural factors affect assessments of parenting capacity;
> - a requirement that practitioners conducting parenting capacity assessments of First Nations parents with disability complete mandatory training to implement best practice standards of cultural competence, using testing tools that are culturally appropriate and disability appropriate; and
> - establishing a review process to ensure the design and implementation of these standards is consistent across states and territories.[83]

A stakeholder consulted during this research noted that, in their experience, Child Safety officers (CSOs) may not always possess the appropriate experience required to fully understand the nature of Aboriginal and Torres Strait Island culture. For example, an Aboriginal or Torres Strait Islander parent with little food in the fridge may be assumed by a CSO to be neglecting their child's health.

However, this is not taking into consideration the Aboriginal and Torres Strait Islander community culture which would see family and friends supporting a family in need of food. The idea of shared responsibility can also extend to parenting itself. A stakeholder provided an example of a parent with a young child who also had her 17-year-old daughter living in the house. Child Safety observed the 17-year-old taking on responsibilities in the home and assumed it was an indication of negligence on the part of the mother, when this was not the case.

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[81] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Volume 9: First Nations people with disability', *Final report*, 2023, p. 124.

[82] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Executive Summary: Our vision for an inclusive Australia and recommendations', *Final Report*, 2023, p. 143.

[83] Ibid., p. 279.

Other marginalised groups

It is also important to consider intersectionality for people with cognitive disability who belong to other marginalised cohorts (LGBTIQA+, culturally and linguistically diverse), leading them to experience additional barriers or exacerbated circumstances when forming relationships and becoming parents.

Supported decision-making

An obstacle faced by parents with cognitive disability is a perception that adults with cognitive disability are unable to make decisions about their own lives and the lives of their children.

In a research report prepared for the Disability Royal Commission it was noted that, while there is no uniform definition of supported decision-making that is widely adopted, 'supported decision-making has been conceptualised as a way to ensure that an individual's "will and preferences" are given effect in decisions about their own lives, in the same way that everyone else's decisions are realised.'[84] The NDIS describes supported decision-making as the 'process of providing support to people to make decisions to remain in control of their lives.'[85] It involves 'building the skills and knowledge of people, their families, carers, peers and professionals.'[86]

There are human rights obligations placed upon government to provide decision-making and parenting support to parents with disability, particularly to meet the requirement of recognition and equality before the law.[87]

Child Safety have advised that the *Child Protection Act 1999* (Qld) does include principles about exercising powers and making decisions that require Child Safety, to the extent that it is appropriate, to obtain the views of a parent or another relevant person and take them into account before a child protection decision is made.[88]

The *Child Protection Act* also provides that, when a person or agency is exercising a power or making a decision under the Act, assistance should be given to a parent who needs help to participate in or understand the decision-making process, or to understand a statutory right relevant to a decision.[89] Parents may also obtain legal advice or be represented by a lawyer or supported by another person, in relation to the decision-making process.[90]

Similarly, the *Child Protection Act* requires that in a proceeding for a child, the Childrens Court must, as far as practicable, ensure the child's parents understand the nature, purpose and legal implications of the proceeding and any order or ruling made by the court.[91] If the child's parents have a disability that prevents them from understanding or taking part in the proceeding, the Court must not hear the proceeding without a person to facilitate the parent taking part in the proceeding.[92]

Where a parent appears in the Childrens Court in a proceeding for a child but is not represented by a lawyer, the court may continue with the proceeding only if it is satisfied the parent has had reasonable opportunity to obtain legal representation.[93]

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[84] C Bigby, T Carney, S-N Then, I Wiesel, C Sinclair, J Douglas, J Duffy, *Research report: Diversity, dignity, equity and best practice: a framework for supported decision-making*, report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Living with Disability Research Centre, La Trobe University, Victoria, 2023, p. 175.

[85] National Disability Insurance Agency, *NDIS Supported Decision Making Policy*, April 2023, p. 4

[86] Ibid.

[87] *Human Rights Act 2019* (Qld) s 15.

[88] *Child Protection Act 1999* (Qld) s 5D(1)(b).

[89] *Child Protection Act 1999* (Qld) s 5D(1)(c).

[90] *Child Protection Act 1999* (Qld) s 5D(1)(d).

[91] *Child Protection Act 1999* (Qld) s 106(1).

[92] *Child Protection Act 1999* (Qld) s 106(2).

[93] *Child Protection Act 1999* (Qld) s 109.

While these provisions reflect the priority to be placed on supporting parents to participate in Child Safety proceedings, some stakeholders have reported that parents have not received the information and support they need to meaningfully participate in those proceedings.

Best interests of the child

The focus on risk management in child protection, along with assumptions about the ability to parent, can create a situation in which the rights of parents with disability to be supported are perceived to conflict with 'the best interests of the child'.[94]

Research conducted to ascertain children's outcomes and experiences having a parent with cognitive disability found some evidence to suggest that children of parents with cognitive disability may face additional disadvantage, such as social stigma, bullying, having additional responsibilities, or feeling lonely and isolated; all of which can have an impact on their wellbeing.[95]

However, the research also indicates that children can 'experience positive feelings and normal experiences of love and connection towards parents with cognitive disability'[96] with any experiences of social stigma, loneliness and isolation being potentially mitigated by a warm caregiving style.[97]

While the policy intent behind the removal of children is to protect them from potential parental maltreatment, it may not fully account for the harm perpetrated through separating children from their families.

Several studies have shown that the trauma of removal and placement of children in out-of-home care can manifest in developmental, educational, social and health disadvantage.[98] Further to this, while most children who experience abuse and neglect do not commit criminal offences, there is evidence of a link between child removal and a child's subsequent involvement in criminal justice systems.[99]

A stakeholder consulted for this research advised of an instance where a child, who had been removed from their parent with cognitive disability, frequently ran away from foster care to their mother's home. In one incident, the child broke into a Child Safety office to find their file as they were fearful that they would be permanently removed from their mother. As a result of this incident, police were called, and the child entered the youth justice system.

The issue does remain complex, given that the link between child protection experiences and the criminal justice system in some ways reflects other vulnerabilities experienced by children who enter the child protection system, including complex trauma, domestic and family violence, housing instability, poverty and mental health concerns.

As the Victorian Public Advocate has noted, 'the State has very rarely been able to demonstrate that children [are] better off in care than if they had remained with their family with supports provided to them.'[100] Yet the trauma experienced by children following removal from their families and throughout their (frequently multiple) placements with carers will often be assumed to relate or be attributed to traumatic experiences with their families prior to their removal from home.[101]

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[94] T Libesman et al., p. 54.

[95] C Tilbury et al., 2013, p. 18.

[96] Ibid., p. 18.

[97] Ibid., p. 18.

[98] M Davis, *Family Is Culture,* Independent Review of Aboriginal Children and Young People in OOHC, 2019, pp. 230–32; F Lima, M Maclean and M O'Donnell, *Exploring outcomes for children who have experienced out-of-home care*, Telethon Kids Institute, 2018; E Galvan, R O'Donnell, H Skouteris, N Halfpenny and A Mousa, 'Interventions and practice models for improving health and psychosocial outcomes of children and young people in out-of-home care: Protocol for a systematic review', *BMJ Open*, vol. 9, no. 9, 2019.

[99] T Libesman et al., p. 50.

[100] Office of the Public Advocate (Vic), *Rebuilding the village: Supporting families where a parent has a disability*, Report 2: Child protection, 2015, p. 20.

[101] Ibid., p. 29.

Regardless of the drivers, there are established links between a child's involvement with child protection and entry into the youth justice system. According to the Australian Institute of Health and Welfare (AIHW), almost two-thirds (65%) of children under youth justice supervision in 2022-23 had interacted with the child protection system in the last 10 years.[102]

Beyond the emotional impact on a family when a child enters the child protection system, there is also a financial cost associated with a child living in residential care. The Queensland Family and Child Commission (QFCC) has estimated that, on average, over $400,000 is spent annually per child living in residential care.[103]

There will always be situations where, despite the provision of the relevant supports, the safety and wellbeing of a child cannot be assured in the custody of a parent with cognitive disability.

However, this could be said of any parent experiencing difficulties, leading to an assessment where it would not be in the best interests of a child to remain in their care. For parents with cognitive disability similar supports to those provided to other parents may not be made available, potentially based (drawing on anecdotal evidence from stakeholders) on assumptions made about their disability.

Child protection laws in Queensland

This section will explore the legal framework that is the basis for the removal (by government) of children from their biological parents in Queensland.

In Queensland, as noted, the *Child Protection Act* is the overarching legislation that relates to the protection, welfare and best interests of children. The purpose of the *Child Protection Act* is to provide protection and promote the safety of children, and to support families caring for children.[104] It is administered by the Queensland Department responsible for Child Safety (at the time of writing, the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS)).

The *Child Protection Act* includes principles that are to be applied when Child Safety is acting under the legislation. In this regard, the paramount principle that applies is the safety, wellbeing and best interests of the child throughout childhood and the rest of their lives.[105] In addition, there are further general principles that are to be considered in decisions relating to the safety, wellbeing and interests of the child.[106] These include: that the child's family has the primary responsibility for their upbringing, protection and development;[107] the preferred way to ensuring a child's safety and wellbeing is supporting their family;[108] and if a child is removed from the child's family, support should be provided to the child and their family to allow the child to return to the child's family.[109]

If Child Safety reasonably suspects a child is in need of protection, Child Safety must immediately investigate the concerns and assess whether the concerns about abuse and neglect can be substantiated.[110] Child Safety classifies the reported concerns that it determines need to be investigated and assessed as a notification.[111] A 'notification' is a record by Child Safety to note a reasonable suspicion that a child is in need of protection.[112]

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[102] AIHW, *Young people under youth justice supervision and their interaction with the child protection system 2022-23*, 2024, p. vi.
[103] Queensland Family and Child Commission (QFCC), *Carer allowances*, QFCC insights paper, 2023, p. 1.
[104] *Child Protection Act 1999* (Qld) s 4.
[105] *Child Protection Act 1999* (Qld) s 5A.
[106] *Child Protection Act 1999* (Qld) s 5B.
[107] *Child Protection Act 1999* (Qld) s 5B(b).
[108] *Child Protection Act 1999* (Qld) s 5B(c).
[109] *Child Protection Act 1999* (Qld) s 5B(f).
[110] *Child Protection Act 1999* (Qld) s 14(1).
[111] Director of Child Protection Litigation, *Annual Report 2023-24*, p. 17.
[112] Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS), 'Glossary', *Child Safety Practice Manual*, [Notification], published 8 August 2019 (accessed 1 May 2025).

The *Child Protection Act* defines a child in need of protection as:

> **10 - Who is a child in need of protection**
>
> A child in need of protection is a child who—
>
> (a) has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; and
>
> (b) does not have a parent able and willing to protect the child from the harm.

A 'child' is an individual under 18 years of age.[113]

Under section 9 of the *Child Protection Act*, 'harm' includes 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing'. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation, and it is immaterial how the harm is caused.

The term 'parent' can include anyone caring in an ongoing way for the child such as a parent, step-parents, or grandparents with whom the child lives.[114] The definition for Aboriginal and Torres Strait Islander parents can be interpreted broadly to include customary relationships within a community or tribal grouping.[115]

Having or being a parent with disability alone is not listed in the *Child Protection Act* as a reason a child may need protection.

Unborn children

Section 22 of the *Child Protection Act* requires Child Safety to take appropriate action when it suspects an unborn child may need protection after birth.

Child Safety can take any action it considers appropriate, such as investigating the circumstances to assess whether the child will need protection after being born or offering help and support to the mother.[116]

For Aboriginal and Torres Strait Islander children, Child Safety can arrange for an independent Aboriginal or Torres Strait Islander entity to help the mother participate in the actions Child Safety takes, but only with the consent of the mother.[117]

The purpose of the actions of Child Safety is to reduce the likelihood of the need for the child to require protection, and not to interfere with the mother's rights or liberties.[118]

Reporting

Section 13A of the *Child Protection Act* allows any person to contact Child Safety to report concerns about a child needing protection.

Mandatory reporters

Under s.13E(3) of the *Child Protection Act*, if a 'relevant person' forms a 'reportable suspicion' about a child, the person *must* give a written report to Child Safety.

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[113] *Child Protection Act 1999* (Qld) s 8.
[114] *Child Protection Act 1999* (Qld) s 11(1).
[115] *Child Protection Act 1999* (Qld) s 11(3)-(4).
[116] *Child Protection Act 1999* (Qld) s 22(2).
[117] *Child Protection Act 1999* (Qld) s 22(3)-(4).
[118] *Child Protection Act 1999* (Qld) s 22(5).

Under s.13E(1), a 'relevant person' is a doctor, registered nurse, teacher, a police officer with child protection responsibilities, a person engaged to perform a child advocate function under the *Public Guardian Act 2014* or an early childhood education and care professional.

Section 13E(2) provides that a 'reportable suspicion' about a child is a reasonable suspicion that the child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse, and may not have a parent able and willing to protect them.

Content of reports

Section 13G of the *Child Protection Act* requires that a written report to Child Safety include the basis on which the person has formed the reportable suspicion.

Section 4 of the *Child Protection Regulation 2023* prescribes the information to be included in these reports.

> 4 – Information to be included in reports – Act s 13G
>
> For section 13G(2)(b) of the Act, the following information is prescribed—
>
> (a) the child's name, age and sex descriptor;
>
> (b) details of how to contact the child;
>
> *Examples of how to contact a child—*
>
> - the address at which the child usually lives
> - the name and address of the school the child attends
>
> (c) details of the harm to which the reportable suspicion relates;
>
> (d) particulars of the identity of the person suspected of causing the child to have suffered, suffer, or be at risk of suffering, the harm to which the reportable suspicion relates;
>
> (e) particulars of the identity of any other person who may be able to give information about the harm to which the reportable suspicion relates.

Child Safety Practice and procedures

This section details the internal policies and procedures developed by Child Safety as part of its response to receiving a report of risk of harm. The procedures detailed are largely sourced from the publicly available content in Child Safety's *Child Safety Practice Manual* (the practice manual) and related practice guidance. In Queensland, this practice manual and associated tools provide Child Safety staff with definitions, policies, procedures and instructions to guide and inform their delivery of child protection services.

> This section of the report details relevant policies and procedures employed by Child Safety, with a focus on parents with cognitive disability. Child Safety's policies and procedures are detailed in its Child Safety Practice Manual, which is available online (https://cspm.csyw.qld.gov.au/).
>
> The Department of Families, Seniors, Disability Services and Child Safety informed the Public Advocate during the consultation for this project that Child Safety's policies and procedures are currently being updated, as part of the Department's Unify project.
>
> With this in mind, the practices and procedures referred to in this section of the report are current as at 30 April 2025, having been downloaded by the Public Advocate in the period between 30 April and 2 May 2025.
>
> Citations refer to the copy of the manual current as at the dates noted above, which has been downloaded by the Public Advocate and can be made available if required.

Receive and respond at intake

The first procedure in the practice manual guides Child Safety staff on appropriate responses when receiving information or allegations from someone (a notifier) about harm, or the risk of harm to a child, or the risk to an unborn child after birth.[119] This stage of the process is referred to as intake.

Child Safety's *Decision making at intake practice guide* (practice guide), most recently made publicly available in April 2025, assists Child Safety staff to understand and undertake the intake process.[120]

Intake processes are initiated when professionals, family members or members of the public contact Regional Intake Services (RIS) or a Child Safety Service Centre (CSSC) with concerns about a child.

The practice manual includes guidance on how to:

- gather relevant information
- assess if there is a reasonable suspicion that a child is in need of protection, or an unborn child will be in need of protection after birth
- decide on a response
- refer families for help and support, where appropriate
- record the intake response.[121]

Gathering information includes obtaining details about the child and the alleged abuse, information about the child's parents and home environment, family stressors and if the child or parents have an intellectual or physical disability, health issue or other type of vulnerability.[122]

Staff are prompted to consider contacting the regional specialist services clinicians for advice and support if the concerns received from a notifier are about:

- a child with a disability
- the child's social or emotional wellbeing or mental health
- a child with a complex health diagnosis
- a parent with a disability.[123]

The practice manual also includes specific guidance on what to do if information is received about a child's death[124] or serious injury to a child,[125] and when to report information to the Queensland Police Service[126] or the Office of the Public Guardian (OPG).[127]

Child Safety staff must also consider all records of Child Safety's contact with or about the child, the child's family and other members of the child's home.[128] The practice manual articulates that a child protection historical record can identify information such as patterns or cumulative harm and risk, and strengths and protective factors in the family.[129]

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[119] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Overview], accessed 30 April 2025.

[120] DFSDSCS, 'Decision making at intake', *Practice Guide*, accessed 30 April 2025.

[121] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Overview], accessed 30 April 2025.

[122] DFSDSCS, 'Information gathering prompts' – handout linked to 'Decision making at intake', *Practice Guide*, accessed 30 April 2025.

[123] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Receive information from notifier], accessed 30 April 2025.

[124] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Other intake matters—receive information], accessed 30 April 2025.

[125] Ibid.

[126] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Receive information from the notifier], accessed 30 April 2025.

[127] Ibid.

[128] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice* Manual, [Check child protection history], accessed 30 April 2025.

[129] Ibid.

In coming to a decision, staff must:

- assess the alleged harm and risk of harm guided by the *Decision making at intake practice guide*;
- consult their senior team leader or the senior practitioner;
- ensure that cultural knowledge informs an assessment relating to an Aboriginal or Torres Strait Islander child;
- request a person's criminal and domestic violence history: and
- seek any additional information to assist in making the decision.[130]

The practice guide includes extensive guidance on what amounts to abuse and how to recognise abuse, including the impact of exposure to domestic and family violence.[131] Known risk factors are identified in the practice guide, namely, domestic violence,[132] mental health concerns around a parent,[133] and evidence of alcohol and drug use.[134]

The practice guide also highlights the importance of considering the strengths and protective factors of each family.[135]

Using these tools, and information gathered from the appropriate sources, Child Safety staff must make an assessment and decide on an appropriate intake response which will either be:

- a notification; or
- a child concern report.[136]

The decision to record a notification is made when the senior team leader decides the information meets the threshold for a notification.[137]

Respond to a notification

The second procedure in the practice manual details the steps involved in responding to a notification. As noted above, a notification is the appropriate response if it is reasonably suspected that a child needs protection, or an unborn child will be in need of protection following their birth.[138]

A child in need of protection is:

- a child who has been significantly harmed, is being significantly harmed or is at risk of significant harm, and
- does not have a parent able and willing to protect them.[139]

The response to a notification will either be a priority response or a standard response (explained below), however both responses will also include a safety and support response, based on a safety assessment.[140]

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[130] DFSDSCS, 'Receive and respond at intake', Child Safety Practice Manual, [Assess the information and decide the response], accessed 30 April 2025.
[131] Ibid.
[132] Ibid.
[133] Ibid.
[134] Ibid.
[135] Ibid.
[136] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the alleged harm and risk of harm], accessed 30 April 2025.
[136] Ibid.
[137] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the information and decide the response], accessed 30 April 2025.
[138] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the alleged harm and risk of harm], accessed 30 April 2025.
[139] Ibid.
[140] Ibid.

Safety Assessment

A safety assessment is used to assess whether a child is safe and, if not, what the child needs to be safe.[141] It is to be carried out as soon as possible at the commencement of a priority or standard response and is the focus of the first contact with the family.[142]

The safety assessment guides decision making about:

- the threat of immediate harm to the child in the child's home.
- what interventions are needed to keep the child safe.
- a safety decision for each child in the child's home.
- whether an immediate safety plan can be developed to ensure the safety of any child who remains in the home, if immediate harm indicators have been identified.[143]

If an immediate harm indicator is identified, an immediate safety intervention will be considered, which will be either:

- non-custody interventions developed and agreed to in an immediate safety plan to keep the child safe in the household; or
- a placement intervention (a care arrangement with an approved carer), if an immediate safety plan cannot be developed to keep the child safe.[144]

When a child is at immediate risk of harm at the time of birth and an alternative safety intervention cannot be implemented, Child Safety staff must consult with the senior team leader and an Office of the Child and Family Official Solicitor (OCFOS) lawyer to decide the immediate action required to secure custody of the child (more information on OCFOS is provided on pp. 48-49 of this report).[145]

To secure custody of the child, the practice manual prescribes one of following actions:

- negotiate with the parents for the child to be placed under a care agreement;
- use powers under section 18 of the *Child Protection Act 1999*;
- apply for a Temporary Assessment Order (TAO) or Care Assessment Order (CAO), where further assessment is required; or
- apply for a Temporary Custody Order (TCO), if no further assessment is required.[146]

The manual prompts Child Safety staff to 'provide opportunities for the parent and newborn child to have safe and meaningful contact that supports bonding and attachment.' This includes options to support breastfeeding.[147]

Aboriginal and Torres Strait Islander children

Specific guidance is provided on how to develop a safety plan for an Aboriginal or Torres Strait Islander child. This includes information on facilitating the involvement of an independent person or engagement with the Family Participation Program (FPP).[148]

An 'independent person' is the person or entity that facilitates a child and family's participation in significant decisions being made about the child under the *Child Protection Act 1999*.[149]

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[141] DFSDSCS, 'Glossary', Child Safety Practice Manual, [Safety assessment], accessed 30 April 2025.
[142] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Other assessment actions], accessed 30 April 2025.
[143] Ibid.
[144] Ibid.
[145] Ibid.
[146] Ibid.
[147] Ibid.
[148] Ibid.
[149] DFSDSCS, 'Glossary', Child Safety Practice Manual, [Independent person], accessed 30 April 2025.

The FPP is an external program that provides targeted support to an Aboriginal or Torres Strait Islander child or family. Staff from the program may accompany a Child Safety Officer when visiting a family at any stage of an assessment.[150]

The FPP includes:

- Supporting the family to participate in significant child protection decisions that affect their lives.
- Aboriginal and Torres Strait Islander family led decision-making processes.
- Helping the family identify an Independent Person (IP) or acting as the IP, if they have capacity and no conflict of interest.[151]

Families can be referred to the FPP by Child Safety (with consent) or the family can self-refer.

Priority response

Child Safety's practice guide provides that a priority response will generally apply to notifications that are higher-risk and will result in ongoing intervention if the outcome of the assessment is that the child is a 'child in need of protection'.[152]

A priority response is appropriate when one or more of the following criteria apply:

- The concerns relate to sexual abuse, significant physical abuse, severe neglect or severe emotional abuse with indicators of significant impact.
- The concerns relate to domestic and family violence and one or more of the following apply:
  - the victim-survivor's perception of the risk is high,
  - the violence is escalating in frequency or severity,
  - the person using violence has threatened to kill the victim-survivor or the subject child (including an unborn child),
  - the person using violence has tried to choke or strangle (including attempts to smother or drown) the victim-survivor
  - the person using violence threatened to use or used a weapon against the victim-survivor.
- An assessment of the child's need for protection is required.
- A parent or alleged person responsible has previously been responsible for causing the death of or a serious injury to a child.
- A child has died in suspicious or unexplained circumstances, and a response is required for other children in the home.
- A child is subject to:
  - an intervention with parental agreement case
  - a directive order
  - a supervision order
  - a child protection order granting custody or guardianship to the chief executive.
- An unborn child has been assessed as being in need of protection after their birth.
- There is credible information that indicates that a parent or pregnant person would relocate to avoid contact, placing the child or unborn child at increased risk of significant harm.
- There are concerns relating to cumulative harm with indicators of significant impact on the child.[153]

A priority response must commence within 24 or 72 hours of a notification being received, depending on whether urgent action is required to assess and ensure the child's immediate safety.[154] As described above, a safety assessment must be carried out at the commencement of a priority response.[155]

The practice manual outlines the steps to be taken once a priority response has been deemed appropriate.

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[150] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Other assessment actions], accessed 30 April 2025.
[151] Ibid.
[152] DFSDSCS, 'Decision making at intake', *Practice Guide*, accessed 30 April 2025.
[153] Ibid.
[154] Ibid.
[155] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a priority response], accessed 30 April 2025.

These steps include:

- reviewing the child protection history;
- identifying relevant activities;
- involving key people and organisations;
- coordinating contact and interviewing the child, the parents and other relevant people;
- deciding roles and responsibilities; and
- considering sources of information.[156]

After undertaking the required steps, and assessing the relevant information, Child Safety staff are guided to make a professional judgement about whether the child needs protection.[157]

A child assessed as needing protection will be subject to ongoing intervention by way of an intervention with parental agreement (IPA) or a child protection order (discussed on pages 50 and 46 respectively). [158]

Standard response

If a notification does not meet the criteria for a priority response, a standard response will commence. A standard response involves Child Safety assessing a child's immediate safety and family support needs and coordinating services to decrease the likelihood of a child becoming a child in need of protection.[159] It is not an assessment about whether a child needs protection.[160]

The first preference for undertaking a standard response is for Child Safety to work with an Assessment and Service Connect (ASC) co-responder.[161] A co-response with an ASC can only occur with the consent of the parent or the pregnant person.[162]

ASC is a model of working with families, in partnership with assessment and service connect co-responder services, to complete an investigation and assessment and determine a child's need for protection and ongoing service provision.[163]

The role of the ASC provider during a standard response is to:

- support Child Safety to engage with the child and their family or the pregnant person;
- enable, support and inform a needs-based response to the child and their family or the pregnant person;
- carry out a targeted assessment of the family's or pregnant person's support needs, with Child Safety; and
- assist the family or pregnant person to access the support and services they need.[164]

The ASC co-responder will assist Child Safety to engage with the family or pregnant person and will lead a family needs assessment.[165]

The Child Safety Officer (CSO) is responsible for 'assessing the child's immediate safety, gathering information to inform a family needs assessment and for all other aspects of the standard response.'[166]

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[156] Ibid.
[157] Ibid.
[158] Ibid.
[159] Ibid.
[160] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the information and decide the response], accessed 30 April 2025.
[161] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a standard response], accessed 30 April 2025.
[162] Ibid.
[163] DFSDSCS, 'Glossary', *Child Safety Practice Manual*, [Assessment and service connect], accessed 30 April 2025.
[164] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [[Undertake a standard response], accessed 30 April 2025.
[165] Ibid.
[166] Ibid.

As part of a standard response Child Safety staff are required to contact the parent or pregnant person to:

- advise that a notification has been recorded and if possible, obtain information that will inform the assessment
- explain that Child Safety would like to talk to them, assess what help and support the family might need to keep their children safe or their unborn child safe after their birth, and how to access this support
- ask if they consent to a co-response occurring, that is, having a person from another agency be a part of the visit with Child Safety, if a co-response is being considered
- explain the need to sight and engage the subject child in the assessment process
- advise that they are able to have a support person
- respond to any question the about the process
- make a time to visit the family or pregnant person.

The first contact with the family must involve Child Safety.[167]

The practice manual emphasises the importance of finding ways to engage effectively with the parent or pregnant person, as well as the child, to assess the child's safety and support needs. This includes assisting them to identify an appropriate support person should they request it.[168]

Once a parent or pregnant person has agreed to engage with Child Safety, the CSO must:

- meet with the family;
- give details of the alleged harm or risk of harm to at least one of the child's parents;
- engage them in relation to the concerns received;
- seek the consent of the parent or other adult living in the child's home to access their criminal or domestic and family violence history;
- sight and engage with the child;
- undertake a safety assessment; and
- undertake a family needs assessment.[169]

If the outcome of the initial or subsequent safety assessment is 'unsafe' or 'safe with immediate safety plan' for any child, the case must be escalated to a priority response.[170]

The development of a family needs assessment involves collaboration with the child, family, and their support network to gather and assess information about the family's circumstances, strengths and needs, to coordinate support to meet the child and family's needs. The practice manual states that, 'the purpose of the family needs assessment is to reduce the likelihood of the child becoming a child in need of protection by connecting families with supports and services to help them safely care for their child.'[171]

Child Safety's practice guide, *Conducting a family needs assessment*, provides comprehensive guidance for Child Safety staff on how to 'gather and analyse information about the child and family's circumstances and behaviour, to determine what help and support a parent requires to meet their child's safety and wellbeing needs.'[172] The family needs assessment also requires Child Safety staff to coordinate supports to address the needs of the family in question.[173]

If the parents are unwilling or unable to engage after reasonable attempts have been made to engage them, or the family refuses support, Child Safety staff must consult with their senior team

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[167] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a standard response], accessed 30 April 2025.
[168] Ibid.
[169] Ibid.
[170] Ibid.
[171] Ibid.
[172] DFSDSCS, 'Conducting a family needs assessment', *Practice Guide*, accessed 30 April 2025.
[173] Ibid.

leader to consider what action is required to ensure the child's safety, or to decide whether to escalate the notification to a priority response.[174]

Safety and support response

A safety and support response is a sub-set of a standard response. It allows Child Safety to make a direct referral to an ASC provider when a notification has been recorded and when the service has capacity to respond.[175]

The ASC provider will visit the family, complete a family needs assessment, and help the family to access services that will address identified risk factors.

A safety and support response may be considered if:

- there are identified strengths within the family that could be built on with the help of an early intervention service, to provide for the child's safety or unborn child's safety after their birth
- the child is visible within their extended family and community, such as at school
- it is appropriate for the service to engage with the family without Child Safety assessing the child's immediate safety.[176]

A safety and support response cannot be made if:

- the ASC does not have capacity to engage the family,
- the parent or pregnant person was unable to be contacted within three business days of the referral being made to the ASC,
- the parent or pregnant person did not give consent to a referral to the ASC,
- the ASC advised that the family did not engage in the safety and support response, or
- the referral to the ASC was not accepted.[177]

If a safety and support response cannot be made, the case will be returned to standard response procedures, which may involve escalation to a priority response (see above).[178]

Responding to an unborn child

Child Safety's *Respond to an unborn child* practice guide (practice guide), directs Child Safety staff on the specific steps to take when a report of concern is received that an unborn child may need protection after birth.[179]

The practice guide sets out the principles to be used to manage and achieve positive outcomes for newborn children and their families.

The principles are:

1. **Prevention** – remain focused on reducing risk and increasing safety for the unborn child after the child's birth, to reduce the need for and level of statutory intervention which may be required after the child is born.
2. **Early intervention** – offer a pregnant person help and support at the earliest opportunity to reduce risk to the unborn child after the child is born. Early and meaningful engagement can identify safety and support networks and other opportunities for reducing risk.
3. **Collaboration** – work closely with health services, as they are universal providers for pregnant people, are able to connect them with other services, and provide information to inform an assessment about an unborn child and pre-birth planning.

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[174] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a standard response], accessed 30 April 2025.
[175] DFSDSCS, 'Respond to a notification', Child Safety Practice Manual, [Overview], accessed 30 April 2025.
[176] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the information and decide the response], accessed 30 April 2025.
[177] DFSDSCS, 'Respond to a notification', *Child Safety Practice* Manual, [Undertake a safety and support response], accessed 30 April 2025.
[178] Ibid.
[179] DFSDSCS, 'Respond to an unborn child', *Practice Guide*, accessed 30 April 2025.

4. **Partner with Aboriginal and Torres Strait Islander services** – refer to and partner with culturally appropriate health and wellbeing services for culturally safe support for the pregnant person of an Aboriginal or Torres Strait Islander unborn child.
5. **Make active efforts** – make timely, thorough and purposeful efforts to apply the elements of the Aboriginal and Torres Strait Islander child placement principle for an unborn Aboriginal and Torres Strait Islander child.
6. **Respect** a pregnant person's right to decide whether and how they participate in Child Safety processes, which services they engage with or whether they engage with services.[180]

The practice guide also details the information sharing framework established between prescribed entities, service providers and Child Safety relating to unborn children.[181] This information exchange is provided for under the *Child Protection Act* and is in place to support Child Safety to fulfill its statutory obligation to take action to reduce the likelihood that an unborn child will be in need of protection after birth.[182] Information sharing may occur with or without a pregnant person's consent.[183]

Child Safety staff must ensure that information is shared with relevant support services to plan for the safety of the newborn child after birth, to mitigate risks, and to identify how attachment and bonding will be supported.[184]

They are also required to collaborate with the health service, hospital and other services working with the pregnant person to plan for the newborn child's safety and wellbeing needs directly following birth, as well as undertake any assessment or intervention that may be required.[185]

The practice guide outlines the steps to take for a priority response and a standard response when a notification is made regarding an unborn child. The safety and support response for an unborn child is the same process that applies to a child after birth (detailed above).

Priority response for an unborn child

The purpose of a priority response before the birth of a child is to:

- assess the likelihood that the unborn child will need protection after their birth
- offer the pregnant person help and support to reduce the likelihood the unborn child will be in need of protection.[186]

Before commencing a priority assessment for an unborn child, Child Safety staff are advised to plan the assessment and 'consider whether there would be increased risk for the unborn child after their birth, if the pregnant person were alerted to the concerns.'[187]

Any decision to delay having contact with the pregnant person until after the child's birth can only be made by a senior team leader when 'there is a high probability that, if alerted to the concerns, the pregnant person would relocate or cease engaging with medical support and intervention to avoid Child Safety intervention at the time of the birth, placing the newborn baby at increased risk of harm.'[188] Should this occur, the priority response will be progressed and an unborn child high risk alert will be completed (see page 41 for information on unborn child high risk alerts).[189]

A priority response for an unborn child can only have a 72 hour timeframe. During this time, Child Safety staff must advise the pregnant person that a notification has been recorded, ask if they consent to another agency being part of the assessment (if a co-response is being considered),

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[180] Ibid.
[181] Ibid.
[182] Ibid.
[183] Ibid.
[184] Ibid.
[185] Ibid.
[186] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a priority response for an unborn child], accessed 30 April 2025.
[187] Ibid.
[188] Ibid.
[189] Ibid.

advise of their right to a support person, answer any questions, and make a time to interview the pregnant person.[190]

Child Safety must then assess the likelihood that the unborn child will need protection after birth, including:

- the level and type of risk
- the services that may assist the pregnant person, where relevant, her partner or the father of the unborn child, to reduce the likelihood the child will be in need of protection.[191]

If the pregnant person is not willing to engage in the assessment with Child Safety or a co-responder, staff must explain Child Safety's obligation to respond to the concerns received, go through the assessment process, the pregnant person's rights, and the help and support they may access during pregnancy to decrease the likelihood the unborn child will be in need of protection after birth.[192]

Child Safety has advised that, under section 159H of the *Child Protection Act*, it is able to make a referral to a particular entity to help a pregnant person meet a child's protection and care needs and promote the child's wellbeing after the child is born.

These entities include the chief executive of a department that is mainly responsible for any of the following matters:

(i) adult corrective services;
(ii) community services;
(iii) disability services;
(iv) education;
(v) housing services;
(vi) public health.[193]

A health service[194] is included as an entity that Child Safety may refer to in these circumstances, as well as the Police Commissioner.[195] Child Safety has advised that they do not require the pregnant person's consent to make these types of referrals.

A differential pathway (contact with other professional) can also be considered if a pregnant person exercises their right not to be engaged in an assessment.[196] The differential pathway relies on another professional, such as an employee of the Department of Education or Queensland Health, engaging with the pregnant person on behalf of Child Safety.[197]

If the differential pathway cannot be used, or the differential pathway was used, but the information obtained suggests increased risk after the child's birth, an unborn child high risk alert will be completed (described below).[198]

Standard response for an unborn child

The purpose of a standard response before the birth of a child is to 'offer help and support to the pregnant person to decrease the likelihood of them becoming a child in need of protection once born.'[199]

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[190] Ibid.
[191] Ibid.
[192] Ibid.
[193] *Child Protection Act 1999* (Qld) s 159H(1)(b).
[194] *Child Protection Act 1999* (Qld) s 159H(1)(ba) and (baa).
[195] *Child Protection Act 1999* (Qld) s 159H(1)(c).
[196] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a standard response for an unborn child], accessed 30 April 2025.
[197] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Other assessment actions], accessed 30 April 2025.
[198] Ibid.
[199] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a standard response for an unborn child], accessed 30 April 2025.

At the commencement of a standard response for an unborn child, the pregnant person is contacted and advised of the concerns, and information is obtained that informs the assessment.[200] Obtaining information to commence the assessment does not require the consent of the pregnant person.[201]

Child Safety staff are then directed to engage with the pregnant person to:

- assess the family's support needs, focusing on the issues that may increase the likelihood that the unborn child will be in need of protection following their birth
- coordinate help and support for the pregnant person to address the identified needs and decrease risk to the child.[202]

If the pregnant person is not willing to engage in the assessment with Child Safety or a co-responder, Child Safety staff must:

- explain Child Safety's obligation to respond to the concerns received,
- go through the assessment process,
- explain the pregnant person's rights, and
- outline the help and support they may access during pregnancy to decrease the likelihood the unborn child will need protection after birth.[203]

Child Safety staff are provided with specific guidance on assessing concerns about an Aboriginal or Torres Strait Islander unborn child and are prompted to arrange an 'independent person' (previously described).[204]

The pregnant person must consent to the involvement of an 'independent person'. The FPP can assist children and families to identify an independent person (information on the FPP is provided on page 35).

Using the differential pathway, contact with other professionals instead of Child Safety can also be considered.[205]

If the differential pathway cannot be used, or the differential pathway was used, but the information provided by the other professional suggests increased risk to the unborn child after the child's birth, an unborn child high risk alert will be completed.[206]

Unborn child high risk alert

An unborn child high risk alert is to be created when:

- a decision has been made by a senior team leader to delay contact with a pregnant woman,
- a pregnant person cannot be located after reasonable attempts have been made to locate them,
- the pregnant person did not engage with Child Safety or another professional using the differential pathway during the assessment.[207]

An unborn child high risk alert involves Child Safety contacting hospitals in Queensland and interstate where a pregnant person is likely to give birth and requesting an immediate notification to Child Safety if the person presents for delivery at their hospital.[208] In addition to alerting the relevant hospitals, Child Safety must also contact the pregnant person's medical practitioner (if known).[209]

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[200] Ibid.
[201] Ibid.
[202] Ibid.
[203] Ibid.
[204] Ibid.
[205] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Undertake a priority response for an unborn child], accessed 30 April 2025.
[206] Ibid.
[207] Ibid.
[208] Ibid.
[209] Ibid.

Support service case

A support service case can be offered to a pregnant person when an assessment has determined that an unborn child will need protection after their birth.[210] It involves providing, or helping to provide, prevention, early intervention and services to support a pregnant person to reduce the likelihood of their unborn child needing protection after their birth.[211]

The aim of providing this support is to decrease the risk of harm to the unborn child after their birth and allow for child protection concerns to be addressed, as far as possible, before the baby's birth.[212]

A support service case can only be opened with the consent of the pregnant person.[213]

Temporary Assessment Order

In circumstances where a child is being assessed as to whether they are in need of protection, Child Safety can seek a Temporary Assessment Order (TAO).[214] A TAO is a three-business-day order that authorises certain actions as part of an investigation to assess a child's protection needs where parental cooperation or consent is not forthcoming, or it is not practicable to obtain consent.[215]

An application for a TAO can be made to a Magistrate by an officer from Child Safety or a police officer. Where a child is believed to be at immediate risk of harm, the application must be made within eight hours of the child being taken into custody.[216]

A Magistrate can decide an application for a TAO without notifying the child's parents or hearing them on the application.[217]

A TAO can authorise any of the following actions:

- contact with a child or young person by Child Safety officers or police officers;[218]
- a medical examination or treatment of the child or young person;[219] and/or,
- Child Safety officers or police officers entering and searching a place to find a child or young person.[220]

A TAO can also direct a parent not to have contact with their child or young person, or to only have supervised contact.

Court Assessment Order

If Child Safety is unable to complete the assessment within the time set by a TAO, it may apply for a Court Assessment Order (CAO).

An application for a CAO is made under section 38 of the *Child Protection Act*. It authorises actions that are necessary as part of a Child Safety investigation to assess whether a child requires protection, where the consent of a parent has not been obtained or it is not practicable to obtain that consent, and more than three days are necessary to complete the investigation and assessment.[221] A CAO is 28 days in length.

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[210] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual*, [Support Service case], accessed 30 April 2025.
[211] DFSDSCS, 'Glossary', *Child Safety Practice Manual*, [Support service case], accessed 30 April 2025.
[212] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual*, [Support Service case], accessed 30 April 2025.
[213] Ibid.
[214] *Child Protection Act 1999* (Qld) s 24(2).
[215] Ibid.
[216] *Child Protection Act 1999* (Qld) s 18(8).
[217] *Child Protection Act 1999* (Qld) s 26.
[218] *Child Protection Act 1999* (Qld) s 28(1)(a).
[219] *Child Protection Act 1999* (Qld) s 28(1)(b).
[220] *Child Protection Act 1999* (Qld) s 28(2).
[221] Department of Justice and Attorney-General (Qld), *Child Protection Benchbook*, second edition, 2023, p. 4.

In contrast to TAOs, CAOs can only be decided at a court hearing and require the parent to be notified before the case is heard.[222] However, CAOs can be made by a Magistrate in the absence of the child's parent, provided the parent has been given reasonable notice of the hearing or it was not practicable to give the parent notice of the hearing. CAOs can also be extended once for a further 28 days, if required.[223]

Child Concern Report

If, after the initial assessment, the information received by Child Safety does not meet the threshold for a notification, Child Safety may register a Child Concern Report (CCR). The practice manual notes that a CCR is appropriate if the information received 'relates to child protection concerns, and there is no reasonable suspicion that a child or an unborn child is in need of protection.'[224]

According to the practice manual, once a CCR response is decided, one of following responses must be provided:

- Closing the CCR and taking no further action;
- Protective advice, which entails providing advice to families about ways of responding to concerns, and talking to the family about seeking support or accepting referrals for support;
- A referral to family support, such as Family and Child Connect, an intensive family support service, or an Aboriginal and Torres Strait Islander Wellbeing Service; or
- An active support response, which entails providing families with community-based support services that can meet their specific needs before they escalate to requiring a more intrusive statutory response.[225]

Child Safety have advised that approximately 80 per cent of reports it receives result in a CCR, rather than a notification. If multiple CCRs are made in relation to a child, Child Safety may consider a notification response based on concerns about cumulative harm. Child Safety has advised that it is in the process of further reforming the intake process to ensure parents who have multiple CCRs registered against them will be contacted to ask if they require additional parenting supports.

Assessment Care Agreements

An assessment care agreement may be put in place when a child is subject to an assessment and there is a need to secure the safety of the child outside of the home while the concerns are assessed.[226]

Under this agreement, the parents will agree to their child living with an approved carer for up to 30 days.[227] During this time, the parent will retain custody and guardianship rights, and retain the ability to make short and long-term decisions about their child.[228]

At the end of the assessment care agreement, if Child Safety decides a child needs ongoing protection, it may refer the matter to the Director of Child Protection Litigation (DCPL), who will decide whether to apply for a child protection order. The role of the DCPL is discussed in further detail on page 48 of this report.

Temporary Custody Order

A Temporary Custody Order (TCO) is sought when a child is assessed as needing protection and is at unacceptable risk of immediate harm.[229]

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[222] *Child Protection Act 1999* (Qld) s 41.
[223] *Child Protection Act 1999* (Qld) s 49.
[224] DFSDSCS, 'Receive and respond at intake', *Child Safety Practice Manual*, [Assess the information and decide the response], accessed 30 April 2025.
[225] Ibid.
[226] DFSDSCS, *Child Safety Policy 415-7: Care agreements*, accessed 30 April 2025.
[227] DFSDSCS, 'Respond to a notification', *Child Safety Practice Manual*, [Other assessment actions, accessed 30 April 2025.
[228] Ibid.
[229] *Child Protection Act 1999* (Qld) ss 51AB-AM.

A TCO can be made if Child Safety is working on the child protection matter with the DCPL, or when the chief executive decides it is the most appropriate action to meet the child's ongoing protection and care needs (for example, if Child Safety is in the process of applying for a child protection order).[230]

A TCO cannot remain in effect for longer than three business days after the day the order is made.[231]

The Magistrate can extend a TCO only once, to the next business day:

- if the Magistrate is satisfied the order has not ended; or
- if DCPL intends to apply for a child protection order during the period of extension.[232]

Under section 99(2) of the *Child Protection Act*, a TCO will continue until the application for a child protection order is decided.

Supporting a child in care

A child will be placed in care if it is assessed that they are unable to remain safely with their family.[233]

In these circumstances, Child Safety are required provide a safe, supportive and therapeutic environment for a child.

Ongoing intervention is provided when:

- an unborn child has been assessed as being in need of protection following their birth and the pregnant woman is provided support through a support service case, with her consent, prior to the birth.
- a child has been assessed as being a child in need of protection and is subject to intervention with parental agreement.
- a child has been assessed as being a child in need of protection and is subject to:
  - a directive order
  - a supervision order
  - a child protection order granting custody or guardianship to the chief executive
- a child is subject to a child protection order granting long-term guardianship to a suitable person. In this circumstance, ongoing intervention is provided in a limited capacity.
- a young person requires support through a support service case after they have turned 18.[234]

Case Planning

When an investigation finds that a child requires protection under section 10 of the *Child Protection Act* and ongoing assistance is required, Child Safety must ensure a case plan is developed[235] and regularly reviewed.[236] A case plan is a 'written plan for meeting a child's protection and care needs'.[237]

Family group meetings are held to develop the case plan.[238] This is intended to allow the family, the child, and anyone who is significant to the child to participate in creating a plan for responding to the child's protection and care needs. These meetings also provide an opportunity for Child Safety to connect parents to appropriate support services.

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[230] *Child Protection Act 1999* (Qld) s 51AB.
[231] *Child Protection Act 1999* (Qld) s 51AG(2).
[232] *Child Protection Act 1999* (Qld) s 51AH.
[233] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Purpose], accessed 30 April 2025.
[234] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual,* [Case Management], accessed 30 April 2025.
[235] *Child Protection Act 1999* (Qld) s 51C.
[236] *Child Protection Act 1999* (Qld) s 51A.
[237] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Case planning], accessed 30 April 2025.
[238] *Child Protection Act 1999* (Qld) s 51G.

Child Safety has advised that support is provided to parents immediately; however, based on feedback from stakeholders, it is often not until a Family Group Meeting is held for the development of a case plan that parents report having a clear understanding of the available support and the goals required for successful reunification.

A case plan states:

- the goal and actions to achieve permanency for the child, and timeframes for achieving them
- an alternative permanency goal, if the primary goal is reunification
- actions to promote the child's safety, belonging and wellbeing
- the people or services who are responsible for completing the actions
- if the child is aged 15 or older, the help and support they require to transition to adulthood.[239]

Usually, the goal of the case plan will be reunification of a child with their parent or parents after being in out-of-home care. However, where reunification is the goal, an alternative permanency option must be recorded and pursued through concurrent planning processes if timely reunification is not possible.[240]

One of the following alternative permanency options must be selected:

- long-term out-of-home care
- guardianship by another person
- young person lives independently
- another permanency option.[241]

Concurrent planning starts at the commencement of the case plan and continues until reunification and case closure, or when an alternative permanent arrangement is achieved.[242]

Child strengths and needs assessment

An assessment of the child's strengths and needs provides a snapshot of a child's functioning over a six-month period. The case plan identifies how to build on the child's identified strengths to achieve stated goals. It includes a plan to address the child's needs, aimed at improving the child's emotional, physical and psychological wellbeing.[243]

A child strengths and needs assessment must be completed:

- once the decision is made that a child is in need of protection
- before the initial family group meeting to develop a case plan for the child
- during case plan reviews, if ongoing intervention is likely to continue.[244]

The child strengths and needs assessment ensures that the child's functioning over time is considered within the same domains, using the same criteria. This allows departmental staff to easily identify and assess changes to a child's strengths and needs, so they can respond appropriately. [245]

Parental strengths and needs assessment

A parental strengths and needs assessment (PSNA) is used to develop an effective case plan.[246] It is reviewed every six months during the period of a short-term child protection order (more information on child protection orders is on page 46 of this report).

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[239] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Case planning], accessed 30 April 2025.
[240] Ibid.
[241] Ibid.
[242] DFSDSCS, 'Permanency Practice Kit', *Child Safety Practice Manual*, [Concurrent planning], accessed 30 April 2025.
[243] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Case planning], accessed 30 April 2025.
[244] Ibid.
[245] Ibid.
[246] Ibid.

The PSNA is a structured decision-making tool that employs a consistent approach to evaluating each parent's strengths and needs when gathering information for the development or review of a case plan.

A PSNA is to be completed:

- after a decision has been made that a child is in need of protection
- before the initial family group meeting to develop a case plan for the child
- to inform each revised case plan, if ongoing intervention is likely to continue
- to inform each case plan until a case is closed or a long-term guardianship order or permanent care order is made.[247]

In order to complete the PSNA, Child Safety staff are guided to meet with parents to:

- Discuss the purpose of the assessment.
- Explore areas of each parent's life, including their cultural background
- Assess each parent's current level of functioning and how this may impact on the safety and risk to the child in the home, using professional judgement and considering:
  - the information gathered from the range of sources
  - information about the child and family
  - the child's and family's child protection history
  - the SDM definitions in the SDM Policy and procedures manual
  - the family's culture.
- Give the approved assessment to the family group meeting convenor to use in developing the case plan.[248]

When completing a PSNA for a parent who is an Aboriginal or Torres Strait Islander person, Child Safety staff are prompted to apply a cultural lens to actively support engagement with family, extended family and community.[249]

PSNAs will be informed by family contact visits should these visits be agreed to as part of a child's case plan.[250] When a child is in care, Child Safety must provide an opportunity for contact between the child and the child's parents and appropriate members of the child's family as often as is appropriate in the circumstances. This is referred to as family contact. It may include contact between the child and their siblings, parents, extended family, community members, people of cultural or ethnic significance, and other people of significance in the child's life. These visits can be supervised or unsupervised.

Child protection orders

If an assessment has deemed a child to need protection and that the child's protective needs will be best met by a child protection order, Child Safety will refer the matter to DCPL who will decide whether a child protection order is appropriate.[251] The role of the DCPL is discussed in further detail on page 48 of this report.

The DCPL can seek for the court to make any one or more of the following child protection orders that the court considers appropriate, depending on a family's situation:

- *Directive order to do or refrain from doing something:* directing a named parent of a child to do or refrain from doing something directly related to their child's protection. This order can be up to 12 months in duration;

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[247] Ibid.
[248] Ibid.
[249] Ibid
[250] Department of Children, Youth Justice and Multicultural Affairs, *Family contact: Information for parents,* <https://www.families.qld.gov.au/_media/documents/protecting-children/family-contact-parents.pdf>, n.d.
[251] *Director of Child Protection Litigation Act 2016* (Qld) s 15.

- *Directive order – no contact*: directing a named parent of a child not to have contact (direct or indirect) with their child. This order prevents any contact between the named parent and their child. This order can be up to 12 months in duration;
- *Directive order – supervised contact*: directing a named parent not to have contact (direct or indirect) with their child other than when a stated person, or a person of a stated category is present. This order provides that any contact the named parent has with their child is to be supervised. This order can be up to 12 months in duration;
- *Supervision order*: an order requiring the chief executive (Child Safety) to supervise a child's protection in relation to the matters stated in the order. This order can be up to 12 months in duration.
- *Custody to either a suitable family member or to the chief executive (Child Safety) order*: grants custody of a child to either a suitable person, other than a parent of the child, who is a member of the child's family, or to the chief executive. This order provides them with the right to the child's daily care and the right and responsibility to make decisions about the child's daily care. This order can be up to two years in duration.
- *Short-term guardianship to the chief executive (Child Safety)*: grants short-term guardianship of a child to the chief executive. This order provides the chief executive with all the powers, rights and responsibilities in relation to:
    - the child's daily care and making decisions about the child's daily care, and
    - … making decisions about the long-term care, wellbeing and development of the child.

  This order can be up to two years in duration.
- *Long-term guardianship to either a suitable family member, another suitable person or the chief executive (Child Safety)*: grants long-term guardianship of a child to either a suitable member of a child's family (other than a parent of the child), or to another suitable person, or to the chief executive. This order provides them with all the powers, rights and responsibilities in relation to:
    - the child's daily care and making decisions about the child's daily care, and
    - … making decisions about the long-term care, wellbeing and development of the child.

  This order ends on the day before the child turns 18 years.
- *Permanent care order*: an order granting long-term guardianship of a child to a suitable person. This order provides them with all the powers, rights and responsibilities in relation to:
    - the child's daily care and making decisions about the child's daily care, and
    - … making decisions about the long-term care, wellbeing and development of the child.

  This order ends on the day before the child turns 18 years.[252]

Permanent Care Orders

Between 2018 and 2021 amendments were made to the *Child Protection Act 1999* which focused on achieving permanency for children in the child protection system. These amendments introduced a limitation to the duration of consecutive short-term child protection orders to a total period of two years from when the first order was made.[253]

After two years have passed, Child Safety will undertake an assessment process to determine whether the child's safety, belonging and wellbeing will be best served by applying for a permanent care order (PCO). In Queensland, when a PCO is made, the child's permanent guardian becomes responsible for the child's daily care, as well as the child's long-term care, wellbeing and upbringing, with Child Safety no longer providing ongoing case management.

A PCO differs from other child protection orders in that the application to vary or revoke the order can only be made by DCPL, meaning that a parent cannot apply to vary or revoke the order once it is made. This can potentially mean that parents have 'one chance' at reunification before permanent options are sought. A stakeholder observed that once a decision is made to apply for a PCO, all efforts for reunification of the child with their parents cease.

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[252] Director of Child Protection Litigation, *Annual Report 2023-24*, p. 79.

[253] *Child Protection Act 1999* (Qld) s 62(4).

Child Safety has advised that, other than in rare circumstances where a long-term order may be sought from birth, all reasonable and practicable steps will be taken to help a child's family meet the child's protection and care needs before applying for a PCO. Courts must also be satisfied that these steps have been taken before granting a PCO.[254]

While there is a provision for a second short-term order to be approved before a PCO is made,[255] stakeholders have observed that, in their experience, the grant of a second short-term order for a child whose parent has a cognitive disability is rare, with most short-term orders leading to a PCO. One stakeholder noted that even if there is evidence of poor case planning on the part of Child Safety, it is difficult to have a second short-term order granted.

Child Safety notes that all information is taken into consideration. OCFOS and DCPL review all of the evidence collated by Child Safety before applying for a PCO, and then the evidence is again considered by the Childrens Court before a PCO is made.

Stakeholders have also observed a notable increase in the number of PCOs being made during and after the COVID-19 pandemic. During the period of the pandemic, in-person support services for parents were limited due to the frequent lockdowns and social distancing requirements. Parents with cognitive disability, who benefit more from face-to-face learning, therefore lost the opportunity to build their skills during that time. According to a stakeholder, families were encouraged to source their own supports but there was limited availability, particularly for parents with cognitive disability who require more targeted assistance to meet their parenting goals.

Child Safety has advised that PCOs were introduced in 2018. As at 30 June 2021, 83 PCOs had been made, accounting for less than 1% of all child protection orders. Further to this, Child Safety advised that any increase in PCOs made during and after the COVID-19 pandemic would be due to an increased understanding of PCOs following their introduction in 2018, and the amendments to the *Child Protection Act* discussed above where permanency outcomes were strengthened.

A stakeholder observed that some parents who want to regain custody of their children may only agree to a PCO to maintain a positive relationship with their child's foster carer.

Director of Child Protection Litigation

As noted above, when Child Safety is satisfied that a child requires protection and a child protection order is the most desirable and appropriate course of action to protect the child, it must refer the matter to DCPL.

DCPL is an independent statutory role within the Department of Justice that makes decisions as to which matters will be the subject of a child protection application and what type of child protection order will be sought.[256]

The main functions of DCPL are to:

a) prepare and apply for child protection orders (including applications to extend, vary or revoke child protection orders) and conduct child protection proceedings in the Childrens Court of Queensland;
b) prepare and apply for transfers of child protection orders or proceedings between Queensland and other participating States; and
c) prepare, institute and conduct appeals against decisions of the Childrens Court of Queensland on applications for child protection orders, and decisions to transfer a child protection order or child protection proceeding to a participating State.[257]

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[254] *Child Protection Act 1999* (Qld) ss 59, 59A.
[255] *Child Protection Act 1999* (Qld) s 62(5).
[256] Explanatory Notes, Director of Child Protection Litigation Bill 2016 (Qld), p. 1.
[257] Director of Child Protection Litigation, *Director's Guidelines*, as at 1 July 2018, pp. 6-7.

A Child Safety referral to DCPL is undertaken through OCFOS. OCFOS is a legal unit within Child Safety with responsibilities including:

a) providing legal services and advice to Child Safety Service Centres (CSSC) about Child Safety's statutory functions relating to the protection of children;
b) applying for temporary assessment orders, court assessment orders and temporary custody orders (emergency orders);
c) working with CSSCs to prepare briefs of evidence for child protection matters that are being referred to the DCPL;
d) working in partnership with the DCPL to prepare matters for filing in the Childrens Court and providing ongoing consultation in the review and management of those matters; and
e) liaising with CSSCs and the DCPL as necessary to progress child protection matters in a timely manner consistent with the safety, wellbeing and best interests of the children.[258]

Before deciding how to deal with a matter, DCPL may ask Child Safety to provide further evidence or information.[259] However, DCPL is not instructed by Child Safety and is not required to concur with a Child Safety assessment.[260]

For each child protection matter referred by Child Safety, DCPL may decide to apply for a child protection order for the child or refer the matter back to Child Safety.[261] If the matter is referred back to Child Safety, DCPL's involvement is at an end.[262] DCPL cannot give directions to Child Safety about how to deal with the child's case when referring a child protection matter back to Child Safety.[263] A child protection matter that is referred back to Child Safety can be referred by Child Safety to DCPL again in specific circumstances.[264]

In deciding how to deal with a referred child protection matter, DCPL should have regard to all the information provided by Child Safety in the brief of evidence. DCPL should apply for a child protection order if DCPL is satisfied there is sufficient, relevant and appropriate evidence to establish on a prima facie basis that:

a) the child is a child in need of protection; and
b) a child protection order is appropriate and desirable for the child's protection.[265]

The safety, wellbeing and best interests of the child must be DCPL's paramount consideration in deciding how to deal with a child protection matter.[266]

Other factors DCPL should have regard to include:

a) the sufficiency of evidence to establish that the child:
    i. has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; and
    ii. does not have a parent able and willing to protect the child from harm;
b) the child's views and wishes;
c) whether the child's protection and care needs could be met by an order on less intrusive terms than the order Child Safety considers appropriate and desirable for the child's protection. Relevant factors may include:
    i. cultural considerations about how the proposed order may impact on the child's identity and future links to their family and community;
    ii. the nature and impact of any support previously provided to the child and the child's parents by Child Safety or other agencies;
    iii. progress made by the parents toward building their capacity to meet the child's protection and care needs;

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[258] Ibid., p. 7.
[259] *Director of Child Protection Litigation Act 2016* (Qld) s 17(2).
[260] Department of Justice and Attorney-General (Qld), *Child Protection Benchbook*, p. 46.
[261] *Director of Child Protection Litigation Act 2016* (Qld) s 17(1).
[262] Director of Child Protection Litigation, *Director's Guidelines*, as at 1 July 2018, p. 19.
[263] Ibid.
[264] Ibid.
[265] Ibid., p. 17.
[266] *Director of Child Protection Litigation Act 2016* (Qld) s 5.

    iv. information available about a member of the child's family or community who may be a suitable person to be granted custody or guardianship of the child, and Child Safety's assessment about the suitability of that person including consultation with the person;
- d) whether there is a case plan for the child that is appropriate for meeting the child's assessed protection and care needs;
- e) the principles contained in sections 5B to 5E of the *Child Protection Act* to the extent they are relevant.[267]

Supporting a child at home

Intervention with parental agreement

If a child is assessed as being in need of protection, but the parents are assessed as being able and willing to actively work with Child Safety to meet the child's protective needs, Child Safety may consider an Intervention with parental agreement (IPA).[268] An IPA can allow the child to remain in the family home for all, or most of the intervention period, provided it is safe to do so.[269] This type of intervention is intended to be short-term and intensive in nature,[270] and does not require a court order.

To decide if an IPA is appropriate, Child Safety must consider:

- the immediate safety of a child – the outcome of the safety assessment must be 'safe' or 'safe with immediate safety plan'. If immediate harm indicators cannot be addressed in a safety plan, consider another type of intervention
- the professional judgement formed about the likelihood of future harm
- the child protection history for the child and family
- the child's views and wishes, depending on their age and ability to understand
- the parents' capacity to understand and acknowledge the child protection concerns. Concerns that are not understood or acknowledged pose a significant risk to a child's safety
- the parents' ability and willingness. At least one parent must
    - be both able and willing to work with Child Safety to meet the safety, belonging and wellbeing needs of the child
    - agree to participate in the development and implementation of a case plan to meet the protection and care needs of the child
    - be assessed as likely to be able to meet the child's need for safety, belonging and wellbeing when the IPA is completed.[271]

The practice manual specifies that an IPA is not appropriate if any of the following apply:

- The child will be at immediate risk of harm if the parents withdraw their agreement to the intervention for the child.
- There are serious risk factors linked with the parents' ability to consent, such as current alcohol or substance misuse or intellectual disability.
- There are serious risk factors linked with the parents' ability to carry out safety planning or meet case plan goals.
- The parents not meeting case plan goals would place a child at unacceptable risk of harm.[272]

Child protection care agreement

During an IPA, if Child Safety determines that a child is not safe to remain in their family home, a child may be placed in an out-of-home care placement with an approved carer using a child protection care agreement.[273]

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[267] Director of Child Protection Litigation, *Director's Guidelines*, as at 1 July 2018, p. 17.
[268] *Child Protection Act 1999* (Qld), ss. 51ZB, 51ZC.
[269] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual*, [Intervention with parental agreement], accessed 30 April 2025.
[270] Ibid.
[271] Ibid.
[272] Ibid.
[273] *Child Protection Act 1999* (Qld) s 51ZE.

Under a child protection care agreement, the parents will agree to their child living with an approved carer for an initial period of up to 30 days.[274] This time period can be extended for up to a maximum of 6 months in a 12 month period, if required.[275] A child protection care agreement cannot be extended beyond 30 days unless the child has a case plan.[276] This is to 'ensure that the child, parents and safety and support network have the opportunity to make a plan around the worries that are contributing to the child needing to be placed in the care of someone other than the parent.'[277]

Child Safety has advised that, throughout the period of the agreement, parents retain guardianship of the child and the right to make significant decisions about their child. However, Child Safety will have legal custody of the child.

The practice manual provides detailed guidance to CSOs on the considerations involved in deciding on a child protection care agreement.[278] This includes the need to seek the views of the child, how to negotiate the agreement with the parents, obtaining consent from each of the child's parents to place a child, and specific considerations for Aboriginal or Torres Strait Islander children.[279]

Child Safety may end the agreement if:

- the concerns that led to the agreement are addressed prior to the agreement end date; or
- a temporary custody order, interim order, or a child protection order is made granting custody or guardianship of the child to the chief executive or a suitable person.[280]

One or more of the parents may also choose to end the agreement.[281]

In-home support funding

In-home support funding may be available to 'increase a family's capacity to care for a child safely in the home and reduce the need for a child to be placed in out-of-home care or to support reunification.'[282] The funding can also assist a child to return home following a child protection care agreement.[283] In-home support funding is appropriate when 'other government or grant funded non-government services are unavailable or unlikely to assist the family and additional support is required for the child to remain safely at home.'[284]

Impaired decision-making capacity vs. parenting capacity

In Queensland, under the *Guardianship and Administration Act 2000* (GAA), if an adult is declared by the Queensland Civil and Administrative Tribunal (QCAT) to have impaired capacity to make decisions about particular matters, the tribunal can appoint a substitute decision-maker (a guardian or administrator) who will have the legal authority to make decisions for the adult on specified matters.

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[274] *Child Protection Act 1999* (Qld) s 51ZH(4).
[275] *Child Protection Act 1999* (Qld) s 51ZH(8).
[276] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual*, [Use a child protection care agreement], accessed 30 April 2025.
[277] Ibid.
[278] Ibid.
[279] Ibid.
[280] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual,* [Use a child protection care agreement], accessed 30 April 2025.
[281] Ibid.
[282] DFSDSCS, 'Support a child at home', *Child Safety Practice Manual,* [In-home support funding], accessed 30 April 2025.
[283] Ibid.
[284] Ibid.

Under the GAA, impaired capacity for legal matters refers only to the need for a person to have assistance in decision-making regarding legal proceedings and to instruct a legal representative.[285] While matters are often referred to QCAT that require an assessment of a person's capacity, QCAT does not have jurisdiction to assess parenting capacity in determining whether to appoint a substitute decision-maker for an adult.

The term 'parenting capacity' is not defined in legislation or at common law, however it is a term used commonly in legal proceedings involving children where there are issues associated with a person's ability to meet the needs of their child or children.

'Parenting capacity' is understood to be the ability of parents or caregivers to ensure that a child's developmental needs are being appropriately and adequately responded to, and the ability to adapt to their child's changing needs over time. This includes providing for the child's basic physical needs, ensuring their safety, promoting the child's intellectual development through encouragement and stimulation, demonstrating and modelling appropriate behaviour and control of emotions, and providing a sufficiently stable family environment.[286]

A stakeholder consulted in the preparation of this report observed that, once QCAT declares that an adult has impaired capacity for legal matters and has the Public Guardian appointed as their decision-maker, it is often assumed that the parent does not have parenting capacity. Consequently, limited effort is made to put supports in place to build the parenting capacity of the adult.

Disability awareness

As discussed above, the practice manual provides Child Safety staff with definitions, policies, procedures and instructions to guide and inform their delivery of child protection services. The practice manual also provides some guidance to Child Safety staff on parents with disability to inform their practice and any decisions they make in the course of their duties.

Child Safety's *Assessing harm and risk of harm* practice guide identifies a parent's intellectual or physical disability as information of relevance when assessing a parent's ability to protect their child.[287]

The Queensland Disability Practice Kit (the Kit) included in the practice manual provides: facts to dispel myths about disability; information on types of disability, relevant legislation and human rights; and tips, tools, and resources on supports available to help child protection workers identify and work with children of parents with disability.[288]

The Kit also includes practice guidance, with information on how to:

- identify a parent with disability;
- understand the impact of the disability on their life and parenting ability;
- develop practical ideas and strategies for listening to and talking with a parent with disability;
- identify supports for a parent with disability; and
- support a child who has a parent with disability.[289]

In Queensland, courses are offered to frontline departmental staff that are relevant to their work in assisting parents with disability who are in contact with the child protection system.[290] Recently, Child Safety has begun using new disability awareness training, 'My role: disability inclusion champion', which is designed to encourage staff to become a champion for disability inclusion, turning their awareness into action. Managers are advised to support a parent with suspected or

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[285] *Guardianship and Administration Act 2000* (Qld) s 18.
[286] Forensic and Clinical Psychology Centre, *Risk Assessment – Parenting Capacity*, fact sheet, n.d, p. 1.
[287] DFSDSCS, 'Assess harm and risk of harm', *Practice Guide*, accessed 30 April 2025.
[288] DFSDSCS, 'Disability Practice kit', *Child Safety Practice Manual*, [Working with a parent with disability], accessed 30 April 2025.
[289] Ibid.
[290] T Libesman et al., p. 116.

confirmed disability, including by supporting them to access the NDIS in a timely manner if they are not already receiving NDIS supports.[291]

Child Safety has confirmed their commitment to helping parents connect with the NDIS, whether directly, through another agency, or via informal support networks. Establishing clear roles and responsibilities to facilitate access to NDIS support can be initiated during Family Group Meetings or as soon as possible, ensuring that parents receive timely assistance tailored to their needs.

Language

At the request of Child Safety, in 2023, Queensland Advocacy for Inclusion (QAI) undertook an evaluation of Child Safety's publicly available policies relating to child protection and disability.

QAI identified four themes of concern in the policies:

- a notable absence of disability pride;
- disability often being posed as a mandatory consideration for Child Safety officers;
- disability being presented in an overtly negative context; and
- no indication of consultation or co-design with the disability community.[292]

QAI consequently developed four recommendations for the Queensland Government to guide updates and reforms in its Child Safety documentation, including:

1. Remove all discriminatory and negative framing of parents with disability.
2. Repeat positive messaging each time disability is addressed, in order to overcome unconscious bias and conscious bias.
3. Update all documentation to ensure clear and repeated guidance is given in relation to disability, ensuring this guidance explicitly states:
    - Disability can be a protective factor;
    - A parent's disability is not a risk factor;
    - Supports for some parents with disability can negate impacts on parenting in the context of disability;
    - Some parents with disability do not need supports in place because their disability has no impact on their parenting;
    - Identification and assessments of disability should only be undertaken in relevant circumstances; and
    - When considering a parent with disability, parenting should only be considered with supports, devices and other disability related adjustments in place. An assessment should never be conducted of the parents without their supports.
4. Child protection policy, guidance and documentation should incorporate a longer exploration of ableism, similar to the exploration of racism in 'Disability in Aboriginal and Torres Strait islander cultures.'[293]

While training on conscious and unconscious bias for Child Safety staff has now been launched ('My role: disability inclusion champion', identified above on page 52), at the time of writing it is unclear whether the remaining recommendations have been implemented.

Child protection – practice observations from stakeholders

As noted above, there will be circumstances where parents with cognitive disability will not be able to provide the appropriate level of care to a child and that child could be at risk of harm should they remain in their custody.

However, there is concern expressed by stakeholders consulted as part of this project and in the literature reviewed from around Australia, that children may be removed from their parent's care

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[291] Queensland Government, *Intensive Family Support Model and Guidelines*, v. 4, January 2025, p. 36.
[292] Queensland Advocacy for Inclusion, *Child Safety's policies on parents with disability,* March 2024, p. 6.
[293] Ibid., p. 19.

potentially due to an aversion to risk. This risk aversion may be based on perceptions related to the ability of someone with cognitive disability to learn and grow as a parent.

The below observations were provided to the Public Advocate prior to the April/May 2025 updates to the Child Safety Practice Manual.

Unborn child reports

Throughout Australia, expectant parents with cognitive disability face their disability being identified in state and territory guidelines as a 'relevant consideration' for health practitioners and others in determinations of whether to file unborn child reports.[294] These reports are based on whether parents are perceived as posing risks of future harm to children following their birth.[295]

Stakeholders consulted for this report noted that, in Queensland, Child Safety has a list of 'risk factors' that activate a notification under section 22 of the *Child Protection Act* when a person is pregnant or gives birth to a child.

Stakeholders further advised that, based on their observations, when a person who has been in out-of-home care gives birth, an investigation by Child Safety is undertaken. While precise figures are not available, stakeholders also noted the high proportion of parents with cognitive disability who have been in out-of-home care. There are also figures to indicate the proportion of children who identify as having a disability in the child protection system being close to 20 per cent.[296]

These dual factors mean that adults with cognitive disability and a history of out-of-home care can come under the immediate scrutiny of child protection authorities when they are pregnant or give birth. This perception of risk is presumed by stakeholders to be based on a belief from Child Safety that the ability to parent is negatively impacted by experiences of trauma, and exposure to negligent parenting practices.

Child Safety has advised that there is no official flagging process for a parent who has been in out-of-home care to prompt an investigation. However, a parent's child protection history is one of the known risk factors that will be considered in deciding whether a child needs protection. This is due, in part, to concerns about the impact a person's upbringing could have on their own parenting, in addition to the likelihood that they may have fewer formal or informal family supports in place.

In Queensland, under section 22 of the *Child Protection Act*, Child Safety is obligated to act if it reasonably suspects that an unborn child will need protection after birth. Child Safety has advised that its policy position is to undertake an assessment should this occur. Child Safety does not require a pregnant person's consent to do this. Child Safety notes that the intention of beginning an assessment is to put supports in place to provide a mother with the best chance of keeping her child. However, if a parent chooses not to participate, Child Safety has advised that it is unable to finalise an investigation prior to the child's birth. Doing so could interfere with a pregnant person's rights and liberties, which is explicitly stated not to be the purpose of section 22 of the *Child Protection Act*.[297]

However, as stakeholders noted, the consequences of choosing not to work with Child Safety on accessing supports is not always understood by prospective parents. This is particularly the case for adults with cognitive disability. Following Child Safety involvement, these parents fear their child being removed if they acknowledge they need additional supports. Stakeholders have advised that adults with cognitive disability may even hide their pregnancy altogether, leading to the potential avoidance of pre-natal care.

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[294] S Wise et al., p. 4.
[295] T Libesman et al., p. 49.
[296] Australian Institute of Health and Welfare, *Child Protection Australia 2020–2021, Children in out-of-home care by disability status and state or territory, 30 June 2021*, Table S5.8, <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>, updated 15 June 2022.
[297] *Child Protection Act 1999* (Qld) s 22(5).

Some stakeholders interviewed spoke of pregnant persons who have left the state to evade scrutiny from Child Safety and the possible removal of their child after birth. It has been observed that parents who have had experiences in out-of-home care, and want to protect their own child from the same trauma they experienced in the child protection system, may take significant measures to avoid the attention of Child Safety.

A similar situation may arise for pregnant persons who have had children previously removed from their care and who fear they are at greater risk of having any subsequent children removed. According to stakeholders, actions by prospective parents in these situations (where decisions are made based on fear and anxiety) can be viewed by Child Safety as confirmation that the parents cannot provide a safe environment for a child.

Healthcare staff

It has been the experience of some stakeholders interviewed that unborn child reports made to Child Safety are often made by health care staff, as this is generally the first point of contact when a person with cognitive disability presents for healthcare related to pregnancy, or immediately after a child is born.

This is confirmed by the data from Child Safety for 2023-24 which indicates that health staff are the largest source of unborn child reports at 32.4 %, followed by police (17.2%), child/family/ friends/ neighbours (13.7%), and school personnel (8.1%).[298]

Early identification of an expectant mother's cognitive disability can lead to positive outcomes when adequate supports are put in place to provide a mother with the skills to ensure a safe environment for their child.

For example, as part of Metro South Health's antenatal service, if a pregnant person is flagged as someone with disability, they will be offered an appointment with a senior social worker who can discuss their current supports and undertake a full psychosocial assessment, which can be used to link them with additional supports if required.

Queensland Health's Midwife Navigators (navigators) also provide more specialised support to people with complex needs. The navigators are a team of senior advanced practice registered nurses who provide a service for patients who have complex health conditions and require a high degree of comprehensive clinical care.

While the programs above represent positive developments, in practice stakeholders have identified gaps in the provision of targeted supports and services that cater to the individual learning needs of mothers with cognitive disability. This is a particular concern for parents in regional and remote areas where services of this kind are extremely limited, if available at all.

High workloads and limited resources also mean that stakeholders remain concerned about the level of accessible support being provided to parents with cognitive disability before and after reports are made to Child Safety.

Clinicians in Queensland Health also have access to the Child Protection Forensic Medical Service, which provides child protection and forensic medical advice and services across Queensland. Queensland Health staff are encouraged to discuss child protection concerns with their local Child Protection Unit when possible if a report to Child Safety is being considered.

In other circumstances, a stakeholder consulted for this project advised that when a pregnant person comes to the attention of Child Safety, for example, through a police incident or engagement with antenatal health, an unborn child report may be made. This can then trigger a

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[298] DFSDSCS, *Concerns received by Child Safety* <https://performance.dcssds.qld.gov.au/working-with-families-in-contact-with-child-safety/what-we-do/concerns-received-by-child-safety#7212>, accessed 20 May 2025. Data is based on the number of intakes received by Child Safety by each source as a proportion of all intakes for 2023-24. Intakes include notifications and child concern reports. If a child was subject to more than one report during the reference period, a notification or child concern report is counted for each instance.

process in which likely birthing hospitals are notified with an alert to contact Child Safety immediately if the baby is born in their facility – known as an 'unborn child high risk alert' (the process undertaken by Child Safety is discussed above at page 41). Stakeholders have advised that, once the baby is born, Child Safety workers will arrive at the hospital to consider a notification response and potential removal of the child. A stakeholder has observed the distress that this process places not only on parents, but also on midwives and other hospital staff in these situations.

Child Safety has advised that there is a very high threshold for an 'unborn child high risk alert' to be sent to likely birth hospitals, which will only occur when there is a risk of significant harm to a child. In most cases the alert will be in relation to a pregnant person who has no fixed address and there is uncertainty as to where they may present when they give birth. Further to this, by virtue of making the alert, Child Safety holds significant concerns for the safety of the child at birth. If Child Safety were to alert a mother, this may jeopardise the child's safety further which is incongruent with the purpose of the alert.

Stakeholder observations indicate that the issuing of an alert without the mother being made aware is more common than rare. A stakeholder advised that while Child Safety may have informed an adult with cognitive disability at some stage in their pregnancy that an unborn child report had been made, CSOs do not always effectively communicate the gravity of an unborn child report. In particular, a person with cognitive disability may not have fully understood the consequences of not engaging with Child Safety and that it could lead to the removal of their child at birth. In some cases, it may be assumed that a pregnant person is unwilling to work with Child Safety when they find it difficult to understand what is required of them.

Child Safety has advised that all pregnant persons in this situation are offered the opportunity to have a support person with them when they speak to Child Safety. However, barriers related to a lack of understanding, a fear of seeking help, or a reluctance to involve anyone else in the process, may mean that not all pregnant persons, and particularly those with a cognitive disability, will elect to ask for a support person to be present.

Pre-birth advocacy

Stakeholders interviewed for this project identified a significant advocacy gap for adults with cognitive disability during pregnancy. Having an advocate able to link them to services, and guide them through the supports that can be put in place, could prevent the need for Child Safety involvement after a child is born. However, while some early legal advocacy programs are in place, funding restraints mean that these services are limited as to who they can support and to what extent.

Notifications after birth

Parents with cognitive disability can also be the subject (as can other parents) of reports to Child Safety later in a child's life, made by police, childcare workers, neighbours, friends or healthcare staff. Some stakeholders consulted for this project also noted that the involvement of Child Safety can be instigated through malicious reports made by an ex-partner against a parent.

According to data from Child Safety for 2023-24 across all age groups, school personnel and early childcare personnel were the largest reporters to Child Safety (30.7%), followed by family/friends/neighbours/child (21.2%), police (15.2%), health sources (13.4%).[299]

A stakeholder observed that reports to Child Safety have been made by health staff based on a single interaction with a new parent with cognitive disability where they appeared to be struggling to adjust to their role as a parent.

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[299] DFSDSCS, *Concerns received by Child Safety* <https://performance.dcssds.qld.gov.au/working-with-families-in-contact-with-child-safety/what-we-do/concerns-received-by-child-safety#7212>, accessed 20 May 2025. Data is based on the number of intakes received by Child Safety by each source as a proportion of all intakes for 2023-24. Intakes include notifications and child concern reports. If a child was subject to more than one report during the reference period, a notification or child concern report is counted for each instance.

Additionally, a stakeholder advised that, at the time of writing, there is no information sharing arrangement in place between Child Safety and the NDIA.

While the NDIA is not a mandatory reporter under the *Child Protection Act*, a stakeholder has confirmed that if an NDIS support worker forms a reasonable suspicion that a child is at unacceptable risk of harm, they are guided by the NDIA to report their concerns to Child Safety.

For some stakeholders, reports of this nature are perceived to be extremely challenging, as the information shared by support workers with Child Safety relates to the most vulnerable moments a new parent can experience. These moments of vulnerability are not necessarily related to their disability and may be challenges faced by any new parent but may be assumed to provide evidence of an inability to provide appropriate levels of care to a child.

Parenting supports

As discussed, in circumstances where a report to Child Safety leads to a notification, and a priority response is decided upon, an assessment will begin as to whether a child needs protection.

Maternal consent is not required for an assessment to commence into whether a child needs protection under the *Child Protection Act*. The outcome of this assessment could be a finding of substantiated harm, followed by a recommendation from Child Safety that DCPL apply to the Childrens Court for a child protection order. Such a referral would only be made after the child is born if the outcome of Child Safety's assessment was that a child protection order was appropriate.

Child Safety has advised that it is its preference to intervene with parental consent and that CSOs endeavour to provide consistent supports to families throughout their entire engagement with Child Safety, beginning at first contact. The case planning provisions of the *Child Protection Act* also require that Child Safety must take all reasonable and practicable steps to help a child's family meet the child's protection and care needs.[300] This includes facilitating regular contact with the child and the child's parents or other appropriate members of the child's family.[301]

However, stakeholders have advised that, in the event a short-term protection order is made by the Childrens Court and a child is removed from the custody of their parents, Child Safety can withdraw any supports it may have provided for the parent and is not obliged to provide any other parental assistance. Stakeholders interviewed observed a lack of inclusive, accessible, and specialised support services for parents with disability once their child is removed.

Without access to appropriate supports, parents with cognitive disability can find it difficult to demonstrate they can address or have addressed the child protection concerns nominated by Child Safety. In these situations, the possibility of reunification with their children is markedly compromised. A stakeholder consulted for this project advised that CSOs do not always have the skills to identify and support a parent with cognitive disability. As a result, they will make uninformed referrals to support services that may not be appropriate to the needs of a parent. Stakeholders also identified a significant service vacuum in the delivery of support services for parents with cognitive disability.

For parents with cognitive disability whose children have diverse needs, support may also be required for targeted intervention and positive behaviour support. This funded support is allocated to foster carers, youth workers, respite carers and specialist disability residential care facilities to support them to care for the child. However, parents with cognitive disability may never have received this kind of support at home and are not provided with it during contact with their child.[302]

The gaps in accessible parenting support services for people with cognitive disability are exacerbated for Aboriginal and Torres Strait Islander parents, culturally and linguistically diverse

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[300] *Child Protection Act 2016* (Qld) s 73(2).

[301] *Child Protection Act 2016* (Qld) s 73(3).

[302] Office of the Public Guardian (Qld), Submission no. 001.00455 to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Rights and Attitudes*, September 2020, p. 8.

parents, and those parents living in regional and remote areas.[303] Several stakeholders noted that many providers of parenting supports do not provide services in regional and remote areas due to the travel costs involved. Parents with cognitive disability and limited access to transport are placed at a significant disadvantage, challenging their ability to demonstrate to Child Safety their commitment to regaining custody of their children.

A stakeholder advised that the NDIA is not informed by Child Safety when a participant's child enters the child protection system, so the onus is on the participant to inform the NDIA if they require additional supports following the removal of their child. At present (but potentially not in the future), the NDIS can provide capacity building support in the area of relationships (Individual Social Skills Development) to assist a parent to respond appropriately to their child and for support to accompany the parent participant to visit their child (Assistance with Social and Community Participation) if that is their priority. However, parent NDIS participants are not always informed of the reasonable and necessary supports for which they may be eligible that would help them gain the skills to maintain contact with their child. An issue identified by one stakeholder was that NDIS plans are designed to support a person's individual needs, but not to provide the different, but disability related, supports they require to parent.

For example, a participant's plan may include funding for a support worker to provide laundry assistance. However, this does not extend to laundering the clothes of the participant's child.

There is an added concern expressed by stakeholders interviewed for this project that Child Safety does not appear to consider the trauma experienced because of child removal, or the re-traumatisation that can be experienced by a parent at each contact visit. Parents are not always connected to trauma-informed mainstream services to address the associated impact on their mental health in these situations and provide supports to the parent to enable the child to return home.

A stakeholder advised of a parent with cognitive disability who had experienced domestic violence being told to independently source supports and counselling, rather than Child Safety assisting with a referral to an appropriate service. Had the parent not sourced this support, there was the potential for this issue to be raised in future custodial applications.

Stakeholders did identify instances of CSOs thinking 'outside the box' to source supports specific to the needs of a parent with cognitive disability and developing strategies to improve skills and abilities to increase the likelihood of family reunification. A stakeholder identified that positive outcomes were often reliant on a CSO having good relationships with providers of targeted support services for parents with cognitive disability.

However, not all parents have this degree of support from a CSO. One stakeholder articulated a concern that many CSOs lack the knowledge or experience to be able to identify the supports that could assist a parent with cognitive disability to build their parenting skills. Stakeholders also acknowledged that the high caseloads of CSOs limit their ability to provide the level of targeted support that may be required by parents with cognitive disability. The high turnover of CSOs, and the emotional toll it takes on an individual officer, were also observed by stakeholders as having an impact on the consistency of support that is made available to parents. In addition, the limited availability of specialist support services, particularly in rural and regional areas, for parents with cognitive disability hinders the type of support a CSO can offer to a parent.

In a response to a request for material to inform this project, Child Safety brought attention to their Enhanced Intake and Assessment Approach (EIAA). EIAA is designed to offer a contemporary way of working with families by providing a range of proportionate, flexible child protection responses which ensure children get the right response at the right time. Under this approach the needs of children and families will be assessed, and earlier support offered directly by Child Safety or a support service. If children are considered at high risk of harm, conventional investigative approaches will be available.

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[303] T Libesman et al., p. 3.

EIAA involves opportunities for earlier assessment of need, as well as targeted support to resolve issues at various points of a child's contact with Child Safety. Child Safety advised that new and revised operational policies, procedures and practice guidance are being developed to support the enhanced approach.

The details of this approach are being progressively made available in the Child Safety Practice Manual. Given the only recent implementation of this new approach, it is not yet possible to determine the effectiveness of the new policies and procedures being introduced in practice.

The important role that appropriate parenting supports can play in building a person's parenting ability is demonstrated in the below case study, shared by a mother with cognitive disability via a non-government support organisation.

Case study – Kiah

Kiah** is a young Indigenous mum. She went into care as a teenager and also had interactions with the youth justice system.

Kiah has been diagnosed with borderline personality disorder, complex post-traumatic stress disorder, obsessive-compulsive disorder, major depressive disorder, autism and anxiety.

At 21, Kiah gave birth to her first child. Her baby was removed by Child Safety at four weeks of age after Kiah 'failed' an in-house parenting support and assessment service for families engaged with Child Safety.

Kiah had her second child when she was 22 years old. The original plan with Child Safety was for Kiah to keep her baby. However, her child was subsequently removed when she was unable to access a place for in-house support and assessment.

Kiah spent the early years of her children's lives engaged with Child Safety, having visits with the kids and working towards reunification. However, her contact with her children was suddenly reduced when concerns about someone else were inadvertently attached to her Child Safety file. Kiah was struggling to deal with her grief and at times resorted to actions that were harming her. She thought she was never going to get her children back, so she got pregnant again.

'I was not able to deal with the grief of losing my children.'
'The number of times I wanted to kill myself … my pregnancy is what kept me alive.'

When Kiah became pregnant with twins, she advocated strongly for herself and her children and was provided with a behaviour specialist who supervised her contacts [with her children], conducted assessments, and made recommendations to Child Safety. Kiah worked with the behaviour specialist for many months in the lead up to the birth of the twins. She was then accepted into the parenting assessment centre.

Kiah successfully completed the in-house program. When she left the centre, she was told she had enough mental health support in place and was able to take her twins home with her.

Once the behaviour specialist had recommended that Kiah achieve full reunification, Child Safety stopped funding their work. Kiah was fortunate to be able to re-engage the worker using her Positive Behaviour Support funding through her NDIS plan for a short time to support the transition.

Her reunification with the older two children was put on hold while she navigated the early months of newborn twins. It then progressed steadily, and within a year of the twins' birth, Kiah had achieved full reunification. Kiah is a proud Aboriginal mum of four happy, healthy kids under four.

***Names have been changed*

Note: The content and wording of this case study has been submitted by a non-government support organisation, with the permission of the parent involved. The content has not been modified by the Public Advocate.

Parent engagement

Stakeholders consulted during the preparation of this report confirmed that parents with cognitive disability can generally express their wishes and preferences in relation to their child and instruct legal representation as to whether they can provide the appropriate level of care required.

In fact, stakeholders noted that these parents are often very honest about any limitations they may have, as they prioritise their children's welfare and want them to live in a safe environment.

Stakeholders have also observed that parents tend to be completely open with Child Safety under the assumption that Child Safety are there to help them improve their skills to achieve family reunification.

Despite the clear commitment by these parents to family reunification, stakeholders have commented that non-engagement by parents with cognitive disability in child protection processes is a significant problem. This is particularly the case for parents who have been in the child protection system themselves.

Parents without cognitive disability faced with the prospect of losing their children would be intimidated by the court processes involved. For parents with cognitive disability, the issues are compounded.

Examples of this include stakeholder-reported incidences of Child Safety serving parents with 300-page affidavits detailing the evidence they have compiled to justify the removal of a child. For parents with comprehension difficulties, reading and understanding this information can be overwhelming, limiting their ability to engage in the next steps of the process. One stakeholder described situations where a police officer will present at a parent's home without notice to remove their child with limited information provided as to what the parents need to do to regain custody of their child.

When a parent does not challenge the information provided to a court in an affidavit, the court then makes decisions based on the information before them provided by Child Safety. A parent's lack of participation can lead to a potentially false assumption that the parent is not interested in reunification and would not be able to prioritise the welfare of their child.

Lawyers representing parents with cognitive disability in child protection proceedings rely on their clients for instruction. When a temporary child protection order comes to an end, the parent may be asked to provide details about events that occurred two years earlier at the time their child was initially removed from their care. Stakeholders noted that recalling information from years ago can be challenging for anyone but is particularly difficult for a person with cognitive disability.

Meanwhile, according to stakeholders, Child Safety has access to a person's full case history over a two-year period that can be presented to court, with final orders being made based largely on information from Child Safety. Stakeholders also noted that, in the absence of information supplied by a parent, there is limited scope to challenge the assumption that Child Safety has actioned commitments to provide support to parents who have been issued with a short-term protection order.

Child Safety has advised that the Childrens Court cannot make a child protection order unless it is satisfied of the specific matters detailed in the *Child Protection Act*.[304] Child Safety must have evidence to support its application, which includes how Child Safety has met its obligations to take 'reasonable and practicable' steps to help the child's family meet the child's protection and care needs.'[305]

Stakeholders have observed that parent engagement with the legal process can diminish if their child is removed under a short-term child protection order. One stakeholder noted that parents

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[304] *Child Protection Act 1999* (Qld) s 59.

[305] *Child Protection Act 1999* (Qld) s 73(2).

have been known to make comments such as, 'they think I'm an idiot', and abandon attempts to challenge any future decisions made by Child Safety and the Childrens Court, believing that they will never regain custody of their children.

Guardianship appointments

Stakeholders identified concerns around protracted outcomes in child protection proceedings when a parent's impaired capacity for the child protection matter is not identified by Child Safety from the outset. One stakeholder noted that, in some instances, it is only when a legal representative recognises that a parent is unable to provide instructions that the matter will be referred to QCAT for a determination as to the adult's capacity. When this occurs, the child protection proceedings will be put on hold, pending the outcomes of the QCAT matter. If QCAT does find that a parent does not have capacity for child protection proceedings, the determination will go to the Childrens Court for a decision on whether a child protection order will be made.

Stakeholders advised that it could take up to a year for QCAT to decide on an adult's capacity in relation to a child protection matter, creating significant delays in the finalisation of child protection proceedings. Meanwhile, the child has been removed from their parent's care and is in the custody either of a family member or Child Safety for a period of up to two years. Stakeholders further advised that the parent is typically not receiving any supports to facilitate reunification during this time.

Case planning is undertaken by Child Safety in tandem with the QCAT proceedings. However, until an outcome is reached as to a parent's capacity, a case plan cannot be finalised. Without a case plan, a child protection order cannot be made which could have put supports in place to enable reunification.

Child Safety has advised that all children in need of protection are required to have a case plan and that a case plan may be revised if a guardian is appointed. Child Safety also noted that regardless of a QCAT outcome, a parent is entitled to an advocate or support person during the case planning processes.

Stakeholders have advised that if QCAT determines that a parent lacks capacity for the purposes of a child protection proceeding and a guardian is appointed for legal matters, the parent will often have their child removed. This is more commonly the case for parents who have no family support or anyone to assume the role of guardian for legal matters, and where the child is already in care (under a short-term protection order). In these situations, the Public Guardian will then be appointed as the guardian of last resort.

Child Safety has advised that it does not remove children solely on the basis that a parent has a guardian.

Assessment of parenting capacity

Various assessment tools can be applied, and expert reports prepared, which offer a professional's opinion as to a person's capacity to provide a safe environment for their child. These reports are used by the Childrens Court to inform decisions about whether a child protection order should be made.

Parenting Capacity Assessment

At times, individual Child Safety Service Centers may commission a Parenting Capacity Assessment (PCA) report.

According to information provided by Child Safety, the purpose of a PCA is to:

- understand the nature of identified risks;

- identify strengths and weaknesses in parenting as they apply to the specific family; and
- recommend appropriate actions to ensure the child remains safe and their needs are met.

A PCA includes information about a child's history, living situation, the views and wishes of all parties based on interviews with everyone involved, Child Safety records, and previous reports.

PCAs are conducted by independent expert witnesses and provide opinions that are entirely independent of the involved parties. Recommendations are made specific to the risks and deficits identified and can cover a broad range of issues. The needs of the child/ren are the primary concern when PCAs include recommendations regarding parents.[306]

These assessments are typically guided by a Terms of Reference document and include a summary of the child protection concerns and provision of all materials filed with the Childrens Court. The court will consider the report's recommendations when deciding whether a child protection order should be put in place for a child.[307]

The completion of a PCA is not a mandatory process for Child Safety. It is instead undertaken at the discretion of a manager who is required to consider the specific needs of parents.

A concern expressed by stakeholders interviewed for this project is that while these assessments may be designed as a tool to identify the support needs of a parent, they are often used to highlight a parent's deficits and to re-enforce a parent's inability to care for a child.

A stakeholder noted that the terms of reference for the assessments often have a focus on highlighting parenting weaknesses, as opposed to identifying the appropriate supports that need to be put in place.

Another stakeholder identified that, based on their experience, PCAs appear to be designed to investigate and assess a person's parenting, not to assist the parent to build on their skills and identify any supports that could assist them to build their capabilities. It is only once an assessment has been completed that the case is assigned to a support team at Child Safety.

This defined structural nature of Child Safety processes was raised as a matter of concern by a stakeholder consulted for this project as it is perceived to inhibit the identification of ways to assist a parent expedite reunification with their child.

Another issue identified by stakeholders is that assessment reports are often completed by psychologists or, in some cases, counsellors linked to Child Safety, who may have a very limited understanding of adults with cognitive disability.

Advice from Child Safety is that counsellors are not employed by Child Safety. Report writers are required to outline their qualifications, that should evidence their ability to make an independent assessment of a parent's parenting capabilities.

Stakeholders also believe that the assessments undertaken by Child Safety to inform these reports are potentially conducted too soon after a child is removed, with parents given insufficient time to build their skills and meet the goals outlined in a Child Safety case plan.

Child Safety has advised that assessment reports are rarely requested during the emergent order stage and are more likely to be requested during the proceeding for a child protection order.

A stakeholder advised that assessments have been performed within two months of a child being born and conducted in a CSSC. Stakeholders also noted that the sometimes 'bleak' environment of a service centre may not be conducive to a parent of a newborn being able to demonstrate their ability to parent.

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[306] Forensic and Clinical Psychology Centre, *Risk assessment – Parenting capacity*, fact sheet, n.d., p. 1.
[307] QFCC, *Information kit on child protection for professionals*, 2020, p. 35.

While a parent with cognitive disability can seek reasonable adjustments during the assessment, they rarely do, either because they are not aware they are able to make such a request, or for fear that seeking support could work against them. Being in these service centres can also be traumatic for parents with cognitive disability who may have had negative experiences in the child protection system themselves as a child.

Concerns were also expressed by stakeholders that assessments rarely include in-home observations of parents. This places parents with cognitive disability at an immediate disadvantage and may result in an assessment that is not an accurate reflection of their day-to-day parenting abilities when at home in a familiar environment. Stakeholders have observed far better outcomes for parents and their children when a parenting capacity assessment is performed in their own home, as opposed to at a CSSC. One stakeholder commented that parents lose their sense of independence in a service centre, which can then affect their level of confidence in parenting their child.

According to some stakeholders, Child Safety can also request information from other agencies, such as the Queensland Police Service, about anyone residing with a parent, or any people who are connected to the family, to inform decisions about a person's ability to provide a safe environment for their child.

This is confirmed in the practice manual, which requires CSOs to consider the 'criminal history of any adults living in the reunification household and identify if any person has a conviction for a serious criminal offence against a child, and how this may impact the safety of the child.'[308]

Parents are generally unaware of this information sharing, which can be included in a parenting capacity report that is considered at court. A stakeholder observed that most parents with cognitive disability going through this process are genuinely committed to doing whatever is asked of them by authorities without question, under the assumption it will lead to their children being returned to them. Unfortunately, in some instances, this information has the opposite effect, with any conclusions drawn from this honesty potentially being used in the case for permanent removal of children.

A lack of targeted supports to assist parents with cognitive disability to understand and respond to assessments also places parents at a disadvantage, leading to a reluctance to challenge any conclusions made by a psychologist or counsellor with which they may disagree.

If parents do lodge a response, it can often be too late in the process to have effect.

Social assessment report

A social assessment report is an element of the litigation process that can follow a child being removed from their birth parents. Under section 68(1)(a) of the *Child Protection Act,* the Childrens Court can adjourn a proceeding for a child protection order for a period decided by the court and request a social assessment report.[309] A social assessment report includes information about a child's history, living situation and views and wishes, providing the court with an independent opinion about the most appropriate way to protect a child's best interests.[310] 'It is written by an accredited social worker, psychologist or other professional considered by the court or tribunal to be an independent expert in child protection.'[311]

A social assessment report may also be requested by a separate representative (when appointed).[312]

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[308] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Case planning], accessed 30 April 2025.

[309] *Child Protection Act 1999* (Qld) s 68(1)(a).

[310] Legal Aid Queensland, *Do you have questions about a social assessment report?,* fact sheet, 2023, p. 1.

[311] QFCC, *Information kit on child protection for professionals*, 2020, p. 54.

[312] Legal Aid Queensland, *Child protection legal information*, <https://www.legalaid.qld.gov.au/Find-legal-information/Publications-and-resources/How-will-a-separate-representative-help-my-child-in-their-protection-matter>, accessed 2 April 2025.

A separate representative is a lawyer appointed to represent a child before the Childrens Court when the Magistrate considers the appointment to be important in protecting a child's best interests. The separate representative must advise the court about what a child wants and make recommendations to the court about what they think is in the child's best interests.[313]

A stakeholder observed that social assessment reports can be of value as an independent evaluation of the assessments performed by Child Safety. However, the quality of these assessments can vary. Stakeholders who have worked with parents with cognitive disability also expressed some reluctance to request a social assessment report, as it could be potentially traumatic for a parent to complete.

Parental strengths and needs assessments and family contact

As noted above, parental strengths and needs assessments (PSNAs) are conducted by Child Safety, after a child has been removed, to systematically identify critical parental problems and strengths, and provide a snapshot of parental functioning over a six-month period to assist in the case planning process.[314]

PSNAs will be, to some extent, informed by observations and outcomes from family contact visits should these visits be agreed to as part of a child's case plan.[315]

Child Safety advised that CSOs endeavour to maintain family connections as much as possible, and decisions about family contact must reflect the goals of the child's case plan, be in the child's best interests, and not place the child at future risk of harm.

Child Safety will also consider face-to-face contact requirements, which are the minimum number of times a CSO must have contact with a child and family during ongoing intervention (for in-home and reunification cases).

Child Safety has advised that CSOs are guided to consider a range of factors when making decisions about the level and nature of family contact.

According to Child Safety, these factors include:

- The child's emotional and physical safety during contact.
- The child's views about the proposed contact and their views about what is in their best interests, having regard to the child's age and ability to understand.
- If family contact is helping to maintain and develop the child's significant relationships.
- If family contact is providing a positive connection between the child and their cultural community.
- If the child's parents are demonstrating an increased capacity to meet the child's safety, belonging and wellbeing needs.
- The type of child protection order to which the child is subject.
- If the child is residing in a kinship care arrangement that has existing family contact arrangements.
- Practical arrangements, including:
    - transport
    - pick up and drop off times
    - expectations about the contact
    - the payment or reimbursement of any costs associated with the contact.

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[313] Legal Aid Queensland, *Child protection legal information*, <https://www.legalaid.qld.gov.au/Find-legal-information/Relationships-and-children/Child-protection-overview/Child-protection-legal-information>, accessed 2 April 2025.

[314] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Assess and prepare to develop the case plan], accessed 30 April 2025.

[315] Department of Children, Youth Justice and Multicultural Affairs, *Family contact: Information for parents*, <https://www.dcssds.qld.gov.au/_media/documents/protecting-children/intervention-parental-agreement-parents.pdf>.

According to stakeholders interviewed for this project, parents are commonly provided with contact visits for no more than a few hours a week to build their capacity and be assessed by a CSO. Limiting parental contact to only a handful of hours a week can compromise the opportunity for a parent to bond with their child and cause the child stress and confusion, which can lead to a perception that the parent cannot provide a happy environment for their child.

Visits are often conducted in an artificial environment, such as a CSSC, which can put significant stress on any parent, particularly one with cognitive disability. When visits take place in the closed environment of a CSSC, parents do not have the opportunity to observe other parents and learn from the 'village' as other parents do.

To decide on a location for safe and meaningful family contact, the practice manual encourages practitioners to work with the child and parents to identify a location:

- the family can easily access
- that will be safe for the child
- that will enable the child and parents to enjoy and participate in the visit.[316]

Child Safety advised that family contact visits will only occur at a CSSC if there is a significant risk to the child or a staff member, for example, where there are threats of violence or the risk of child abduction.

Child Safety also advised that CSOs are responsible for making reasonable adjustments for a child or parent with disability.

Stakeholders confirmed that the family contact visits may occur in public places, such as a playground, community centres or shopping centres. However, for many new parents, these environments can be challenging and over-stimulating, not allowing a parent to demonstrate their parenting skills, particularly when the interaction lasts for no more than a few hours.

Stakeholders have also noted that parents may be expected to travel long distances for contact visits. For parents without private transport, travelling long distances can incur a significant expense, particularly for those with mobility issues. A stakeholder advised that one client needed to take three buses to attend a contact visit with their child. Failure to attend one of these contact visits would be reported to Child Safety and potentially used as an indicator of a parent being unable to prioritise the needs of their child.

An additional, and significant, concern expressed by stakeholders regarding contact visits is the inherent power imbalance, real or perceived, between Child Safety and a parent with cognitive disability who has had their child removed.

Intervention with parental agreement

As noted above, if a Child Safety investigation finds that a child requires protection and the parents are assessed as being able and willing to actively work with Child Safety to meet the child's protective needs, Child Safety can proceed with an IPA.[317] An IPA allows a child to remain in the family home for all or most of the intervention period, provided it is safe to do so.[318]

During the term of this agreement, Intensive Family Support Service (IFS) programs are offered by various not-for-profit organisations, funded by Child Safety.

The IFS is designed to support parents to achieve their parenting goals in their IPA. Through the 12-week IFS program, children and families can receive intensive support to assist them to build their ability to provide a positive and stable family environment.

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[316] DFSDSCS, 'Support a child in care', *Child Safety Practice Manual*, [Decision making for a child], published 1 May 2025.
[317] Queensland Government, *Director of Child Protection Litigation Annual Report 2022-23*, p. 26.
[318] DFSDSCS, *Intervention with parental agreement,* <https://www.dcssds.qld.gov.au/our-work/child-safety/parents-families/ongoing-intervention/intervention-parental-agreement>, accessed 30 April 2025.

While a valuable service, some stakeholders interviewed for this project expressed concern that access to the program is solely reliant on a decision of a CSO to refer a parent to IFS. There is no option for a parent to utilise IFS should a CSO not deem it suitable, leaving a parent without the support that could prevent the need for a child protection order to be made.

One stakeholder also identified obstacles for parents in regional and remote areas where IFS programs may not be readily available. This is also the case for Aboriginal and Torres Strait Islander families who may have difficulty finding and accessing culturally appropriate IFS services.

The QFCC noted, in its review of supports delivered to children during an IPA, that achieving genuine engagement and meaningful participation of families during an IPA is challenging, as it is based on Child Safety playing a dual role of both surveillance and support.[319]

The QFCC observed that Child Safety workers 'need to be skilled in communicating clearly and openly with families about the child protection risks and the non-negotiable elements of child safety, without jeopardising the working relationship and the progress of the intervention'.[320] Given that many parents with cognitive disability have had previous experiences with Child Safety when they were growing up, this dual role played by Child Safety under an IPA can be traumatic. This is particularly complex for Aboriginal and Torres Strait Islander families due to the impact and legacy of past child protection and removal policies.[321]

One stakeholder noted that parents accept assistance under an IPA assuming that Child Safety is there to assist them to reach their parenting goals. This was confirmed in the QFCC report, which noted concerns from stakeholders that parents can be confused about the nature of an IPA and the intervention, including the seriousness of the concerns, believing it to be like voluntary family support services or a type of order.

However, throughout an IPA, Child Safety is also monitoring parenting behaviour which will be noted in the six and twelve-week reports prepared as part of an IPA. This can lead to confusion at the conclusion of the IPA if a parent's child is removed under a child protection order.

According to the observations of one stakeholder, CSOs do not always clearly communicate the consequences for a parent if they do not agree to enter an IPA. This is an area where early legal advice during pregnancy could facilitate better outcomes for parents with cognitive disability so they can understand what an IPA is, and that not agreeing to an IPA could, in some instances, lead to a child protection order being recommended by Child Safety to the DCPL, and the removal of their child.

QFCC's case file review in its report identified that, in 13 percent of cases, the IPA ended with a child protection court order being sought. The QFCC also noted a significant decline in the use of IPAs, with a 25 percent drop in the number of children on an IPA over 2021-22.[322] Stakeholders consulted as part of this project have observed the underutilisation of IPAs and link it partially to parents not being appropriately supported to consider an IPA.

NDIS

As noted, stakeholders interviewed for this project identified gaps in supports for parents with cognitive disability that impact on their everyday life, but do not meet the threshold for funding under the NDIS. These parents would benefit from additional supports, however they are reported to not be available.

A stakeholder advised that recent changes to NDIS funding rules have seen parental capacity building supports no longer being funded as a specific line item under a participant's plan. Long-

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[319] QFCC, *Keeping children in focus: A systemic review of supports delivered to Queensland children and families during Intervention with Parental Agreement*, December 2022, p.17.

[320] Ibid., p. 30.

[321] Ibid., p.17.

[322] Ibid., p.15.

term support from a social worker is also not considered for inclusion in an NDIS plan, with deference being made to a participant's support coordinator to perform this role.

Feedback from stakeholders suggests that parental capacity building supports are vital to the development and maintenance of a family unit, particularly for participants with cognitive disability. When a child is removed from a family and reunification is a goal, the multitude of parties involved necessitates the long-term involvement of a trained social worker to provide the much-needed support to a parent with cognitive disability who is required to navigate a complex system.

Losing this funding could have a significant impact on parents either currently involved, or at risk of involvement, in the child protection system. The introduction of foundational supports (to sit alongside specific NDIS funded supports) by states and territories, which follows the independent review of the NDIS conducted in 2023, may see mainstream capacity building supports for parents with cognitive disability introduced.

However, until any new supports are developed, parents are not able to access the supports they need to build their parenting capacity, meaning they could remain at risk of their children being placed, or being held, in care.

Parents who are not NDIS participants

Parents with cognitive disability who are not in receipt of NDIS funding, which may be because they have not applied for it or because they do not meet the eligibility criteria, can be significantly disadvantaged. Indeed, some parents who may be eligible for NDIS funding may be reluctant to apply, for fear that it will be used against them as proof that their disability is significant enough that they would not be able to care for a child. These parents may also be daunted by the NDIS application process and the financial barriers to obtaining the various reports required for an NDIS application to be finalised.

In the absence of any kind of additional living supports, these parents will be entirely reliant on mainstream services throughout their parenting journey, which may not make the reasonable adjustments required to meet their needs.

Without this additional support, such parents can be perceived as being unable to provide a safe environment for a child.

Domestic, family and sexual violence

It is well established that women with disability are far more likely to be victims of domestic, family or sexual violence than women without disability. According to an Australian Bureau of Statistics (ABS) disability and violence report, women with disability are almost twice as likely as women without disability to have experienced physical or sexual violence by a cohabiting partner over a 12-month period (2.5 per cent compared with 1.3 per cent).[323]

A woman with a cognitive or psychosocial disability is at even greater risk, being almost three times more likely than a woman with a physical disability to experience physical or sexual violence by a cohabiting partner.[324] She is also more than twice as likely to experience emotional abuse by a cohabiting partner.[325]

Specifically in relation to sexual violence, in a research report prepared for the Disability Royal Commission, it was noted that, 'since the age of 15, 21% of people with disability (764,792 people)

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[323] Australian Bureau of Statistics, *Disability and violence – In focus: Crime and justice statistics*, <https://www.abs.gov.au/statistics/people/crime-and-justice/focus-crime-and-justice-statistics/disability-and-violence-april-2021>, April 2021.

[324] Ibid.

[325] Ibid.

report experiencing sexual violence compared to 10% of people without disability.'[326] The research identified that one in two women with psychological and/or cognitive impairment have experienced sexual violence in their lifetime.[327] For adults with cognitive disability who experience sexual violence, there is a chance that this violence will result in an unexpected pregnancy, which may also see the involvement of Child Safety.

Stakeholders interviewed for this project have indicated that they have observed some issues involving mothers with cognitive disability who have been the victims of domestic and family violence. A stakeholder provided an example of a mother who had her youngest child removed at birth due to concerns that she would not be able to protect her baby from his violent father. This is despite the mother no longer residing with the child's father and still having custody of her other children, all of whom were being monitored by Child Safety. The mother has two-hour weekly contact visits with her youngest child who is living with her eldest daughter. The father also has weekly visits with all the children, despite his history of violent behaviour. Despite the mother's ongoing compliance with the conditions of the child protection order, it is anticipated by the stakeholder that the child will be placed under a Permanent Care Order soon.

This example is consistent with several narratives from the Disability Royal Commission which describe women with disability experiencing domestic and family violence and having their children removed by Child Safety based on a perception that they do not have the ability to protect their children from harm.[328]

In *Hear Her Voice, Report One*, the Women's Safety and Justice Taskforce recommended that the Queensland Government embed 'a common approach to respond to intersectional issues associated with domestic, family and sexual violence, so that services and supports are more accessible and responsive to the needs of victims with multiple and complex needs',[329] including people with disability. This recommendation would 'support all parts of the system'[330] and consequently may involve changes to the child protection system to more effectively respond to the needs of parents experiencing domestic, family and sexual violence that affects their parenting.

Long-term contraception

Stakeholders consulted as part of this project also reported that new mothers, whose children had been taken into the child protection system after birth, were being strongly encouraged by Child Safety and Queensland Health to consent to the insertion of long-acting contraceptive implants, such as an intrauterine device (IUD), prior to leaving hospital.

Conclusion

This report has identified significant questions about the adequacy of the parenting support provided to parents and soon-to-be parents with cognitive disability, either during pregnancy or in the first few years following the birth of a child. This may result in their involvement, and the involvement of their children, in the child protection system.

The two recommendations made in this report (below) have been drafted to enable the identification of the full extent and nature of this problem, and at the same time would, if they are accepted, enable us to begin to work on needed reforms.

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[326] Centre of Research Excellence in Disability and Health, Research report: *Nature and extent of violence, abuse, neglect and exploitation against people with* disability in Australia, report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021, p. 10.

[327] Ibid., p. 14.

[328] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Volume 1: Voices of people with disability', *Final report*, *Book 1* 'Serenity' p. 491; *Book 2*, 'Hillary, Robson and Coralie' p. 87; *Book 3*, 'Liddy', pp. 113-114, 'Micaela and Calista', pp. 677-678, and 'Charis' p. 817.

[329] Women's Safety and Justice Taskforce, *Hear Her Voice - Report One: Addressing coercive control and domestic and family violence in Queensland*, Volume 2, 2021, p. ii (recommendation 16).

[330] Ibid.

Recommendations

Recommendation 1: The Queensland Government should establish a Ministerial Advisory Committee with the responsibility to review the policies and procedures that apply, and the current practices that occur, when parents with cognitive disability interact with the child protection system.

The Committee could potentially be established under section 222 of the *Disability Services Act 2006*, which provides that the Minister may establish 'committees to advise on disability issues, disability services and NDIS supports or services.'

Ideally, the Committee would operate for a set period (up to two years) and report periodically (six-monthly) to the Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence.

The Committee could consist of:

- the Directors-General (or their delegates) from the Department of Families, Seniors, Disability Services and Child Safety and Queensland Health;
- the Chief Practitioner (Child Safety);
- the Chief Midwifery Officer (Queensland Health);
- the Public Advocate;
- the Director of Child Protection Litigation (or their delegate);
- up to three lived experience representatives (including an Aboriginal or Torres Strait Islander person); and
- up to two representatives from non-government advocacy organisations.

Other parties with an interest in the work of the Committee could also be invited to participate on an as-required basis.

In undertaking the proposed review, the Committee would likely need to be supported by one or more internal, cross-departmental working groups (in addition to those already established by the Chief Practitioner, Child Safety), which could be responsible for developing and actioning specific initiatives required by the Committee.

The proposed core business of the Committee would be to review:

a. early intervention policies, procedures and practices;
b. the adequacy of the support given to parents with cognitive disability; and
c. the accessibility of the child protection litigation process.

In reviewing **early intervention policies, procedures and practices**, the Committee could consider:

- mandatory reporting procedures;
- requirements around the provision of support persons;
- unborn child notifications;
- the potential creation of specialist disability Child Safety officer positions;
- parenting capacity assessments;
- the suitability of Child Safety Service Centres as venues for child-parent visits;
- the in-practice efficacy of Child Safety's new (2025) Enhanced Intake and Assessment Approach; and
- the need for greater coordination between pre-birth and post-birth intervention and support services (in the health, child protection, NDIS, independent advocacy, domestic, family and sexual violence, and legal services fields).

In reviewing the **adequacy of support given to parents with cognitive disability**, the Committee could consider:

- the extent to which reasonable adjustments are being made, and need to be made, in the provision of existing ante-natal and post-natal services;
- whether increased NDIS support needs to be available to parents with cognitive disability;
- whether there is a need for a program of therapeutic supports to be provided to parents as part of the services provided to parents when children are in care;
- whether other NDIS reforms are warranted (for instance, whether a participant's pregnancy should automatically trigger an NDIS plan review); and
- the availability of culturally appropriate support for Aboriginal and Torres Strait Islander parents with cognitive disability.

The Committee could also consider proposing new and innovative practices and initiatives, such as:

- the establishment of one or more 'mother and baby' units to provide intensive assistance to pregnant persons with cognitive disability who are in crisis;
- the funding of peer support groups for parents with cognitive disability; and
- the development of family fostering and capacity building programs, in which parents with cognitive disability are provided with in-home assistance to build their parental capacity.

In reviewing the **accessibility of the child protection litigation process**, the Committee could consider:

- the accessibility of existing procedures and information materials;
- the use that is made of litigation guardians;
- the adequacy of parenting capacity assessments; and
- whether, and how, parents with cognitive disability might be better supported during their involvement in child protection litigation.

Current and future working groups established by the Chief Practitioner (Child Safety) that are exploring ways to better support parents with an intellectual disability could also report to the Committee on key developments and any trials of new initiatives.

In concluding its work, the Committee would ideally identify clear reform priorities. It would also outline the timeframe and proposed outcome measures associated with its recommended reforms.

Recommendation 2. The Queensland Government should fund, as part of the Queensland Disability Advocacy Program, a specific program of advocacy support for parents and soon-to-be parents with cognitive disability.

The aim of this advocacy support would be to assist people with cognitive disability before, and following, the birth of their children, in navigating the variety of systems with which they must deal to receive the services and supports to which they are entitled.

The program should include the option for an advocate to be engaged on a one-off basis (single issue), or over a longer term, where they are available to assist at multiple points during a parent's pregnancy journey and the first few years of a child's life.

A key objective of the program would be capacity building among parents with cognitive disability, and in particular ensuring that the voice of parents with cognitive disability is heard during any interactions they have with the child protection system, in keeping with the Queensland *Charter of Rights for parents involved with the child protection system in Queensland*.

Appendix – List of stakeholders

Aged and Disability Advocacy Australia

Basic Rights Queensland

Community Living Association

Department of Families, Seniors, Disability Services, and Child Safety

Department of Health (Queensland)

MICAH Projects I Family Inclusion Network

Legal Aid Queensland

Metro South Hospital and Health Service

Office of the Public Guardian

Office of the Director of Child Protection Litigation

Queensland Advocacy for Inclusion

Queenslanders with Disability Network, including QDeNgage who organised a focus group of adults with lived experience

WWILD-Sexual Violence Prevention Association Inc.