NSW Ombudsman

Review under section 13 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*

Group review of the situation of children younger than five in out-of-home care and under the parental responsibility of the Minister for Community Services

Contents

1. INTRODUCTION

Under section 13 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA), the Ombudsman may review the situation of a child or a group of children in care. In carrying out such a review, we look at the welfare, status, progress and circumstances of the children the subject of review.

This report details observations arising from the Ombudsman's review of a group of young children in out-of-home care, conducted in 2007.

2 BACKGROUND TO THE REVIEWS

In 2003, this office reported on the findings and observations of our review in 2002 of a group of children who entered care prior to turning five. The review highlighted the importance - in terms of cost effectiveness, carer satisfaction and individual outcomes for children - of providing appropriate resources and support when young children are placed in care.

The 2003 group review report highlighted areas where the child protection system appeared to be providing an inadequate service to both children and their carers. The health and development needs of children were often not established when they entered care and some carers were not prepared for the sorts of problems children presented with. When these problems emerged, responsibility for addressing the issues was often left to the carer. Permanency planning for some children lacked clarity and, at times, it was difficult to establish whether the plan for a child was long-term out-of-home care or restoration.

In the interim, little attention was paid to how the child's immediate or medium-term needs would be met while in care; and for some children, monitoring of their parents' progress to address identified concerns did not occur. More broadly, we found that once children were placed with carers and their care orders finalised, the monitoring and support of placements were generally inadequate. Ensuring placement stability for children in care was not a casework priority unless problems emerged. For some children, these arrangements culminated in their placements breaking down.

Since our 2003 group review report, there have been a number of significant changes that have impacted on the out-of-home care program. The program has been one of the areas to benefit from the government's 2002 five-year funding package to improve the NSW child protection system. Of the total $1.2 billion package, $613 million is allocated to improving out-of-home care. This money is being provided incrementally over a six-year period, with 75% of the total amount provided in the final three years.

Projects identified to improve out-of-home care have focussed strongly on improvements to both foster and relative care, with expanded foster care recruitment and training; an increase in Aboriginal foster placements and services; better support to retain carers and to maintain placements; and the development of a specialist foster care support model to provide for children and young people with high and complex needs. Strategies to improve service delivery have also included a revised carer payment system; the recruitment of 150 additional out-of-home care DoCS

caseworkers; and significant improvements in the training, support and supervision of departmental caseworkers.

Concurrent with these initiatives, certain provisions of the *Children and Young Persons (Care and Protection) Act 1998* (the Act) - relevant to out-of-home care - have been proclaimed. The law now:

- requires out-of-home care service providers to be accredited and carers to be authorised;
- requires carers to be provided with information about a child, prior to the child's placement;
- requires carers to be provided with information for the purpose of medical care and safety;
- provides for carers to have the authority to make decisions in relation to the daily care and control of children in their care; and
- requires placement reviews at specified times to determine the safety, welfare and wellbeing of children and young people in out-of-home care.

To ensure compliance with these and other relevant statutory requirements, DoCS has developed and implemented relevant policies and guidelines. The department's online Business Help provides comprehensive guidance to departmental staff on matters relevant to the out-of-home care program area, including care and permanency planning; case planning and case management; transfer of case management responsibility; supervision and support of authorised carers; the payment of carer allowances and financial support; and placement reviews.

According to the department's 2006 Annual Report, the department is on track to receive full accreditation as a designated agency before the legislation deadline of July 2013. The department has a three year Quality Improvement Plan, has completed an annual progress report, and participated in the Office of the Children's Guardian's annual case file audit.

In addition to these developments, DoCS has developed Memorandum of Understanding with NSW Health (2006) and the Department of Ageing, Disability and Home Care (2003). Both memoranda are relevant to the provision of services to children and young people in out-of-home care.

As at 30 September 2006, children under the age of five made up 23% of the 10,623 children in statutory care in NSW.[1] It is now generally recognised that young children are highly vulnerable to the effects of abuse and neglect and often enter care with significant needs. Without proper support, this can lead to placement instability and, for some, multiple placements. Research has shown that young children may experience neurological trauma if not permitted to develop a secure and responsive

[1] NSW Department of Community Services Out-Of-Home Care Quarterly Data, June 2005-September 2006

attachment with a caring adult. Placement instability has been linked to a range of poor outcomes both during childhood and into adulthood.

Against this background, the NSW Ombudsman determined to revisit the issue of very young children in out-of-home care.

3 METHODOLOGY

The scope of our individual reviews included children younger than five in out-of-home care as the result of final orders made by the Children's Court, allocating all or aspects of parental responsibility to the Minister for Community Services.

In January 2007, pursuant to section 20 of the *Ombudsman Act 1974*, we examined Children's Court records held by the Port Kembla, Campbelltown and Parramatta Children's Courts. A group of 49 children who met our review criteria was identified and selected for review. The Children's Court issued final orders for these children between October 2005 and March 2006.

On 29 January 2007, we advised DoCS of our decision to review the group of children that we had identified. Pursuant to section 18 of the *Ombudsman Act*, we sought copies of the children's departmental files and made arrangements to interview their caseworkers and carers.

Individual reviews were informed by an examination of each child's file, and where relevant, an examination of files held by funded out-of-home care agencies. We held interviews with children's caseworkers and/or casework managers, and the children's carers. Where individual reviews identified matters warranting further action, we sought further information from DoCS, pursuant to s18 of the *Ombudsman Act.*

On completion of the individual reviews we provided the department with a report on the results of each review.

Twenty-one Community Services Centres (CSCs) held case management responsibility for the 49 children we reviewed. To provide a context, we consulted with casework managers in the 21 CSCs about practice for children in out-of-home care. We asked about the participation of out-of-home care teams in care planning, caseloads and allocations, the transfer of files and foster care support.

On 18 September 2007, we provided DoCS with a draft report. On 1 November, DoCS provided us with a submission.

4 KEY OBSERVATIONS

Our reviews focussed broadly on the following key practice areas: care planning, health screening and assessment, case management, placement support, and contact and identity. The following observations are based on the results of the 49 reviews.

Care planning

Care planning for the 49 children that we reviewed was generally child centred; involved the participation of families in decisions about how their child's safety, welfare and wellbeing would be enhanced; and, in contrast to our 2003 findings, clearly detailed how permanency - that is, secure and stable care - would be achieved. However, and consistent with our previous findings, consultation between child protection and out-of-home care teams at the care planning stage did not generally occur.

We observed significant improvements in the care planning for children the subject of short-term orders. Planning for this group of children was thorough. Restoration plans clearly detailed what was required of parents for their children to be restored to their care, and parents received good casework support to understand these requirements, to access relevant services and to maintain meaningful contact with their children pending restoration. Caseworkers closely monitored parents' progress against undertakings, and where compliance issues were identified these were addressed. For a number of the children we reviewed, the department applied to the Children's Court to vary care orders when permanency was unlikely to be achieved through restoration.

Where possible, siblings were placed together. The Aboriginal Placement Principles were adhered to. Regardless of whether permanency for the child was to be achieved through restoration to parental care or through long-term out-of-home care, departmental staff were mindful of the negative consequences of placement changes on young children and worked to minimise these.

For children whose permanency plan provided for long term care, the possibility of placement with relatives was considered in all instances. Except in two matters, carers were assessed for the purpose of authorisation. However, it is concerning that the files for a number of the children did not hold a copy of the carer assessment relevant to the placements.

Departmental staff attempted to ensure culturally appropriate placements. For a number of children from culturally diverse backgrounds, this was not possible due to a shortage of appropriate carers.

Adoption was specified in the care plan for one of the 49 children, although three others had case plans that included adoption. Adoption had not significantly progressed for any of these children. Our reviews identified another four children in long-term foster care for whom adoption appeared feasible but had not been canvassed. Adoption was not a priority for caseworkers or their managers and these staff appeared to have limited information about the adoption process. Given that adoption is an effective way of achieving permanency, particularly for those children with minimal contact with their family of origin, this was concerning.

The Children's Court made section 82 orders under the Act for 24 of the 49 children. Section 82 orders require a written report to be lodged with the Court regarding the implementation of care plans. In 11 instances, the department did not submit the required report to the Court. This failure did not trigger a response by the Children's Court. Poor compliance with completion of these reports, and the Court's apparent

failure to identify that the reports had not been submitted, is of concern. This is particularly so given the non-proclamation of the other provisions of the Act providing for external monitoring of the progress of individual children and young people in care.[2]

Attention to the individual needs of children: health screening and assessment

Consistent with our previous findings, our reviews in 2007 indicate that insufficient attention continues to be paid to benchmarking young children's health and developmental status when they enter care. At the time of our reviews, 39% of the children had not received a paediatric assessment, 78% had not had a dental assessment, and 53% had not received a developmental assessment.

In the sample of children we reviewed, those least likely to receive health screening upon entry into care appeared to be children who had a history of neglect prior to their placement in the care of relatives. Significantly, most of the Aboriginal children we reviewed fell into this category. In addition, the monitoring of the health and progress of children placed into the long-term care of relatives was often inadequate.

In contrast, those children who entered care as a consequence of physical abuse, or who were born with significant health problems, were more likely to receive ongoing health screening. Those children who were the subject of short-term orders, or who had been restored at the time of our reviews, also received health screening. It was pleasing to see that recommendations arising from health and developmental assessments for these children were implemented - often as a consequence of significant casework advocacy to ensure the timely provision of appropriate services.

For those children requiring speech pathology, being in statutory care did not ensure priority access to these services. In a number of matters, timely access to speech therapy required the department to purchase these services from private providers.

The department failed to obtain health records detailing children's health histories for a significant number of children, and documentation pertaining to medical assessments by specialists was often not contained in the file. This was particularly so for those children in the care of relatives. We found that, other than the blue book, immunisation record and Medicare card, there does not appear to be a consistent understanding across CSCs concerning what documentation should be obtained. This should be clarified.

We also found that it was particularly difficult to track children's health and developmental progress through examining their departmental files. Pertinent information is filed chronologically and critical health and other key information can become 'lost' in the file, particularly when cases are reallocated, as often happens. A number of caseworkers told us that they do not have time to thoroughly review

[2] Section 150(1) of the 1998 Act requires designated agencies having placement responsibility of a child or young person in out-of-home care to conduct placement reviews for the purpose of determining whether the safety, welfare and wellbeing of a child or young person is being promoted by the placement. Section 150(5), which is yet to be proclaimed, requires all reports on s150 reviews to be provided to the Children's Guardian. Section 181(1)(d) provides for case plans and reviews of case plans to be provided to the Children's Guardian. This section is not yet proclaimed.

children's files. Caseworkers also frequently demonstrated poor knowledge/understanding of the child's health history.

For children in long-term care, there continues to be a perception that health care is the responsibility of carers – this is particularly so if the carer is a relative. Our reviews found that a number of the children in long term relative care had not received the assessments outlined in their case plans.

While most carers told us that the department provided them with the standard health care records (the 'blue book', immunisation record and Medicare card), failure to provide these documents in a timely way, without reasonable explanation for the delay, was a reason for complaint for some carers.

Case management

As indicated elsewhere, we found that the case management of the children placed in short term care, or who were restored, was generally of a high standard. In the main, these children had an allocated caseworker, the monitoring of their circumstances was thorough, and effective collaboration and cooperation between caseworkers and other agencies was evident. Consistent with local practice, a number of these matters remained with the child protection teams upon completion of the final orders. This did not appear to adversely impact on casework quality.

Four of the children were case managed by funded services. Three of these four children had an allocated DoCS caseworker at the time of our review. Case management for all four children was thorough.

In 2001, this office investigated concerns relating to DoCS' procedures for the transfer of child protection and 'ward' files. We found the department's policy and procedure for file transfers to be inadequate. We also found poor staff compliance with the procedures that were in place. Poor compliance with the case management transfer policy was also identified as an issue of concern in our 2003 group review report. As part of its reform agenda, the department's practice requirements for file transfers and record management have been updated.

We are concerned that compliance with business rules around cases transferred continues to be inadequate. In 2007, we found that there were significant delays in the transfer of case management responsibility between child protection and out-of-home care teams. When case management responsibility was transferred between units or between teams within the same unit, handover meetings did not always occur. However, when these meetings took place they usually involved carers. Handover meetings aside, the transfer of case management responsibility did not occur in accordance with the department's business rules for a number of children.

Twenty-six of the 36 children who received long-term orders were not allocated a caseworker when their care matters were finalised. Children the subject of long term orders and placed with relatives were the least likely to have an allocated caseworker, and were the least likely to receive a home visit in the first six months following finalisation of their care matter. We are concerned that those children under the

parental responsibility of the Minister who were placed with relatives, were such a low priority for case management.

Our reviews found that placement reviews in accordance with the requirements of section 150 of the Act, did not occur for 21 of the 49 children. These reviews were even less likely to occur for children placed with relatives. Our reviews established that for a number of children, this meant that problems with their placements were not identified in a timely way. It is also concerning that many of the placements reviews that did occur, appeared superficial and relied on the report of the carer as to the progress of the child. In our view, this is not adequate. As previously noted, the provision of the Act that provides for external monitoring of compliance with section 150 is yet to be proclaimed.

All of the 49 children had case plans in place at the time final orders were made. However, at the time of our reviews, case plans for 29 children had not been reviewed in the previous 12 months.

Carer support

Most carers, including those whose children in their care did not have an allocated caseworker, reported that they felt well supported by the department. A number of foster carers were very positive about the support that they received from foster care support workers.

A number of carers who did not have an allocated caseworker for the child in their care said that having a caseworker would make their job easier, and would prevent the need to 'repeat their story' to DoCS' staff when seeking assistance.

Seventy per cent of all carers said that they felt well supported in meeting the identified needs of the children in their care; 80% said that they were well supported in relation to contact with the parents, and 75 % said that they would be well supported in relation to any issues of concern, which might emerge.

The majority of carers reported being provided by the department with relevant information about the children's circumstances and what to expect from the department following placement. Most said that they were provided with relevant information about the child's identified needs and relevant health care records. While most were provided with a copy of the child's case plan, 14 carers were not.

Despite these encouraging results, it is important for the department to aim for full compliance with the statutory requirements relating to the provision of information and documents to carers.

While most carers reported no current problems with receiving the carer allowance or financial support, a number had experienced problems in 2006. These problems coincided with new payment systems that were introduced by the department in 2006. Where there were ongoing problems - for example, with the payment of childcare fees - departmental caseworkers were generally responsive to the carers' concerns, although carers reported being frustrated with the time taken to resolve matters. We

also identified instances where grandparents were not provided with clear information about the Federal Government's Grandparent Child Care Benefit.

Of the 10 carers who had made a complaint to DoCS, six were satisfied with the outcome. A number of these complaints related to financial support.

For the children we reviewed, those who were placed with relatives were more likely to be the subject of a risk of harm report during the period of the placement, than those who were placed with foster carers. For two of the children we reviewed who were placed with relatives, out-of-home care case management was provided only after risk of harm reports were made for the children in the placements. The placement circumstances for both these children suggest that case management should have been provided prior to the risk of harm reports being made.

Contact and identity

It was pleasing to see that caseworkers gave appropriate consideration to the circumstances of siblings when making placement decisions.

In contrast to our findings in 2003, we found caseworkers also ensured that children the subject of short term orders had appropriate contact with their parents. Generally, DoCS caseworkers provided good support in relation to contact for both short and long-term orders, and most carers evidenced a good understanding of the importance of contact with the family of origin for the children in their care. Many of the foster carers facilitated sibling contact.

Generally, most carers also had a good appreciation of the importance of life story work.

5 DoCS' RESPONSE

In response to the draft report, DoCS noted the areas of reported practice improvements since the group review of very young children conducted in 2002.

The department provided information on a range of initiatives currently underway to improve out-of-home care service delivery. Where relevant, these initiatives are noted in this report.

The department also told us that departmental Regional Directors had been provided with a copy of the draft report and were working to address the issues identified.

Additionally, the department provided information on regional initiatives. Specifically, the department told us that the Southern Region has committed to improving service delivery in relation to adoption planning where adoption has been identified as a case plan goal, and health checks - particularly for children in relative and kinship placements. The Metro West Region has established an out-of-home care assessment clinic. This clinic will ensure that children entering care receive appropriate assessments.

6 RECOMMENDATIONS

The Department of Community Services is in the process of implementing systems that will allow the department to conduct quality reviews across all CSCs over a four-year time span. These reviews will be informed by an analysis of qualitative and quantitative data on CSC performance, file review, observation of practice, focus groups with clients and interviews with local partners. Each review will result in a Quality Improvement Plan.

Our review of a group of very young children in out-of-home care has identified practice areas that, in our view, warrant improvement. These include, but are not limited to adoption practice, compliance with section 82 orders under the *Children and Young Person's Care and Protection Act,* the identification of children's health and developmental needs when they enter care, documentation of children's health and developmental progress over time, compliance with the department's rules around case transfer, completion of placement reviews and compliance with the statutory requirements relating to the provision of information and documents to carers.

Against this background, the Department of Community Services should:

1. Advise this office by 26 January 2008 whether the practice weaknesses identified in this report will be addressed by the department's quality review program or by other initiatives (and if so, how?)

2. Provide reports to the Ombudsman in June 2008, December 2008, June 2009 and December 2009 with detailed evidence of the progress made by the department in addressing the practice weaknesses identified in this report.

Steve Kinmond
Deputy Ombudsman

7 GROUP REVIEW REPORT: CHILDREN UNDER FIVE

7.1 Characteristics and circumstances of the children selected for review

Reasons for entry into care

The primary reason for the 49 children entering care related to parental or carer substance abuse (33 or 67%). These 33 children were also frequently the subject of reports regarding domestic violence and neglect. Parental mental health issues were reported for 11 of the children. Seven of the 49 children entered care following a report of physical abuse.

No children entered care because of concerns related to sexual assault.

Care orders

Most children were the subject of care orders placing them under the parental responsibility of the Minister until the child attained 18 years of age (34). Fifteen children had two-year orders with a view to restoration.

The department had applied, or was in the process of applying, for a variation of orders in respect of 11 of the 49 children (22%). The 11 included some children who were in long term care at the time of our reviews.

Just under half the children (24) received an order for monitoring by the Children's Court.

Age

Over half the group (27) were 12 months or younger when they entered care. Half of these children (14) were aged three months or younger at the time of entry into care.

Cultural background

One quarter of the children were from non-English speaking backgrounds (12). Nine of the children were identified as Aboriginal.

Disability and identified health/developmental needs

Two of the 49 children had disabilities: one had an intellectual disability and one had both a physical and intellectual disability. Eighteen children had a developmental delay. Of these, most had delayed language (14), eight had attachment disorders, seven had behavioural problems, four had delayed physical development and three had delayed intellectual development.

Placement

At the time of our review, 22 of the 49 children were in foster care, 21 were in the care of relatives and six had been restored.

Of those in foster care, 18 were in long-term placements and four were in short term placements with a view to restoration. Of those children in relative care, 18 were in

long-term placements and three were in short-term placements with a view to restoration.

Four of the restored children had been previously placed with relatives and two had been placed with foster carers.

Placement provider

Eight of the 22 children in foster care were placed with carers authorised by funded agencies. The remainder were placed with carers authorised by DoCS.

Length and number of placements

At the time of our review, and excluding those children who had been restored, just under half of the children had been in their current placement for 12 to 18 months and one quarter had been in their current placement between 18 months and two years. In only one matter was the length of the child's placement not consistent with the case plan.

The majority of children had experienced between one and two placements in their lifetime.

Siblings in care

Forty-one of the 49 children had siblings. Of the 41 children with siblings, 33 had either all or some of their siblings in care. Thirty were placed with either one or more siblings.

7.2 Emerging themes: what the reviews found

At the time of our review, 21 Community Services Centres held case management responsibility for the 49 children. As part of our review, we consulted with casework managers in the 21 CSCs about their practices for children in out-of-home care. We asked about the participation of out-of-home care teams in care planning, caseloads and allocations, the transfer of files and foster care support.

Participation of the out-of-home care team in care planning

A small number of CSCs reported that their out-of-home care staff become involved in matters as soon as the department begins to consider recommending that a child be placed into long-term care. One casework manager advised that care planning – the process by which the department, parents and other relevant parties address issues of concern affecting a child or young person - '*works better'* when there is participation by the out-of-home care team. A small number of CSCs advised that there is an expectation that the out-of-home care team will participate in care planning when their out-of-home care teams are expanded.

Caseloads and allocations

Almost all CSCs reported that priority for allocation is given to 'high needs' children and young people in high cost placements, and in some instances, advised that this

meant that other cases could not be allocated. After this group, priority is given to the cases with the greatest need or where there is a specific problem: for example, placement breakdown, the children or the carers struggling, or concerns being raised during a foster care review. Very few CSCs (2) advised that priority is given to allocation of cases involving young children.

Managers reported that a low priority for allocation is given to children placed with funded services, where parental responsibility is allocated to a family member, and where the children are placed with kin or relatives.

A quarter of the CSCs reported having a significant number of unallocated cases – between 50% and 80%. Most of the CSCs advised that there is no typical caseload due to the variety in the types of cases managed. Caseloads ranged from six to 25 cases per caseworker.

Across the CSCs, there are different practices for the management of risk of harm reports about children in care: however, most CSCs allocate responsibility for assessment of these reports to the out-of-home care team. Risk of harm reports for children the subject of short-term orders, or who have been restored, appear to be the responsibility of child protection teams.

Where funding enhancements to CSCs have occurred, reported improvements to out-of-home care practice include the establishment of new or additional out-of-home care teams, increased capacity to conduct placement reviews of children under the parental responsibility of the Minister, and increased capacity to conduct reviews of unallocated matters.

Transfer of files

There was significant variation between the CSCs that we consulted in relation to their practices for transferring files from their child protection team to their out-of-home care teams following the Children's Court making its final orders. Generally, the CSCs do not have set timeframes for the transfer of files in these circumstances.

Most CSCs advised that the transfer occurred as soon as possible following the making of final orders. In this regard the transfers took from 20 days to three months. Nine CSCs advised that short term and/or restoration cases remain with their child protection teams after the Court makes its final orders. Three CSCs advised that cases often remain with their child protection teams due to the limited resources of their out-of-home care teams.

Seven CSCs reported that their transfer of files always involves a case conference and/or a placement review, with all relevant parties invited. Two CSCs reported that a case conference on transfer will only occur if the case is complex: in other cases, the transfer process will simply involve discussion between the managers casework of the respective CSCs and will not involve the carer or the parent/s.

Foster care support

Most of the CSCs we consulted told us that they have a foster care support team or a foster care support worker. Some CSCs advised that the foster care support team only provides support to short term and new carers. Others advised that the foster care support team provides support to short and long-term carers for a period of one year. Some foster care support workers provide ongoing support to carers, regardless of the length of time the carer has been fostering.

7.2.1 Out-of-home care planning - permanency

Our work in 2002

In our previous report, we observed that children experienced problems when care plans were unclear about whether their time in care was going to be long term or short term. Some carers also told us that they were unclear about the plans for the children in their care.

Some of the children who had short-term orders also experienced uncertainty and unnecessary placement changes because there was no clear plan in place about how their restoration would be achieved, or how their circumstances would be monitored once they returned to parental care.

Consultation between the child protection and out-of-home care teams at the care planning stage did not generally occur.

Practice requirements and developments

Since January 2002, there has been a legislative requirement for care plans to show how the proposed placement for each child will lead to permanent and stable care. Additionally, out-of-home care may be provided for a child or young person only by an authorised carer.

DoCS' Business Help provides clear guidance regarding the department's care plan and case planning requirements, and authorisation of carers. DoCS' practice rules require that care plans allocating all or aspects of parental responsibility to the Minister, must include details of how the proposed placement will relate to permanency planning.

For all children whose care plan provides for removal of a child from the care of their parents, the department's practice rules also require consultation between the child protection and out-of-home care teams for the purpose of informing *'case plan strategies aimed at supporting and achieving the case plan goal'*.

In response to the draft report, DoCS told us that as part of the department's out-of-home care major project, it has established a working group on the 'child protection and out-of-home care systems interface'. The department advised that work is progressing on defining the practice issues that require joint work between child protection and out-of-home care teams within CSCs and how best to support joint work. An integrated child protection and out-of-home care policy manual is expected to be in place by December 2007.

In May 2006, DoCS began a Permanency Planning demonstration project at four metropolitan Community Services Centres. This project focuses on permanency planning for children up to the age of two. In response to the draft report, DoCS advised that 11 sites have now received training and 26 CSCs have been identified to participate in the third stage of the roll out of this project across NSW. The project aims to improve casework practice in assessment, decision-making and planning for children entering out-of-home care – including when adoption should be considered for children entering care.

The department also told us that it is regionalising its Adoption and Permanent Care Services. This initiative is intended to improve caseworker knowledge about the adoption process.

What we found – 2007

Care planning

- Similar to our findings in 2002, the care planning process involved, as far as practicable, the participation of families in decisions about their child's safety, welfare and wellbeing. Families were given the opportunity to air their views, contribute to discussion about care options, and were informed of their responsibilities and rights.

- Of the nine Aboriginal children we reviewed, eight were placed with relatives and one was placed long term with a sibling through Kari Aboriginal Resources Inc. Eight of the nine had long term orders.

- Consistent with our findings in 2002, there was little consultation between the child protection and out-of-home care teams in the care planning for children. Out-of-home care staff participated in the development of the care plans for 4 of the 49 children (8%) and, generally, no other form of consultation took place between teams to inform the care planning process for the other 45 children.

- In contrast to 2002, we found that 48 of the 49 care plans detailed clearly how permanency would be achieved. As described below, the one child for whom this did not occur, experienced unnecessary placement disruption.

> The three year old child's care plan remained before the Children's Court for 12 months during which time the care plan changed several times – care plans variously included restoration, parental undertakings, supervision orders, long term placement with foster carers and long term placement with family. Upon assuming his care, the department initially placed the child with foster carers. One month later, he was placed with a cousin, and was then restored to his mother's care while she attended a court-ordered rehabilitation program. This decision was made prior to the department obtaining a Children's Court Clinic assessment. When a clinic assessment was obtained, it raised concerns about the mother's parenting history (child removed) and lack of change since 1999 (ongoing drug dependency). When the mother advised the department that she was not coping with the child, the department placed the child with foster carers. These carers' circumstances changed and so the child was then placed with a third foster carer, by which time the child was displaying 'tantrums'. He was then placed long term with relatives. Aspects of the final care plan for the

> child appear to lack clarity. For example, the goal is recorded as restoration even though the department sought a long term order. Despite the fact that the child had been placed with family carers, the care plan recommended placement with departmental foster carers. The care plan also recorded, *'If* [either parent] *are able to actively demonstrate change over a significant period of time, the department feels that restoration to either parent may be considered. However should such a change not be evident…following a period of two years.*…[the child] *should remain in departmental foster care until the age of 18 years'.*

- For 11 of the 49 children (22%), the department had applied, or was in the process of applying, for a variation of the care order. In all but one of these matters, the child had an allocated caseworker monitoring the child's progress prior to the decision to vary the order.

- Pursuant to section 82 (1) of the *Children and Young Persons (Care and Protection) Act 1998*, the Children's Court monitored progress in relation to the implementation of the care plan and permanency for 24 of the 49 children (49%). In 11 of these matters, the department did not submit the required report to the court. This included three instances where an initial report was submitted; however, a second report was not. Failure to submit the report often occurred when case management responsibility had transferred from one CSC to another.

  Section 82 (2) of the Act provides for the court to review orders: *'If, after consideration of such a report, the Children's Court is not satisfied that proper arrangements have been made for the care and protection of the child or young person…'* Failure to submit reports in accordance with the requirements of s82 (1) did not trigger any response by the Children's Court for any of the 11 children. The following is an example of the department's failure to comply with an order under section 82.

  > The child and his siblings were placed in their grandmother's care. The family identify as Aboriginal. The child was removed from his mother's care shortly after birth, and was nine months old when placed with his grandmother. The Children's Court made an order requiring written reports, within six and 12 months of completion of the care proceedings, on both his progress and the support provided to his grandmother. The first report was submitted and the file was then transferred to another CSC where, until recently, it has remained unallocated. In reviewing this matter we raised concerns that there was no information on the departmental file regarding the child's health and that there had been limited discussion with the grandmother regarding what support she required. We also noted that no contact was occurring with another sibling who had been placed in departmental foster care. In addition, there had been no follow up regarding the grandmother's possible entitlement to the Commonwealth Government 'baby bonus'; a submission for financial support was not progressed when the file became unallocated; the contact plan had not been reviewed; and the second report to the Court had not been submitted.

  In an earlier review of the Children's Court, we have noted that there is no data on the use of section 82 reports and that legislative change may be required to clarify the scope of the Court's power under section 82.[3]

[3] NSW Ombudsman, *Care proceedings in the Children's Court – a discussion paper,* pp29-31, August 2006

- Most of the care plans specified a date for review by the department. We found that these review dates were generally adhered to where the order was short term; sometimes adhered to where the child was placed in long term foster care; and generally not adhered to where the child was placed long term in the care of relatives (see below).

- The Children's Court made contact orders in relation to 17 of the 49 children. Generally the department adhered closely to the terms of these orders.

- Overall, child protection workers were sensitive to the negative consequences that placement changes can have on young children, and attempted to minimise these. Seventeen of the 49 children had only one placement in their lifetime, while 15 experienced two. For the 49 children, most of their placement changes were planned (77%).

Short-term orders with a view to restoration/restored

- For the 13 children that we reviewed who had either been restored or who were the subject of short-term orders, the department's casework was generally comprehensive.

- Where restoration was dependent on parental compliance with undertakings, departmental staff communicated effectively with the parents about what was required of them. In this respect, our reviews identified that the parents of 12 of the 13 children received good casework support.

- Monitoring was generally thorough, and effective collaboration and cooperation between the department and other agencies was also evident. Where monitoring raised compliance issues, the department acted quickly to address these. The following case studies are indicative of the casework that the 13 children received.

> During care proceedings, the child was placed with his grandmother. The Children's Court subsequently made a two-year order with a view to restoring the child to his mother's care. The case plan presented to the Children's Court provided for his mother to meet certain undertakings that had been developed to minimise identified risks to the child. The undertakings included urinalysis, attendance at parenting courses, participation in anger management and drug and alcohol counselling. On finalisation of the care proceedings, case management responsibility was transferred to an out-of-home care team in another CSC and a caseworker was allocated. The caseworker liaised closely with the mother and regularly sought information from the agencies providing her with services. When the mother's compliance with the caseplan dropped off, the caseworker let the mother know that the department would seek a variation of the care order. While the mother's compliance initially improved, leading to an increase in unsupervised contact, the improvements were short lived. Subsequent liaison between the department and support agencies confirmed ongoing problems. This led to the department reviewing the case plan and at the time of our review the department was in the process of applying for a variation of the order.
>
> In a separate matter, final orders for two young children and their two older siblings were made in June 2005. At the time, the children were placed separately with relatives and departmental foster carers. Parental responsibility for the four children

was allocated to the Minister for a period of three years. The care plan outlined a detailed restoration plan conditional on the parents attending various support services and addressing drug and alcohol issues and domestic violence. Later, a supervision order was made for a fifth child, who was then seven weeks old. In August, the department filed an application to vary the orders for all the children as the mother had breached her undertakings. The department proposed that parental responsibility for all five children be allocated to the Minister until each child turned 18. The Children's Court did not support this proposal. Following a preliminary conference in March 2006, the department presented a revised permanency plan for restoration. During the following months, the department put in place strategies and services to support the restoration and closely monitored progress. The department also held regular case meetings with the family and other agencies. By December 2006, serious problems were evident regarding the mother's compliance with the restoration plan, her supervision and management of the children and her attention to their health needs. Support services were intensified. In April 2007, the department applied to vary the 2006 orders and sought long-term care orders for all five children.

- At the time of our review, six of the 13 children who were the subject of short-term orders had been restored. Five of the six children's families were engaged with family support services. Two of the six children had been restored earlier than planned because of placement breakdown. However, for both these children family support services had worked intensively with their families prior to and after restoration. No active monitoring occurred for one child.

Long-term placement in relative care

- At the time of our review, 18 children were placed in long-term relative care. In relation to 16 of the 18 children, carers were assessed prior to or shortly after the children were placed in their care. For two children, a carer assessment in accordance with departmental practice requirements did not occur.

- 17 of the 18 children in the long term care of relatives were placed with one or more siblings.

- Two of the relatives who were assessed as appropriate to have children placed with them, were young men in their early 20s. These assessments did not appear to give adequate weight to the specific circumstances of the young men. One placement subsequently failed, and the other was unstable at the time of our review.

Long-term placement in foster care

- For 18 of the 49 children, the permanency plan involved placement in long-term out-of-home foster care. In all matters, adequate consideration was given to the possibility of relative care.

- Short-term carers for six of the 18 children were reassessed as long-term when culturally appropriate placements could not be located. One of the six children was Aboriginal. A decision regarding the permanency of one child's placement had not been resolved at the time of our review. This child's circumstances are described below.

> The child was born drug dependent and was initially reported to the department at the age of two months, following allegations that his father may have put methadone into his feeding bottle. The child was three and a half when he and his older sibling were removed from their parents' care in December 2005. They were placed in a short-term 'high cost' placement with a funded agency. The Children's Court made final orders in February 2006, placing both children under the parental responsibility of the Minister until the age of 18. The children's case plan provided for a long-term placement to be located for them. Our review established that the children had been in their placement for 22 months; and while the younger child presented with a range of difficult behaviours, he was doing well in other ways. We found various reports on the children's file recommending that they remain in their placement. However, at the time of our review, no decision had been made about permanency. The child's departmental caseworker could not tell us why the placement had not been confirmed as long term.

- Generally, carers reported that the children in their care were doing well and anticipated that the placements would be long term.

- For four of the 18 children, adoption had been discussed but not progressed. Adoption had not been considered for a further three children who had been placed prior to the age of two, had not had contact with their parents for over 12 months and who were in stable placements. Our reviews of the four children whose case plans included adoption, raised issues about caseworker understanding of the adoption process for children in out-of-home care. Caseworkers also told us that adoption was not a casework priority for them. The following case studies are illustrative.

  > The child's mother ceased contact with him prior to finalisation of proceedings before the Children's Court. The child was placed with carers identified through DoCS' Adoption and Permanency Care Services (APCS). APCS recommended that the CSC with case management responsibility monitor the child's placement and facilitate contact between the child and his father to determine whether adoption might be considered in the future. Our review established that the child's file has been unallocated since it was transferred from the child protection team to an out-of-home care team in the supervising CSC. Contact between the child and the father had not been facilitated for over a year. In these circumstances, we were concerned that permanency through adoption would not be pursued for the child. APCS told us that the lead role in such matters is with the local CSC; however, the child's carers themselves may push for adoption at sometime in the future.
  >
  > In another matter, the child we reviewed had been placed with long-term carers when he was eight months old. At the time of our review he was two. His carers told us that they would like to adopt the boy, and that this had been raised in reviews with DoCS. The manager casework told us that while the department was supportive of the child being adopted by his foster carers, the resources to progress the adoption were not available and there were other priorities for the out-of-home care team.

- For one of the 18 children placed in the long term care of relatives, the caseworker advised that the department was considering applying for a variation of care orders with sole parental responsibility being allocated to the relatives. However, at the time of our review, this option was not formalised in the child's case plan.

7.2.2 Attention to the individual needs of the child: health screening and assessment

Our work in 2002

In our previous report, we observed that the care planning process for the children we reviewed appeared to be dominated by protection and placement considerations, with little attention given to establishing whether children had any particular health care or therapeutic needs. While a number of the children we reviewed in 2002 had some form of health care and/or developmental assessment, very few received comprehensive multi-disciplinary assessment after entering care.

In 2002, child protection case workers told us that health care issues would be picked up by out-of-home care caseworkers once care matters were finalised. We found that, in practice, this did not generally occur.

This was of concern given that children entering out-of-home care have a high prevalence of developmental delay and health problems. Children often have undiagnosed hearing, vision and oral health issues, in addition to problems such as speech delay. These problems left untreated can impact on a child's school readiness, behaviour and learning.

Given our observations, we recommended that DoCS ensure that all children entering out-of-home care have a paediatric, dental and developmental assessment prior to finalisation of care proceedings. Through adopting these procedures, the department could be sure that children's health care and therapeutic needs are identified and addressed in the case planning process. These assessments would also provide a benchmark for later assessments, and reviews, of a child's progress.

Practice requirements and initiatives

The department's current business rule governing the development of care plans states:

> 'Where possible and appropriate all children who enter into the parental responsibility of the Minister, or have aspects of parental responsibility to the Minister, should undergo a thorough paediatric, dental and developmental assessment as soon as possible after the order has been made. This should be included in the case plan that is presented to the Children's Court as part of the care plan.'

This rule is consistent with recommendations made recently by the Royal Australasian College of Physicians in relation to children in out-of-home care. That body recommended all children who enter out-of-home care should receive physical, developmental and mental health assessments; their needs should be monitored; and they should have timely access to therapeutic services.[4]

The Australasian Paediatric Dentistry Board recommends oral health checks for all children at 12 months of age.[5] The implications of poor oral health in young children

[4] *Health of children in "out-of-home" care*: RACP 2006
[5] Australasian Academy of Paediatric Dentistry, 2000 Standards of Care policy document

can be serious and far-reaching,[6] affecting sleeping and eating patterns as well as behaviour.[7] Research indicates a link between poor oral health in children and delayed growth and development.[8] Poor oral health has also been linked to the development of a number of chronic diseases such as diabetes and coronary heart disease.[9]

A paediatric dentist we consulted recommended dental checks for all children entering out-of-home care, noting that childhood tooth decay is a common problem for all children and will almost always be present in children who have been subject to abuse or neglect.[10] [11] While the commencement of good oral hygiene under the supervision of a carer is helpful, this will not be sufficient to resolve existing tooth decay.[12]

In response to our draft report, DoCS told us that the department is developing a training session to familiarise caseworkers with the new contents of the 'blue book'. The department advised that it is also committed to promoting the effective implementation of 'My First Health Record' by staff working with families. According to the department, the screening process outlined in My First Health Record will facilitate early identification of health and developmental concerns.

The department advised that it has developed a proposal for the assessment of the health, dental, dental, developmental and social/behavioural adjustment difficulties for all children and young people who enter care and remain in care for at least 60 days. This is part of the out-of-home care expression of interest, the assessment of which will be finalised in December 2007. Where the expression of interest does not result in adequate access to services, service delivery will be negotiated directly with NSW Health.

The department also noted that specialist clinics for the health assessment of children and young people in out of home care have been established in partnership with NSW Health. Sites include the Sydney Children's Hospital and the Westmead Children's Hospital. The department told us that its Wraparound Service Policy acknowledges that when health services and services from the Department of Ageing, Disability and Home Care are not available in a reasonable timeframe, departmental staff should consider the option of purchasing the service on a fee-for-service basis.

What we found - 2007

- For 17 of the 49 children, their case plans provided for a paediatric assessment.
- For three of the 49 children, their case plans provided for a dental assessment.

[6] Hallett and O'Rourke (2005) "Caries experience in preschool children referred for specialist dental care in hospital" in *Australian Dental Journal* v.51, no.2, 2006
[7] Interview with Dr Juliette Scott, 24 August 2007
[8] Spencer, "Dental Care: Federal Government Funding Still Deficient" in, *Nursing Australia* v.6, no.1 Autumn 2005
[9] Dr Lee, "Access to dental services in rural and remote communities" in *Developing Practice* v.18, Autumn 2007
[10] Dr Juliette Scott
[11] Hallett and O'Rourke (2002) "Social and behavioural determinants of early childhood caries" in *Australian Dental Journal* v.48, no.1, 2003
[12] Ibid

- For eight of the 49 children, their case plans provided for a developmental assessment.

- Some of the children received paediatric, dental or developmental assessment, even though this was not specified in their case plans. At the time of our reviews, 30 of the 49 children (61%) had received a paediatric assessment. Eleven children (22%) had had a dental check and 23 (47%) had undergone a developmental assessment. While most of the developmental and paediatric assessments occurred prior to finalisation of the children's care matters, the dental assessments usually occurred once care orders were finalised and were generally initiated by carers.

- Of the 23 children who had a developmental assessment, 18 were identified as having a developmental delay. Fourteen had delayed language development, eight had attachment disorders, seven had behavioural problems, four had delayed physical development and three had delayed intellectual development. We found that many carers and caseworkers had difficulty accessing speech pathology services.

- Children who entered care as a result of maternal substance abuse during pregnancy or who entered care as a result of physical abuse, were more likely to receive a health and developmental assessment and ongoing review by health and allied professionals than those children who had histories of neglect and who had been placed long term with relatives (see below). The department obtained the health records for 26 of the 49 children.

- There appeared to be some correlation between the type of order the child received and the adequacy of health and developmental assessments and reviews. Eleven of the 13 children who were the subject of short-term orders or who had been restored, received health care screening and assessment. Most of the case plans for these children incorporated some aspect of health care screening and most of these children had an allocated child protection caseworker. Monitoring by caseworkers of these children's progress, health and development, was generally very good. The following case studies are illustrative.

  A two-year-old was removed from her mother due to concerns that were related to neglect, lack of parenting capacity, and physical abuse. The child was born at 36 weeks, required resuscitation at birth, and remained in hospital for two months following birth. The department obtained relevant medical records and these are on the child's file. An assessment by the Children's Court Clinic found the child to be moderately developmentally delayed. While the matter was before the Children's Court, the child protection caseworker made arrangements for the child to be medically assessed, and also arranged for speech pathology, physiotherapy and occupational therapy assessment. While in foster care, the department ensured that the child received the recommended therapeutic interventions. The child was restored to her mother's care with intensive family and therapeutic supports in place.

  In a separate matter, reports of domestic violence, parental substance abuse, failure to respond to medical needs, failure to thrive and poor parental engagement with support services, resulted in care proceedings being initiated for two children. While the children's matter was before the Children's Court, their child protection caseworker ensured that both children received comprehensive paediatric and developmental

> assessments, including speech, vision and hearing assessments. The paediatric assessment identified the need for both children to have their tonsils and adenoids removed and for grommets to be inserted. The department paid for these operations. While in foster care, the children benefited from ongoing speech therapy, attendance at pre-school and regular paediatric review. The caseplan is for these services to continue when the children are restored to their mother's care.

- In contrast, children placed long term in relative care, were less likely to have their progress, health and development closely monitored. Files for these children generally contained very little information on children's progress, health and development. This was the case for the seven Aboriginal children we reviewed who were placed long term with relatives. By way of example:

> The child we reviewed was placed with his grandmother who already had the care of three of his four older siblings. Despite child protection concerns regarding his mother's heavy drinking during pregnancy, we found very little information on the child's file regarding his health or developmental progress. The case plan for the child made no reference to health or developmental assessment. At the time of our review, the child's file had been unallocated since transfer from another CSC.

- Our reviews also established that children from non Aboriginal backgrounds placed in the long term care of relatives also experienced inadequate monitoring of their health and developmental needs and progress generally. The following case study is illustrative.

> The child and his twin siblings were placed in the long-term care of an older sibling. Child protection histories for all three children included exposure to domestic violence, neglect and parental alcohol abuse. The need for a paediatric assessment was an aspect of the children's case plan presented to the Children's Court. This was particularly significant for the youngest child, who was born with features in keeping with foetal alcohol syndrome. Departmental records indicated that, at the time the children's matter was before the Children's Court, the department had concerns that relevant medical follow up had not occurred for this child. However, despite a paediatric review being part of the case plan, our review found very little information on the children's files about their health or development. There was no information to indicate whether the youngest child had special needs or whether he would benefit from early intervention. Our review established that six months after the children's matter was finalised in the Children's Court, the department decided that a paediatric review was no longer required. The reason for the change in case plan was not recorded. Our review established that two and half years after entering care, none of the children had received paediatric or developmental assessments.

- We found that it was often difficult to determine whether children had received appropriate health and therapeutic assessments - or whether recommendations arising from these assessments had been implemented – by reviewing a child's departmental file. There appears to be no consistent understanding of what documentation departmental caseworkers should obtain in relation to children's health and development. Some caseworkers also reported that they do not always have the time to peruse children's files in any detail. With information about children's health and development filed chronologically, there is a risk that relevant matters will be overlooked.

- Eighty two per cent of carers told us that the department provided them with relevant health care records (blue book, immunisation record, Medicare card) for the children placed in their care. However, a failure to provide these documents in a timely way, without reasonable explanation for the delay, was a reason for complaint and frustration for some carers.

- Some children were in short term foster placements while their matters were before the Children's Court, and were then transitioned to long-term placements. When this occurred, carers told us that it was particularly helpful to meet up and talk with the previous carer about the child.

7.2.3 Case management

Our work in 2002

In our previous report, we identified problems with the transfer of cases following the issuing of final orders, including delays in transferring cases and inadequate consultation. Often when a child's file was transferred from the child protection to the out-of-home care team – or was transferred between CSCs – handover meetings between casework managers did not occur, and when they did, carers and other stakeholders were frequently excluded from the process.

We also identified problems with case planning and review following final orders being made. Often children's circumstances were not reviewed and their case plans were not amended to reflect their changed circumstances. These were critical issues when restoration was the case plan goal.

Practice requirements and developments

Over the past four years DoCS has put in place a set of comprehensive practice guidelines addressing the department's requirements in relation to case planning, placement reviews for children and young people in out-of-home care, and the transfer of case management responsibility between teams and Community Services Centres.

In summary:

- case plans for children in out-of-home care should be documented, approved and reviewed;

- where the review process indicates that the case plan goal or objectives are not being met and other interventions are required, a new case plan should be developed;

- where an order allocating parental responsibility is made, the child or young person's case plan must reflect set review dates in accordance with s150 of the *Children and Young Person's Care and Protection Act 1998;*

- the transfer of case management responsibility between CSCs should involve both CSCs, the child or young person, their family and where

appropriate, agencies that are providing services and support as part of the case plan.

The guidelines do not specifically address the transfer of case management responsibility from child protection to out-of-home care teams within a CSC. Nor do the guidelines specify timeframes for the transfer of case management responsibility.

In response to the draft report, DoCS told us that its Business Help Procedures for placement reviews have been updated and these will be released in conjunction with relevant training. According to the advice provided, the revised procedures *'streamline the process for placement review'*.

What we found – 2007

- At the time of our reviews, for 35 of the 49 children (71%) an out-of-home care team had case management responsibility. For 12 of the 35 children (34%), the time taken to transfer the files from the child protection to the out-of-home care team was six months or longer.

- For the 18 children placed in long term foster care, 12 of the 18 children were not allocated a caseworker when their care matters were finalised and/or the file moved from the child protection team to an out-of-home care team.

- For 13 of the 18 children, handover meetings occurred, involving carers, and in some instances parents.

- For the 18 children placed long term with relatives, 14 of the 18 children were not allocated a caseworker when their care matters were finalised and/or the file moved from the child protection team to an out-of-home care team.

- For 10 of these 18 children, handover meetings occurred. Generally, these meetings involved carers.

- Twelve of the 13 children who were either restored or the subject of a short-term order, had an allocated caseworker following the finalisation of care orders. Generally, these children received active case management.

- Those children who were either restored or the subject of a short-term order, were more likely to receive home visits in the first six months following finalisation of care orders, than those children in long term foster care. Children placed with relatives were the least likely to be visited. In relation to the 49 children:

    - 15 were not visited by a caseworker in the six months after final orders were issued;
    - 14 received 1visit;
    - 2 received 2 visits;
    - 3 received 3 visits;
    - 2 received 4 visits;
    - 8 received 6 visits;
    - 3 received 8 visits;

  - 1 received 12 visits; and
  - 1 received 14 visits.

- At the time of our reviews, 14 of the 49 children did not have an allocated caseworker and their cases had been unallocated for an average of 12 months.

- Of the 35 children with an allocated caseworker, 11 did not have an allocated caseworker for a period of time following the finalisation of their court orders.

- Three of the four children case managed by a funded agency also had an allocated DoCS caseworker.

- Following finalisation of care matters, case management responsibility for 29 of the 49 children should have been transferred to another CSC. The transfer of case management responsibility did not occur in accordance with the department's business rules for 15 children (31%). Some of these matters remained with the child protection team for extended periods before being transferred to the out-of-home care team. At the time of our review, six matters that should have been transferred to another CSC had not been transferred. The following case study is illustrative.

  > One of the children we reviewed was born premature and drug dependent. The department removed this child from her parents' care when she was seven-months old, following a serious domestic violence incident. The Children's Court made long-term care orders in January 2006, and the child was placed in foster care interstate. The child's file was then transferred from the child protection team to the out-of-home care team. In March 2006, the carer requested that the file be transferred to her state. At the time of our review, this had not occurred. The carer told us that she has found the department to be unresponsive to her requests for support and assistance. She said that she had received insufficient information about the child's background and health at the time of the placement, and had been concerned about the delay in receiving documentation including the child's birth certificate. Our review established that in a 14-month period there had been no review of the case plan and the child's placement had not been reviewed. The allocated caseworker told us that the case had not been transferred interstate because of the existence of complex contact orders; however, our review of the file established that neither parent had had contact with the child since July 2005.

- For 21 of the 49 children, placement reviews occurred in accordance with s150 of the *Children and Young Persons (Care and Protection) Act 1998.* Placement reviews were less likely to occur for children placed with relatives. For some children, this meant that problems with their placements were not identified in a timely way. The following case study is illustrative.

  > The Children's Court made final orders for the child in October 2005. The child was placed with her grandfather. The child's caseplan provided for supervised contact between the child and her mother. The child's file was transferred from the child protection to the out-of-home care team, and the grandfather participated in the handover meeting. The child's file was allocated to a caseworker, and the caseworker conducted a home visit in March 2006. At the time of our review no further home visits had taken place and the department could not tell us where the child was living or what contact was occurring between the child and her mother. It was only when the

department received a risk of harm report about the child that the department was able to establish that the child was living with her mother.

- We also found that where placement reviews occurred, these did not always adequately consider the child's progress. The following case study is illustrative.

  We reviewed the circumstances of a child for whom the Children's Court had made final orders in January 2006. Our review established that the child's file was transferred from the child protection to the out-of-home care team eight months after final orders were made. We found that placement or case plan reviews had not occurred in the first 12 months of the placement. When the carer requested that a case conference be held to discuss the contact schedule, a case conference was held in September 2006, and this involved all family members. However, despite the opportunity to conduct a review of the case plan at that time, the discussion focused solely on arrangements for contact. Other aspects of the case plan, and the placement more generally, were not discussed.

- At the time of our reviews, 20 of the 49 children had a case plan that had been reviewed in the previous 12 months. Case plans for a number of children did not accurately reflect their circumstances, in particular their contact with their parents and other family members.

7.2.4 Placement support

Our work in 2002

In our previous report, we observed that, once final orders were made, little attention was paid to what children, their carers, or their parents, needed in the early stages of the children's placements. Both relative and foster carers reported that their role as carers would have been made easier had they been provided with ready access to support, relevant information about the child's needs, clearer information about roles and responsibilities and comprehensive information about the child's case plan.

Practice requirements and developments

Since our report in 2002, DoCS has introduced a range of initiatives to support foster carers. The emphasis in many of these new programs is "partnership". The establishment of regional foster care advisory groups,[13] and the regular publication of a quarterly newsletter for foster carers, '*Fostering Our Future,'* provide communication channels between foster carers, caseworkers and the department more broadly.

In 2006, there was an extensive review of the carer payment system. This resulted in a return to payments based on the age of the child, the indexing of allowances to the Consumer Price Index, and the removal of the requirement that carers pay the first $250 per quarter for all medical and allied health services. Significantly, kin carers are now eligible for the same payments as statutory carers. The department has produced and widely distributed a 'fact sheet' on carer allowances and financial support.

[13] This program aims to improve service delivery at a regional level through providing a forum for foster carers to have a say in how the regional or local DoCS foster care program runs and to identify solutions to existing problems.

The importance of providing more than just financial support to foster carers has been recognised through the development of carer support teams and foster care caseworkers. Initiatives to provide culturally appropriate services include the Metro Muslim Foster Care Program and the new role of Vietnamese Carer Support Worker in some regions.

Other agencies also play a very important role in supporting and assisting foster carers. The Association of Children's Welfare Agencies with funding from DoCS has developed a tool to help prospective carers decide if they are suitable for foster care, *Step by Step*, as well as an education resource, *Real Kids, Real Carers*, to provide information and advice to carers around key issues, such as the impact of fostering on carer's families. The Foster Care Association provides support, advice and advocacy to foster carers and has recently extended its service by establishing a new '1800' helpline providing 24-hour support to carers.

The Aboriginal State Wide Foster Carer Support Service (ASFCSS) provides support to Aboriginal carers. In 2005, ASFCSS produced a culturally specific foster care handbook for current and potential foster carers. The department and the Association of Child Welfare Agencies have developed a new training package for potential Aboriginal carers – *Our Carers for Our Kids.*

In response to our draft report, the department advised that it has developed training for carer support teams working with authorised carers. In 2006, the department also endorsed its policy concerning case management and support services for relative and kinship carers. According to the department, this policy identifies the types of assessment and authorisation, training, casework support, monitoring and review which best assist relative and kinship in court Ordered or DoCS initiated placements.

What we found in 2007

- Overall, most carers, including those who did not have an allocated caseworker, reported that they felt well supported by the department. A number, including those without an allocated caseworker, reported that they would not hesitate to contact DoCS if they required assistance. A number of foster carers were very positive about the support they received from foster care support workers. A number of those carers without an allocated caseworker reported no difficulties taking up issues with 'duty' caseworkers.

- Seventy per cent of all carers said that they felt well supported in meeting the identified needs of the children in their care; 80% said that they were well supported in relation to contact, and 75% said that they felt well supported in relation to emerging issues of concern.

Provision of information

- In relation to the department providing important information relating to the placement of the 49 children:

- carers for 37 children said they were well briefed or knew the child's circumstances before accepting the placement;
- carers for 35 children said that they knew what contact to expect with the department following placement;
- carers for 35 children said that they had been provided with the child's caseplan;
- carers for 37 children said that they were provided with relevant information about the child's identified needs;
- carers for 40 children said that they were provided with relevant health care records;
- carers for 40 children said that they were provided with information on the carer's roles and responsibilities; and
- carers for 32 children said that they had been provided with information about local carer support networks.

- Fourteen carers - both relative and foster carers - advised that they had not been provided with a copy of the child's case plan. Generally though, these carers were aware of the child's care plan. In a small number of instances, parents did not cooperate with caseworker's requests for information and this delayed the provision of relevant documents to carers. However, this sort of obstruction accounted for only a small number of the delays:

> At a case conference in November 2005, the carer requested a Medicare card, a birth certificate and relevant documentation in order to support the placement. File notes indicate that the carer had not received these documents by October 2006. The carer told us that she was not provided with some of these documents until early 2007. She also advised that she still did not have a copy of the case plan.

- Just under three-quarters (74%) of the carers reported being invited to participate in case conferences concerning the children in their care.

Carer allowances and financial support

- While most carers reported no problems with receiving the carer allowance and/or financial support, nine carers experienced some form of problem with the carer's allowance, eight had problems with establishment costs, and 10 experienced problems with reimbursement for contingency expenses.

- Many of the problems with the payment of carer allowances appeared at the commencement of the placements and coincided with the new payment systems that were introduced by the department in 2006. In other instances, caseworkers were simply not aware of practice requirements. The following case study is illustrative.

> We reviewed a child who was initially placed in short-term foster care and then with relative carers. Final orders were made in February 2005. The carer allowance was commenced seven months after the child's placement. The placement broke down the following month. A submission for back payment of the carers allowance noted that the caseworker who had carriage of the case was not aware that family members who are allocated parental responsibility by the Children's Court are entitled to receive a standard foster care allowance. The same caseworker also did not understand what was required to stop payments to the child's initial carer. This resulted in an overpayment of $3,000 to the carer who was later required to reimburse the department.

- Generally, if carers did identify payment problems, the department moved quickly to remedy the situation.

- Problems with the payment of financial support occurred in circumstances where the child did not have an allocated caseworker or where case management responsibility was transferred. The following case study is illustrative.

> Six children were placed in the long-term care of their grandmother. In June 2006, a psychological assessment recommended ongoing support to the carer, including the provision of financial assistance with the purchase of a larger car so they could do things as a family. The file records that the then allocated caseworker spoke with her manager in relation to the case, and was advised that assistance could be provided towards a deposit on the car. Our review established that once the allocated caseworker moved to another office, and the children's file was not reallocated, no further action was taken to assist the carer with a deposit for the car.

- In a small number of instances, the provision of financial support appeared to vary significantly. For example, three relatives carers who had the care of three or more siblings, requested financial support to purchase a car. Despite the carers' circumstances being similar, requests were processed and approved for two of the carers - including eventually the carer of the six children referred to above - but not the third.

- Three of the carers with children attending day care, experienced particular problems with the payment of child care fees. One carer new to fostering said that during training she and her husband were given the impression that child care, in certain circumstances, would be paid for as a matter of course. However, she said that in practice, she has been made to feel that financial support for childcare is a privilege.

- Assistance with child care fees was part of the caseplan presented to the Children's Court for another child. Despite this, our review established that this assistance was not provided. For another carer, a communication problem led to problems with the child care fees.

- We also identified instances where grandparents were not provided with clear information about the Federal Government's Grandparent Child Care Benefit.

Support

Even in circumstances where children had an allocated caseworker, often the contact and relationship between the carer and caseworker was minimal. For a number of children, the case was allocated specifically for the purpose of an annual review or because there was a contact order. The following case study is illustrative.

> The original care plan for the two children was restoration and this was supported by a detailed permanency plan. The children were placed with an extended family member and were allocated a caseworker who monitored the family's progress, held regular meetings and liaised regularly with services involved with the family. The department has since applied to the Children's Court to vary the order to long term. The carer told us that, as a family carer, she received little support from the department, other than financial. She did not have a foster care support worker and had little contact with the allocated caseworker. She has not been involved in care planning or case meetings in any way. She also did not receive copies of case plans for the children.

Complaints

Ten carers had made a complaint to DoCS, either to their caseworker or to the department's complaint's unit. While six of the 10 were satisfied with the outcome, four were not. The following is a case study from our reviews, which is illustrative of what we consider to be an appropriate response to the carer's complaint.

> When the children first entered care, they required an urgent placement. The department recognised that the only placement available was culturally inappropriate from the outset. The carers found it difficult to manage the four-year old child's behaviour and requested the department undertake a Care +1 assessment. In the interim, the carer placed the child in pre-school five days a week without consulting the department. The assessment that was undertaken did not support a Care + 1 allowance. The carer lodged a complaint, and requested that the assessment be reviewed. The department arranged for another caseworker to undertake a further Care + 1 assessment, which again did not support payment of Care + 1. The carer terminated the children's placement.

However, the handling of some complaints appeared to us to be less than adequate. The following case study is illustrative.

> The child and her two siblings were placed with their grandmother. The children's grandmother told us that she received limited support when the children were first placed with her. The grandmother told us that she was not adequately informed about her responsibilities and rights after final orders were made, and described a series of difficult experiences when the case management for the children was transferred between CSCs. She told us that she did not believe that she was provided with adequate information regarding planning for the children. She said that the CSC did not give her enough notice prior to contact visits between the children and their mother. The grandmother also raised her concerns about the response she received when she made queries of the department regarding financial entitlements, specifically in relation to the youngest child's preschool fees. She alleged that she was told by the manager casework that she could afford to meet the costs herself, and that if she couldn't manage, DoCS could remove the children and place them elsewhere. The grandmother said that she made a complaint to DoCS' complaints unit and was not satisfied with the response she received. She stated that she was told that she must

> have misunderstood the manager casework, and was advised to raise her concerns directly with him.

Risk of harm reports

- At the time of our review, 26 of the 49 children were placed with foster carers, or had been placed with foster carers prior to restoration. Ten of the 23 carers were new to fostering.

- The other 23 were placed with relatives, or had been placed with relatives prior to restoration. 15 of the 23 were placed with grandparents.

- Three of the 26 children placed in foster care were the subject of risk of harm reports while in foster care. Two of these children were siblings. The report concerning the siblings does not appear to have been assessed in a timely manner. The report for the other child was.

> The four-year-old told staff at his preschool that his carer had slapped him on the face for jumping on the bed and had said that she would kill him if he were not good. This was reported to the DoCS Helpline. A week later the child disclosed that his carer had taped his mouth, and taped his younger brother's hands to stop him touching the TV controls. This was also reported. Five weeks after the child made the initial disclosure, a case review identified that the child's allegations required investigation. Two months after the child's disclosures, caseworkers met with the carer to discuss 'concerns regarding the placement'. The children were moved to another placement eight weeks later. The risk assessment in relation to the allegations was completed five months after the child made the initial disclosure.
>
> In another matter the department - in the absence of a culturally appropriate long-term foster placement - assessed the short-term carer as a suitable long-term carer for the child. Final orders were issued in December 2005, and in February 2006, case management responsibility was transferred to another CSC. The carer was involved in the handover meeting and was advised that the child would not have an allocated caseworker. In November 2006, the department received a report that the child had said that her carer smacked her for being bad. The report was allocated to an out-of-home caseworker and a secondary risk of harm assessment was undertaken. The assessment established the need for carer training and for counselling for the child in relation to past trauma. We found that appropriate services were put in place.

- Six of the 23 children placed in relative care were the subject of risk of harm reports following finalisation of their care orders.

- Risk assessment for two children (not related) established that the children were living with people other than the authorised carer – in one instance this was the mother from whom the child had been removed. There had been minimal casework concerning this child since finalisation of her care orders. The other child and his two siblings had not had an allocated caseworker since the transfer of their file from the child protection to the out-of-home care team.

- Reports for the other four children related to their contact with parents. As a consequence of these reports, contact arrangements for one child were changed,

advice was provided to the carer of two children (siblings) and arrangements were put in place to monitor the fourth child's contact arrangements.

7.2.5 Contact and identity

Our work in 2002

In 2003, we found that, regardless of whether the caseplan goal was restoration or permanent out-of-home care, parents were rarely supported or encouraged to maintain contact with their children once orders were finalised. For those children placed in long-term care, the department had rarely reviewed contact arrangements within six months of the finalisation of care orders.

In all circumstances, the department considered placing siblings together and siblings were more likely to be placed together if they entered care at the same time, had the same fathers, and were of a similar age.

'Life Story Work' helps support the personal identity and development of children and young people in out-of-home care. For the majority of children, Life Story Work - that is, the collation of family and personal history and the sharing of this information with the child - was not a casework priority.

Practice requirements and developments

The principles of the *Children and Young Persons (Care and Protection) Act* 1998, place emphasis on the rights of children placed in out-of-home care to preserve their identity (language, culture and religion) and to have a close relationship with significant people. The Act provides for the Children's Court to make contact orders, which are appropriate for the specific circumstances of each child.

The department has practice requirements for Life Story Work and for maintaining personal records. These were published in March 2004. In 2006, the department updated the *My Life Story Book.* This book assists carers to collate children's family and personal history.

What we found – 2007

- Forty-one of the 49 children had siblings and 33 of the children had some or all of their siblings in care. We found that caseworkers considered the circumstances of siblings when making placement decisions.

- In contrast to our findings in 2002, we found caseworkers paid particular attention to ensuring that children the subject of short-term orders had appropriate contact with their parents.

- Of the 18 children placed long-term in the care of relatives, DoCS supervised parental contact for five children, carers supervised contact in relation to 10 children and the parents of two children had ceased contact. One child's caseplan provided for DoCS to facilitate contact between the child and his parents but this had not occurred.

- Of the 18 children placed long term in foster care, DoCS supervised parental contact for five children. Another child should have been receiving supervised contact but this had not occurred. The parents of nine children had ceased contact. For nine children, contact with siblings in other placements was facilitated and supported by their carers.

- Most of the relative and foster carers we interviewed evidenced a good understanding of the importance of parental contact. Generally, foster carers also had a good understanding of the importance of Life Story Work, and approached this work constructively and sensitively. A small number of the carers, who had children placed with them from different cultural backgrounds, reported struggling with 'cultural planning'. The following case study is illustrative of the Life Story Work our reviews found to be occurring.

  > DoCS assumed the care of the five-month-old child, initiated care proceedings, and placed the child with short-term foster carers authorised by Wesley Dalmar. The care plan presented to the Children's Court provided for the child's placement with his grandmother with a view to his restoration to his parents' care. The child remained in his foster placement for seven months. During the time the child was in foster care, his carer undertook Life Story Work. This included photos, narrative on the child's activities and developmental progress and the immunization record. The original documents were provided to the family when he left the placement.