Review of a group of children aged 10 to 14 in out-of-home care and under the parental responsibility of the Minister for Community Services

30 January 2009

1. INTRODUCTION

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

This report details observations arising from the Ombudsman's review of a group of children, aged 10 to 14, in out-of-home care, conducted in 2008.

2. BACKGROUND TO THE REVIEW

In 2007, this office reported on the findings and observations of our review of a group of children under five in out-of-home care. Separately, we also examined issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them provide quality out-of-home care.

In 2008, we determined to follow up this work by reviewing a group of children who were older when they entered care. Our purpose was to gain some insights into how well the out-of-home care system was responding to their particular needs.

The children we reviewed in 2008 were aged eight years or older when their care orders were finalised by the NSW Children's Court. They were aged between 10 and 14 at the time of our review.

Ten to 14-year-olds fall within a category sometimes referred to as '*middle childhood'*. These particular years span significant developmental stages, taking in the end of childhood and the beginning of adolescence. It is a time of rapid physical and emotional change.[1] Experiences in middle childhood can sustain, magnify or reverse the advantages or disadvantages that children acquire in the preschool years.[2]

Children in middle childhood in out-of-home care are likely to be particularly vulnerable at this time because their experience of the normal challenges of adolescence will most likely be compounded by their care and protection histories.

Research indicates that older children entering care are more likely than their younger counterparts to have been exposed to a higher number of adverse and stressful life events,[3] and to enter care with significant behavioural and emotional

[1] Commission for Children and Young People (2008) Kids Stats Middle Childhood (10 – 14) http://www.kids.nsw.gov.au/kids/kidsstats/agegroups/middlechildhood.cfm
[2] Huston A & Ripke M (2006) *Developmental contexts in middle childhood*, Cambridge University Press, New York
[3] DoCS, Research to Practice Notes, '*Mental Health of Children in Out-Of-Home Care in NSW'*, July 2007

problems.[4] A history of such experiences has, in turn, been associated with a range of health and

social problems - the number of conditions increasing in correlation with the number of adverse experiences.[5]

Older age at entry into care has also been associated with poorer mental health outcomes,[6] and a greater risk of placement instability. The risk is greater when the young person has developmental and/or behavioural problems.[7]

Placement instability has been linked to poor educational outcomes for young people in out-of-home care.[8] Studies have shown that children and young people in out-of-home care perform significantly less well at school than the general population, and that educational performance generally deteriorates after entry to care.[9]

Whilst DoCS' data specific to the 10 to 14-year-old population in out-of-home care is not publicly available, the NSW Department of Community Services' (DoCS) child protection quarterly data indicates that children aged 12 to 15 constitute the second largest group in care. As at 30 June 2007, children aged 12 to 15 years made up 26 per cent of the 12,712 children in out-of-home care in NSW.[10] [11]

The importance of ensuring children in middle childhood are appropriately supported has been recognised by the NSW Parliamentary Joint Standing Committee on Children and Young People. The committee commenced an inquiry into children and young people aged 9-14 in February 2008. The inquiry is considering a number of issues relevant to these children, including the extent to which their needs vary according to age, gender and disadvantage; the activities, services and support required; and the extent to which changing work place practices have affected them. The NSW Children's Guardian has provided the inquiry with a report on its case file audit findings in relation to the needs of children in the age range being considered by the inquiry.

There has been a significant injection of funds to improve the NSW care and protection system over the last five years. This has included an allocation of $613 million to improve out-of-home care programs. Initiatives relevant to children in middle childhood include the development and funding of care models for the provision of support to children and young people with high and complex needs;

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[4] Dr P Delfabbro & Prof. J Barber *'Steps forward for families: research, practice and policy: Proceedings of the 8th Australian Institute of Family Studies Conference / Australian Institute of Family Studies'*: pp.1-8, 2003
[5] CREATE Foundation, *Australian Children and Young People in Care*, Report Card on Health, January 2006
[6] DoCS, Research to Practice Notes, '*Mental Health of Children in Out-Of-Home Care in NSW'*, July 2007
[7] DoCS, Research to Practice Notes, '*Permanency Planning and Placement Stability'*, July 2007
[8] Placement changes have been associated with a range of issues including lack of continuity with the curriculum; strained relationships; and lower high school completion rates.
[9] CREATE Foundation, '*Australian Children and Young People in Care*', Report Card on Education 2006
[10] DoCS Out-Of-Home-Care Quarterly Data, July 2006 – September 2007
[11] Children aged five to 11 years make up the largest percentage of children in out-of-home care.

the development of a casework model to support children and young people with high needs; an expansion of foster care recruitment and training; strategies to improve carer support; and strategies to improve the training, support and supervision of child protection and out-of-home care caseworkers.

Other initiatives include the development of Memoranda of Understanding between DoCS and the Department of Ageing, Disability and Home Care (2003), the Department of Education and Training (2005), the Department of Juvenile Justice (2004) and NSW Health (2006), to ensure children and young people in out-of-home care receive the supports and services they require.

In response to our draft report, DoCS told us of other initiatives the department has implemented to improve placement stability, placement support and case management for children and young people in out-of-home care. These include a *'case mix approach for service delivery and funding'* which allows the department and service provider to agree on the number and type of service categories to be supplied by the service provider; the expansion of existing non government agencies; the establishment of new agencies; and the provision of an increased range of service delivery models including intensive residential placements. Case management initiatives include funding agencies for case management services; and the use of performance based contracts allowing for performance of out-of-home care services to be monitored and reviewed against agreed outputs and outcomes.

The Special Commission of Inquiry into Child Protection Services in NSW has recommended that responsibility for aspects of out-of-home care service delivery, including case management for certain children, should be transferred from DoCS to the non government sector over the next three to five years.

Our decision to review a group of children in middle childhood who are in out-of-home care, took into account the findings and observations of our review of the group of children younger than five, and the particular challenges faced by older children in out-of-home care.

3. METHODOLOGY

The scope of our individual reviews included children who were aged 10 – 14 at the time of our review and in out-of-home care as a result of final orders made by the Children's Court between August 2005 and August 2006, allocating all or aspects of parental responsibility to the Minister for Community Services.

In November 2007, pursuant to section 20 of the *Ombudsman Act 1974*, we examined records held by the Broadmeadow, Woy Woy and Parramatta Children's Courts. A group of 35 children who met our review criteria were identified and selected for review.

On 16 January 2008, we advised DoCS of our decision to review the group of children[12] that we had identified. Pursuant to section 18 of the *Ombudsman Act 1974*, we sought copies of the children's departmental files. Where relevant, we also sought copies of the children's files from non-government agencies responsible for their placements.

Individual reviews were informed by an examination of each child's departmental file, and where relevant, an examination of files held by out-of-home care agencies providing the placement. We held interviews with children's caseworkers and/or casework managers, children's carers, and other relevant service providers. Where appropriate, we also offered young people an opportunity to be involved in the review. Where individual reviews identified matters warranting further action, we sought further information from DoCS and/or other designated agencies, pursuant to s18 of the *Ombudsman Act.*

On completion of the individual reviews, we provided the department and, where relevant, other designated agencies with a report on the results of each review.

Information from the individual reviews was then collated quantitatively and qualitatively, to analyse emerging issues. This was supported by a literature review on the experience of older children in care, and a review of relevant industry standards, including DoCS' policies and procedures.

DoCS was provided with a copy of our draft group review report in November 2008, and responded to this on 18 December 2008.

4. KEY OBSERVATIONS

Our reviews focussed broadly on the following key practice areas: care planning with a particular focus on permanency planning; attention to the individual needs of children with a particular focus on participation, health screening and assessment, identifying and responding to children's educational needs, contact, and identifying and responding to children with high needs; case management; and placement support.

The following observations are based on the results of the 35 reviews. At the outset, it is relevant to note that while the sample of children is small, our findings and observations generally concur with the findings of similar reviews conducted by this office, and are consistent with the relevant literature and the NSW Children's Guardian case file audit findings for children aged between 9 and 14.

At the time of our review, 15 of the 35 children were in foster care, 15 were in the care of relatives, four were in residential care, and one child had been restored. All of the children in foster care were in long term placements. Of the four children placed in a residential setting, three were in individually designed placements, where one-to-one care was provided.

[12] We have defined a 'child' as a person who is under the age of 16 years.

Of those children in relative care, 13 were in long term placements, including three with their fathers. Two children were in short term placements with a view to restoration.

Six of the 15 children in foster care were placed with carers authorised by DoCS. Two children with complex care histories were placed with carers who were not authorised at the time of our review. Seven of the children in foster care were in placements provided by a non-government organisation. Six of these children were in placements that were designated as high needs placements.

In total, 11 placements were provided by a designated non-government organisation. One of these children's placements was funded and monitored by DADHC.

Sixteen Community Service Centres (CSCs) held files for the 35 children we reviewed. The CSCs represented five regional areas; Metro West, Metro Central, Metro South-West, Southern Region and the Hunter and Central Coast region. Over half of the children resided in the Central Coast and Hunter areas at the time of our review.

Care and protection histories

Although the children we reviewed were aged between eight and 13 years at the time their final orders were made, many had care and protection histories extending over their lifetime. Over a third of the children were reported to DoCS before the age of one and most of the remaining children were reported by the age of five.

Just over half the children had previously been placed in out-of-home care – either through temporary/voluntary arrangements, or through court proceedings – prior to the initiation of court proceedings resulting in their current orders.

For many of the children with extensive care and protection histories, the child protection case work goal in their earlier years was to support the family to retain the care of the child. This was attempted through a range of casework intervention strategies, including the provision of family support and restoration following periods of care. However, some of the children we reviewed who were reported early in their lives, initially received limited assessment and/or support.

Significantly, of the nine children identified as having high needs at the time of our review, eight had extensive care and protection histories. The ninth child - who had severe developmental delay and autism - did not have an extensive care and protection history but on the basis of assessment on his entry into care, should have.

For these eight children, the evidence from our reviews demonstrates that the focus on family preservation and reunification has meant that they have experienced high levels of adversity and disadvantage. Now in middle childhood

and receiving extensive support, it is difficult to see how some will move through adolescence without further significant problems. In this regard, it is relevant to note that those children we reviewed who were initially reported to DoCS at age one or younger, were more likely to have additional needs - such as developmental delay, mental health issues or educational issues - in middle childhood than the group as a whole.

A number of the children we reviewed had placements with kin prior to the initiation of court proceedings resulting in their current orders. For 17 children, their most recent final order was the result of an application to the Children's Court to rescind and/or vary their care order. These included six children placed with kin whose placements had broken down. While we did not examine how well these earlier placements were assessed and supported, our review of children currently placed with kin found that these were the children least likely to be visited by a caseworker after their orders were finalised; the least likely to have a current case plan; and the least likely to have their placements reviewed. This raises a question as to whether some of the children now identified as requiring high needs placements, would not have become 'high needs' if their earlier placements had been better assessed and supported.

We also note that some children we reviewed had been in kinship placements which broke down or were terminated by the department over issues that we would have expected to be raised during a placement assessment. This raises a question about the quality of the kinship care assessment in some instances.

In an earlier review of the Children's Court, we have commented on the fact that there is no accurate and reliable statistical data about the nature and outcome of care proceedings.[13] While we acknowledge the sample of children we reviewed is small, an examination of the children's care and protection histories emphasises the importance of both policy makers and researchers, having access to reliable Children's Court data. Without this data, it is difficult to answer important questions such as to what extent applications for rescission orders arise from placement breakdown and what proportion of these are kin/foster care placements.

Care planning and permanency

Consistent with the findings arising from our review of a group of very young children in 2007, the care planning process for the 35 children we reviewed was child centred. As far as practicable, the participation of families in decisions about their child was generally encouraged and supported. Child protection caseworkers sought the views of children and these were taken into account, particularly in relation to contact with their parents and other family members.

Thirty two children had a care plan goal of permanent out-of-home care and three of restoration. Only three of the 35 children had an out-of-home care worker

[13] NSW Ombudsman, *Care proceedings in the Children's Court – a discussion paper*, p1-2, August 2006

participate in the development of their care plan. This was surprising given that for 17 of the children we reviewed, their most recent final order was the result of an application to the Children's Court to rescind and/or vary the child's care order.

Most of the 35 children were in stable placements at the time of our review. Twenty six of the 35 had been in their current placements since finalisation of their care orders and 15 had not experienced a placement change since their most recent entry into care. Siblings were placed together where possible.

However, eight of the 35 had experienced four or more placement changes during their current care episode and three of the eight had experienced seven or more placement changes over the past three years. Six children had been in their current placement for less than 10 months at the time of our review. Most of these children had been in and out of care earlier in their lives. As noted, these children were more likely to have developmental problems than the group as a whole and this contributed in part to either a lack of placement options and/or to their placements breaking down. All these children now receive intensive casework and support.

Permanency planning for the three children with short term orders with a view to restoration was comprehensive, although implementation of the case plan to support the care plans for two of the children (siblings) was disrupted when the case became unallocated for a five-month period.

While carer assessments occurred for all but two children (siblings), some carers were assessed after the children's placements had been finalised. DoCS had some supervisory responsibility for these children.

The Children's Court made section 82 monitoring orders under the *Children and Young Persons (Care and Protection) Act* 1998 for all 35 children. Reports were generally submitted, although in 10 instances the required number of reports was not submitted. For three children, the section 82 report resulted in a review of the existing order.

In response to the findings of our 2007 review of a group of very young children in care, which identified a relatively high number of instances of the department not submitting the required report to the Court, DoCS told us that the department is considering what mechanisms could be introduced to prompt caseworkers that a section 82 report is due. This, or similar action, appears warranted. As we have noted elsewhere,[14] poor compliance with completion of these reports is of concern 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.[15]

[14] NSW Ombudsman, *Group Review Report, Children Under Five*, p 5

[15] Section 150(1) of the *Children and Young Persons (Care and Protection) Act 1998* 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

Participation

Children in out-of-home care, including those in middle childhood, are dependent on caseworkers and carers identifying and ensuring that their individual needs are met. The objective of case management is to ensure individual children's needs are met.

It is recognised that for out-of-home care case management to be effective, children and young people must be involved in the case management process. They must be given the opportunity to voice their interests, needs and wishes, in order to provide them with the support they need.

While the views of the children we reviewed were generally considered at the time of care planning, children in foster care and kinship placements provided by the department were far less likely to have been supported to participate, and to have participated, in the ongoing planning/review of their care.

Thirteen children were supported to participate in planning/review of their care. Three of the 24 children in kinship and departmental foster care - one in a kinship placement and two in foster care placements – were supported to participate compared to seven of the 11 children in NGO foster care or residential care.

Of the 13 children supported to participate in the ongoing planning/review of their care, 10 participated. Three children in NGO foster care or residential care were supported to participate in their planning, but chose not to.

These findings suggest that children and young people, when supported, will generally participate in decisions that affect them. The findings also indicate that children placed with NGOs may be more likely to be given the opportunity to participate.

We appreciate that children's participation does not necessarily mean only attending or being actively involved in their most recent case or placement review. However, while children may have been consulted during home visits or may have discussed their care with workers or carers on a day-to-day basis, this was difficult to quantify, particularly as documentation in children's files was not always comprehensive.

Health screening and assessment

Consistent with our findings regarding very young children entering care, we experienced some difficulties establishing whether children had received appropriate health screening on their entry into care. The majority of the children's departmental files we reviewed did not contain relevant information regarding health screening.

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 also not yet proclaimed.

While a number of the children's departmental files recorded that they had received a paediatric assessment, details such as when the assessment occurred, who conducted it, and the outcome of the assessment were missing from the file. Some files recorded that children had received health screening while in a former placement. However, when these children had a change in placement, the details of those assessments do not appear to have been obtained.

Similar to our findings arising from our review of very young children, children entering care in middle childhood were more likely to receive health and developmental screening if they presented with overt health or behaviour issues.

At the time of our review, the nine children in high needs placements had received appropriate health screening and were receiving appropriate health care. In contrast, children placed with either DoCS' foster carers, or with kin, were less likely to receive comprehensive health screening on their entry into care. It was disappointing to find that even when some form of health screening occurred, this did not guarantee that identified needs were addressed over time. It was also disappointing to find that none of the three children on short term orders with a view to restoration received health screening.

Twenty-two of the 35 children were assessed as requiring counselling, and 21 children received counselling. Not all of the children who received counselling had been assessed as requiring it, and three of the children assessed as requiring counselling did not receive any. Counselling was provided by a range of services. Nine children received counselling from PANOC[16], and 12 received counselling from other services. Six children received counselling from sexual assault services. Children also received counselling from DoCS' psychologists, community mental health teams, and school counsellors.

Consistent with previous observations, we found that it was particularly difficult to track children's health and developmental progress through examining their departmental files. This was particularly so for children placed in kin care and departmental foster care. As with our review of a group of very young children in out-of-home care, a number of caseworkers told us that they do not have time to thoroughly review children's files. In these circumstances, the chronological filing of pertinent health information is problematic. Not surprisingly, caseworkers also frequently demonstrated poor knowledge of children's health histories.

We also found that the files of children placed with departmental carers or kin were often allocated for a specific task, for example the completion of a section 82 report or to review contact arrangements. Some of these caseworkers we spoke with had very limited or no prior contact with the child.

Our 2007 review of very young children in out-of-home care raised similar issues. In response, DoCS told us that it is the department's policy for all children and

[16] Physical Abuse and Neglect of Children (PANOC) services of NSW Health; provide a range of counselling services to families and children where child abuse has been established.

young people entering out-of-home care to undergo a comprehensive health assessment addressing their physical health, developmental and mental health/behavioural needs shortly after they enter care; and that they receive health reviews during their time in care. To help facilitate this, the department is currently negotiating a state-wide out-of-home care health assessment service.

To address the issue of documentation, the department has developed an out-of-home care client checklist which includes a check of immunisation, dental and medical records for the child or young person. The department anticipates that this will be applied as an initial step in the annual placement review.

While this or a similar initiative appears necessary to ensure health records are updated, it is relevant to note that many of the children we reviewed placed with kin or departmental foster carers are not receiving reviews, either in accordance with legislative requirements[17] or the department's casework practice guidelines. We also note that some managers casework told us that while these reviews are now required they do not have the resources to ensure the annual review of all children under DoCS' supervision. For children whose circumstances are not reviewed annually, the client information checklist will be of limited value.

Identifying and responding to children's educational needs

Consistent with research findings, 25 of the 35 children we reviewed had identified educational needs at the time their current care orders were finalised or subsequently. A number of the children had multiple school placements before being placed in care and some had histories of poor school attendance and school suspension. Many of the children were performing below average in relation to literacy and numeracy skills.

It was pleasing to find that some children whose academic performance was below average at the time their care orders were finalised, had since made significant improvements in their academic achievements. These children had benefited from additional support including in-class support, tutoring, and assistance from school counsellors.

Child protection caseworkers and workers from other designated agencies were generally mindful of the impact of placement disruption on children's education and took this into account when making placement decisions.

Most of the children in 'high needs' foster care placements and those in residential placements had identified educational needs and, at the time of our reviews, these needs were being addressed. Two children with extensive care and protection histories, including multiple placement breakdowns, had dropped out of the formal education system and the option of distance education was being explored for both. One child with autism and an intellectual disability remained at

[17] Section 150 of the *Children and Young Persons (Care and Protection) Act 1998*

the same special school after he was placed in care and has since made significant progress.

At the time of our reviews, two of the 10 children placed long term with kin had identified educational needs that had not been met. Five of the eight children in DoCS' foster care had unmet educational needs. The education needs that had not been addressed included assessments to identify learning difficulties, the implementation of behaviour management strategies, and the provision of counselling and tutoring. It is noteworthy that six of the seven children with unmet educational needs did not have an allocated caseworker, some had significant behavioural problems, and their carers told us that they felt poorly supported by the department.

Identifying and responding to children with high needs

A quarter of the children we reviewed (9) were identified by DoCS as having 'high needs' due to their challenging or anti-social behaviours, acute mental health issues or severe disability. These children had complex health, developmental and behavioural needs that required extensive specialist/expert intervention and intensive levels of support.

These children had extensive child protection and out-of-home care histories and had frequently experienced placement instability.

Six of the nine children resided in foster care placements, and three were placed in intensive, one-to-one residential programs. All nine placements were provided by designated non-government agencies.

Some of these children presented with complex issues prior to being placed in care, and had had their needs identified and planned for prior to or shortly after they entered care. Some continued to be monitored by health professionals who had been involved in their care for several years.

The nine children with identified high needs were in placements that were providing high levels of support and co-ordination of therapeutic interventions. All children had a current and comprehensive case plan and these were reviewed regularly. All had a key worker or caseworker with the non government agency providing their placement. Where the department retained case management for these children, they were also allocated a departmental caseworker.

Two children in intensive support placements that provided one to one care had experienced foster care and residential care placement breakdowns.

We note that as part of a DoCS Expression of Interest process in 2007, several non-government organisations have now signed service agreements to provide new models of care, for children with intensive and/or challenging support needs.

Our reviews identified another two children who also appeared to have high needs associated with their physical and mental health issues and behaviour. These two children were placed in kinship care and at the time of our reviews, neither had an allocated caseworker, and their placements had not been reviewed. These children had not received the kind of supports received by those children in designated 'high needs' placements. The children's carers did not feel that they were receiving adequate support from the department.

Contact and identity

Almost all the children we reviewed had care plans that provided for contact with their family. In addition to contact being outlined in care plans and minutes of care orders, 19 children had a section 86 contact order and 22 had a detailed contact plan. These arrangements, in part, reflected the children's older ages when they entered care.

Consistent with our findings regarding very young children entering care, children with contact orders were supported to have contact in accordance with their orders. Contact orders were varied for three children following the filing of section 82 reports.

Contact was not occurring as planned for 13 of the children we reviewed. Children with a current case plan were more likely to have contact occurring as planned than those children who did not have a current case plan.

Contact with family varied according to the type of placement the children were in. All the children in residential and/or high needs placements were having some form of contact with their families. Children in departmental foster care were the least likely to have contact with their parents, while children placed in kinship care were more likely to have contact – both planned and unplanned – than children in foster care.

Case management

DoCS has comprehensive practice guidelines which address the department's requirements in relation to case planning, placement reviews of children and young people in out-of-home care, and the transfer of case management responsibility between CSCs.

Consistent with the findings of previous reviews conducted by this office, the case management service provided by DoCS to the children we reviewed was inconsistent. While children on short term orders and those in high cost placements generally received a comprehensive and professional case management service, those placed long term with either departmental foster carers or with kin, often did not.

The children on short term orders and in high cost placements all had an allocated caseworker – either a DoCS worker or a worker from the agency with

whom they were placed. Four children had both. Generally, the monitoring of these children's circumstances was comprehensive. They had current case plans that identified their needs and the strategies to address these. Their case plans were reviewed and amended as required.

In contrast, most of the children in DoCS' long term foster care did not have an allocated DoCS caseworker and less than half the children in relative care had a caseworker. Most unallocated cases had been unallocated for over a year and three had not had an allocated caseworker for two years.

Since 2001, this office has raised concerns about the transfer of children's files within DoCS. As part of its reform agenda, the department's practice requirements for file transfers and record management have been updated. However, consistent with the findings of our review of very young children in out-of-home care in 2007, compliance by departmental staff with the department's guidelines for case transfer was inadequate for the older children. Following finalisation of care matters, case management responsibility for 16 of the 35 children was transferred to another CSC. For half of these children, the transfer did not accord with the department's practice guidelines. We also identified nine children whose files should have been transferred to another CSC at the conclusion of their care matters but the files had not been transferred. Handover meetings did not comply with practice guidelines for eight of the children.

Placement reviews in accordance with statutory and practice requirements had not occurred for 17 of the 35 children. For a number of the children this meant that issues were not being identified and addressed in a timely way. In this regard, it is significant to note that over half the children had unmet needs at the time of our review, relating to matters such as the children's behaviour, health and education. Sixteen of the 35 children did not have a current case plan.

Even where reviews occurred, they did not always include the children's carers and often did not appear to be informed by the views of the child.

Eleven of the 35 children's placements had not been visited in the first six months after their care orders were finalised. DoCS had case management responsibility for all 11 placements.

At the time of our reviews, DoCS caseworkers told us that they had case management responsibility for 29 of the children and non government designated agencies had case management responsibility for five. Four of these five children were in 'high needs' foster care placements with one agency and the other was placed with Barnardos. For one other child it was unclear which agency bore case management responsibility.

The 11 children placed through non government designated agencies generally received a better case management service - regardless of whether DoCS or the non government designated agency had case management responsibility - than children placed in DoCS' long term foster care or in kin care. Children placed

through non government designated agencies had current case plans and an allocated caseworker. They were encouraged to participate in the review of their circumstances. Consequently, they were less likely to have unmet needs than the children placed through DoCS.

Placement support

Just under half the children we reviewed (16 children) were placed in the care of a relative or parent by DoCS.

Although it was evident that some gains have been made in providing equitable financial and practical support to kinship carers, these carers continue to have a different experience to foster carers in many respects.

Thirty one of the 35 children we reviewed were cared for either by authorised foster carers or kin carers at the time of our review. Kinship carers were less likely to have been visited by a departmental caseworker since final orders were made and were less likely to have been provided with support than foster carers. However, they were as likely, if not more likely, to report being satisfied with the support they receive than foster carers. We also found that kinship carers were as likely to be caring for children with mental health issues and educational problems as foster carers.

More than half the kinship carers did not have a copy of the case plan for the child in their care. Noting this, only five of the 16 children had a current case plan.

Kinship carers were much less likely than foster carers to have information on their responsibilities as carers. Just under one third of the kinship carers had experienced delays with the carer allowance compared to one foster carer. Just over half of the kinship carers had no allocated caseworker involved with the placement of the child in their care.

Of the 15 children placed with foster carers, seven were placed through non government designated agencies and eight with carers authorised by DoCS. Carers supported by non government designated agencies were more likely to have been visited by a caseworker and were more likely to have been involved in case reviews and planning.

Five of the foster carers were new to fostering and the child we reviewed was the first child that they had fostered. Two of these carers were supervised by a non government designated agency and were visited frequently during the first six months of the child's placement. Three were supervised by DoCS and had received minimal support – two received no visits from a departmental caseworker after final orders were made.

Generally, as a group, carers said they were satisfied with the support they received from the primary agency supervising the child in their care. Carers appeared to adapt to the level of support they received. Several carers who had

not been visited, had not taken part in planning, had not been given a copy of the case plan and had experienced delays with payments also said that they were generally satisfied with the support they received.

Noting this, seven carers who cared for nine of the children we reviewed, expressed dissatisfaction with the support they received from the agency with primary case management responsibility for the child or children in their care. One was a foster carer with a non government designated agency, three were DoCS foster carers and three were relatives. Most carers who felt unsupported had children in their care with no current case plan. Four of the carers who expressed dissatisfaction with the support they received had children placed with them with high support needs.

Four carers had made a complaint whilst caring for a child: one was satisfied with the outcome of the complaint.

5. CONCLUSIONS

Our review of a group of middle childhood children in out-of-home care has identified a number of practice areas that, in our view, warrant improvement. Many of these are similar to the areas identified as warranting improvement through our 2007 review of a group of very young children in out-of-home care. For example, compliance with section 82 orders under the *Children and Young Persons (Care and Protection) Act 1998*, the identification of children's health and developmental needs when they enter care, documentation of children's health and development progress over time, compliance with the department's practice requirements around case transfer and completion of placement reviews.

In addition to these issues, the current review has highlighted the importance of permanency planning, no matter what age the child when they enter the out-of-home care system. This review has reinforced the importance of ensuring all placements are properly reviewed and supported, not only those identified as 'high needs'. It is also evident that children in out-of-home care will not benefit if casework practice supports their needs being identified, but does not support those identified needs being met.

In our 2007 group review report, we noted that DoCS was in the process of implementing systems that would allow the department to conduct quality reviews across all CSCs over a four year time span. These reviews, the trial of which remain on hold pending industrial relations negotiations with the NSW Public Service Association,[18] 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. Although not yet operational, DoCS has told this office that the department's Quality Reviews of cases will address the issues identified

[18] Letter to the Deputy Ombudsman from DoCS' Assistant Director, Complaints and Information Exchange, 17 October 2008

by the 2007 group review *'via holistic review of compliance, quality and systems supporting good practice'.* The department has also advised that it will be rolling out Best Practice Standards *'as soon as Public Service Association concerns in relation to quality reviews are resolved'.* In the interim, DoCS has advised that child protection casework specialists are providing support to caseworkers and managers to improve practice.

The Special Commission of Inquiry into Child Protection Services in NSW has recommended that the trial of the quality review tools should proceed immediately and subsequently, each CSC should be audited.

In response to our draft report, DoCS has provided this office with information on a number of strategies it is implementing to build capacity in the out-of-home care system to improve outcomes for children under the parental responsibility of the Minister for Community Services. The department advises that these strategies will be *'reviewed in light of the recommendations of the Special Commission of Inquiry into Child Protection Services in NSW, to assess their appropriateness in the longer term'.* Where relevant, these initiatives are noted in this report.

6. RECOMMENDATIONS

The NSW Ombudsman and the Children's Guardian each have roles and responsibilities in relation to children in out-of-home care. The legislative provisions for these roles and responsibilities ensure that the work of both agencies is complementary rather than duplicative and, accordingly, the recent inquiry into NSW child protection services did not suggest any change to the arrangements.

At a meeting in December 2008, the DoCS' Director General, the NSW Children's Guardian and my office met and agreed to a coordinated monitoring of the issues raised by the Ombudsman and the Children's Guardian in connection to out-of-home care issues.

Against this background, I now recommend that after consultations with the Ombudsman's Office and the Children's Guardian, DoCS establish a system for reporting on practice improvement strategies and outcomes in response to systemic issues identified in this and earlier reports concerning reviews of children and young people in out-of-home care.

Steve Kinmond
Deputy Ombudsman

7. GROUP REVIEW REPORT: CHILDREN IN MIDDLE CHILDHOOD

7.1 Characteristics and circumstances of the children selected for review

Reasons for entry into care

The primary reason for the 35 children entering care related to parental substance abuse (24 or 70%). The children were also frequently the subject of reports regarding domestic violence. Eleven children entered care following reports of physical abuse, and six following reports of sexual abuse. For eight children in the group, parental mental health issues contributed to their entry to care.

Close to half the 35 children we reviewed were reported to have been neglected.

Care orders

Most children were the subject of care orders placing them under the parental responsibility of the Minister until they attain 18 years of age (32). Three children had two year orders with a view to restoration. One of these children had been restored at the time of our review.

Twenty three children were the subject of care orders allocating parental responsibility solely to the Minister. Nine children had aspects of parental responsibility allocated to the Minister and aspects allocated to another person; a further three had parental responsibility shared between the Minister and another person. This person was a kinship carer (parent).

Almost 50 per cent of final orders (17) were the result of a rescission application to the Children's Court. Four children were younger than eight when they entered care and met our criteria for review due to the timing of a rescission order.

All 35 children reviewed received an order for monitoring by the Children's Court. Nineteen orders were accompanied by section 86 contact orders.

Age and Gender

The children we reviewed were aged between eight and 13 years at the time their final orders were made. Twenty nine children were aged between nine and 12 years.

At the time of our review, the children's ages ranged from 10 years and three months to 14 years and 11 months, with the average age being 12 and a half years.

Just over half (18) of the children were female.

Cultural background

Four children were from culturally and linguistically diverse backgrounds.

Four of the children were identified as Aboriginal. For two of these children who were siblings, their mother identified as indigenous, their maternal family did not identify as indigenous and the children did not consider themselves Aboriginal.

Disability and identified health/developmental needs

Three of the 35 children had an intellectual disability ranging from mild to severe. Twelve children had a developmental delay, including four who had delayed language development, four who had attachment disorders and four with general global delays. Sixteen children had experienced learning difficulties.

Sixteen children were identified as having behavioural problems. Of these sixteen, eight had a developmental delay, and eight had mental health issues.

Ten of the children we reviewed had a diagnosed medical condition. These included obesity, epilepsy, and congenital conditions. Fourteen children were identified with dental problems on entering care. A significant number of these were receiving dental treatment at the time of our review.

Nineteen children had experienced mental health problems at some stage. These problems included anxiety, depression and suicidal ideation. Seven children were prescribed psychotropic medication. Most of these children had a diagnosis of ADHD. Three children were prescribed antipsychotic medication.

Placement

At the time of our review, 15 of the 35 children were in foster care, 15 were in the care of relatives, four were in residential care, and one child had been restored.

All of the children in foster care were in long term placements.

Of the four children placed in a residential setting, three were in individually designed placements, where one-to-one care was provided.

Of those children in relative care, 13 were in long term placements. Three of these children had their parental responsibility, or aspects of parental responsibility, allocated to the Minister and were placed by the department with their fathers. Two children were in short term placements with a view to restoration.

Placement provider

Six of the 15 children in foster care were placed with carers authorised by DoCS. Two children with complex care histories were placed with carers who were not authorised at the time of our review. Seven of the children in foster care were in placements provided by a non-government organisation. Six of these children were in placements that were designated as high needs placements.

In total, 10 placements were provided by a non-government organisation, six of these provided by Life Without Barriers. One child was placed through a non-government organisation and this child's placement was funded and monitored by DADHC.

Of the four indigenous children reviewed, three were in kinship placements; one with an aunt who also identified as indigenous. The fourth was placed with a non-indigenous foster carer.

Siblings in care

Thirty-two of the 35 children had siblings. Of the 32 children with siblings, 25 had either all or some of their siblings in care. Twenty-one were placed with one or more of their siblings.

7.2 Emerging themes: what the reviews found

7.2.1 The children's care and protection histories

Although the children we reviewed were aged between eight and 13 years at the time their final orders were made, some had care and protection histories extending over a decade.

As a consequence, a number of the children were the subject of case management practices which are no longer endorsed by DoCS. For example, the use of 'informal undertakings' - whereby parents would undertake to a child protection caseworker to complete certain tasks or actions - is no longer departmental policy. Such undertakings have been replaced by Parental Responsibility Contracts which, while still voluntary, are binding. Temporary care agreements are now time limited and outcome focussed. All children entering care are now required to have a permanency plan.

Child protection histories

- Most of the children we reviewed had extensive child protection histories commencing when they were very young. Thirteen of the children were reported to DoCS before the age of one. A further 16 were reported by the age of five.

- Prior to the initiation of court proceedings resulting in their current orders, 10 children had been the subject of between 25 and 45 risk of harm reports, 19 had been the subject of between five and 15 reports; and four the subject of four or fewer reports. We could not establish the number of reports for two of the children.

- Four of the children spent some of their childhood interstate or overseas. Departmental files contained limited information on these children's child protection experiences while not in NSW, including in one instance where the child was known to have spent time in out-of-home care.

- Thirteen of the children and their families had involvement with a non-government family support or parenting support service prior to coming into care.

- Those children initially reported to DoCS at age one or younger were more likely to have additional needs in middle childhood than the group as a whole:

    - 50% had developmental delays compared to 34% of the group as a whole.

    - 79% had mental health issues compared to 46% of the group as a whole.

    - 93% had educational issues compared to 71% of the group as a whole.

Previous experiences of out-of-home care

- Seventeen children had previously been placed in out-of-home care - either through temporary/voluntary agreements, or through court proceedings - prior to the initiation of court proceedings resulting in their current orders.

- Many of these children and their families had been provided with supports during periods of restoration, or generally at the time of child protection concerns and out-of-home care placement. Four had engaged with a non-government service specifically during a restoration process.

- There was evidence that some orders and agreements were allowed to expire or continue without support or supervision from the department.

- Children placed in high needs foster or residential care at the time of our review tended to have had a number of previous out-of-home care experiences.

Temporary Care Agreements

- Eleven children had been the subject of temporary or voluntary care agreements prior to DoCS initiating the care proceedings resulting in their current orders.

- These 11 children had been the subject of between one and seven separate temporary care arrangements. These had lasted between two days and seven months. The earliest of these placements was in 1995, when the child was aged less than one.

  One child we reviewed had been placed in care on nine separate occasions before long term care orders were issued when the child was aged 10. Seven of these occasions were pursuant to temporary care agreements. The child was first placed in temporary care prior to turning one after his mother was admitted to a psychiatric facility. Over the following 12 months he had three further placements in temporary care as a consequence of his mother's mental health issues. At the age of five he spent seven months in temporary care and had further periods in temporary care at the age of eight. At the time of our review the child was in a high needs foster care placement.

- Four children were placed in temporary care as a consequence of their mother's mental health; for example, following an involuntary hospital admission. Three were provided with temporary/voluntary care as a consequence of their parent/s' drug and alcohol use.

Court Orders

- Twelve[19] of the 35 children had been the subject of previous Children's Court care orders, including one child who had been the subject of three separate finalised orders. This child was initially placed in out-of-home care at the age of one and a half.

- Five of the 12 children were previously placed with relatives and eight were placed with foster carers.

- For three of the children reviewed, the Children's Court made a determination that was not in line with DoCS' recommendations. These three placements ultimately broke down. The following case is illustrative.

  The child was initially placed in short term care following the physical abuse of one of her sisters. While the sister was placed in long term care, the child we reviewed was restored to her mother's care where she remained for a further two years. Following an incident where the child was physically abused by her mother, DoCS initiated care proceedings and the child was placed in foster care. The Children's Court awarded custody of the child to her grandmother. This decision was not consistent with the department's proposed care plan which was for the

[19] This is the number of children who have had separate episodes of out-of-home care placement through Children's Court proceedings.

child to remain in foster care with one of her siblings. The grandmother relinquished the child's care after five years. At the time of our review, the child was in an intensive needs foster placement having experienced three subsequent placement breakdowns due to her behaviour and emotional demeanour.

Rescission Orders

- For 17 of the children we reviewed, their most recent final order was the result of an application to the Children's Court to rescind and/or vary the child's care order. This included eight children who had previously been placed in out-of-home care through Children's Court orders. It also included five children who had initially been the subject of short term orders with a view to restoration, which were then changed to long term orders until the age of 18.

- Ten of these applications did not change aspects of parental responsibility but rather made changes to certain aspects of the child's care, such as contact. For example, one child's order was varied after the child's mother appealed the decision in the District Court. Although the parental responsibility to the Minister was upheld, changes were made to increase the child's contact with his mother. There were four instances where parental responsibility for contact was allocated to the Minister, due to difficulties the carers experienced engaging with the birth family of the child in their care.

- Seven of the rescission applications resulted in a change to allocation of parental responsibility or custody of the child. Four of these occurred five years after the previous order had been made. One occurred a year later, and the remaining two occurred less than one year after the previous order had been made.

- For one child, the rescission application was the result of the death of her grandmother, who had sole parental responsibility for her. Parental responsibility for this child was subsequently allocated to her uncle with the exception of contact, which was allocated to the Minister.

- The six remaining changes to custody or parental responsibility arrangements all involved ongoing child protection concerns for the child in care. For three children the department initiated care proceedings and terminated the placement due to these concerns. Three of the changes to custody or parental responsibility were due to the carer relinquishing the child's care.

7.2.2 Out-of-home care planning – permanency

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' casework practice guidelines provide clear direction regarding the department's care plan and case planning requirements, and authorisation of carers. DoCS' guidelines 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 their removal from the care of their parents, the department's guidelines 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'*.

Since 2006, DoCS has rolled out a number of strategies to improve permanency planning for children entering care, including the option of adoption for younger children. The strategies include the release of permanency planning good practice guidelines (May 2007) and associated training. In response to our draft report, the department told us that its Permanency Planning Project – which currently aims to improve casework practice in assessment, decision-making and planning for children under two entering out-of-home care – '*will be rolled out to all CSCs across the state by the end of 2009'.* Additionally, the project *'will be enhanced over time to include Aboriginal children and young people, and to increase the age parameters'.*

Section 82(1) of the *Children and Young Persons (Care and Protection) Act* 1998, provides for the Children's Court to monitor progress in relation to the implementation of a child's care and permanency.

Section 82 (2) of the *Children and Young Persons (Care and Protection) Act* 1998 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…'*

What we found

Care planning

- Similar to the findings of our review of a group of very young children, 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.

- As noted, for 17 of the 35 children, their current care order was the result of a rescission and/or variation of a previous order.

- Most of the children's views were obtained during the initial care planning stage. Children's views were particularly taken into account in relation to contact with their parents and other family members.

- All the children reviewed who required a case plan, had one in place at the time their orders were finalised. 32 children had a care plan goal of permanent out-of-home care and three had a care plan goal of restoration.

- In the main, care planning was undertaken by DoCS child protection staff. Only three of the 35 children had an out-of-home care case worker participate in the development of their care plan.

- For two children (siblings), a carer assessment in accordance with departmental practice requirements had not occurred. These children were initially placed by their parents informally with family friends. Care proceedings were not initiated by DoCS until some years later.

- Pursuant to section 82(1) of the *Children and Young Persons (Care and Protection Act) 1998*, the Children's Court made section 82 orders for all of the 35 children reviewed. Reports were submitted by DoCS for 31 children. Of the four that were not submitted, one was not completed, two were not yet due, and there was one instance where the Court determined that the section 82 report was no longer required. There were 10 instances where the required number of reports was not submitted. In most of these instances the first required report was submitted but not the second report.

- For eight of the children we reviewed, their file was allocated for the specific purpose of completing a section 82 report.

- For three children, the section 82 report resulted in a review of the existing orders. For these three children, the review resulted in a variation to the contact orders. For two siblings, contact requirements were removed from the order so that they no longer needed to attend contact with their mother against their wishes. For the third child, contact arrangements were amended to increase contact between the child and his mother.

Permanency

- Most of the 35 children were in stable placements at the time of our review. Twenty six of the 35 had been in their current placement since finalisation of their care orders and ten of these had not experienced a placement change during this 'care episode'. Twenty one of the 35 had been in their current placement for over two years.

- Adoption has not been considered a permanency option for any of the children we reviewed although recent case conference meeting minutes for one of the children record a departmental manager casework advising a foster carer that *'Under new legislation you could go to court and basically have all parental responsibility and adopt her (the child under review)'.*

  This child is now 11, has been in care for two years, and has fortnightly supervised contact with her mother. It was unclear from the case conference

meeting records and the child's departmental file on what basis the department considered adoption would meet this child's assessed needs.

- Eight of the 35 children had four or more placement changes during their current care episode. Three of the eight children had experienced seven or more placement changes over the past three years.

- Six children had been in their current placement for less than ten months at the time of our review. Most of these children had extensive and complex care and protection histories and had experienced mental health and educational problems.

Short term orders with a view to restoration

- Three of the children were the subject of two year orders with a view to restoration. Two of these children were siblings. All three were placed with relative carers.

- Supervision of the three children has remained with departmental child protection teams.

- The case plans to support the care plan goal of restoration were comprehensive for the three children. They detailed the actions required by the children's parents to address issues of concern; the minimum outcomes to be achieved for restoration to occur; the contact arrangements; and the children's issues to be addressed.

- At the time of our review, one of the three children had been restored. Our review identified that restoration had been achieved through a combination of comprehensive casework, intensive service provision and significant commitment and motivation by the child's mother.

  DoCS received risk of harm reports over a period of seven years for the child and her siblings. These raised concerns about domestic violence, the parents' drug and alcohol use, the mother's mental health and the care of the children generally. The department initiated care proceedings and the children were placed with an aunt. A two-year order was made allocating parental responsibility to the Minister, with a view to restoration. Over an 18 month period a departmental caseworker worked with the mother to obtain housing, parenting assessment and support, and community mental health services. Contact between the children and their mother was supported. A departmental caseworker has maintained a monitoring and support role following the child's restoration.

- The other two children are yet to be restored. These children did not have an allocated caseworker for a five month period during 2007. Our review identified that this delayed the implementation of the children's case plan in relation to placement support; obtaining educational support for one of the children; and formalising the plan for their restoration.

Long term placement in relative care

- Ten children with long term care orders were placed with relatives. Seven were placed with an aunt/uncle, three with a grandmother and one with a cousin.

- Eight of the 10 children placed in the long term care of relatives were placed with one or more siblings.

Long term placement in foster care

- Fifteen children were placed with foster carers. Eight of the 15 were placed with DoCS' foster carers, and seven with non government agencies. Six of these placements were designated as 'high needs'. For six of the seven children placed through non-government agencies in foster care placements, there was evidence that their placement had been matched to their needs or circumstances.

Children placed with parents

- At the time of our review four of the 35 children were living with their parents. One of these children was the subject of a short term care order and had been restored. The other three had been placed with their parent by DoCS. One of these children remained with his father despite a magistrate describing the father as an unsuitable carer.

> On removal from his mother's care, the child was placed with grandparents while three of his siblings were placed in departmental foster care. The child absconded from his grandparents and also repeatedly from foster placements. He self placed with his mother and sometimes his father. The department ultimately placed the child with his father, pending finalisation of court proceedings. A Children's Court clinician stated any placement of the children with their father should be *a 'graduated and monitored process'.* During court proceedings the Magistrate noted that neither parent was a suitable carer for any of the children. The case plan stated that the child was to be placed in kinship care, but did not identify the carer. The child remained with his father. In a section 82 report to the Court, the department stated that *'placing the child in departmental care was assessed as placing him at risk of harm due to his absconding from placements'.*

Residential care/individually designed placements

- Four children were placed in residential care placements. One child was placed in a funded residential unit with four other children and young people. The other three were placed in individually designed and funded placements where one to one care was provided. All three had challenging behaviours and complex needs. The following case is illustrative.

> The child has a history of extreme challenging behaviours including self-harm, suicide attempts, multiple assaults, serious damage to property, and numerous

periods in detention. He had been variously diagnosed with ADHD, post traumatic stress disorder, suicidal and homicidal ideation, conduct disorder, and reactive attachment disorder. He has been scheduled under the Mental Health Act on numerous occasions, and has been prescribed a range of medications from the age of three, including antipsychotics, antidepressants, and anticonvulsants. He has a history of multiple placements, placement breakdowns, and at times remained in detention due to the lack of viable placement options. The child is currently in a specifically designed one on one placement where he receives support from two staff during the day and one at night. His staff receive regular supervision and training in relation to his behaviour. The child is on antipsychotic medication, and attends regular appointments with a psychologist and a psychiatrist.

- At the time of our review, one child was placed in one-to-one care as his intellectual disability, autism and related behaviours precluded him being placed in foster care. This child had made significant progress and at the time of our review his case plan provided for his placement with foster carers.

7.2.3 Attention to the individual needs of the child

Children and young people's needs differ depending on their age and developmental stage; family, community and cultural background; personal characteristics; and experiences. Children's needs also change over time as they develop and incorporate new experiences. Middle childhood is a particularly important time in the development of children and young people as individuals. During this time they develop their sense of identity, their independence and social skills, as well as making significant educational transitions.

Children in out-of-home care, including those in the middle years, are dependent on caseworkers and carers identifying and ensuring that their individual needs are met. The objective of case management - which includes a range of processes including assessment, planning, decision making, implementation, monitoring and review – is to ensure individual children's needs are met.

It is well understood that for case management to be effective, children and young people must be involved in the case management process. They must be given the opportunity to voice their interests, needs and wishes, in order to provide them with the support they need.

7.2.3.1 Participation - practice requirements and initiatives

The *Children and Young Person's (Care and Protection) Act 1998* and NSW out-of-home care standards require agencies to ensure that children are assisted to participate in decisions relating to their care. DoCS' casework practice guidelines provide clear direction regarding the department's requirements in relation to the participation of children and young people in decisions that affect them.

Participation – what we found

- Based on our review of the 35 children's departmental files it appeared that most of the children had had informal contact with a child protection caseworker to obtain their views during the initial care planning stage.

- Once care orders were finalised however, only 13 of the 35 children were supported to participate in ongoing planning for their care. Three of the 24 children in kinship and departmental foster care - one in a kinship placement and two in foster care placements – were supported to participate, compared to seven of the 11 children in NGO foster care or residential care.

- Ten of the 13 children supported to participate, actually participated in formal planning processes. Three children placed in NGO 'high needs' residential (2) and foster care (1) placements chose not to participate in planning for their care.

- Eight children had raised concerns about their care with the agency responsible for their case management. Our reviews established that where children raised concerns these were adequately addressed by agencies.

7.2.3.2 Health screening and assessment – practice requirements and initiatives

In relation to health assessments for children and young people entering out-of-home care, DoCS' casework practice guidelines state:

> '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 case plan'.

DoCS' draft caseworker manual (March 2008) states that the physical health assessment should include a complete medical history profile of the child and family, an immunisation register check, a physical examination to check for growth delay and signs of malnutrition, screening for visual and hearing deficits, screening for pathological conditions such as foetal alcohol syndrome, and dental health screening. The developmental assessment should include general cognitive functioning, language and communication, gross and fine motor functioning, and socialisation. For older children it should include screening for basic numeracy and literacy skills. The draft notes that there is a Memorandum of Understanding between DoCS and NSW Heath on prioritising access to health services for children in care.

In response to our group review of children younger than five in out-of-home care (2007), DoCS told us that while its policy is for comprehensive health screening

for all children and young people entering care, *'the consistent provision of timely health and education assessments for children in care remains a critical gap in the OOHC service system, as does the provision of appropriate services to ensure these needs are met…'*[20]

To help address this gap, DoCS told us that in mid 2007, it undertook an Expression of Interest Process (EOI) to identify a provider of health assessment for children in care. *'Negotiations have commenced with [Catholic Health Care], about establishing a State-wide out-of-home care health assessment service. Details about the scope, format and frequency of assessments to be provided through this service have not yet been finalised. It is envisaged that when the service is fully operational it will result in more consistent and equitable access to health assessment and follow up for all children and young people in care, particularly those in remote rural areas'.*[21] We discussed some of the implications relating to this initiative in our 2008 report, *Supporting the Carers of Aboriginal Children*. In response to our draft report, DoCS told us that *'the negotiation of a separate contract for Health Assessments from a NGO provider has been suspended pending the Government's response to the recommendations of the Special Commission of Inquiry'.*

In our group review of children younger than five, we observed that it was often difficult to determine whether children had received appropriate health and developmental assessment - or whether recommendations arising from these assessments had been implemented – by reviewing a child's departmental file. We observed that there appeared to be no consistent understanding of what documentation departmental caseworkers should obtain in relation to children's health and development. In response to this observation, the department told us that *'dependant on industrial negotiations with the Public Service Association, it is intended that an 'OOHC Client Information Checklist will be introduced on new procedures and training on Placement Reviews. The checklist includes a check of immunisation and dental and medical records for the child'.* The training is scheduled for October-December 2008.

More recently, the department has advised that as *'part of the OOHC Reform new procedures have been established to clarify all information requirements at the time of transfer of case management responsibility for a child or young person to a nominated service provider. Health assessment form part of the transfer information'.*

Health screening – what we found

Overall observations and findings

- Similar to our findings in 2007 when we reviewed a cohort of very young children entering care, we experienced some difficulties establishing whether

[20] Letter to the Deputy Ombudsman from DoCS' Assistant Director, Complaints and Information Exchange, 17 October 2008
[21] ibid

the children we reviewed in 2008 had received appropriate health screening on their entry into care. While some of the children's files contained relevant information regarding health screening on entry into care, these were a minority. Only 15 of the 35 children had health assessment records/reports on their departmental file.

- In a number of instances, children's departmental files recorded that they had received a paediatric assessment. However, details including when the assessment occurred, who conducted it, and the assessment outcomes were missing from the file. Some files recorded that children had received a paediatric assessment while in a former placement, for example while placed with relatives. However, when these children had a change in placement the details of those assessments do not appear to have been obtained.

- Similar to the findings from our review of very young children, children entering care in middle years were more likely to receive health/developmental screening if they presented with overt health or behavioural issues. For example, all six children in *'high needs'* or *'high cost'* foster care placements had health/developmental needs identified during the care planning stage and all six received appropriate health screening. Children placed with relatives and/or DoCS foster carers were least likely to have received comprehensive health assessment.

Twenty four of the 35 children had health/developmental needs identified during the care planning process.

Health screening by placement type

Children placed long term in relative care

- Six of the 10 children placed long term in relative care received some form of health screening at the time their matter was before the Children's Court or shortly after their matter was finalised. Health screening on entry into care however did not guarantee that identified needs were addressed over time.

- The four children who did not receive paediatric assessment included one child whose care plan provided for paediatric assessment; however, two years after the finalisation of orders, assessment was yet to occur.

> DoCS' involvement started with the Aboriginal family in late 1997, when the child we reviewed was two months old and reported to be neglected and dehydrated. Over the ensuing seven years, the department received a further 34 reports concerning the child and his four siblings, all of whom were born premature and subsequently identified as having special needs. Reported issues included failure to thrive, domestic violence, physical abuse, neglect and medical neglect, maternal mental health, squalid living conditions and parental drug and alcohol abuse. DoCS' records indicate that the family history included ongoing failures to engage with support services and to acknowledge the health needs of the children and to attend to medical appointments. One of the children had cerebral palsy,

one hydrocephalus, and all had severe speech delays. DoCS initiated care proceedings for the children. These were finalised in May 2006. The case plan goals included ensuring the children receive appropriate medical and developmental assessment. Our review established that the health assessments foreshadowed in the care and case plans had not occurred. A school assessment at the commencement of the 2008 school year found that the child we reviewed had language difficulties, possibly associated with a broader cognitive disability, and that further assessment was required.

- The departmental files for all ten children contained limited information on their health and development.

Children on short term orders with a view to restoration

- None of the three children who had short term orders with a view to restoration received formal paediatric or developmental assessment at the time of their entry into care or subsequently. These three children were placed with relatives, including one already restored to a parent.

Children living with parents

- The file of one of the three children living with a parent[22] records that the child has received ongoing health screening since first being referred for paediatric assessment at the Westmead Children's Hospital in 1997, following a series of injuries. There is no evidence that the other two children received health screening on their entry into care.

Children placed with departmental foster carers

- Three of the eight children placed with departmental foster carers received comprehensive health screening on their entry into care. Three received no health screening and two received psychiatric assessment only.

- Where treatment was provided following assessment, the children appeared to benefit. The following case is illustrative.

The child was first reported to DoCS at the age of seven months after he sustained an injury during a domestic violence incident. The parents separated following this incident. At the age of three, the child was placed in foster care and then with his father. In 2004, reports were made to DoCS regarding severe physical abuse of the child at home. The child's father returned him to his mother's care where he was the subject of further reports alleging physical abuse. The child's mother abandoned him when he was eight at a child and adolescent mental health unit, stating that she could not cope with his behaviour. On admission the child was found to be on a number of medications, including Dexamphetamine for ADHD and Risperidone, an antipsychotic agent occasionally prescribed for severe behavioural disturbances in children. He was diagnosed with a severe attachment disorder.

[22] This number excludes the child who had been restored.

> Since final orders in late 2005, the child has continued to have all aspects of his health regularly reviewed, including six monthly paediatric reviews with respect to his ADHD. His long term placement with a departmental foster carer is settled; he has regular visits with his father and siblings, he is progressing satisfactorily at school, and his behaviour has stabilised.

Children with long term orders placed through non-government agencies in foster care placements

- The seven children with long term orders placed through non-government agencies in foster care placements had received comprehensive health screening either prior to or after finalisation of their current order. This included paediatric assessment, developmental assessment and for four, psychiatric assessment. Six of these seven children were in placements variously described as 'high needs' or 'high cost'.

- These six high needs children all had health records on their files and five had copies of health assessments. As noted earlier, four of the six children with high needs in foster care had mental health issues. These commonly related to their experiences of grief, trauma and abuse, and presented through challenging behaviours including aggression and violence. Two were on psychotropic medications at the time of our review and three continued to see a psychiatrist or psychologist. Appropriate consents were on file. Three of the six experienced ongoing incontinence problems.

Children in residential care

- Health records had been obtained for all four children in residential care and three had copies of health assessments on file. Three of the four had received paediatric assessment prior to entering care.

- Three of the four children in residential care had identified mental health issues. These commonly related to their experiences of trauma, grief and loss, and presented through challenging behaviours, suicidal ideation, aggression and violence and risk taking behaviours such as drug use. One child was diagnosed with attention deficit hyperactivity disorder, conduct disorder and post traumatic stress disorder. Another child was diagnosed with severe reactive attachment disorder. This child had autism and functioned in the severe range of intellectual disability. Both were on psychotropic medications.

- The four children in residential care had their health and development regularly assessed and reviewed.

7.2.3.4 Educational needs – practice requirements and initiatives

Children and young people in out-of-home care are at a significantly higher risk of poor educational achievement, unemployment, homelessness, substance abuse and mental health problems.

A Memorandum of Understanding (MoU) between the NSW Department of Education and Training and DoCS in relation to educational services for children and young people in out-of-home care has the objectives of reducing these risks and ensuring positive educational outcomes, early identification of problems and timely provision of government services to school children who are in out-of-home care. The MoU provides a framework for a coordinated approach by the two departments in responding to the needs of children and young people in out-of-home care who require additional support. This support may include help with changing schools, managing academic requirements, behavioural problems, suspension and learning difficulties.

Educational needs - what we found

- Twenty-five of the 35 children had identified educational needs at the time their current care orders were finalised or subsequently.

- Child protection caseworkers were generally mindful of the impact of placement disruption on children's education and took this into account when making placement decisions.

- Five of the ten children placed long term with relatives had received tutoring since entering care. At the time of our review two of the ten children had identified educational needs which had not been addressed – one of these required speech pathology and the other tutoring.

- The three children on short term orders with a view to restoration to their parents' care all received appropriate educational support.

- Five of the eight children placed in DoCS' long term foster care had identified needs associated with their education. Four of these five children had unmet educational needs at the time of our review:

  Child 1: A DoCS psychologist recommended that the child who had a history of poor school attendance before entering care, be referred for assessment by a school counsellor to determine if he had any specific learning difficulties. This had not occurred.

  Child 2: The child had a history of poor school attendance prior to entering care. At the time of our review the child was suspended from school. He did not have an allocated caseworker or a current case plan. The carers told us they required support with managing the child's behaviour at school.

  Child 3: The section 82 report submitted by DoCS to the Children's Court described the child as academically below average, but receiving no educational support. The carer made a request to the department to have the child enrolled in a local non-government school, so that the child could access additional supports and a more inclusive educational program. The outcome of this request is unclear from

the child's file, although the carer told us the child attends a non-government school. The carer told us that she had initially enrolled the child at a private high school but was unable to afford the fees for the school and the department did not approve payment of the school related costs. In February 2007, the department identified that the child required counselling. At the time of our review, the department told us that the child remained on a waiting list for this counselling.

Child 4: In 2000, a psychologist assessed the child as having a mild intellectual disability. In 2004, she was assessed as functioning within the borderline to low average range of intelligence. The psychologist recommended that she be referred to a learning disorders clinic. This has not occurred. Recent assessment has found that the child has below average literacy and numeracy and requires additional support. The carer was unable to advise us who would provide this support. The department told us that the child's file is currently allocated for the purpose of compiling a section 82 report that was due in mid 2006. The child's file will then be unallocated.

- Six of the seven children in foster care placements supported by non government agencies, had identified educational needs. At the time of our review, these needs were being met. For example, one child was placed in an IM[23] class and was receiving in-class support and had been provided with assistive technology. Three were receiving home tutoring and some assistance in class.

- Three of the four children in residential care settings had significant educational needs while one was achieving above average results. One of the three children with educational difficulties had an intellectual disability. His educational needs were being met appropriately through a special purpose school. The other two children had experienced multiple school changes, had missed significant amounts of school in their early years and later experienced multiple suspensions. These two had disengaged from formal education and distance education was being considered for them. The children's behaviour and lack of engagement - rather than lack of support - appeared to be why neither was involved with any training or education program at the time of our review. Both children had experienced multiple placement breakdowns and had been in their current placements for less than 10 months at the time of our review.

7.2.3.5 Children and young people with complex and/or intensive needs

The Department of Community Services defines children and young people as having 'high needs' if they:

[23] Intellectually moderate

- exhibit challenging and /or risk taking behaviours of such intensity, frequency, and duration that they place themselves or others at serious risk of harm; and/or

- have mental health presentations which impair their ability to participate in an ordinary life and which reduce access to services, activities and experiences; and/or

- have a disability with high level challenging behaviours or complex health issues which are life threatening or require continuous monitoring or intervention. [24]

The department estimates that children with high needs represent approximately 2% of the children in care.[25]

DoCS' casework practice guidelines provide comprehensive guidance to departmental staff on matters that are particularly relevant to high needs children such as case planning, carer support and supervision, financial supports, and the management of critical events in out-of-home care.

In 2003-04, DoCS initiated a casework service for children and young people with high needs known as the Intensive Support Service (ISS). ISS caseworkers provide

intensive/specialist casework services to children with high needs with objectives including the promotion of placement stability and transitioning children and young people to less intensive placements.

We understand that several non-government organisations signed service agreements in 2004 to provide residential placements and specialist foster placements to children with high and complex needs. In mid 2007, the department undertook an Expression of Interest Process (EOI) to identify service providers to undertake intensive service provision with high needs children and young people, including residential service, therapeutic foster care and wrap around services. It is unclear if any services have been engaged to implement the intensive residential treatment program model developed by the department in April 2007.

In the interim, the department has in place header agreement contracts with organisations to fill service gaps and supplement funding arrangements through Individual Client Agreements. The department anticipates that changes to funding arrangements, particularly through the 2007 EOI process, will result in the need for few, if any, header agreement contracts in the future.

[24] Department of Community Services (2006) *Literature Review: Models of service delivery and interventions for children and young people with high needs.*
[25] Department of Community Services (2008), *Submission to the special commission of inquiry into child protection; Out-of-home Care*

Supporting children with high needs - what we found

- Nine of the 35 children we reviewed were identified by DoCS as having high needs and were placed in high needs placements. All nine were placed through non government agencies - six in foster care placements and three in individually designed placements where one to one support was provided by rostered staff. One child was identified as requiring a high needs placement due to the complex needs of her siblings, with whom she was to be placed.

- Eight of the nine children had extensive care and protection histories and had experienced placement breakdowns. Seven of the nine had mental health issues. Two had an intellectual disability.

- All nine children identified by DoCS as having high support needs had a current and comprehensive case plan at the time of our review.

- The three children in residential or individually designed placements had a key worker. The six children in foster care placements were supported by a worker specifically designated as responsible for monitoring the child's progress and planning for their care as well as a worker contracted to provide support to their carer and a clinician to provide psychological support and intervention.

- All nine children identified as having high needs had a caseworker. The three children in residential/individually designed placements were case managed by DoCS – two of these by a DoCS ISS caseworker. Four of the six children with high support needs in foster care had a DoCS caseworker in addition to a caseworker from the non government agency.

- While the children with identified high support needs had a range of complex needs, our reviews established that these children were being appropriately supported.

- By way of contrast, two of the ten children placed long term with a relative appeared to have high support needs and neither had an allocated caseworker at the time of our review. The carers of both these children expressed disappointment with the level of support provided by the department. The following case is illustrative.

  > The child we reviewed is now 13 and has a history of significant medical, emotional and behavioural problems and learning difficulties. Before being placed with his grandmother, his life was characterised by prolonged instability, and prolonged exposure to emotional and physical abuse. His behaviours include encopresis[26], smearing faeces on walls, and hoarding of food. At school his behaviour has included swearing at teachers, aggressive outbursts, and inability to engage in tasks. According to his departmental file, his behaviours have been attributed to a combination of ADHD and trauma/neglect symptoms. The carer,

[26] Incontinence of faeces not due to organic defect or illness.

who lives in rented accommodation, told us that she is not happy with the level of support provided by the department. She said that she is rarely able to have a break from the child as there are few people prepared to care for him. She said that she would like some help, but stated that she has been denied requests for respite by the department. She said that she has not been provided with a copy of the child's case plan, and that she would like a caseworker as the child's father harasses her and the child on a regular basis. She said that the child needs dental treatment and speech therapy but she cannot afford either.

7.2.3.6 Access to counselling/therapy services

- Of the 35 children reviewed, 21 children and/or their families were referred to PANOC, and five of these were referred on more than one occasion. In some instances, referrals were made during child protection interventions, and others were made after final orders were made.

- Of the 21 children/families referred, 11 resulted in provision of a service from PANOC. Of this 11, two received a service prior to entering care, two during restoration, and seven received a service after being placed in long-term care.

- There were 12 occasions where a PANOC service had not been provided at the time of our review. Three children remained on a waiting list, two for more than a year. For two families where more than one referral was made, one referral resulted in provision of a service, whilst another referral was rejected. Referrals were rejected for a range of reasons including the existence of ongoing risk for the child, lack of a stable placement, the absence of final court orders, and two were refused as the children were still residing with a perpetrator of sexual abuse. In three instances, it was not clear why a service had not been provided.

- Twenty-two children were assessed as requiring counselling, and 21 children received counselling. Not all of the children who received counselling had been assessed as requiring it, and three of the children assessed as requiring counselling did not receive any. Counselling was provided by a range of services. Nine children received counselling from PANOC, and 12 received counselling from other services. Six children received counselling from sexual assault services. Children also received counselling from DoCS' psychologists, community mental health teams, and school counsellors. Two children received counselling from both PANOC and another service.

7.2.3.7 Contact and Identity - Practice requirements and developments

Under the *Children and Young Persons (Care and Protection) Act* 1998, children in out-of-home care have a right to preserve their identity and to have a relationship with significant people in their lives.

Designated agencies are required to maintain records documenting the personal development, history and identity of children and young people in out-of-home care.

We understand DoCS is currently in the process of finalising policy to improve the management of contact arrangements between children and young people in out-of-home care and significant others.[27]

In response to our draft report, the department said that *'work is being undertaken to improve support for contact arrangements. A new Contact Guidance Direction has been developed which outlines appropriate contact arrangements for particular stages (e.g. the assessment phase, medium term and long term arrangements, sibling contact arrangements, etc.)'*

Contact and identity – what we found

- Almost all the children we reviewed had care plans that provided for contact with their family. In addition to contact being outlined in care plans and minutes of care orders, 19 children had a section 86 contact order and 22 had a detailed contact plan.

- At the time of our review 22 children were having contact with members of their family. This included supervised and unsupervised contact, email, letters and phone contact.

- Contact was not occurring as planned for 13 of the children we reviewed. This was mostly due to parental circumstances and/or children's wishes.

- Eight children were having more frequent contact than stipulated in their contact plans or orders. For most this was a natural increase due to their wishes and improvements in their parents' circumstances. For some however, this contact was unplanned and identified as impacting negatively on their stability and well being.

- Children with a current case plan were more likely to have contact occurring as planned than those children who did not have a current case plan. The following case is illustrative.

  > The child was first reported to DoCS in 2004, and shortly after DoCS removed the child and her sibling and placed with them an aunt when the sibling was physically assaulted by his father. Their mother had died in 2000. The Court issued long term care orders for the child and her sibling in late 2005. DoCS have shared parental responsibility for the child in relation to contact. The child's file has been unallocated since January 2006. The child's carer has advised the department that both children would benefit from having contact with their father but that this is not occurring.

[27] Department of Community Services (2008), *Submission to the Special Commission of Inquiry into Child Protection; Out of Home Care*

- Children in kinship care and non-government foster care were more likely to have planned contact than children in departmental foster care. Children in kinship care were more likely to have additional, unplanned contact than children in all other placement types.

- All children in residential placements were having contact with their families. Children in high needs foster care were also having contact with their families; three were having contact as planned and one other child was having contact more frequently than planned.

- Only two children in departmental foster care were having contact with their families. Children in departmental foster care were the least likely to have contact with their parents.

- For children in foster care, life story work[28] was more likely to occur for those children in placements supervised by non government designated agencies, than those supervised by DoCS.

7.2.4 Case management

Practice requirements and developments

DoCS has 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 (CSCs). The department's case management policy defines case management as *'the process of assessment, planning, implementation, monitoring and review, which aims to strengthen outcomes for children and young people in care'.*

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;*

[28] Life story work helps support the personal identity and development of children and young people in out-of-home care through the collation of family and personal history and the sharing of this information with the child.

- 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 our group review of children younger than five in out-of-home care, which identified problems with the transfer of cases following the issuing of final orders, DoCS told us that the department is currently reviewing its casework practice procedures 'Transfer of Case Management and the Case Plan'*. 'This review will consider the actions that are required to facilitate case transfer, timeframes for these actions, and transfer between staff within units and between units. Work is underway to define the structures and functions of child protection and out-of-home care workers, which, when endorsed, will result in clear definitions for this work. A further project will occur in 2008/09 to define handover procedures between DoCS teams and review any current inadequacies'.*[29]

Our group review of children younger than five in out-of-home care also identified significant problems with the adequacy of placement reviews. We observed that placement reviews were less likely to occur for children placed with relatives and for some children this meant that problems with their placements were not identified in a timely way. In response to the draft report arising from our review of children younger than five in out-of-home care, DoCS told us in October 2007 that its procedures for placement reviews had been updated and that these would be released in conjunction with relevant training. According to the advice provided, the revised procedures *'streamline the process for placement review'.*

DoCS current practice guidelines on case plan review and placement review both indicate that for children over five who have a case plan in place and are in stable placements, a *"formal placement review is not necessary"* and that a review of the existing case plan is sufficient.

In October 2007 - in response to the our group review report of children younger than five - DoCS told us in relation to the completion of case reviews, that a revised procedure is to be introduced between October and December 2008, on this area of practice. *'A review template has been prepared to assist caseworkers complete the review and record it on KiDS. This includes a procedure to be completed for 'resubmit' or 'unallocated' OOHC cases'.* More recently, the department has told us that *'training for caseworkers in the newly developed Annual Case Review Procedures is scheduled for the April-June quarter of 2009.*

[29] Letter to the Deputy Ombudsman from DoCS' Assistant Director, Complaints and Information Exchange, 17 October 2008

[The new procedures] outline review requirements for all children and young people in OOHC. They identify a range of responses, which depend on the status of the cases (allocated, unallocated, statutory care and supported care)'.

Case management – what we found

Overall observations and findings

- At the time of our reviews, DoCS told us they had case management responsibility for 30 of the children and non government designated agencies had case management responsibility for five of the children. Eleven of the 35 children were placed with non government designated agencies. Children had an allocated caseworker as follows:
    - All children placed in NGO foster care had an allocated caseworker through the agency providing their placement.
    - Four of the seven children in NGO foster care had an allocated DoCS caseworker in addition to an NGO caseworker. For the three who did not, the NGO had case management responsibility.
    - Three of the four children in residential care had an allocated DoCS caseworker, two through ISS. The child without a departmental caseworker received case management through DADHC.
    - Fourteen of the 30 children under DoCS' case management responsibility, had an allocated caseworker at the time of our review.[30]
    - Three of the eight children in DoCS' foster care had an allocated caseworker, while seven of the 16 children in relative care had an allocated caseworker.
    - Most unallocated cases had been unallocated for over a year. Three cases had been unallocated for over two years.
- Following finalisation of care matters, case management responsibility for 16 of the 35 children was transferred to another CSC. For nine of these children, the transfer did not accord with the department's practice guidelines. Handover meetings did not comply with practice guidelines for eight of the children. We also identified eight children whose files should have been transferred to another CSC at the conclusion of their care matters but the files had not been transferred.

[30] CSC staff told us that they did not have case management responsibility for five of the 30 children we reviewed. Only one of these children was placed with Barnardos.

- In ten of the cases, carers were invited to attend the handover meeting between CSCs. In seven instances, the carer attended the meeting.

- Placement reviews in accordance with practice requirements had not occurred for 17 of the 35 children. At the time of our review, 16 of the 35 children did not have a current case plan, developed in the last 12 months. Where the child did have a current case plan, it did not adequately address the children's identified needs in seven cases; for example, there were no timeframes or allocation of actions to be undertaken.

- Our reviews found that seventeen of the 35 children had unmet needs (behavioural, mental/physical health, educational). Some of these had been previously identified and were ongoing and some were identified through the review process. For twelve of the 17 children, the required reviews had not been carried out. Significantly, ten of the 12 carers who felt unsupported, had a child/children in their care for whom the required review had not occurred (see below).

- None of the four indigenous children had had a review completed as required.

- Eleven of the 35 placements had not been visited in the first six months after the children's care orders were finalised. DoCS had case management responsibility for all of these placements.

Case management by placement type and provider

Children placed long term in relative care

- At the time of our review, only two of the 10 children placed long term in relative care had an allocated caseworker. One child had an allocated caseworker because the child's behaviour had deteriorated and the other was allocated for the purpose of case transfer to another CSC.

- As a group, the 10 children placed in the long term care of relatives received inadequate case management. Generally, case plans had not been updated since the children's care orders had been finalised; placement reviews had not occurred in accordance with statutory requirements, and case transfers did not involve the children's carers. For the ten children we reviewed we found:

  Child 1: There had been no case review or placement review since finalisation of the care order in late 2005. At the time of our review, the child's file was held at a regional CSC. This was despite the child and her sibling being placed with relatives in Sydney in 2005.

  Child 2: Final orders were issued in late 2006 and a placement review occurred in November 2007. The results of the review are not on the child's departmental file. The child has lived with his carer on the

Central Coast for over two years. However, at the time of our review the child's file was held by the metropolitan CSC that initiated the care proceedings.

Child 3: Final orders were issued in October 2005. At the time of our review there had not been a placement or case plan review.

Child 4: There has been no case review since orders were finalised for the child in May 2006.

Child 5: Care proceedings for the child and his sister were initiated by a metropolitan CSC in August 2005 at which time the children were placed with relatives in the Newcastle area. The proceedings were finalised in December 2005 and the file was transferred in April 2006. The file has been unallocated since transfer and there has been no placement or case review since that time.

Child 6: The child's placement has been reviewed in accordance with statutory and other practice requirements, although it is currently unallocated.

Child 7: The child's placement was visited by a caseworker in June 2006 and her care orders were finalised the following month. A case review was conducted in November 2006, although the outcomes from this were not apparent from the file. The carer could not recall when a departmental caseworker last visited her. At the time of our review it appeared from the file that the placement had not been visited since June 2006. Section 82 reports were completed in March and August 2007. While these reports highlighted some of the needs of the child and her sibling, there was no case plan to address them.

Child 8: The child's care order was finalised in September 2006. There have been no formal placement or case reviews for the child since final orders were made.

Child 9 & 10 Care orders for the children were finalised in April 2006. The file was transferred to the CSC with supervisory responsibility in September 2007, where it has remained unallocated. At the time of our review it did not appear to us that there had been a case or placement review since October 2006. A manager casework told us that the case plan was last reviewed in September 2007, in conjunction with a handover meeting between CSCs. The handover was not attended by the carer and the handover meeting record does not include a case plan.

- At the time of our reviews a further three children who were the subject of long term care orders were living with a parent. Four of the 13 children in long term relative care had current case plans.

- At the time of our review nine of the 16 children in kinship care[31] had unmet needs in relation to either their mental and/or physical health and/or education.

Children placed long term in DoCS' foster care

- Three of the eight children in DoCS' foster care had a current case plan at the time of our review.

- Five of the eight children had an allocated caseworker. Two were recently allocated in response to the carers' concerns about lack of support. Two siblings were allocated for the purpose of completing a section 82 report which was due in July 2006. One child was allocated a caseworker for the purpose of the annual review.

- Five of the eight children in long term departmental foster care had identified needs in relation to their education and/or behaviour and/or health but had no case plan to address these. The following cases are illustrative.

  One of the children we reviewed had an extensive child protection history related to domestic violence, parental drug and alcohol use, neglect, lack of appropriate supervision, verbal abuse, poor school attendance and medical neglect. She is now 14. Her carer told us that the child is a withdrawn and difficult to engage young person who avoids affection. The carer told us that she believes the child would benefit from counselling. Our review established that DoCS referred the child to counselling (PANOC) in February 2007; the outcome from this referral was unclear from the file; and the child has not had an allocated caseworker since September 2007. The manager casework told us that the child remains on the PANOC waiting list.

  In another matter, the child we reviewed was assessed with mild to borderline intellectual disability. The child's file indicates that in December 2000, the child was seen by a speech pathologist who assessed that she had a speech deficit and required speech therapy. In 2004, the department referred the child to a psychologist who recommended that that the child be referred to a learning disorders clinic and that she have a hearing examination. The carer told us that while the child could benefit from speech therapy she has not received speech therapy as recommended. The carer also advised that she has not been referred to a learning disorders clinic.

Children living with their parents

- As noted, at the time of our review four of the 35 children were living with their parents. One of these children was the subject of a short term care order and had been restored. That child had a care plan as did one other of the four children. Despite two of the children having significant needs associated with

[31] This includes the ten children placed long term with relatives, the three children placed with their fathers and the three children who were the subject of short term final care orders.

their child protection histories, neither had a current case plan at the time of our review.

Children in residential placements / specifically designed placements

- The four children in specifically designed placements / residential placements all had caseworkers and current case plans which had been appropriately reviewed over time.

Children in non government foster care placements.

- As noted elsewhere, the seven children placed in foster care through non government agencies were all receiving appropriate case management services.

7.2.5 Placement support

Practice requirements and developments

Over the past five years DoCS has introduced a range of initiatives to support both authorised foster carers and authorised relative carers. DoCS practice guidelines note that appropriate supervision and support of authorised carers *'will assist placement stability and help achieve successful outcomes for the child or young person'* in care. The guidelines also note that relative carers tend to be older, have fewer financial resources and more health care problems than non relative carers. Relative carers are also noted to be less likely to seek out support of caseworkers than non relative carers.

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's policies and guidelines for financial support for children and young people in out-of-home care provide for payments additional to the carers allowance in certain circumstances. These are known as contingency payments and must be part of an approved case plan for the child.

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. The department has established regional foster care advisory groups,[32] and produces a quarterly newsletter for foster carers, '*Fostering Our Future'.* In response to our draft report, the department said that *'significant work*

[32] 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.

is being undertaken to improve the responsiveness and effectiveness of the DoCS Recruitment, Assessment and Training Program. Productivity savings should enable extra resources to be diverted to improve support to all Foster Carers and Relative Carers in the establishment phase of placements, at significant milestones and events, and to need assessment needs'.

Other agencies also play a very important role in supporting and assisting foster carers. The Association of Children's Welfare Agencies (ACWA) 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 carers' families.

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 ACWA have developed a training package for potential Aboriginal carers – *Our Carers for Our Kids.*

Placement support – what we found

Thirty one of the 35 children were cared for by either foster carers (15) or relative/kin carers (16) at the time of our review.

- Five of the foster carers were new to fostering and the child we reviewed was the first child that they had fostered. Two of these carers were supervised by a non government agency and were visited frequently during the first six months of the child's placement. Three were supervised by DoCS and had received minimal support – two received no visits from a departmental caseworker after final orders were made.

- Only two of the eight departmental foster carers had had contact with a foster care support worker.

- Eleven of the children/their carers had not been visited at all by a caseworker in the first six months after final orders, and four had been visited only once. These 15 children were in DoCS supervised placements.

- Twenty of the 31 carers felt well briefed about the child prior to their placement.

- Fifteen of the 31 carers had a copy of the child's current case plan. A further two carers had copies of previous case plans.

- Twenty-nine carers reported having health records for the child: Medicare, blue book, and information on immunizations. Thirty carers had a copy of the child's birth certificate.

- Twenty-five carers of the 31 carers had information on their responsibilities as a carer and 14 reported having information on local support networks.

- Generally, carers were satisfied with the support they received from the primary agency supervising the child in their care. Carers appeared to adapt to the level of support they received. Several carers who had not been visited, had not taken part in planning, had not been given a copy of the case plan and had experienced delays with payments also said that they were generally satisfied with the support they received.

- Carers supported by non government agencies were more likely to have been visited regularly and were more likely to have been involved in case reviews and planning.

- Seven carers, who cared for nine of the children we reviewed, expressed dissatisfaction with the support they received from the agency with primary case management responsibility for the child and children in their care. One was a foster carer through a non government agency, three were departmental foster carers and three were relative carers. Half of the carers, who expressed dissatisfaction with the support they received, had children placed with them with high support needs.

- In relation to specific issues:

    - Twenty-three carers felt supported concerning contact

    - Twenty-one carers felt supported concerning emerging issues.

    - Most carers who felt unsupported had children in their care with no current case plan (10/13).

    - Four carers had made a complaint whilst caring for the child, only one was satisfied with the outcome of the complaint

    - Fourteen carers had raised concerns about the child in their care and seven said those concerns had been addressed.

    - Six carers told us they had experienced delays in receiving their carer allowance and 13 expressed that they had experienced delays in receiving reimbursements for costs associated with the children in their care.

    - Five carers had experienced delays in receiving establishment costs, and in at least one instance, the department determined that the carers were not entitled to establishment costs.

Kinship Care

Kinship or relative care in NSW is now the predominant kind of out-of-home care.[33] At the time of our review, 16 of the 35 children were placed in the care of a relative or parent. Significantly, seven of the children who were placed in foster care or residential care placements at the time of our review had also previously been in a kinship placement or placement with a parent that had broken down.

Although it was evident that some gains have been made in providing equitable financial and practical support to kinship carers, these carers continued to have a different experience to foster carers in many respects.

In relation to the 16 children in relative/kin placements case managed by DoCS, we found:

- Kinship carers were less likely to have been visited by a departmental caseworker since final orders were made and were less likely to have been provided with support than foster carers. However, they were as likely, if not more likely, to report being satisfied with the support they receive than foster carers.

- Contact and accessing services were the issues kinship carers felt least supported in dealing with.

- Kinship carers were as likely to be caring for children with mental health issues and educational problems as foster carers.

- The children we reviewed in kinship care, like those in departmental foster care, were more likely to have unmet needs compared to the group placed with non-government organisations. The following case is illustrative.

  Between 2002 and 2005, 32 reports were made to DoCS about the child and his family. The child was eight when he and his siblings were removed. Psychological assessment at that time indicated that he had been diagnosed with ADHD since preschool and Oppositional Defiant Disorder, for which he had taken Dexamphetamine and for which he was currently taking Ritalin. He displayed extremely sexualised behaviours for his age and was highly emotionally disturbed. During our review the carer expressed disappointment with the level of support provided to her by the department. The carer told us that she has to instigate contact with the department and will often not get a response to issues she has raised. She highlighted her concerns about the impact this has on her ability to care for the child long term. The child has not had an allocated caseworker since his file was transferred in September 2007. The manager casework told us that this is due to a lack of resources and competing priorities.

[33] Department of Community Services, *KiDS Data*, 2007

- Eleven of the 16 kinship carers did not have a copy of the case plan for the child in their care. Noting this, only five of the 16 children had a current case plan.

- Kinship carers were much less likely than foster carers to have information on their responsibilities as carers.

- Just under one third of the kinship carers had experienced delays with the carer allowance compared to one foster carer.

- Just over half of the kinship carers had no allocated caseworker involved with the placement of the child in their care.

- Some children we reviewed had been in kinship placements which broke down or were terminated by the department over issues that would have been expected to be raised during a placement assessment. This raises some concerns about the quality of the kinship care assessment process.