PART IV

CHILDREN IN OUT-OF-HOME CARE
SERVICES FOR CHILDREN IN OUT-OF-HOME CARE

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OVERVIEW

When the state obtains a long-term order taking a child into care it assumes the heavy burden of providing for the physical, emotional, psychological and developmental safety of that child over possibly many years. Children raised in these circumstances have a right to expect a high quality of care, including priority access to health and educational services, and a high level of attention to, and investment in, helping them to recover from the experiences that brought them into care.

Families SA, the agency reporting to the Minister, is responsible for looking after these children and young people. It must meet their needs for a high standard of care and endeavour to ensure they benefit from a supportive environment and expert therapeutic support.

The Standards of Alternative Care in South Australia record the following principle of good practice 1:

**Children and young people in care should be afforded the same rights and opportunities that other children in the community have. The child or young person in care may require extra efforts to redress the disadvantage they have already experienced. Extra care is required to prevent further harm through the child or young person’s experiences of the process of alternative care itself.**

A major challenge to providing these children and young people with a normal upbringing is the assignment of parenting responsibilities to three separate entities: the Agency, who is responsible for major decisions about their care; their carers, who attend to their day-to-day care needs; and their families of origin, with whom they often have close emotional connections and continuing contact. Good case planning and case management by the Agency is essential to meeting these challenges.

Good case management also has the potential to protect children from abuse in out-of-home care. A recent literature survey commissioned by the federal Royal Commission into Institutional Responses to Sexual Abuse highlighted the fact that creating an environment where children feel safe enough to disclose their concerns is an important aspect of keeping them safe in alternative care environments. 2

For some children in care, the fracturing of relationships in their families of origin and the circumstances that brought them into care mean that they have few, if any, adults on whom they can rely. A recent audit of annual reviews conducted by the Guardian for Children and Young People (GCYP) found that of the 203 reviews audited, 14 children had no significant person in their lives outside the Agency and siblings. 3 Children who are isolated from stable and trusting relationships with adults outside the care system are especially vulnerable to exploitation: if they are exploited or abused, they may not have anyone they feel they can safely confide in.

Data consistently shows that across a number of important measures children in care experience poorer outcomes than their peers.

This chapter principally relates to the Commission’s Term of Reference 5(d) in the context of Terms of Reference 1 to 4. It discusses the situation for children in care in this state, and makes recommendations for improvements.

LEGISLATION AND POLICY

Once a child is placed under a guardianship order, the Minister assumes responsibility for that child ‘to the exclusion of the rights of any other person’. 4 The powers of guardianship are broadly defined at common law 5, although some aspects of the Minister’s power are specifically set out in the Children’s Protection Act 1993 (SA) (the Act):

51—Powers of Minister in relation to children under the Minister’s care and protection:

(I) Subject to this Act, the Minister may from time to time make provision for the care of a child who is under the guardianship of the Minister or of whom the Minister has custody pursuant to this Act, in any of the following ways:

(a) by placing the child, or permitting the child to remain, in the care of a guardian of the child or some other member of the child’s family;

(b) by placing the child in the care of an approved foster parent or any other suitable person;

(c) by placing the child in a home (not being a training centre) established or licensed under the Family and Community Services Act 1972 or in any other suitable place, and by giving such directions as to the care of the child in that home or place as the Minister thinks fit;

(d) by making arrangements for the education of the child;

(e) by making arrangements (including admission to hospital) for the medical or dental examination or treatment of the child or for such other professional examination or treatment as may be necessary or desirable;
(e) by making such other provision for the care of the child as the circumstances of the case may require.

(2) In making provision for the care of a child pursuant to subsection (1), the Minister must, if appropriate, have regard to the desirability of securing settled and permanent living arrangements for the child.

This section clearly intends that the Minister will rely on the care services of others, including foster parents or other suitable persons, to discharge the responsibility of guardianship. This includes placement of the child in a registered residential care facility.

The progress of a child under a long-term guardianship order should be kept under constant review. Section 52 of the Act mandates an annual review of the child’s circumstances. The review is to be conducted by a panel appointed by the Minister for the purpose, and the conclusions of the panel must be produced in writing and provided to the child, the child’s guardian and the person is whose care the child is residing.

The Act requires persons exercising functions or powers under a relevant law, in any dealings with, or in relation to, a child under the guardianship or in the custody of the Minister, to have regard to and seek to implement the Charter for the Rights of Children and Young People in Care, which is developed and reviewed regularly by GCYP. The charter gives all children and young people living in care the right to be treated like other children and young people.

The Standards of Alternative Care require that:

Families SA caseworkers will ensure their work with children, young people, their families and carers is based upon an ongoing assessment and planning framework. Monitoring and review of casework will ensure children and young people are provided with all identified opportunities/services to allow them to realise their full potential.

Other more specific standards require that each child or young person will have an allocated caseworker who:

• maintains regular contact and is a key support;
• will have face-to-face contact with the child at least once a month;
• will make a thorough assessment of their placement options with decisions supporting the need for settled and stable placements long term;
• will have a case plan that is developed, monitored and reviewed as part of a regular six-monthly planning cycle.

Education, employment, health care and other life domains must be addressed by a child’s care team. The South Australian standards also encourage visionary aspirations for children in care, which are reflected in care planning.

The National Standards for out-of-home care also require that each child and young person has an individualised plan detailing their health, education and other needs; has their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way; and accesses and participates in education and early childhood services to maximise their educational outcomes.

It is evident that there is no shortage of guidance about the standards applicable to caring for children in out-of-home care. The challenge for the Agency lies not in identifying relevant benchmarks and principles, but rather in ensuring that the many practice and policy guidelines are translated into actions that make a difference to the lives of children and young people.

Rapid Response is a plan that was developed in 2005 as part of the government’s Keeping Them Safe agenda to ‘ensure that children and young people under the guardianship of the Minister … do not miss out on the supports and services available to children with strong family networks’. It was developed and applied across a number of government departments, focusing on providing a coordinated approach to physical health, psychological and emotional health, developmental progress, disability needs, education, housing and post-guardianship services.

One aspect of improved service delivery contemplated by the Rapid Response plan was priority access to services where possible. The development of the plan was overseen by a cross-government guardianship steering committee which reported quarterly to the relevant Minister.

It is clear to the Commission that a refreshed focus is needed on the principles and actions agreed upon through Rapid Response. One young person who was approaching the age of leaving care told the Commission that she had never heard of Rapid Response, and she had not been made aware at any time of the possibility of priority access to services. A number of foster parents expressed frustration that their child’s care status did not appear to be taken into account in assessing their eligibility for government services. The momentum for a cross-agency approach has slowed and is not receiving active attention now that the previous government structure has been dismantled.

Some specific aspects of service provision for children in care are discussed throughout this chapter.
However, the Commission considers that a more comprehensive review of Rapid Response is urgently needed, to restate the principles and practical operation of the Rapid Response plan, and reaffirm the inter-agency commitment that accompanied its initial development.

This should include the establishment of an inter-departmental group to review and reissue the plan. Any reissue should also include regular future reviews (at least biannually) to ensure that momentum is maintained.

CASE PLANNING

Case planning is an integral part of the broader service delivery approach of case management for each child or young person. Case planning is “the process which provides the framework for making decisions about a child/young person in order to achieve identified outcomes”.23 This critical activity is based on an assessment of the child’s needs and establishes a guide for the tasks and activities of all parties involved in the child’s care. The case manager takes a leadership role in this process, and is the point of reference when issues need to be resolved.

As the parenting of a child in care is divided between the carer who provides day-to-day care and the statutory agency that represents the Minister, careful planning and consistency of focus are essential. The effectiveness of the planning depends on the collaboration of all parties, including the child or young person, their carers and other service providers.

Quality standard 2.6 of the Standards for Alternative Care requires that every child in care have a case plan that is developed, monitored and reviewed every six months.23 This document records the aims and outcomes of the case planning process, lists the activities and services that will be required to achieve those goals, and describes how and when those services will be delivered. It is a formal record which provides transparency of action for all parties who retain a legitimate interest in the child’s wellbeing. The planning process also allows a child or young person to contribute their goals, aspirations and intentions in the short and long term, and to record how these contributions have been taken into account in planning.

A case plan tells all parties what is to be done, how it is to be done and why it is to be done.

The existence of a good quality case plan reflects a relationship between a child or young person and their worker which is current, active and purposeful, and reveals a level of attention to, and engagement with, the young person concerned. It also provides a measure against which to track progress and assess the utility of services provided to a child or young person. Without a formal case plan, there is a risk that the needs of a child will be neglected, and their case left to drift.

DATA ABOUT CASE PLANNING

The Commission sought data about the number of children whose case plans are current, as a measure of the level of active engagement of caseworkers with children.

In 2011/12 the Australian Productivity Commission began tracking, for the first time, data about children in care who have a documented case plan. South Australia was not able to supply this data for financial years 2011/12, 2012/13 or 2013/14 due to recording issues. Although other jurisdictions were also unable to supply the data in the early years of reporting, by 2013/14 only South Australia and the Northern Territory were unable to report against this measure.23 In the most recent report, for 2014/15, the Northern Territory remained unable to report due to recording issues. South Australia advised the Productivity Commission that the barrier to reporting for 2014/15 was due to system changes made to support Solution Based Casework™.24

When the Commission asked the Agency whether it could now report the number of children in care who had a current case plan, the Agency advised that six days of work would be required to extract the data. In light of this, the Commission did not pursue the request.25 As current case plans are an important measure of quality casework and engagement with children, the lack of consistent monitoring of this data by the Agency is concerning.

The most recent data produced by the Productivity Commission for the rest of Australia for the 2014/15 financial year showed variable performance across jurisdictions. New South Wales was the lowest with 58.8 per cent of children having a current documented case plan, and Queensland was the highest with a rate of 97 per cent. The Australian average (excluding South Australia and the Northern Territory) was 75.1 per cent.

Evidence received by the Royal Commission suggests that South Australia’s performance is likely to fall at the lower end, reflecting a lack of attention to formal case planning.

Life Without Barriers (LWB) reported to the Commission that of 74 children they supported in foster care placements, only nine had a current documented case plan (12 per cent).24 Of those nine, LWB had been involved in the planning process for one, and foster parents had been involved in two.27
Aboriginal Family Support Services (AFSS) reported a similar experience. No more than 10 per cent of the 126 children AFSS supported in foster care had current case plans.

GCYP recently audited the annual reviews of 203 children managed across 12 Families SA offices: this constituted 9 per cent of all reviews which were required in the 2014/15 year. The audit identified 33 children among that sample (16 per cent) who did not have a current case plan. Caution should be applied in extrapolating this data to all children and young people in care, however. This is because GCYP attends annual reviews for audit purposes by invitation, and the sample attended is small, and may not match the profile of the out-of-home care population overall.

However, if this evidence does indeed reflect the level of attention to case planning for children in care across the board, it is cause for considerable concern. It is unlikely that a child or young person without a formal written plan would be delivered the quality of care that they are entitled to expect from the state, nor is there any way of tracking the effectiveness of their care.

RELATIONSHIPS WITH CHILDREN

In evidence, Pam Simmons, the former GCYP, highlighted the potential conflict for caseworkers in the Agency working within a system that does not always operate to secure what is genuinely in the best interests of the child. She observed:

Caseworkers and social workers and supervisors can be very courageous, and I have seen much evidence of that, advocating for something for a child in the face of either systemic or organisational opposition. So it is certainly possible for people to advocate, and they do it all the time: advocate for the best interests of the child. There are organisational imperatives, though, which mean … two things: one is that sometimes they are directed to either change their position, or [told] this is the way it will be. Or, secondly, people start to view what the options are for children through the lens of what is available rather than what is needed.

For children in care, caseworkers are the face of the system. It is important that caseworkers are available and helpful in meeting children’s needs. Caseworkers, where appropriate, should advocate on behalf of children, as is expected of an involved and committed parent. For some young people their caseworker will be the only adult in their life with whom they have a reliable and trusting relationship.

In 2013 CREATE Foundation conducted a major survey of 1069 children and young people across Australia, asking about their experience of out-of-home care. Forty per cent of the respondents did not feel that they could contact their caseworker as often as they wanted, and thought that caseworkers could be more helpful. South Australia performed a little better than some other jurisdictions, with respondents more likely to report that they could see their caseworker as often as required.

A common theme in responses was that children and young people wanted caseworkers to ‘do what they promised, when they promised it’. A similar theme was observed in this Commission’s consultation with young people in care, one contributor emphasising that they ‘want workers to keep their promises—ask to do something and they say maybe tomorrow, maybe next week and we never get to do it’.

A common theme from children and young people was that they wanted caseworkers to ‘do what they promised, when they promised it’.

Securing the trust of children in care requires that case managers be able to make good on promises and undertakings. The CREATE survey found that a large proportion of respondents considered their carers more supportive of their interests than their caseworkers. The CREATE report concluded that if caseworkers were to work in a way that children and young people valued, they needed to focus more on advocacy rather than ‘bureaucratic gatekeeping’. To do this, caseworkers should have a well-developed understanding of the child or young person’s needs.

A useful strategy is to engage children in the case planning process. This need not be attendance at formal case management meetings, but could include more creative and informal engagement strategies that make the process meaningful for the child. The CREATE survey found that less than one-third of the children and young people surveyed knew about a case plan developed for them, and of those who knew about their case plan, only one-third had been involved in its preparation.

GCYP’s audit of annual reviews for the 2014/15 financial year found that only 15 per cent of children and young people judged capable of contributing had attended in person at their annual review. A further 24 per cent had contributed by completing a survey form which had been posted to them. These levels of participation were improvements on the figures from the previous financial year, but suggest that there is room for improvement.
DEMANDS ON CASEWORKERS

A child’s caseworker should be a significant and stable influence in their life. One supervisor from a country office described the intensity of the role in the following terms:

"So you take them on outings, you get to know what their favourite colour is, what they like to eat, you know who their best friends are, and the point is that then if they have issues in placement they will disclose them, because they trust you and they’ve got great confidence in you… making sure that their health is good, their education is good, their peer social relationships, their leisure, they’ve got an understanding of their identity."

To provide a high quality service to a young person in care requires time; it requires an ability to collaborate and bring together all the parties who have an interest in the child or young person being their best; and it requires an understanding of the services that are available, as well as assertive advocacy on behalf of the child to ensure they gain access to those services.

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In 2008, the Children in State Care (CISC) Inquiry extensively reviewed numerous cases of sexual and physical abuse. The CISC report recommended that every child and young person should have a social worker, and that the worker should provide face-to-face contact, at least monthly, regardless of the stability or nature of the placement. The recommendation was especially important because of the consistent theme that young people who were victims of abuse in care lacked a trusted social worker to whom they could complain, and that regular contact with a caseworker was an important protective factor. This recommendation was accepted by the government, but evidence obtained by this Commission suggests that not all children are receiving a service at the required level.

A number of children in care have not been allocated a caseworker. They do not get regular visits and do not enjoy the benefits of proactive case management. Rather, they are provided services on an as-needs basis by a duty worker or a supervisor at the local office. However, casework with vulnerable children and young people in the care of the state is not an administrative function, and should not be done on this basis. These children require a relationship with someone they trust on whom they can call if a problem arises. A child who is unsafe in their placement, and who is struggling with personal relationships, health or education, is highly unlikely to contact their local office to speak to someone they do not know or seek assistance from a duty worker.

Families SA supplied data to the Commission showing that 53 children and young people subject to long-term orders were unallocated as at 22 October 2015. However, evidence given by a large number of workers reflected a much higher level of unallocated cases in local guardianship hubs. GCYP’s audit of annual reviews for the 2014/15 year also observed a higher proportion, with 29 cases of the 203 audited not allocated to a caseworker. One possible explanation for this divergence is that the rate of allocation has changed significantly over the time in which the Commission has been gathering evidence.

However, being assigned a social worker does not guarantee children and young people a proper service response: they may receive less frequent support because of an assessment method used by the Agency to rationalise the workload when it exceeds worker capacity. A ‘differential response’ tool evaluates the level of attention required by each case, and the resulting rating is used to justify the provision of a lower level of service. This may include reducing visits to three-monthly, six-monthly or even yearly. Some children are listed against a caseworker’s name in the C3MS database but in terms of the service response they are effectively unallocated.

The children and young people likely to receive a lower level service response are those who are in long-term stable care placements, who are surrounded by adults who are concerned for their wellbeing, and who are well engaged in the community. However, this is not always the case. GCYP reported on one child who, at the age of 11, was in a placement that was considered ‘not ideal’.
His case was unallocated, and he was only sighted by the Agency because other children in the same placement were allocated and social workers visiting those children happened to see him.45

Some children do not welcome the intrusion of the Agency into their lives, as they do not wish to be identified as a child in care. Where children are in stable arrangements and an as-needs service response is appropriate, these children should be actively assessed for Other Person Guardianship (OPG) orders, which permits carers to officially, as well as practically, take responsibility for the children and or young people in their care.

Both unallocated cases and differential response cases contribute to workers’ discomfort with the current system. One told the Commission about being instructed not to record resourcing issues as service barriers in case notes. She explained that she wanted to be honest and transparent with young people, who might eventually have access to these records, and show them that the lack of service response did not mean that no-one cared about them: it was simply that the office lacked the capacity.46

The Commission attempted to identify a caseload that was professionally sustainable and would permit a service to be delivered at optimal intensity for the child. Some witnesses reported caseloads of approximately 20 children per worker in the past, although this had settled to between 14 and 16.47 Even at that level, depending on the needs of the children, it might not be possible to deliver an adequate service to the less demanding ones.

There was one experienced worker who was asked in the meeting held at least monthly.

I think, ideally, to be spending more time with the kids ... it sometimes does get to a point where it’s just crisis response with certain children that are so time consuming ... some of the children that are very settled, they are just [as] entitled to your time, and [ask] ’Could you come to my school play? Are you going to come to my sports day?’ You know, all these things where you want to just have that time to pick them up after school, but you’re so busy chasing the children that are really, really needing us at that time ... I think some of the more settled children, unfortunately, do get a little bit pushed to one side.48

If caseworkers are to deliver a service in accordance with the standards adopted in this state, they should be adequately resourced, and these resources deployed in a more effective way. Chapter 5 recommends providing more administrative support to workers, and reducing the administrative burden by allowing decisions to be made at lower levels. Both these reforms should permit a greater focus on face-to-face client engagement.

Children and young people can also be engaged in ways that do not require formal meetings. Mobile phone, text messages, email and other technologies that facilitate communication permit connections to be sustained without formal meetings. However, these tools should be a supplement to, never a replacement of, personal meetings held at least monthly.

Ultimately, the number of cases that constitute an acceptable level of work will depend on the complexity of needs of the children concerned. It is not possible to be prescriptive about the matter. However, the Commission makes the observation that evidence suggested that a total of 14 cases was likely to be at the upper level of acceptability, with allowances made for those cases in which a child had especially complicated needs.

The differential response tool should be abandoned insofar as it justifies a departure from the standards of care clearly identified in state and national standards. Where a less intense level of service is genuinely required, but OPG orders are inappropriate, a revised service response should be a matter of formal agreement between the child, the caseworker and the child’s carer, and should reflect the best interests of the child, not the resource imperatives of the Agency. No child should be unallocated, or unaware of the identity and function of their caseworker. They should be visited on a monthly basis.

The turnover of caseworkers in the Agency also undermines children’s ability to form trusting and stable relationships. The CREATE survey found that across Australia 35 per cent of respondents had been allocated more than five caseworkers over the course of their time in care.49 GCYP’s audit also showed a high turnover in caseworkers by measuring the length of time the worker had been allocated to the case at the time of the annual review. Figure 10.1 demonstrates that the overwhelming majority of children reviewed had been allocated to their worker for less than 12 months.

![Figure 10.1: Relative lengths of time social workers had been allocated to children or young persons at their annual review, 2014/15](image-url)
It is clear to the Commission that the casework staff charged with supporting the most vulnerable children in this state are not in a position to offer the best service. In order to improve the quality of response offered in this important area, staffing levels should be increased. The additional staff should be appropriately qualified, and exclude those whose experience and occupational classification is operational. Efforts should be made to ensure that, as far as possible, consistent relationships over time between children and caseworkers are promoted and supported. One way of achieving a greater level of stability is to adopt an approach within an office which matches children with both a primary and secondary worker to deliver greater continuity.

Children who are in stable placements and who do not require an active service response from the Department should be proactively assessed for OPG orders.

NON-GOVERNMENT ORGANISATION OUTSOURCING

The Child and Family Welfare Association (CAFWA), along with several other non-government organisations, has advocated outsourcing the case management of children under long-term orders to registered foster care agencies. This model has been adopted in other Australian jurisdictions.

CAFWA argues that the overlap of function between the Agency supporting the child and the registered foster care agency supporting the placement can lead to unnecessary conflicts, and that the alignment of responsibilities within one body would provide much needed clarity. It contends that this outsourcing would not change the ultimate role of the Minister as guardian, but would reduce duplication of effort.

Although there is a precedent for this model in other jurisdictions, the Commission has concluded that this level of outsourcing is inappropriate. As guardian, the Minister holds a heavy responsibility for the wellbeing of children within the care of the state. It is not appropriate that this responsibility be discharged at arm’s length through a non-government agency.

Further, where children are in stable placements that permit the Agency to appropriately withdraw from its role, OPG processes should be actively pursued. However, there is a role for continuing the support of carers acting under OPG orders, and this is discussed in Chapter 13.

ANNUAL REVIEWS

According to section 52 of the Act the Minister is obliged to annually review the circumstances of children and young people on long-term orders. The review must be carried out by a panel appointed by the Minister and the panel must produce its conclusions in writing. The obligation in section 52 is key to ensuring that planning for children is regularly scrutinised and updated.

Section 52(3) requires the reviewing panel to ‘keep under constant consideration whether the existing arrangements for the care and protection of the child continue to be in the best interests of the child’. GCYP described annual reviews as:

‘a ‘pause’ in the day-to-day business of parenting a child who is in care. It is a time for reflecting on the goals and ambitions, achievements and challenges for each child or young person. It can sometimes be the one time in a year when the many adults in a child’s life can confer on whether they can ‘parent’ better.’

Annual reviews are delegated by the Minister to any staff member of or above the supervisor level. This staff member chairs the panel. The panel must consist of no fewer than two people. For Aboriginal or Torres Strait Islander children, there must be an appropriate cultural representative.

The discussions and considerations of the annual review panel are guided by a two-part pro forma. Part A contains relevant detail of the child’s case management, including their needs, strengths and arrangements for their care, and details of the carer family and their living environment. It extends over four pages.

Part B is labelled ‘conclusions’ and comprises only one-and-a-half pages. It requires the panel to record a brief summary of the circumstances of the child or young person, and a ‘summary of the areas requiring intervention and any recommendations of the panel’. The conclusion section requires a surprisingly small amount of detail. It fails to direct the attention of the panel to the statutory question of whether the existing arrangements for the child remain in their best interests. By focusing on areas requiring intervention, the form focuses discussion on deficits and does not encourage the aspirational planning that is required in the South Australian standards.

The division of the form into these two parts, whether by design or coincidence, enables the Agency to provide only a small portion of the panel’s discussions and observations to the child; the child’s guardian and any person who has care of the child, as it is only the review’s conclusions (Part B) that must be provided. The current design of the form undermines the overall intent of the legislation: to provide a transparent and open process that includes all relevant parties. The annual report pro forma should be redesigned to reflect the standards of alternative care and the legislative intent.

The GCYP’s audits of annual reviews provide an important insight into the quality of casework being conducted on behalf of children and young people. Despite the fact that annual reviews are mandated in legislation, in the 2013/14 financial year the Agency completed reviews for only 53 per cent of children in care.
For the 2014/15 financial year 2100 children were entitled to an annual review. Eighty-three per cent, or 1740 children, were reviewed. This was a substantial improvement on the previous year. The Commission was advised that the Agency had brought a sharper focus to annual review responsibilities, resulting in a marked increase in compliance. However, it meant that for 2014/15 there were still 360 children in care who were not reviewed in accordance with the requirements of the legislation.

GCYP noted some examples of quality casework, including regular face-to-face contact between the child and the caseworker, and active advocacy on the child’s behalf. However, an inconsistency of approach was observed across different offices, with associated variations in quality. GCYP observed a greater depth of analysis and quality of discussion when external providers or panel members independent of the case were involved. Unsurprisingly, she also observed a higher quality of review when more than half an hour was allocated for discussion. It is difficult to be satisfied that an annual discussion of no more than half an hour has the capacity to deliver the comprehensive and reflective consideration required.

Very few reviews began by identifying the previous year’s recommendations and reviewing progress against them. In 29 of the 203 cases audited, the caseworker had limited knowledge of the child or young person, or was not working with the child at the time of the review.

The poor rate of compliance with the legislative requirements should be urgently addressed. It is unsatisfactory that such high numbers of children in care are not receiving the quality of care required by legislation, let alone the quality standards dictated at the national and state level.

The Agency should take urgent action to improve the rate and quality of annual reviews. The Commission recommends that the policy guidance be reviewed to require that the annual review panel be chaired by a suitably qualified person who is independent of the case. The pro forma should also be redesigned, with the intention of providing the whole record to the parties identified in section 52 of the Act, except where this would not be in the best interests of the child. The independent chairperson should be asked to guide discussions to ensure that the review is a genuine opportunity to study the child’s circumstances and plan for their future.

GCYP suggested that the following shift is required in approaching annual reviews (among other important casework functions):

The imperative for the ‘corporate parent’ is to shift from ‘worker’ thinking to ‘parent’ thinking to consider how the child is, what the child thinks, what brings meaning to the child’s life and what the child finds funny or misses, or hopes for. To be truly informed, questions need to be asked and others who see parts of the child’s life need to be closely listened to. A review has to conclude that the child has all the necessary supports to meet their needs, or identify actions and responsibilities to acquire the necessary supports.

The Commission adopts this as an important guiding principle.

STABILITY OF PLACEMENT

Research supports the proposition that stable care arrangements are associated with better psychosocial outcomes for children and young people. There are a variety of factors that appear to influence this relationship. A South Australian study looking for factors associated with placement stability identified:

- entry into care at an early age (entry as an infant under two);
- a shorter exposure to an abusive environment before coming into care;
- clear and decisive actions regarding the child’s long-term future at an early stage; and
- the relative skill of the carers.

The majority of children in care in South Australia are in stable long-term arrangements. However, there is a concerning proportion who experience high levels of placement instability, as shown in Figure 10.2. Fifty children who left care in the 2014/15 financial year had experienced 11 or more placements during their period of care. A further 53 had experienced between six and 10 different placements.

The proportion of children experiencing high levels of instability is much higher in South Australia than any other jurisdiction (see Figure 10.3 and Figure 10.4). However, stability of placement can be improved by better initial planning and assessment of placements, and by better support of placements at risk.
complexity measures of behaviour and special needs.

A decision that can have long-term consequences regarding a child’s quality of care is the choice of a placement. Initial decisions are often made in pressured circumstances when a child urgently needs to be removed. At that early stage it can be challenging for Agency staff to conduct a comprehensive search for suitable family members. Agency staff often need to rely on parents from whom the child is being removed to identify alternative options for care as the parents will not always be objective about the process.

Placement decisions are at times made on the basis of short-term expediency, with limited consideration of the long-term suitability of the placement.

Where a family member or other suitable carer cannot be identified for the child, alternative care is arranged through the Agency’s Placement Services Unit (PSU), also known as ‘matching and allocation’. This unit receives and acts on referrals for placement by identifying what is available to best fit the child’s needs. There is no doubt that the current crisis in home-based placements means that very often a child’s allocation is dictated by what is available at the time rather than what is the best fit for the child.

COMPLEXITY RATINGs

Children and young people in care are scored according to a complexity assessment tool (CAT) which is then used to guide service provision. The CAT score is also used to consider eligibility for therapeutic care placements, and loadings for foster parents and kinship carers. The overall score represents a combination of ratings based on complexity measures of behaviour and special needs.

The CAT score is not a formal assessment, but a guide to the severity of a child’s multiple problems on presentation. It does not identify children who are at high risk of developing complex behaviours but have not as yet manifested any signs, possibly due to good quality care in a stable family environment.

In general terms, complexity assessment is a useful overall tool for identifying children with high needs, but care must be taken in placing too much reliance on an absence of identified complexity when making decisions about the appropriateness of care placements.

CONCURRENT PLANNING

Families SA’s care planning policy emphasises the need to minimise instability for children in out-of-home care by concurrent planning.63 Concurrent planning is a concept which recognises that care should minimise disruption to a child’s attachments and relationships while reunification with their family is pursued.64 Concurrent planning requires that, where possible, children are placed with carers who will support reunification but also be prepared to offer a long-term placement if that is required. The care planning policy emphasises that for this approach to be successful, full disclosure to the birth parents, carers and, where appropriate, the child is necessary.65 The policy notes that concurrent planning recognises the harm that is caused by ‘sequential plans to attempt reunification followed by attempts to seek a long-term placement after reunification has failed’.66

In the Commission’s case study of ‘Abby’ (see Vol. 2, Case Study 2), the child was removed from the care of her mother when she was two months old. Attempts to reunify her with her mother persisted until Abby was two years and seven months old. Shortly after her removal, Abby was cared for in three different foster care families. At nine months, just as Abby was entering her critical attachment phase, she was moved to a residential care facility staffed by a group of rotating carers. This situation was recognised as unacceptable by her case manager, who continued to advocate for Abby to have a home-based placement. When Abby was 14 months old she entered the care of Ms K, an experienced foster parent who was raising her own biological children together with a foster daughter on a long-term order.
Figure 10.3: Percentage of children on a Care and Protection Order and leaving out-of-home care in 2014/15 by number of placements

Source: Data for all states except South Australia from the Productivity Commission’s *Report on government services 2016*. South Australian data supplied by Families SA. The Commission was advised in response to an enquiry that data supplied by Families SA to the Productivity Commission for this measure was inaccurate. Accurate data was then supplied to the Commission. This data therefore is different from that contained in the Productivity Commission report.

Figure 10.4: Percentage of children on a Care and Protection Order and leaving out-of-home care in 2014/15 having experienced more than 11 placements

Source: Chart compiled using data contained in the Productivity Commission’s *Report on government services 2016*.
Abby remained in Ms K’s care for nearly 18 months until she was two years and seven months old. This was the longest continuous attachment relationship Abby had ever enjoyed.

Unbeknownst to Ms K, very soon after Abby was taken into care, Families SA had undertaken family scoping and identified family members living interstate who were prepared to offer Abby long-term care. This was especially significant because Abby is an Aboriginal child and the Aboriginal placement principle required that great weight be given to keeping her within her cultural community. The placement interstate was not pursued because of the barriers that were perceived (incorrectly) to prevent a transfer of the court orders. In addition, no effort was made to introduce Abby to her interstate relatives although in the future she might need to be placed with them long term.

In the final stages of the failed reunification efforts, Families SA finally made contact with Abby’s interstate family and assessed them for long-term care. Ms K became aware, for the first time, that she was not being considered for long-term care of Abby because of the family interstate. Given the attachment that had developed between Abby and Ms K, this transfer was not supported by the Aboriginal Family Support Service, the agency that Families SA was obliged to consult on placement decisions for Aboriginal children.

At the age of two years and seven months Abby was transferred to the care of family members over a period of five days. Before this, Abby had spent no more than an hour in their company. A number of professionals who gave evidence expressed concern about the brevity of the transition.

Quite apart from the length and quality of the transition, case planning for Abby did not place her at the centre of decision making. While considerable effort was directed towards helping Abby’s mother address the issues that prevented her from safely caring for her daughter, there was a lack of focus on Abby and her long-term wellbeing, and the critical role that secure attachment relationships played in supporting her emotional, developmental and psychological wellbeing.

Abby is not an isolated case. In the hearing of the McCoole case study, the Commission heard that one of McCoole’s victims, ‘Chelsea’, was subjected to a similar process of poor case planning. Chelsea had been cared for in a home-based placement with foster parents during a short-term order which contemplated reunification with her mother. When reunification failed, Chelsea was transitioned over a period of five days to the care of a relative whom she had not previously met.

Both of these cases highlight the need for comprehensive and child focused planning at an early stage, especially for infants who are in an active attachment phase, and especially vulnerable to the effects of instability and emotional trauma. Clear plans with built-in contingencies that are well known to all parties are critical to ensuring that the child’s best interests dominate all case planning decisions.

Where children are on short-term orders, case plans should include clear consideration of concurrent planning, and how the child’s attachment and developmental security are being assessed. For children who are not in kinship placements, careful attention should be paid to comprehensive scoping of suitable family members. A care plan should be developed and shared with all interested parties, including foster parents, which describes appropriate concurrent planning for the child’s stability.

SUPPORTING PLACEMENTS AT RISK

Research supports the view that those care placements most likely to experience instability and risk breakdown can usually be identified at an early stage. This highlights the importance of early intervention to prevent such a breakdown.

Children entering care in today’s environment have increasingly complex behaviours and medical needs. This is changing the nature of care provision. When carers are not adequately supported while dealing with difficulties that children in their care are facing, placements break down. Early support should be available to identify and address issues before placements are put at risk.

Flexible support for carers is critical to identifying problems, and addressing them in a timely way. Sally Rhodes, an experienced social worker who works with families where placements are at risk, was questioned by the Commission:

Q. What are the kind of risks that might be associated with a placement that would increase the danger that it would break down or wouldn’t be sustainable?

A. Lack of support is the main thing, in my opinion. Lack of support is a huge issue. Lack of information, I guess, to carers around what has happened for children and therefore what to expect. Lack of training, support, and when I say ‘support’, I mean support that they can access 24 hours.

Q. What do you mean by ‘support’? Is it having someone to talk to or having someone to answer questions?
A. I think both ... they often say carers come in with the best of intentions and they want to do the best that they can, but they don’t know what they don’t know, and what they don’t know is what trauma looks like over a period of time and what that means to be dealing with on a day-to-day basis and the effect it has.70

One witness who often works with children and young people with complex developmental issues relating to trauma told the Commission he is yet to encounter a foster parent or kinship carer who, before taking on the care of a child, genuinely appreciated the complexity of the undertaking, and that instinctive notions of how to parent might not be appropriate for these children.71

Regarding trauma, another witness observed that:

I think lots of the time it would be missed that there’s a need for therapeutic support to placement. Foster carers are usually meant to have had a lot of training in childhood trauma and attachment, but quite often when we’ve met with them, their understanding is fairly rudimentary … I’m constantly surprised that the information we’re imparting to them about the child is usually a bit of a surprise to them.72

Home-based carers are not experts in trauma. They rely on the professionals to support them by identifying and addressing issues which emerge as the child grows. Two principal barriers to therapeutic support for placements were identified: one, that foster parents fail to communicate with support workers about the nature and severity of the problems with which they are grappling; and two, that professionals charged with supporting the placement do not refer the foster parents to appropriate support at an early stage.

Some caseworkers appeared to misunderstand the nature of therapeutic support that might be available to a placement. The Commission became aware of two instances in which caseworkers had not made referrals for psychological support, stating that the children involved were too young. This misconstrues the nature of available support. An experienced psychologist told the Commission that:

therapy … quite often in our context is via the caregivers because children are either too young or reluctant or what have you, [so together we try to] make this therapeutic environment for this child; so it’s often around supportive work with the carers.73

The challenge of delivering therapeutic support to these children and young people is that the treatment of developmental trauma is not rapid and cannot be delivered by professional intervention alone. Therapy requires consistent long-term work, with changes to the child’s care environments (home, school, therapy, birth parents) to accommodate the distorted ways in which the child relates to the world and responds to circumstances.74 Negotiating a path through the various services supporting a complex child was described as ‘difficult and sometimes impossible’ for a therapist.75

Carers are often at the heart of delivering therapies for better outcomes for children. It is important that they understand that therapy is delivered through changes in the child’s care environment, with close attention to building healthy relationships. Carers should be assured that this does not reflect shortcomings in the care they are delivering, but rather the fact that such children often need specialist care.

The need for a coherent approach underscores the importance of having an assertive and knowledgeable case manager who can lead and coordinate efforts and deliver consistency across the child’s environments. Greater emphasis is needed on early intervention in placements exhibiting signs of stress.

MOVING TO A NEW PLACEMENT

There will be occasions when moving a child to a new placement is in their best interests. Where the care is inadequate or inappropriate, and the supports provided have not remedied the deficits, then often a child’s interests may be better served in an alternative care environment. However, when placement changes are neither wanted nor planned, it is an important part of case planning to review the reasons for the placement breakdown, to determine what factors might prevent a recurrence in the future. Greater emphasis should be placed on reviewing these situations to identify any systemic contributors.

Children and young people should be involved wherever possible in decision making about such moves. Children whose placements end can experience a range of negative feelings:

Without preparation for moves, children can become prone to chronic fears and anxiety and may withdraw or become overly compliant. Others may become more assertive and try to control everything. Yet others may develop chronic guilt as they hold themselves responsible.76

Children should understand what is happening, and be assured that someone is in control, and is planning for their future.77 Sudden moves and abrupt loss can make it more difficult for the child to grieve even when the placement was not optimal.78 One child involved in the Commission’s consultation with children and young people observed that the relationship worked ‘as long as the child is aware and the carer is a good communicator and clear with boundaries and honest.'
Some say you will live with them forever and [then] you are moved’.79 Others made the following comments about moving while in care 80:

• When you move it sucks.
• I want to be consulted if I have to move.
• If I am moved I want visits first and I don’t want to be immediately cut off.
• If in residential care, make sure you don’t move constantly—that sucks.

‘Some say you will live with them forever and then you are moved’

The Commission was made aware of a number of circumstances in which children were removed from placements suddenly and without warning to either the child or the carers. These matters are discussed further in Chapter 11.

When children move to a different geographic area, it can also mean a change of caseworker, to one from an office closer to the child’s new home. Whether continuity of relationship with a caseworker is more important than physical proximity should be carefully considered in partnership with the child. Where possible children should be given a choice about whether or not they are allocated a new worker.

HEALTH

The Health Standards for Children and Young People under the Guardianship of the Minister govern the relationship between the Agency and SA Health in the delivery of health services to this vulnerable group.81 The standards are based on the Rapid Response framework which aims to encourage better collaboration in meeting the needs of those in care, and also give them priority access, where possible, to government services.82

Rapid Response seeks to ‘provide opportunities for equitable outcomes in education, health, and development’ by supporting children in care with services that ‘will align their level of education, health, emotional and psychological development with the population average’.83

Unless funded by their carers, these children do not have the benefit of private health cover and rely on public health services.84 They often enter care with a number of unmet health care needs, which should be properly assessed and addressed. Case managers within Families SA should actively track and coordinate children’s health to ensure that these needs are met.

The South Australian Health Standards sit against a background of the National Clinical Assessment Framework for children and young people in out-of-home care.85 The national standards emphasise the need to identify issues early so that intervention can be offered when it will be most effective.86 The national standards therefore require a two-stage health assessment when a child enters out-of-home care. The first stage is a preliminary health check to be conducted within the first 30 days; the second stage is a more comprehensive assessment to be completed within three months.

The Standards for Alternative Care require that these children receive an initial health assessment within two months of them entering care.87

Nathan—Dealing with complex needs in care

(The full case study of Nathan is in Volume 2, Case Study 4: Nathan—Children with complex needs in out-of-home care.)

At the age of 10 ‘Nathan’s’ psychological and emotional problems became so great that his foster parents faced significant challenges in caring for him. On occasions, his behaviour made them fear for their safety. Families SA decided that it was no longer safe for the placement to continue, and he would be moved to a large residential care unit. Families SA decided not to tell Nathan about the decision because they feared his reaction.

When the day of the move arrived, Nathan was driven by his caseworker to the unit. On arrival, for the first time, he was informed that this would now be his home.

Nathan was highly distressed by the news. He responded by damaging property at the unit and assaulting workers. Police were called and Nathan was arrested and refused bail. He spent his first weekend away from his foster parents at the Adelaide Youth Training Centre. This was Nathan’s first of many admissions to youth detention that were to follow his move to the unit.

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INITIAL HEALTH ASSESSMENT CLINICS

In South Australia arrangements have been made for initial health checks of children and young people in care to be conducted at clinics constituted specifically for this purpose. Clinics are held at the Women’s and Children’s Hospital (WCH), the Flinders Medical Centre (FMC) and the Lyell McEwin Hospital (LMH). The initial health assessment is designed to achieve the following goals:

- identify any medical, psycho-behavioural or developmental conditions that require ongoing care;
- develop a health care plan that sets recommendations for the psychological health, physical health and developmental needs of the child or young person;
- make referrals to appropriate services as required;
- negotiate a process with Families SA to implement the health care plan; and
- implement the care plan and monitor the child or young person’s ongoing health status.

The clinics at FMC and WCH have the better developed models. Both clinics attempt to include a psychosocial component to the assessment by having a clinical psychologist or social worker attend when most needed. A key member of the team is the clinic coordinator, who is either a psychologist or social worker. Before the child’s appointment, the coordinator gathers relevant information from the Agency, SA Health (including birthing hospitals where relevant) and other health providers. The clinical skills of the coordinator are invaluable in identifying gaps in the documentation, summarising the child’s health history and identifying issues of relevance for the paediatrician who conducts the medical assessment. The clinic coordinator also engages with Families SA to ensure the attendance of the caseworker and the child’s carer.

The LMH clinic operates on a far more limited basis. The clinic is managed by a clinical nurse who gathers information before the appointment, and there is no psychosocial aspect to the assessment.

When undertaken comprehensively, the initial health assessment offers an opportunity to assemble all that is known about a child’s health and related health needs. It will frequently identify inaccuracies in the Agency’s records, which can include incorrect recording of a child’s immunisation status. This, however, can be checked against the National Immunisation Register. One practitioner reported that in reviewing the health history for one child she discovered that they were at risk of contracting Hepatitis C, but had not been tested. No-one had spoken to the child’s foster parents about the issue.

Several common themes emerged when representatives from each of the clinics gave evidence to the Commission regarding the initial assessments. These included behavioural problems, sleeplessness, feeding challenges and anxiety. All practitioners reported language delay as a common developmental issue in younger children being assessed. An emerging issue for children in care was obesity and emotionally disordered eating.

All representatives regarded it as important that the clinics viewed problems through a trauma lens. Children who have had traumatic experiences may well present with symptoms that are consistent with conditions such as autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD). However, for some of these children, such developmental issues will right themselves when stable and supportive care with appropriate therapy is offered.

The experience of staff at both the FMC and WCH hospital clinics was that very few, if any, children referred for an initial assessment had received a health check by a general practitioner within 30 days of them entering care, as contemplated by the national standards. The purpose of the early check is to identify any health conditions that need urgent attention, but also to provide some baseline information about height and weight which will enable the child’s growth to be tracked after they enter care.

The clinics rely on the Agency to identify children in need of assessment: they have no independent way of identifying them. The clinics consistently receive referrals for children who have been in care for much longer than two to three months without having an initial health assessment. The clinic coordinator for the WCH clinic told the Commission that of 45 referrals received by her, only one child had been referred within two months of coming into care. The others ranged from two months to up to 12 years.

Delayed referrals have consequences for children’s wellbeing. Many children whose initial assessments are delayed are later identified as having issues that would have benefited from earlier intervention. Furthermore, with the recent shift in disability funding arrangements to the National Disability Insurance Scheme (NDIS), children seeking to access funds under the early intervention pathway because of a developmental delay will be excluded if they are six years of age or older. The initial health assessment can identify and document important information to establish eligibility and pathways to NDIS funding.

An initial health assessment concludes with the paediatrician providing a report that is to be followed up by the child’s case manager. Review appointments can be scheduled as required, or referrals made back to the child’s primary health provider.
The initial health assessment is an important step in a child’s care journey—an opportunity to comprehensively take stock of their health history, status and future. It is an opportunity that should not be missed, particularly when there are clinics equipped to provide good quality assessments.

THERAPEUTIC SUPPORT

Medical practitioners involved in assessing children in care indicated that, in general terms, they were surprised at the low level of engagement with therapy. Children in care, almost by definition, have experienced trauma in their lives. Many carers expressed frustration about the difficulties they faced accessing therapeutic help for children in their care.

In a review of unmet mental health needs of children in care, published by GCYP in February 2012, a random audit of 60 files showed that 54 of the 60 children had received a mental health assessment of some kind. However, most of these were performed to assist in court proceedings, rather than to identify and guide therapeutic services. Many of the assessments did not meet the relevant out-of-home health care standards for a psychological assessment.

There was evidence that some children for whom therapy had been recommended had not been given a referral, and for others there were long delays between a referral and the first available appointment. There were four cases in which carers were dismissive of mental health plans and actively obstructed the child’s attendance for therapy.

Therapeutic services for children in care are scattered across a number of agencies, each of which apply their own criteria for eligibility. These include Families SA, child protection services at the WCH and FMC, Child and Adolescent Mental Health Services and private providers.

The CISC Inquiry recommended that the therapeutic services provided by these various agencies be reviewed, to increase the level of response available to children and young people. This recommendation was made in the context of therapeutic responses to children who have been the victims of sexual abuse. Evidence available to the Commission suggested that, notwithstanding this recommendation, the therapeutic needs of many children in care are still being neglected. While there are some examples of very good service from the Agency, not all children with a demonstrated need are receiving assessment and support.

The Commission was made aware of a number of promising developments in service provision across the child protection system. These initiatives should be nurtured to address children in care’s therapeutic needs.

FAMILIES SA PSYCHOLOGICAL SERVICES

Families SA employs clinical psychologists who provide both assessment and therapeutic services. The service structure and focus was in a state of flux at the time that evidence on the topic was taken by the Commission.

Chapter 9 recommends that eventually the assessment function for court purposes should be removed from the Agency but the assessment function for therapy be retained, enabling the Agency’s psychological services to focus more strongly on providing therapy for children in care and a consultation and training service for other staff.

Psychological services would also need to retain responsibility for coordinating private providers of therapeutic services.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Child and Adolescent Mental Health Services (CAMHS) is part of SA Health’s Women’s and Children’s Health Network. It provides community-based services for children and young people up to the age of 15; Boylan Ward, an inpatient hospital ward located at the WCH (for children between approximately 12 and 17); an emergency mental health team available at the emergency department of the WCH; and consultant liaison services at FMC and WCH. CAMHS also provides a perinatal and infant mental health service at WCH, and an infant reunification program.

At its Enfield campus, CAMHS provides an adolescent day service for young people who are struggling at school because of emotional problems or anxiety. The service is not designed, however, for young people with significant behavioural or emotional dysregulation. A behaviour intervention service is provided at the same site for children under 12.

CAMHS has recently undergone a significant restructure in response to a comprehensive review of its services completed in November 2014. At the same time, it has rolled out the Radical Redesign project, providing an opportunity to pilot a number of innovative service models responding to areas of need.

One of those pilots is a small inter-agency therapeutic needs panel, conceived to better coordinate the provision of therapeutic needs for children in care. The pilot was led by Dr Prue McCrady, the clinical director of CAMHS, who was concerned that although some children in care had been assessed many times, responses to their needs were not well coordinated. CAMHS recognised that there were occasions when there was no doubt a child required therapy, but there was a lack of thoughtfulness about the best type, and the best provider. There was also a need to coordinate children’s educational needs as part of any therapeutic strategy.
The panel currently comprises senior staff from Child Protection Services (FMC or WCH), Education, Families SA and CAMHS.

The panel started by considering 20 referrals arising from initial health assessments at the WCH, FMC and LMH clinics. These included some children who had recently entered care, and others who had been in care for some time.

The panel is still at a pilot stage, but offers promise in terms of its capacity to better coordinate assessment of and action on children’s therapeutic needs. It brings people together at a level of seniority that permits rapid and decisive action. Having the relevant agencies collaborate in this formal way also enables them to build a more comprehensive picture of the overall therapy needs of the population of children in care, and contribute to coordinated planning and service design. The model is especially worthwhile if it is able to also consider those highly complex young people whose needs are not always well coordinated.

EXCEPTIONAL NEEDS UNIT

The Exceptional Needs Unit in the Department for Communities and Social Inclusion (DCSI) administers (among other programs) a management assessment service, helping people who have especially complex needs. This covers clients whose needs are challenging existing services beyond their specialist capacity; clients whose needs are beyond the collaborative capacity of existing services; and clients for whom the absence of a primary diagnosis restricts their eligibility for services.

The service provides support at various levels of intensity, from consultation and advice to other service providers, through to a management assessment panel for eligible clients, and finally, referral to the Exceptional Needs executive committee where appropriate.

Management assessment panels are convened when a referral is considered to warrant a high level of assistance. Panel members are drawn from a group of 50—60 professionals who have agreed to participate, and are appointed in accordance with the particular issues of the client. Appointees must not have previously provided services to that client as they are expected to offer a fresh perspective on the client’s circumstances. The client is offered the opportunity to attend the panel or submit their views if attendance is not possible. The management assessment service provides the panel with a report which outlines current and past service provision, including what has been tried, and what has and has not worked.

The aim of the panel is to:

make a well informed and unconstrained consideration of what the issues are and not so much think about what service systems are available now, but [come] at it from the other end; starting out with the individual’s needs and trying to come up with a sense of what is required … developing service specifications, and then looking to what the best departments and agencies would be to provide that.\(^{104}\)

The management assessment panel is able to expedite service provision in a creative individualised way that is not possible through established programs. It can access a small budget to fund support services and is also in a position to negotiate ongoing funding with government and non-government agencies.

The management assessment service and its panel accept referrals for young people under the age of 18 where other eligibility criteria are satisfied. This includes a number of children in care who have complex needs that are not being met by the current service systems.\(^{10}\) The panel has identified two main groups who fall into this category. The first consists of children and young people who are subject to short-term guardianship orders, but whose long-term stability has not been secured. They appear to move in and out of the child protection system in a way that is not helpful to their wellbeing. These young people are often supported by the panel advocating on their behalf with the Agency to elicit a more assertive statutory response. The second group consists of children in care approaching the age of 18 who will need additional support after the Agency withdraws.\(^{10}\)

At a system level, the management assessment service is in a position to identify and highlight particular system deficits that arise frequently for the clients they see. These issues can be escalated to the Exceptional Needs Unit’s executive committee.

The purpose of the executive committee is ‘to facilitate and lead high level, strategic oversight of contemporary government policy and service responses for people with high and exceptionally complex needs’;\(^{10}\) Members of the committee are drawn from services including Housing SA, SA Health, Disability Services, Special Education, Office of the Public Advocate, Aboriginal Affairs and Reconciliation, Department for Correctional Services, Families SA and South Australia Police (SAPOL).

The structure and functions of the Exceptional Needs Unit prompt agencies to think beyond their service silos and cooperate at a higher level to help clients with very complex needs. This could be a model for the development of a panel and associated committee that focuses solely on the needs of children in care.
YARROW PLACE

Yarrow Place, an agency provided by SA Health through the Women’s and Children’s Health Network, provides services that includes forensic medical examination, follow-up therapy and counselling for anyone who has been sexually assaulted.

In response to Recommendation 42 made by the CISC Inquiry, Yarrow Place established a mobile youth team that offers a flexible and assertive outreach service to children and young people in care who are at risk of absconding and associated sexual exploitation. The team prioritises referrals for children and young people living in residential care facilities, and works closely with the residential care directorate to identify children at risk in those settings.113

Each clinician on the youth team carries a caseload of between five and six young people, permitting a more intense and flexible approach to engagement. Vanessa Kolarz, the director of the service, explained that the team’s mobility enabled them to ‘keep on their tail … maintain and build rapport, and find out where they are’.114

Referrals to the program are received only through Families SA, although children and young people might initially be identified by other agencies, such as SAPOL. Acceptance to the program depends on the child or young person’s case manager agreeing to become actively involved, as the person holding decision-making power.115 Importantly, once a young person is accepted, the program will continue to work with them as required to the age of 25. The program is currently limited to clients in the metropolitan area.

Flexible and assertive outreach is essential for children and young people who are commonly missing from their placement and engaging in high risk behaviour in the community.

REFORMING DELIVERY OF HEALTH AND THERAPEUTIC SERVICES

There is no doubt that many children receive high quality health and therapeutic services that are appropriately matched to their needs. However, the Commission is satisfied that some children’s needs are recognised later than they should be, and there should be a greater emphasis on prevention.

HEALTH

Initial health check clinics should continue to be supported at the WCH, FMC and LMH hospitals and should adopt a consistent model of service delivery based on the one currently followed at FMC.

The scope of initial assessments should be broadened to always include a psychosocial element, even where the information available suggests that a child is unlikely to experience problems of this kind. The clinics should also investigate the contribution a consultant liaison psychiatrist might offer to the assessment.

Chapter 9 recommends the establishment of a child protection service at LMH. An initial health assessment clinic should be part of that service, modelled on the clinics currently working at FMC and WCH.

THERAPEUTIC SERVICES

A greater investment in therapeutic services is needed for children entering and living in care. The assessment of their needs, and the processes for referring them to the appropriate service, should be better coordinated. The pilot panel process currently being evaluated by CAMHS provides a valuable model for an expanded assessment panel that is connected to children and young people whose needs are assessed at the initial health check. The panel should include at a minimum representatives from:

- Child Protection Services
- Education
- CAMHS
- Yarrow Place
- the Agency’s psychological services.

The Commission is also attracted to aspects of the model being delivered by the Exceptional Needs Unit’s management assessment service. Although that service is available to children under 18, including those in care, the Commission considers that a similar service should be developed in conjunction with the CAMHS therapeutic needs assessment panel to coordinate service delivery for children with complex needs and young people in care.

The Commission recommends that the agencies identified above work together to develop a management assessment service model that can provide coordinated intervention for children in care with complex needs. CAMHS should lead this work.

The Commission’s enquiries made it clear that there are young people (especially adolescents) who are prone to risk-taking behaviour in the community.
These young people are frequently absent from their placements. Some of these young people will be at risk of both absconding behaviour and sexual exploitation, and will therefore be eligible for the Yarrow Place program. Many vulnerable young people will be at risk because of other factors, such as drug taking, self-harm or criminal behaviour. These young people also need a mobile, intensive therapeutic service to engage them. The Commission recommends that the Yarrow Place service be expanded significantly to deliver an equivalent service to children and young people in care who frequently abscond and who are at risk of harm from factors apart from sexual exploitation.

‘It’s hard when friends ask how many mums and dads you have—you have to say you have heaps’

EDUCATION

Education plays a critical role in helping children in care to reach their full potential. Early traumatic experiences, however, can impact on a child’s ability to learn and to interact appropriately in the school environment. Children with a history of trauma and abuse may have an impaired ability to regulate their emotions and this can result in conflict with teaching staff and other students. There is also a greater risk that a child entering care will experience language delays, weakening their ability to socialise and learn. A good educational environment can contribute to overcoming children’s early disadvantage. Children consulted by GCYP confirmed that the benefits of school attendance reached beyond academic learning:

They say they like school because they can mix with friends and learn new things and that there is a stability in the same place and faces. They are usually able to do the same things as everyone else their age. School can positively contribute to their social and emotional wellbeing.

Osborn and Delfabbro, prominent researchers in this area, have observed that:

Education is essential for good outcomes later in life including employment and as a protective measure against risk factors such as substance abuse, homelessness and criminality. Therefore, it is essential that education is given priority within the care system so that children and young people are not placed in a position that is likely to lead to negative life outcomes.

Attending school and socialising with friends who enjoy traditional family structures can be challenging. Children and young people consulted by the Commission reported varying experiences of school. The following negative aspects were identified:

• It’s hard when friends ask how many mums and dads you have—you have to say you have heaps.
• It is hard at school because you have to tell everyone; they ask why and tell everyone. Mum rocked up to OSH—I used to tell a few people but moulised Mum was telling everyone about how and why I was in foster care. It is important I get to tell people.
• Form signing takes time.

Some children, however, spoke about the positive support that they have received in their educational environments:

• I have not been bullied, but the whole school knows—they are there for me.
• In primary school I told more people as I had the principal’s support.
• Last year I had no support. The principal changed everything.

Although there was evidence of children having very good school experiences in supportive and caring environments which understood the child’s individual needs, the Commission also heard evidence of schools, including Department for Education and Child Development (DECD) schools, which were reluctant to enrol students who had challenging behaviours or special educational needs because of a history of trauma and abuse. More than one witness reported that schools had indicated a reluctance to accept enrolment of children in care, telling Families SA staff that they ‘had their quota.’

School attendance can not only support educational success, it can also improve placement stability. As part of the Commission’s examination of the circumstances of Nathan (Case Study 4) the Commission heard from Mr and Mrs P, foster carers who had looked after Nathan in the years immediately preceding his move to a large residential care unit. As a result of serious abuse in his infancy, Nathan suffered from reactive attachment disorder, a pervasive psychological disorder.

Mr and Mrs P worked tirelessly to engage Nathan in education, seeking a learning environment that met his needs, but Nathan’s behaviour resulted in repeated suspensions and exclusions from school. These were followed by long periods of disengagement from school while protracted bureaucratic negotiations occurred about the conditions of his return.
Reactive attachment disorder

Reactive attachment disorder (RAD) is a psychological disorder that is described by reference to disturbed and developmentally inappropriate social relatedness. By definition, it originates in a child’s exposure to extreme levels of insufficient care in one or more of the following:

- social neglect or deprivation in the form of a persistent lack of basic emotional needs for comfort, stimulation and affection met by caregiving adults;
- repeated changes of primary caregivers that limit opportunities to form stable attachments (for example, frequent changes in foster care);
- rearing in unusual settings that severely limit opportunities to form selective attachments (for example, institutions with high child-to-caregiver ratios).

Children with attachment disorders struggle with the relational skills that other people develop from loving and nurturing care. They will often struggle to be in charge as a way to deal with relational challenges, and struggle to regulate their own emotions. Children who suffer from RAD do not respond as other children to regular discipline. They experience it as rejecting, and it can take a heavy emotional toll on them. They will approach relationships as something to be feared, or a device to manipulate to have their needs met, and act in one of two distinct ways: by using charm to control and regulate others and have their needs met, or by being hostile and distanced towards others. Attachment disorders often cause children and young people to see the world as an unsafe place, and be perpetually behaving according to the flight/fight/freeze response.

This condition of itself demonstrated a misunderstanding of the chronic nature of Nathan’s condition, and the role that the school had in helping Nathan to develop his skills. The Commission’s examination of Nathan’s educational circumstances revealed little evidence of Education being prepared to work collaboratively with the Agency and Nathan to ensure his education was not threatened by long periods of disengagement.

Mr and Mrs P, together with Families SA caseworkers and other private professionals, attempted to advocate for Nathan’s access to education. These attempts were so consistently unsuccessful that Mr and Mrs P, on behalf of Nathan, filed a complaint with the Equal Opportunity Commission of South Australia. Mr and Mrs P, on behalf of Nathan, complained that the education system persisted with traditional behaviour management techniques, which had been identified by a variety of professionals involved in his care to be inappropriate and ineffective. In fact, for Nathan, a traditional disciplinary approach risked escalating his emotional dysregulation and leading him to act in even more extreme ways.

Before the complaint was resolved, arrangements were made to enrol Nathan in an independent school which, it was hoped, would offer a more suitable approach. At the time of Nathan’s enrolment at that school, Mrs P told Families SA that she was convinced that if Nathan did not start attending school, the placement would fail. The family could not withstand the constant pressure of Nathan’s lack of educational engagement, and continue to manage him at home on a full-time basis.

Mr and Mrs P’s experience is not isolated. A report prepare by UnitingCare New South Wales, a major provider of out-of-home care services in that state, observed that ‘our experience is that school suspension or exclusion creates significant strains on the care placement and may lead to placement breakdown’.

ACCESS TO SCHOOLS

Every public school in South Australia has a notional catchment area, and some schools experiencing enrolment pressure are zoned. Any child of school age living within that zone has a right to enrol. Children who are in care may be exempt from zoning restrictions. The education arm of the DECD attempts to ensure that each child in care is enrolled at an educational site appropriate to their needs. Jayne Johnston, Chief Education Officer, told the Commission that it would be unacceptable for a school principal to decline to enrol a child on the basis that they already had met their quota of children in care with trauma-related behaviours. A principal can be directed by departmental staff to enrol a student.
Ms Johnston expressed the ‘absolute view’ that if Families SA made a recommendation about the educational needs of a child who is in care, Education would facilitate that.134 Ms Johnston acknowledged that a minority of teachers and school principals might be anxious about supporting a student like Nathan and might avoid taking on such a challenge.135

School principals are obliged to provide a safe learning environment for school staff and students. Imposing special conditions on enrolment and providing additional support may be needed in some circumstances to mitigate risk.136 However, conditions must not be imposed that are so onerous as to effectively exclude high needs students from participation.

The Commission received evidence that children in care sometimes struggled with the requirements of their educational environments, and were frequently suspended from school in response to behavioural issues. Data obtained by GCYP confirms that children in care are suspended at a much higher rate than their peers. The same data demonstrated a higher proportion of children in care were subject to school exclusions.137

The Education Regulations 2012 (SA) provide for the suspension, exclusion138 or expulsion139 of students. A student may be suspended by the principal for no more than five consecutive school days. A student may not be suspended for a total of more than 15 school days; or on more than four separate occasions in a calendar year without authorisation being given by a more senior officer.139 An exclusion may only be for a period of between four and 10 weeks, unless it is at the end of a school term and there are fewer than four weeks remaining.139 A student may not be excluded for a total of more than 20 weeks in a calendar year without authorisation being given by a more senior officer. A student cannot be excluded without first being suspended.139 A school principal may not suspend or exclude a student indefinitely, nor are they entitled to prevent the student from returning to their school site. A decision of that kind must be made at a higher level.139

A suspension is intended to be a ‘relatively short and sharp process’.139 Students under suspension should be provided with support to reflect on their behaviour, and schools should work towards avoiding a repeat of the conditions giving rise to it. For students who have a challenging environment outside school or a background of trauma or abuse, an important part of a principal’s behaviour management repertoire is an internal or in-school suspension.139 During exclusions a student may also be referred to a learning centre. The child should be given help managing their behaviour and serious re-engagement work should occur.140 A learning centre may also be used as a stepping stone to a student attending a new mainstream school.140

Through the government’s Rapid Response framework, DECD undertook to ‘ensure that all avenues for preschool, school and post-compulsory education-based supports are explored before suspension or exclusion … are considered’.141 Evidence before the Commission suggested that this commitment was not always being honoured in practice.

SMART TRAINING

In 2005 the Department contracted with the Australian Childhood Foundation to deliver training in Strategies for Managing Abuse Related Trauma (SMART). This training is designed to equip teaching staff to respond more effectively to children and young people who struggle with the educational environment because of abuse-related trauma. The Department has recently renewed this commitment for a further three years.142

A number of teachers across the Department have completed the SMART training, and some have completed training to train others.143 The Commission considers this an important step towards changing the attitude of teachers to children facing educational challenges of this type. However, unless the training changes teaching practice, it is a hollow endeavour. The Department has held a contract to deliver this training since 2005, but evidence indicated that there remained a high level of misunderstanding of the needs of children in care.

The Department’s learning centres take advantage of a much higher teacher–student ratio than conventional schools and provide education for periods up to 10 weeks to students who have been excluded from their schools. Behaviour centres operate on a similarly intense level and provide intervention for students who are at risk of disengaging from schooling.

SMART training is a foundational skill for all learning and behaviour centre staff; they are also expected to have a greater understanding of students with trauma backgrounds.144 Nathan attended a learning centre during one period of disengagement from school. Staff at the centre described Nathan as a psychotically calculating and dangerous, an evaluation contrary to their SMART training, which should have given them a more sophisticated understanding of Nathan’s challenges.144 At one time Nathan was locked in a classroom following an incident with a teacher, a strategy that was completely counterproductive in the face of Nathan’s limited emotional regulation abilities in that environment.144 The time Nathan spent at learning centres did not lead to his reengagement in mainstream education.
Patricia Strachan, the former executive director of the Office for Children and Young People within the Department, was asked about the value in having schools specifically identified as ‘SMART’ friendly schools, or as schools with a high proportion of SMART competent teaching staff. Ms Strachan expressed caution about such an approach, observing that:

"It would be very difficult to label all our schools with ... names [such as] autism friendly, dyslexia friendly. Really, schools need to be able to provide inclusive education to meet the needs of their students, irrespective of the profile of disabilities, challenging behaviour, children who have been traumatised. So they need to be able to do all elements, really." 144

Ms Johnston agreed with these observations, noting that while the Department had taken an important first step towards embracing trauma-friendly principles, there was a need to lift the level of understanding within all schools to better meet the needs of students. Ms Johnston considered that greater investment in these skills in pre-service training was required, and that this would be achieved by greater engagement with the tertiary sector. Graduate teaching programs for teachers in their first three years also needed to include a greater emphasis on supporting students who came from a trauma background. Ms Johnston observed that many teachers entered the profession with very little appreciation of the complexity of problems some children at school might be facing. 145

IN-SCHOOL SUPPORT
Where a child who is not in care has additional needs, school services officers may provide extra support. This support is not paid for by the child’s parents and is funded by the Department. 150 The Commission was told that where a child is in care, the Education arm of the Department frequently expects Families SA to fund this support. 151 Negotiations about these issues can delay a child’s enrolment or return to school. There is no reason to treat children in care any differently from other children when considering funding responsibilities for their in-school support. Delays concerning funding should never contribute to a child’s absence from school.

REDUCED HOURS OF ATTENDANCE
It is helpful to some students experiencing challenges in the school environment to have their hours of attendance varied for a limited period of time. If a student is attending school less than full time, specific exemptions are required. Variation of hours for less than a month can be authorised by the school principal. For longer periods the exemption must be approved above principal level 152 and must be recorded in writing. Given that school attendance is compulsory, arrangements for reduced attendance should be strictly tracked and not allowed to drift. The Commission heard evidence which suggested that these requirements were not always met.

Nathan attended school on the basis of reduced hours at a number of departmental sites for a number of years. Departmental records obtained by the Commission, however, did not indicate that relevant exemptions were always in place. The Office for Education held only two exemptions for Nathan covering July to December 2014.

Part-time attendance to address behavioural challenges should always be regarded as transitional. Any exemption should be supported by a clear plan for return to full-time engagement. As a process, it should be rarely used. 153 However, the evidence obtained by the Commission suggests that there has been inconsistent compliance with the necessary safeguards on a wide scale. Wendy Dale, the manager of Families SA’s School Engagement Program, reported that children in care who are referred to that program attending less than full time generally do not have part-time exemptions or plans for educational re-engagement in place. 154

INDIVIDUAL EDUCATION PLANS
Individual education plans should be in place for all children in care. The government’s Rapid Response action plan recommended that all preschools, primary schools and high schools develop an individual education plan for students in care. 155 An individual education plan should anticipate the challenges that might arise and identify in advance what support is to be provided, by who and to what end. It should include specific measures to address educational disadvantage and, where appropriate, promote an environment of care that supports recovery from trauma.

REFORMS IN EDUCATION
It is critical that Education regards itself as a partner of the Agency in delivering appropriate services to children in care. As outlined earlier, remediation of psychological damage sustained when a child is abused or neglected is achieved through cohesive and consistent care across a child’s environments. A child’s education should be approached as a part of the therapeutic solution.

Ms Johnston recognised that the flexibility needed within the system was not always evident. 156 A culture of preparedness to engage with vulnerable students should be fostered within Education.
Professional development as well as practical supports are necessary. The level of understanding of students with significant trauma backgrounds needs to be improved within all schools. All schools need to be ‘trauma friendly’. To this end, Education should continue to encourage staff to undertake SMART training, and should ensure that these skills have a high profile in professional development programs.

At an individual school level, there is scope for the child wellbeing practitioners referred to in Chapter 8 to also play a role in sharing knowledge about the needs of children in care, and contribute to training on these topics.

Policies relating to suspension, exclusion, expulsion and reduced hours should be reviewed for their appropriateness for children with trauma backgrounds. In particular, greater effort should be made to deal with their behaviour by providing in-school options that have a learning component. These children should also be given opportunities to reflect on their behaviour, and helped with strategies to avoid such behaviour in the future. All other options should be explored before suspensions or exclusions are utilised.

Records should be regularly audited by Education to ensure that the necessary authorities are in place for students on reduced hours of attendance and, most importantly, that there is a current plan to return them to full-time schooling.

Funding arrangements should be clarified to show that Education remains responsible for funding any additional school support required for children in care. Funding should be allocated on the basis of the needs of the child, as guided by expert assessment and input from Families SA and the child’s carer. Policy guidance for funding should reflect the special duty that the state owes to children in care to address the disadvantages of their early experiences.

Specifically trained school support officers may provide one aspect of the assistance required. Education should recruit and train people who have skills in helping children with these behaviours, and who can deliver services where needed.

**CHILDREN WHO GO MISSING**

The CISC Inquiry exposed the plight of vulnerable children who were frequently missing from their care placements and made a number of recommendations to improve the safety of children and young people who behaved in that way.

This Commission is aware that the problem of missing children is a continuing one, but is also concerned that some of the tools and strategies recommended in the CISC Inquiry have not yet been deployed to their full extent.

The Commission examined records of children missing from their placements during the 2013/14 financial year. One 16-year-old male during that year had been missing from his placement a total of 178 times. The longest continuous period was five-and-a-half days. A 13-year-old female during the same period had been missing 96 times. The longest sequential period for her was 19 days. Absences of this frequency and length were not uncommon.

Children who leave their placements are influenced by factors that can be broadly described as ‘push and pull’. Push factors are reasons the child wants to leave, perhaps because they do not feel happy in or connected to their placement or they don’t like other young people with whom they have been placed. Pull factors are the features of the world outside the placement that attract them. For some children this will be cigarettes or alcohol and illicit drugs; for others it will be relationships with adults with whom they cannot associate in their placement. Often these two matters will be interrelated.

There is no simple solution to the problem. Keeping more children safely in their placements depends on improving the quality of their care environment, coupled with efforts to reduce the pull from outside.

These challenges are not unknown in conventional family structures. There, however, established relationships of trust and feelings of belonging help the young person explore their world in a safer way.

For children who live in less nurturing circumstances, there are greater challenges. Laura Kelly, a program manager within the residential care directorate with particular experience in this area, told the Commission:

> It’s all good and well to have fantastic workers and staff and clinicians and services and care teams and practice guides and procedures, but if children aren’t there, you can’t use them. And if you’re competing with drug dealers and people in the community because the children are desperate to make connections and, you know, try as they will—the staff are mostly really excellent people—the children will choose people with whom they can continue an ongoing relationship post-care, so they will connect with anyone and everyone in the community, quite often, and I think that’s such a problem that probably just needs more time and resources, not just from child protection, but from other agencies.
Since the CISC Inquiry, the Agency has developed a risk assessment to be completed for all children in residential care which identifies their risk in the community should they go missing. It takes into account factors such as their age, their connections in the community, and the chance of them engaging in risk-taking activities. The assessment is intended to be actively reviewed and guides the response that the Agency takes to children and young people who go missing. It advises whether a formal missing persons report should be lodged with SAPOL, and what level of response from the police is sought.

The use of this tool, and the associated guidance on responding to absences, has resulted in a significant drop in the number of children and young people being reported to SAPOL as missing. There has been a corresponding change to the way in which SAPOL is engaged when there is a low risk associated with their absence. There was also evidence that a greater level of cooperation and collaboration has been possible between the Agency and SAPOL; for example, training has been delivered jointly by the Agency and SAPOL to residential care staff as well as some staff at guardianship hubs. The training includes using the risk assessment tool, but also provides staff with greater knowledge and understanding of the triggers that cause children to go missing as well as better skills to deal with them. This process should continue.

The use of the risk assessment tool and greater collaboration with SAPOL will not change the behaviour of children who wish to leave their placement. Training workers in understanding children’s triggers, and how to manage them, are an important part of the training, and should continue to receive emphasis.

REGULATING EXPLOITATIVE RELATIONSHIPS

One tool that is available to Families SA that is not available in traditional family structures is the legislative power to give written directives to adults in certain circumstances. This power enables Families SA to intervene between young people in care and unsuitable adults who would seek to exploit them.

The power to give written directives originated in recommendations made by the CISC Inquiry, which observed that although there was a range of criminal offences that could be employed against adults who exploit young children in care, proof of those offences usually depended on the willingness of the child concerned to give evidence. Young people who are vulnerable will frequently be unwilling to speak against exploitative adults. This may be due to fear and intimidation, or gifts and bribery. The value of written directives lies in placing the onus to manage contact on the adult rather than the young person, and reducing the places to which a young person could run if they decided to leave their placement.

Section 52AAB of the Children’s Protection Act permits a written directive to be issued by the chief executive of the relevant department prohibiting a person from:

- communicating or attempting to communicate with a specified child during a specified period; or
- harbouring or concealing or attempting to harbour or conceal a specified child during a specified period.

The chief executive must not issue such a notice unless they believe that it is reasonably necessary:

(a) to avert a risk that the child specified in the notice will—
   (i) be abused or neglected, or be exposed to the abuse or neglect of another child; or
   (ii) engage in, or be exposed to, conduct that is an offence against Part 5 of the Controlled Substances Act 1984; or

(b) to otherwise prevent harm to the child.

An offence against Part 5 of the Controlled Substances Act includes the trafficking, manufacture or cultivation of controlled drugs and the trafficking or cultivation of controlled plants.

The scope for the deployment of a written directive is wide. It can be applied where there are concerns about physical abuse, sexual abuse, self-neglect or neglect of other children, and involvement in, or exposure to, the trafficking, manufacture, cultivation, possession or use of controlled drugs, including cannabis. The words of the section assume that exposure to drug possession or use will be harmful to a young person.

The Families SA fact sheet on written directives was examined by the Commission. It inaccurately advises that ‘a written directive is appropriate in circumstances where there are reasonable grounds to suspect that the child or young person in care has been abused or is likely to be at risk of harm by an adult’. The fact sheet replaces the words of the legislation with concepts that are not consistent with, and are more stringent than, the test set out in the legislation.
The fact sheet further advises that ‘[when] considering whether to issue a written directive, the case manager and supervisor must have made an assessment that issuing the directive is reasonably necessary to avert a risk that the child or young person will be abused, neglected or harmed by an adult’.176

The notion of future harm is repeated later when the fact sheet states that ‘evidence or proof that the child or young person has already been harmed is not required as the aim of a written directive is to prevent further known or potential harm from occurring’.177 These statements introduce to the test the additional requirement that the state of mind must include a risk of harm to the child. In fact, a written directive can be lawfully issued to prevent a risk that the child will engage in, or be exposed to, offences against Part 5 of the Controlled Substances Act without any belief or state of mind about specific harm that might follow from that engagement or exposure.

Further, the fact sheet refers to conduct against Part 5 of the Controlled Substances Act and specifies concerns about the use, manufacture or sale of drugs and/or firearms. Part 5 encompasses a much wider range of drug-related conduct, which may well occur in the presence of a young person or be engaged in by a young person. Importantly, it includes possession of drugs even for personal use, supply of drugs (for example, sharing drugs with young people), cultivation of controlled plants, and possession of equipment to smoke cannabis. Part 5, contrary to the fact sheet, makes no reference to firearms whatsoever. Any written directive based on a risk associated with firearms would need to be justified under section 52AA(B)(3)(b) ‘to otherwise prevent harm to a child’.

Any staff member who considers the fact sheet without reference to the applicable legislation may well be left with the impression that the scope of written directives is restrictive. The nature of the risk in fact required could be as low as exposure to a person possessing drugs for their personal use, sharing cannabis or possessing a pipe to smoke it. Properly understood, the power to issue a written directive to control an adult’s access to a young person in care has a wide application to a variety of situations. The Families SA fact sheet presents an unnecessarily restrictive picture of that power.

In the Commission case study into the circumstances of Hannah (see Vol. 2, Case Study 3), a distinct reluctance to employ the tools was evident. Hannah was frequently absent from her placement, and there was a legitimate fear that she was at risk of abuse and exploitation from adults with whom she associated during those absences. Despite this, caseworkers exhibited a poor understanding of the utility of written directions, and were reluctant to assertively use them to keep Hannah safe. This is surprising given that the power to issue written directives has been available to Families SA staff since June 2010.178

There should be a review of Families SA’s guidelines for written directions. Accurate guidance should be provided about their scope and application, and staff should be encouraged to use them proactively in appropriate situations to keep children in care safe.

## Prioritising the Experience of Children in Care

In the Commission’s case studies of Hannah and Nathan (see Vol. 2, Case Studies 3 and 4 respectively), neither young person’s voice was strongly apparent in making decisions about their welfare. Each young person was at an age where they were capable of contributing to decision making, and although their preferences could not always be accommodated, they should have been given clearer opportunities to contribute.

The low rate of young people’s participation in case planning and annual review planning is concerning, and suggests practice that does not value their contribution in determining the course of their own lives, and understanding their own experiences. The Commission came across many examples of decisions being made about children without their consultation.

National out-of-home care standards require that children and young people in care participate in decisions that have an impact on their lives, in accordance with their age and developmental stage. One of the overriding principles identified in the South Australian standards is that children and young people are given ‘a voice in decision making and [are] involved in the design and delivery of services’.179 More specific policy guidance or unenforceable standards have, to date, made few differences to practice.

The Commission recommends that the entitlement of children and young people in care to contribute to decision making should be enshrined in legislation, in a more direct way than is currently provided.

The current Children’s Protection Act section 3(3) requires that the views of that child (if the child is willing and able to express such views) must be taken into account by any person making a decision under the Act. This includes decisions made by the Youth Court regarding guardianship of the child. The way in which these views are provided to the Court are discussed in Chapter 9. ‘Taking into account’ a child’s views is not the same as involving them in decision making. For some decisions, including decisions made by the Youth Court, ‘involvement’ would not be appropriate. However, for some decisions, there is greater scope for involvement of a child, in addition to simply providing their views.
Many decisions made by the Agency according to the guardianship order and the powers of care and control inherent in that order are identified (although not exhaustively) in section 51 of the Act. In the Commission’s view it is appropriate to go further than simply having regard to children’s views and insert a requirement that they be included in decision making in those circumstances.

GCYP’s submission to the Commission recommended an express legislative amendment to provide that:

- in all decisions that affect the child, the child will be included in the decision making to the extent that they are capable and willing; and
- the views of the child will be given due weight in accordance with the age and maturity of the child.178

The Commission agrees with that proposal. An amendment should be made to section 51 of the Act to reflect this.

**MONITORING THE QUALITY OF CARE**

As is noted elsewhere in this report, the South Australian Standards for Alternative Care are not actively monitored or reported upon. At this stage, it would be cumbersome and counterproductive to require the Agency to report performance against all of the standards. However, these children are the responsibility of the state, and the Minister should be regularly informed about the quality of care being offered to them as a group.

For this reason, the Commission considers it necessary that the Agency report to the Minister quarterly on the following Standards of Alternative Care:

- Standard 2.1—A caseworker is allocated to each child and young person in alternative care.
- Standard 2.2—Each child and young person will have face-to-face contact with their allocated worker a minimum of once a month.
- Standard 2.6—Each child in long-term care has a case plan that is developed, monitored and reviewed every six months.

The Agency should also report quarterly on the proportion of children who enter care who have their medical and psychosocial needs assessed in accordance with the relevant health standards for children entering care, and the proportion who are reviewed pursuant to section 52 of the Act at the time that the annual review falls due.

This data should also be provided, at the same time, to GCYP for monitoring purposes.
The Commission recommends that the South Australian Government:

75 Review and republish Rapid Response with updated guidance as to the extent of priority access for children in care.

76 Reinstate the inter-departmental committee overseeing Rapid Response to review its operation, at least biannually.

77 Ensure that every child or young person in care has an allocated caseworker who has face-to-face contact with them once a month at a minimum.

78 Assess all children who are currently receiving a differential response for eligibility for Other Person Guardianship.

79 Assess whether allocation of a primary and secondary worker to deliver guardianship case management would improve the continuity of relationships with children.

80 Review the policy guidance and all other documents used for annual reviews to ensure compliance with section 52 of the Children’s Protection Act 1993, including requiring greater sharing of the information discussed at annual reviews.

81 Require that all annual reviews be chaired by a suitably qualified person who is independent of the case.

82 Give concurrent planning greater emphasis in case planning, especially for children during their active attachment period.

83 Review all placement breakdowns to determine and correct identified system deficits.

84 Provide therapeutic support to placements that are identified as being at risk or under stress.

85 Fund initial health assessment clinics at the Women’s and Children’s Hospital, Flinders Medical Centre (FMC) and Lyell McEwin Hospital to operate in accordance with the service model employed at FMC. This includes funding clinics at a level that enables a psychosocial component to be offered at every initial health assessment.

86 Invest in the ongoing development of a therapeutic needs assessment panel led by Child and Adolescent Mental Health Services for children in care whose therapeutic needs are identified in their initial health assessment.

87 Develop an inter-agency panel modelled on the Exceptional Needs Unit’s management assessment panel to support case management of those children in care with complex needs who are not appropriately managed by existing services.

88 Develop a mobile outreach service modelled on Yarrow Place’s mobile youth team for children and young people who frequently abscond from placement, and who are at risk because of factors other than sexual exploitation.

89 Improve the profile of Strategies for Managing Abuse Related Trauma (SMART) training for educational staff, requiring that to be part of professional development where appropriate.

90 Review and promote Education’s policies regarding school suspension, exclusion and expulsion to ensure that they are used as strategies of last resort for children in care.

91 Regularly conduct an audit of children in care who are on reduced hours of attendance at school and ensure they have plans to re-engage them in mainstream education.

92 Require Education to fund any in-school support needed by children in care.

93 Recruit and train a panel of school services officers to support children with trauma-related behavioural challenges.

94 Amend the practice guidelines regarding written directives to comply with the provisions of the Children’s Protection Act 1993 and provide training to child protection workers to ensure that they understand them.

95 Amend section 51 of the Children’s Protection Act 1993 to include a requirement that in all decisions affecting the child that are made in accordance with an order for guardianship, the child must be included in the decision making to the extent that they are capable and willing, and that the views of the child are given due weight in accordance with the age and maturity of the child.
Require the Agency to report quarterly to the Minister and to the Guardian for Children and Young People, and make public a report as to the following matters:

a compliance with the Standards of Alternative Care in South Australia 2.1, 2.2 and 2.6;

b the proportion of children entering care whose health needs are assessed in accordance with the requirements of the relevant health standards; and

c the number and proportion of children and young people who have been reviewed in accordance with section 52 of the Children’s Protection Act 1993 at the time the review falls due.
NOTES

1 Department of Families and Communities (DFC), Standards of alternative care in South Australia, revised 2009, Government of South Australia, p. 10.
2 S South et al., Scoping review: Evaluations of out-of-home care practice elements that aim to prevent child sexual abuse, Parenting Research Centre and the University of Melbourne, commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, revised 2015, p. 7.
4 Children’s Protection Act 1993 (SA), s. 43.
5 For example, see Youngman v Lawson [1981] NSWLR 439, pp. 445–446.
6 Children’s Protection Act, s. 52.
7 ibid., Part 7A, Division 3.
8 GCYP, Charter of rights for children and young people in care, GCYP, no date.
9 DFC, Standards of alternative care in South Australia, p. 25.
10 ibid., p. 27.
11 ibid., p. 28.
12 ibid., p. 29.
13 ibid., p. 35.
14 ibid., p. 37.
16 Department for Families and Communities (DFC), Rapid Response: Whole of government services for children and young people under the guardianship of the Minister, Government of South Australia, 2005, p. 3.
17 ibid.
18 ibid., p. 5.
19 Oral evidence: Name withheld (W60).
20 Submission: Guardian for Children and Young People.
22 DFC, Standards of alternative care in South Australia, p. 35.
24 ibid., chart 15A, 17.
26 Oral evidence: J Longbottom.
27 ibid.
28 Oral evidence: P Simmons.
30 The CREATE Foundation is the national peak consumer body for children and young people with a care experience.
31 J McDowall, Experiencing out-of-home care in Australia, p. 36.
32 ibid., p. xix.
34 J McDowall, Experiencing out-of-home care in Australia, p. xix.
35 ibid.
36 ibid.
37 GCYP, The circumstances of children and young people in care, p. 16.
38 Oral evidence: Name withheld (W51).
40 ibid.
41 Families SA, data supplied to the Child Protection Systems Royal Commission, 24 December 2015.
42 Oral evidence: Name withheld (W59).
43 Oral evidence: Name withheld (W76).
44 Oral evidence: R Whitten.
45 GCYP, The circumstances of children and young people in care, p. 20.
46 Oral evidence: Name withheld (W76).
47 Oral evidence: Name withheld (W72); name withheld (W49); name withheld (W59).
48 Oral evidence: Name withheld (W49).
49 J McDowall, Experiencing out-of-home care in Australia, p. 86.
51 ibid.
52 Children’s Protection Act, s. 52.
56 ibid.
57 Children’s Protection Act, s. 52(4).
58 GCYP, The circumstances of children and young people in care, p. 23.
59 ibid.
60 GCYP, correspondence with the Child Protection Systems Royal Commission, 4 July 2016.
62 ibid.
63 Families SA, ‘Care planning policy version 1.0’, internal unpublished document, October 2010.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
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NOTES

132 Education Regulations 2012 (SA), r. 45.
133 ibid., rr. 46, 47: A student may not be expelled from a school by the head teacher (a principal) for less than six consecutive months, unless the exclusion is for the remainder of the school semester, or for more than 18 consecutive months. The Director-General may expel a student from all schools and other specified facilities for not less than one year, unless the expulsion is for the remainder of the school year, and for not more than five years. A student cannot be expelled without first being suspended.
134 ibid., r. 44.
135 ibid., r. 45.
136 ibid.
137 Oral evidence: J Johnston.
138 ibid.
139 ibid.
140 Oral evidence: J Johnston; P Strachan.
141 Oral evidence: P Strachan.
142 DFC, Rapid Response: Whole of government services for children and young people, p. 28, recommendation 3.7.3.
143 Oral evidence: P Strachan.
144 Oral evidence: J Johnston.
145 ibid.
146 GCYP, ‘Record of meeting’, internal unpublished document, September 2012, pp. 11, 64.
147 Oral evidence: Mr and Mrs P (Vol.2, Case Study 4: Nathan)
149 Oral evidence: J Johnston.
150 ibid.
151 Oral evidence: Name withheld (W73); J Johnston.
152 Oral evidence: J Johnston; W Dale.
153 ibid.
155 DFC, Rapid Response: Whole of government services for children and young people, p. 28.
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159 ibid., p. 10.
160 Data supplied by Families SA.
161 Oral evidence: L Kelly.
162 ibid.
163 ibid.
164 ibid.
165 ibid.
166 ibid.
168 ibid., p. 474.
169 ibid.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
# CARING FOR CHILDREN IN HOME-BASED CARE

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There is no doubt that in most circumstances the best care for children who cannot live at home is in an alternative home-based environment.

In South Australia, people who open their homes to care for children who have been removed, do so on a voluntary basis, with reimbursement of the estimated cost of caring for the child or children. One witness referred to the enterprise as ‘extreme volunteering’, a description that captures the challenges and rewards conveyed to the Commission in the course of hearing from foster and kinship carers.1

A healthy and robust foster and kinship care system is critical to the functioning of the child protection system for the following reasons:

• Children in out-of-home care do best in ongoing, stable environments where their emotional, relational and developmental needs are met.
• Where the supply of foster and kinship carers is insufficient, children who cannot live at home are cared for in rotational styles of care. These care arrangements often deliver poor quality care, at a higher cost, and do not satisfy a child’s emotional and relational needs.
• Heavy reliance on rotational care burdens the child protection budget and makes it more difficult to fund prevention and family preservation activities.
• Child protection workers might be reluctant to remove children from unsafe environments when they are not convinced that placing the child in the alternative situation would be any better.

Investment in growing home-based care options for children removed from their families is a critical step in reforming the current system. The system must get foster and kinship care right to make inroads in other areas. A number of barriers currently exist to growing the sector. Some are within the control of Families SA (the Agency), but others reflect wider social and economic conditions which are not easily addressed. The system should also invest in looking after existing carers. Supporting carers to parent children well should be seen as strengthening protective factors for children in care.

However, home-based care options must not be grown by risking children’s safety in accepting less than satisfactory placements. Inappropriate or unsafe care can compound existing trauma, and increases the risk that children will suffer long-term psychological, emotional and relational difficulties.

In 2008 the Office of the Guardian for Children and Young People (GCYP) asked their youth advisors what made a good foster parent.

One contributor said ‘the focus for someone considering becoming a carer should be on wanting to provide a home and a heart for a child who can’t live with their family’.2 Young people who participated in the consultation for the Commission also emphasised these aspects of belonging:

That the foster carers treat me like they love me, and like I’m their actual kid.

I don’t call her mum but she is my mum. She is now my guardian.3

‘The focus for someone considering becoming a carer should be on wanting to provide a home and a heart for a child who can’t live with their family.’

The Agency cannot parent a child. It cannot provide the sustained and consistent relational safety that many children entering out-of-home care desperately need. The Agency can endeavour to find the best people to carry out this important task, and support and monitor them to make sure they do it in the best possible way.

This chapter considers how the numbers of home-based carers can be increased, and how the quality of the care offered can be improved, consistent with keeping children in home-based care safe.

This chapter principally relates to the Commission’s Term of Reference 5(d), in the context of Terms of Reference 1 to 4.

The rate of children in care has risen steadily over the past decade for both Aboriginal and non-Aboriginal children, (see Figure 11.1) and consequently substantially more children need out-of-home care. These rates are unlikely to decrease significantly in the short term, and they have not been matched by a commensurate increase in available home-based care placements.
Most South Australian children in care live in stable, long-term placements, most, if not all, of which are home based. GCYP reported that a 2013/14 audit of 208 annual reviews revealed that 81 per cent of children were living in stable, long-term placements. The most recent figures show that 85 per cent of children in care live in home-based care (see Figure 11.2). The number of children in home-based care is steadily increasing, but has not increased proportionally because the population requiring care has also grown overall.

The proportion of children in home-based placement has remained steady since 2007, maintained by a large increase in reliance on kinship care, not by substantial growth in recruitment and retention of foster parents (see Figure 11.3 and Figure 11.4). The last decade has seen a 350 per cent increase in the numbers of children being cared for in this way.

South Australia’s spending on out-of-home care per child per night is among the highest in the nation, until 2013/14 outpaced only by WA and the NT (see Figure 11.5). The 2013/14 financial year saw a sharp increase in the costs of out-of-home care, attributable to the high costs of residential and commercial care placements. As at 30 June 2015 the annual cost per child of residential care in South Australia was $275,903. Non-residential care (including home-based care) was less than a fifth of that figure at $48,736.00. Foster and kinship care is not only the best quality care for children, in most circumstances, it is the most economical type of placement.

**LEGISLATION AND POLICY**

The categories ‘foster care’ and ‘kinship care’ are departmental operational categories which do not align with the legislative definition of foster parent set out in the *Family and Community Services Act 1972* (SA). The term ‘foster care’ is not defined in the Act at all. Rather, section 4 of the Act defines a ‘foster parent’ and ‘a foster care agency’. Foster care is referred to in subdivision 3, section 40, where the purpose of foster care and the foster care system is set out.

In Specific Child Only (SCO) care, approval is restricted to foster care of a specific child by a person with whom the child has an existing relationship, although the carer might not be a relative. Kinship carers, and some SCO carers, are subject to assessment, support and supervision regimes which differ from those which apply to foster parents.

The provision of foster care is regulated by legislation which mandates regular monitoring and review. By contrast, kinship care is largely unregulated, the growth in numbers not having been matched by a growth in formal regulation.

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![Figure 11.1: Children in out-of-home care: rate per 1000 South Australian children aged 0–17 years](source: Data from Productivity Commission, *Report on government services 2016*, Australian Government, 2016.)
Figure 11.2: Children in out-of-home care in South Australia by home-based or non-home-based care


Figure 11.3: Number of children in home-based care and residential care

CARING FOR CHILDREN IN HOME-BASED CARE

Figure 11.5: Out-of-home care placement expenditure per night
Notes: ACT and Queensland data omitted. These figures fall in the range below South Australia, but above Tasmania.

Figure 11.4: Percentage of children in home-based care and residential care
DEFINITIONS

The Family and Community Services Act governs the manner in which some types of family and community services are delivered. The Department for Education and Child Development (Department; DECD) administers various aspects of this Act including licensing agencies which provide foster care, approving persons who wish to be foster parents, and the ongoing review of the agencies and individuals involved in that service provision.

The Act applies only to foster parents, who are defined as:

a person (not being a guardian or relative of the child) who, for monetary or other consideration, maintains and cares for a child on a residential basis, but does not include the licensee of a children’s residential facility.6

‘Relative’ is further defined to mean a step-parent, brother, sister, uncle, aunt, grandfather or grandmother.7

The requirements of the Family and Community Services Act therefore apply to care which is provided in the circumstances described above and which is not provided by a step-parent, brother, sister, uncle, aunt, grandfather or grandmother. This means that the various powers provided in the Act do not apply to relative carers, even where the care is provided on behalf of the Minister as the Guardian of the child, and attracts a reimbursement for providing that care.

Families SA practice definitions do not align with legislative definitions. Kinship care is defined to include a much wider category of people than the legislation contemplates. The Relative, Kinship and Specific Child Only Care: Practice Guideline and Procedure defines a relative or kinship carer as a person who:

• The child is related to by blood or marriage.

• Is a member of the child’s community, clan, skin or language group who is bound by a defined relationship that is in accordance with traditional practice or custom. 8

An SCO carer is defined as a person who:

Has a significant relationship with the child based on identity, cultural connection or emotional attachment.9

A Families SA internal audit of kinship care processes observed a lack of clarity about the defining features of kinship and SCO carers. This is important because carers who fit the categories of kinship or SCO carer are assessed and supported in a way that it very different from foster parents. The specific differences are discussed later in this chapter.

THE LEGISLATIVE FRAMEWORK

A person is not entitled to act as a foster parent to a child unless they have been approved in accordance with sections 41 and 42 of the Family and Community Services Act.10 The Chief Executive of the Department is authorised to grant approvals, once satisfied that a series of criteria have been met.11 Any approval granted must specify the number of children the carer is permitted to care for at any one time, and is subject to an overall limit of three children except in special circumstances approved by the Chief Executive.12

Licensed foster care agencies are also defined and regulated in the Family and Community Services Act. Foster care agency is defined as ‘the business of placing children in the care and control of foster parents’.13 A person must not carry on the business of a foster care agency unless they are licensed.14 In order to grant a licence to an agency the Chief Executive of the Department must be satisfied of a number of criteria.15 The agency must retain certain records, and must conduct regular reviews of the foster parents supported by that agency.16

None of these provisions apply to persons who come within the definition of a relative in the Family and Community Services Act. They do apply to carers who, although related or known to the child in some way, stand outside the narrow definition of ‘relative’ in the Act. Therefore, some carers who are treated by the Department as ‘kinship carers’ come within the legislative definition of a ‘foster’ parent in the Act.

QUALITY STANDARDS

South Australia’s provision of alternative care is subject to the Standards of Alternative Care in South Australia17 which were developed in conjunction with the not-for-profit sector, and organisations concerned with promoting the voice of children in alternative care. The standards refer to entry into care, case management, provision of care, participation of children and young people, care records, and transition planning. Standard 1.1 requires that ‘all children and young people requiring alternative care will be matched to a suitable placement and provided with services that meet their specific needs’.18 There is currently no requirement that service delivery organisations report against these standards.19 The impact of the standards on the quality of service delivery has therefore been difficult to track.
National Standards for Out-of-Home Care were developed as a project of the National Framework for Protecting Australia’s Children 2009–2020. Standard 1 emphasises stability and security for children in care. It requires that ‘children and young people are to be matched with the most suitable carers and the care environment according to their assessed needs’, noting that ‘research shows that stability, connectedness and security are essential to achieving successful transition to adulthood and are strong predictors of outcomes for children and young people in out-of-home care’. Performance reporting against these standards is in development.

In a submission to the Commission, GCYP observed that the current system gives little choice in placements for children, and serious compromises are frequently made in placement decisions. Decisions are often made on the basis of what is available rather than what is the best fit.

The state’s ability to meet quality standards depends, to a large extent, on improving the way in which home-based care is sourced and managed.

CHALLENGES IN KINSHIP CARE

Families SA has a strong policy preference for placing children in need of out-of-home care with kinship carers. The Families SA Care Planning Policy provides that:

The first preference is for a child to be cared for safely within their own family and community. Where this is not possible, placement within the child’s community with significant others is next preferred. The placement of children must be based on their assessed needs and children will be matched with the best option possible. Placement within a family, preferably from the child’s cultural group, is preferred over non-family based care. Where non-family based care is necessary, it will be provided in the least restrictive and most normalised manner possible.

The Relative, Kinship and Specific Child Only Care: Practice Guideline and Procedure refers to a ‘child placement principle’, which outlines a hierarchy of care options for children in need of out-of-home care. The hierarchy identifies placement with relatives or kin as the first preference, closely followed by placement with significant others in the child’s social network. Home-based foster care is the next preference, followed by rotational and other types of care. The practice guide represents the child placement principle as underpinned by the objects and principles enshrined in the Children’s Protection Act 1993 (SA), which before the 2016 amendments emphasised the desirability of a child remaining within established familial and neighbourhood networks, or in an environment where they have an established sense of connection. These references were removed by amendments to the Act made by the Children’s Protection (Implementation of Coroner’s Recommendations) Amendment Bill, which came into force in 2016. The guide does not yet reflect these amendments.

However, the child placement principle as described in practice guidance which places a relative or kin placement at its apex has no legislative basis or force (nor did it at the time that the practice guide was written). Contrary to the strong implication in the practice guide, it does not have the same status as the Aboriginal placement principle which has a basis in legislation.

Notwithstanding these legislative changes, kinship care is likely to continue as the preferred care option for many children who enter the child protection system. It is a natural outcome of placement decisions being made in the best interests of each child.

The submission made to the Commission by the Australian Association of Social Workers argued that many social workers were concerned that there is an uncritical promotion of kinship care as necessarily in the best interests of children. They argue that there is a ‘limited acknowledgement that complex and poorly functioning families may be the result of generations of poor parenting and that removal of a child to grandparents may still leave them exposed’.

A recent survey of relevant literature from Australia, Canada and the US summarised the respective demographic characteristics of foster parents as most likely to be:

- female;
- white;
- married in two-parent household;
- earning a mid-range income;
- without post-school education;
- in a household in which one person in the house is in paid employment;
- aged between 35 and 54;
- parents of their own birth children;
- in homes with under-utilised space; and
- wanting more children.

Kinship carers, by contrast were more likely to be:

- grandparents;
- from minority ethnic backgrounds;
- single;
- older;
• have less formal education;
• in poorer health than foster parents;
• live in poorer accommodation with overcrowding; and
• working.

Research has highlighted that kinship carers often enter the arrangement out of a sense of obligation to members of the family. Carers face the additional challenge of having to negotiate altered family relationships including that with the child’s birth parents. This can be especially difficult for Grandparents who may experience a sense of responsibility for their child’s personal difficulties.\textsuperscript{30} In South Australia, 41 per cent of kinship carers are grandparents.\textsuperscript{31}

For some carers, generational changes in parenting style can be challenging. Some research has highlighted that kinship carers are more likely than foster parents to resort to physical forms of punishment and overall harsher discipline styles. Punitive care styles are unlikely to address underlying psychological and emotional consequences of trauma and abuse.\textsuperscript{32}

This is not to blame kinship carers or suggest that they cannot deliver appropriate care. The likelihood that kinship carers enter the caring arrangement at greater social disadvantage, with less training, and potentially more complicated family relationships to negotiate, highlights the need to provide a more, rather than less, rigorous assessment and support program.

WHOSE RESPONSIBILITY?

Recruitment, assessment, training and support of foster parents in South Australia is managed exclusively by foster care agencies. Each agency is funded in accordance with a service agreement with Families SA, and their delivery of these services is reviewed at regular intervals.

Over time, funding for each agency has been negotiated individually, and then rolled over contract to contract. The result is inconsistent funding across agencies delivering the same service.\textsuperscript{33} In the past, some agencies received as little as $4000 per placement per year; others were paid $15,000 for the same service. Recently, the gap was reduced to bring the lowest cost agencies to $8000 per placement.\textsuperscript{34} The historical gap might be seen as reflecting prudent use of public funds to obtain a service at the lowest cost to the taxpayer, but the evidence suggests that the lowest cost placements were associated with poorer quality carer assessment, and higher rates of care concerns for children in care.\textsuperscript{35} Agencies who delivered services at the lowest cost were unable to provide a quality service at the intensity necessary to support carers to do their job well.

An agency funded at a high rate has a greater capacity to deliver a quality service to foster parents. However, there is no transparency about these funding discrepancies to enable carers to make an informed choice of agency. The fact that contractual details are negotiated confidentially, and considered commercial in confidence, also prevents the agencies knowing where their funding level sits in the applicable range.

Fundamental service parameters require an agency to complete regular home visits with their foster parents and track their progress on a regular basis. Some agencies are able to provide additional services. For example, Life Without Barriers provides psychological support, and other programs such as a mentor program for children in care. Lutheran Community Care has available the Marte Meo attachment-based program to develop strength in caring for children, which is funded from a non-government source.\textsuperscript{36}

There is no transparency about these funding discrepancies to enable carers to make an informed choice of agency. The fact that contractual details are negotiated confidentially, and considered commercial in confidence, also prevents the agencies knowing where their funding level sits in the applicable range.

The agencies identified as problematic were typically among those funded at the lowest level. Any critical assessment of their performance relative to other agencies should therefore take account their comparatively poor funding for delivering appropriate services.

Ultimately, if an agency is expected to deliver a comparative service, it should be funded at a comparative rate, especially when they are not profit-making ventures, but are funded to deliver critical services. If agencies underperform even when funded at an equivalent level, then action should be taken to address the deficits or else decline the renewal of service agreements. Comparative funding and performance should be reviewed to bring greater equity to services being provided to foster parents.
FOSTER CARE AGENCIES

In South Australia, 12 agencies hold licences to operate as foster care agencies:

- Aboriginal Family Support Services
- Anglican Community Care
- Anglicare
- Baptist Care SA
- Centacare
- Centacare Catholic Diocese Port Pirie
- Key Assets
- Life Without Barriers
- Lutheran Community Care
- Time for Kids
- UnitingCare Wesley Adelaide Homelink SA
- UnitingCare Wesley Country.

Each operates across different geographical areas. In some areas more than one agency operates. Key Assets, Life Without Barriers and UnitingCare Wesley Adelaide Homelink SA provide specialist foster care services for children with high needs. Each agency is funded by Families SA to provide services to recruit, train, assess and support foster parents. A prospective foster parent approaches the agency of their choice and is recruited, trained and assessed by that agency. The final registration is undertaken by Families SA.

RECRUITMENT

As numbers of children in care grow, so does the need for appropriate foster and kinship care placements. However, transformative social changes since World War II have undermined some fundamental social assumptions on which foster care was based:

The problem with this growing reliance on foster care is that it is at odds with the most dramatic social trend to have occurred in Australia since the Second World War—the torrent of women entering the workforce. Both in its scale and implications for society, Australia has witnessed few other movements like it ... With women traditionally filling the role of carer, their increased workforce participation has meant that there is a shrinking pool of volunteer carers, and there has been a continual struggle to attract new ones into areas such as foster care.

The problem is compounded by the ageing of Australian society which has meant that working women and men are increasingly called upon to care for elderly relatives. In fact in the 21st century, more employees will have dependent elders than dependent children. 28

These changes to the social landscape are permanent and the traditional foster care model should be reviewed in this light. A major challenge is whether the role should continue to be conceived as a voluntary endeavour, or whether changing social conditions, and changes in the needs of children coming into care, mean the role should be reconsidered as a profession with associated wages and conditions.

In South Australia, the number of foster parents entering the sector has been far outstripped by the number leaving. In the 2014/15 financial year, 82 households entered and 138 left. In the preceding financial year, 145 entered and 241 left. Over the same period, Victoria, Queensland and the NT recorded more foster parents entering than exiting the system, suggesting that a different recruitment approach might help, and that the overall loss is not due to social conditions alone.

Research has identified other barriers to a greater level of foster care in the community. Reasons include the disruption to family circumstances with fostering, and the associated financial cost. 40 A 2014 study found that the two reasons most frequently cited for not becoming a foster parent were that the person had never been asked, and fostering a child was too big a commitment. The researchers argued that the prominence of the first reason highlights an opportunity for good communication to increase numbers. 41

Broad-based media campaigns have been employed in the past to address the low level of knowledge in the community about fostering. Such campaigns raised awareness and created initial interest in fostering, but showed limited return in recruiting carers. 42 Greater success has been shown in localised recruitment campaigns, especially word of mouth. 43 The same results were identified in the recruitment of Aboriginal carers, with success being influenced by the involvement of Aboriginal people. 44

In South Australia registered foster care agencies are funded to recruit carers. Each agency chooses how and when to recruit to suit their target market, funding level and numbers of existing carers. Evidence to the Commission from these agencies confirmed that word of mouth remained the most powerful and effective recruitment tool. Foster parents who speak about their experience and model the difference their service can make in the life of a child have proved to be the best motivator for other families.

The Child and Family Welfare Association (CAFWA) is the peak body in South Australia which represents not-for-profit organisations that provide child protection services for children, young people and families (especially out-of-home care services). 45 CAFWA has argued for a role in developing a centralised marketing and recruitment process for foster parents, eliminating...
potential double handing of current enquiries made to Families SA and or foster care agencies. The interim report of the Select Committee on Statutory Child Protection and Care in South Australia, published on 23 September 2015, recommended that this centralised function be pursued. A collaborative approach to marketing foster care would undoubtedly generate benefits in accessing the economies of scale.

One agency, Lutheran Community Care, sounded a note of caution about this centralised approach. They ran a centralised recruitment process between 2004 and 2006, but now recruit carers only for their own agency. They observed that recruitment marks the start of a relationship with potential foster parents and the continuity of relationship from first contact can be beneficial to the overall process. Agencies managing their own enquiries have more opportunities to screen out unsuitable applicants early in the process by exploring initial enquiries in greater detail.

An independent evaluation in 2007, of the centralised recruitment service managed by Lutheran Community Care, found that of 900 calls received, only 55 parties were referred on to other agencies for assessment. The review concluded that recruitment, training and assessment could be more effectively undertaken at one location and potentially by a single agency. They emphasised the importance of consistency of relationships, and reduced duplication of information throughout the process.

In South Australia, a large number of enquiries about fostering received by agencies do not convert to applications for registration. These numbers should not necessarily be interpreted as lost opportunities; a well-functioning system should aim to identify candidates who are ill suited to the role at an early stage. However, the large gap between enquiries and applications arguably highlights a level of interest that should be tapped more effectively (see Figure 11.6).

Figure 11.6 shows a reasonably steady level of interest in foster care, evidenced by the number of enquiries fielded by agencies. However, the number of applications and subsequent approvals show a substantial decline over the last three financial years.

Recruitment efforts need to present flexible options in foster caring. The 2007 review of centralised recruitment in South Australia observed a shift towards young and more highly educated candidates. These candidates tend to be more interested in short-term care options. Greater take-up of this type of care would not address the dearth of long-term foster parents, but candidates prepared to undertake short-term roles might consider a more long-term commitment when circumstances allow. Carers who offer respite only are also critical to reducing stress on long-term carers, contributing to the sustainability of existing long-term arrangements. The need for carers to support the system in flexible ways should be identified in promotions.

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**Figure 11.6: Foster parent applications, assessments and approvals in South Australia 2011/12 to 2014/15**

Note: Data for applications and approvals for 2011/12 not available.

Source: Data provided by Families SA.
Information provided at recruitment is critical to ensuring that candidates understand the rigours and challenges of the role. To attract and retain the right carers it is critical that a realistic and honest message is delivered, balanced with promotion of the associated rewards.54

Broad-based media campaigns could promote a heightened awareness of foster care in the community. However, the required high numbers of new foster parents are more likely to be delivered by local targeted strategies—using existing word of mouth networks and existing carers to help identify potential new carers. There is evidence that using existing carers in the recruitment process improves credibility.54

There is good reason, therefore, to be cautious about moving to a centralised recruitment model. Unless carefully structured, such a model could take a generic focus with a media campaign improve knowledge generally, but not delivering a large number of new carers. Local agencies with community knowledge and access to existing carer networks may well be in a better position to conduct the kind of recruitment that research shows is effective.

Recruitment should remain the responsibility of individual agencies, and could be complemented by collaboration on worthwhile and cost-effective individual campaigns.

A number of foster parents told the Commission that the recruitment and assessment process did not equip them for the reality of foster care. One witness said the information provided was delivered in an inexpert way, was out of date and presented an inaccurate picture of the relationship with the Department.55 Had the witness not had independent knowledge of the reality of the foster care system from other sources, she may well have been dissuaded from taking on the role.56

Departmental workers should participate in information sessions for potential foster parents to ensure that information is accurate and up to date. Current carers should also contribute their perspective on the challenges of the task. This combined range of perspectives would be more likely to give potential carers a realistic picture of the challenges and rewards involved. Children in care should also participate in these endeavours, to provide a child’s perspective on the rewards and challenges of foster care.

ASSESSMENT AND REGISTRATION

FOSTER CARE

Foster parents are assessed through the Step by Step competency-based program, developed interstate and widely used across Australia. The program prescribes a series of five to six interviews with the family (as well as individual interviews which may be conducted with family members who may stay or board in the home from time to time), with time in between to allow potential carers to consolidate information, and for reports to be prepared. Families SA tracks registered agencies against key performance indicators, which include how many assessments are completed within five months, the minimum period prescribed for assessment.57

CAFWA advised that the Step by Step process was seen as unnecessarily restrictive, repetitive and ‘tick box’ focused. The timeframe anticipated by the program itself can be expanded by delays in obtaining screening clearances, and the time it takes for Families SA to consider the assessment and application for registration. Some contributors thought that delays in registration contributed to a loss of momentum for families, who might thus lose interest in fostering.

Some agencies have discussed with the Families SA Carer Assessment and Registration Unit (CARU) innovative ways to shorten the time between assessment visits, with a view to shortening the overall assessment time.58

Peter Sandeman, Chief Executive Officer of Anglicare, the largest registered foster care agency operating in South Australia, told the Commission that his agency preferred to take a longer time to assess a family, because gaining an understanding of the family’s relationships brings more information to the assessment.59 He observed that:

the issue for us is we use the 12 month process to winnow out people who shouldn’t be there. So what’s the nightmare for an organisation like ours? Being infiltrated by a paedophile … So we’re very careful to make sure that recruitment processes are a little bit arduous and people have lots of option for self-referring out, and we have a lot of opportunity to get to know these people really, really well. So yes, it takes a long time. The conversion rate is low and the people we get are really good.60

A carer’s decision to open their home to an unrelated and unknown child is not to be taken on a whim. It is a life-changing decision, particularly for families interested in providing long-term care. For the sake of the child, it should not be subject to the vagaries of a changed mind because an assessment ‘takes too long’. There is a balance to be struck between, on the one hand, developing efficiencies to ensure time is not wasted and, on the other, recognising the value of relationship building over time. The Commission considers the current balance of a minimum five-month period is appropriate.

The Parliamentary Select Committee report published on 23 September 2015 recommended that a fast track option be developed for training foster parents, including a full-time intensive program.61 In light of the advantages
of an assessment that takes place over a lengthier time period, the Commission does not support a full-time intensive foster care assessment process.

Some contributors directed criticism at delays once an assessment was lodged for registration with CARU. A complete review of documentation for registration purposes takes a staff member three days. However, the Commission heard evidence that there was a backlog of six to ten weeks in the CARU process. Many applications have to be returned to the assessing agency seeking further information—expanding the review process towards 10 weeks. Priority assessments (where a child has been identified for placement with the applicants) are fast tracked, but this delays other work.62

The Redesign process of reform (discussed in Chapter 5), which began in 2013, made changes to processes and structures across the Agency. Before Redesign, CARU was staffed by four licensing officers, each social work qualified (AHP 2 classification). After Redesign, social work staff were reduced to two, and seven ASO staff were employed (ASO being the administrative stream which does not require any formal tertiary qualification).63 The reduced overall expertise in the section has resulted in a greater load for the remaining professional staff and supervisors.64

The task of assessing foster care applications for registration is not administrative. It requires more than a satisfaction that documentation is in order. A robust consideration of the issues raised requires critical thinking and an ability to look behind the information provided to identify gaps:

an example would be the applicant has a history of depression, and that's fine, because many people in the community can manage their depression, but the

information to mitigate that risk hasn't been provided. So we have to go back and make further enquiries, and say 'can you provide additional information?'. So it is going through the competencies and making sure all the key competencies are met and if there are any indicators, we go back and ask for further information.65

That is not to say that the position necessarily requires social work qualifications. The Commission understands that there is a move back towards requiring tertiary qualifications for appointment to the position.66 The Commission supports a move towards requiring higher level formal qualifications for analytical work of this kind. The unit should also be resourced to provide a timely response to completed assessments. Where children are waiting in unsuitable emergency accommodation for a home-based placement, it is critical that the availability of that home is not delayed by resourcing constraints. Staffing levels should be maintained on the basis of a service benchmark of 14 days for an uncomplicated application.

Obtaining screening clearances also unnecessarily delays the registration process. The carer registration process applied by Families SA anticipates a screening clearance will be obtained by the assessing agency before beginning the Step by Step program.67 In practice, many agencies begin assessment before clearance based on information from an applicant.68 On occasion, concerning information comes to light after the assessment has begun, and time invested has been wasted.69

A screening clearance is not the end of probity checks for a foster parent. Once a completed assessment is returned to CARU, they search a number of internal databases, checking for adverse information about carers and other adults frequently in their household.

The need for early preliminary assessment1

Case one: A foster care agency conducted a full assessment of a couple and forwarded the documentation, together with the relevant screening clearance for approval. CARU’s database search found that the female applicant had a history of childhood abuse, and a history of seeking financial assistance from Families SA after being raped as an adult. The male applicant had a history of seeking financial support from Families SA and a history of schizophrenia and contact with mental health services, and was reported to have attempted suicide on more than one occasion. Neither applicant had disclosed these matters to the foster care agency in any detail, when questions in the assessment specifically raised the issues. These matters were relevant to (although not decisive of) the applicant’s capacity to provide foster care. They should have been investigated before undertaking any thorough assessment.

Case two: A couple completed the full Step by Step assessment and identified their daughter as in regular daily contact with them and their household. Any child placed with them would also have a close relationship with their daughter. Their daughter had a lengthy child protection history including serious physical abuse of her own children. This information, if known, would have disqualified the couple at an early stage.

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1. Foster care assessment files provided by Families SA.
Information is sometimes identified during this search that makes registration inappropriate, and renders the lengthy assessment futile.

Applicants for assessment as a foster parent should therefore supply sufficient preliminary information to enable CARU to search the databases at an earlier stage in the process. This will prevent resources being expended on applicants whose circumstances or relationships make them unsuitable to provide foster care in any capacity. The separate screening clearance remains essential.

A number of foster care agencies, with the support of CAFWA, recommended that final registration of foster parents should be delegated to the agencies themselves. It was suggested that this move would better clarify the separation of functions between Families SA as funder and regulator, and the registered agency as provider, with not-for-profit agencies responsible for all functions from recruitment, through assessment and registration. This model is used in other states.

The CARU registration assessment is more than a rubber stamp. The current placement of final registration with the Department provides a quality assurance process. CARU commonly identifies gaps in assessment, and seeks further information from assessing agencies.

Only a small proportion of carers who are recommended for registration by agencies are not subsequently registered by Families SA. The Commission examined all applications for registration as a foster parent made to CARU between 1 July 2011 and 1 December 2014, a period of approximately three and a half years. Over this period there were 553 applications, 17 of which were not approved. Of those 17 non-approvals, 15 were not recommended for approval by the assessing agency, but were submitted to CARU to make the final decision. Two applications in the period were recommended for registration by the agency, but were not recommended by CARU. The number of applications which were not recommended by the agency, and yet still forwarded for a decision by Families SA highlights the continuing function of separate quality assurance. Clearly some agencies would prefer Families SA to make the final decision to exclude unsuitable candidates rather than themselves having difficult conversations with such applicants.

To put the above numbers in context, agencies do screen out applicants in the course of the process when it becomes clear that they are unsuitable. Many unsuitable applicants never reach Families SA for a registration decision. The Step by Step guide clearly identifies a number of ‘screen outs’ or factors which identify an applicant as unsuitable. CARU does, from time to time, receive applications which should have been screened out at a much earlier stage in accordance with the guide. The Commission was advised that CARU now asks agencies to notify them about applicants who have been screened out without a formal registration decision being made, so they can be tracked centrally in case they choose to approach another agency for assessment.

The Commission recommends that the Department be notified of applicants who are screened out, or withdraw from assessment for any other reason, in order to track applicants who might be tempted to ‘agency shop’. This requirement should be formalised as a part of service agreements with registered agencies.

In the Commission’s review of applications for registration, themes such as domestic violence within households, and mental or physical health challenges, were identified. In general, there was a greater tolerance for issues of these kinds when the applicant was seeking to provide care to a specific identified child. In one case, the strengths of a couple were seen to outweigh serious health concerns of the female applicant, who was in such poor health she would be unable to lift a child. In another, current domestic violence risks were not considered as sufficiently serious to disqualify an applicant seeking registration to provide respite care to a known child. These issues also emerge strongly in considering the standards applied to the assessment of kinship carers. There was an overall sense that carers with an existing relationship to the child were approached with a greater tolerance of circumstances that ought to have raised concerns. It was not clear whether this was a result of different assessment processes, or an overall greater tolerance of risk in kinship placements.

INTERIM REGISTRATION PROCESSES

Where children are subject to an unplanned removal there is rarely time to conduct a comprehensive assessment of the adults who are available to provide care. The child’s best interests are usually served by them remaining in a familiar environment, with adults who are known to them. In these circumstances, carers who fit the definition of SCO or kin may be registered quickly using an initial registration process called the ‘iREG’.

The iREG is intended as a preliminary assessment of suitability. The applicable practice guide provides that ‘iREG does not endorse the child/ren remaining with the carer on a long term basis or mean that kinship carer registration will automatically occur. Kinship carer registration requires further assessment and decision making within the early months of the care arrangement to ensure registration occurs within three months of iREG endorsement.’
To complete an iREG, the following details must be considered:\(^78\):

- personal details;
- details of children under 18 also living at the premises;
- details of any adults also living at the premises;
- two referee reports;
- a safety assessment which indicates whether immediate safety risks have been identified, and whether identified risks can be managed with the use of a safety plan; and
- consent forms for Families SA to search the Client Information System and the connected client and case management system (C3MS) databases and obtain a criminal history check.

Health assessment of a potential carer relies on a self-report rather than an expert medical opinion,\(^79\) and no screening clearance is required.

The iREG process is designed to provide sufficient information to place a child for no longer than three months, and is insufficiently rigorous to ensure a child’s safety in the long term. However, it is evident that significant delays in kinship assessments mean children are placed on these limited assessments for much longer than three months. The iREG process requires that referrals of these registrations must be made to Placement Services Unit (PSU) for a full assessment within 14 days. This timeframe gives PSU the best chance of completing the necessary assessment within three months. However, recent data showed that only 27 per cent were referred within that timeframe; the rest were referred between 14 days and three years later.\(^{80}\)

As at 9 October 2015, 967 children in the care of the Minister were residing in kinship placements. They were being cared for by 899 carers in 633 households (some households contain more than one registered carer). Of those 967 children, 376 were living with carers who had not been formally assessed, but were registered on the basis of an initial registration. This is approximately 39 per cent of all children in kinship placements.

Removing from consideration children who have been in placements for less than three months, approximately 34 per cent of the children are in kinship care placements that have not been assessed according to Families SA’s own guidelines. Table 11.1 shows the applicable time delays.

Table 11.1: Children in placements registered only on iREG status

<table>
<thead>
<tr>
<th>TIME IN PLACEMENT</th>
<th>NUMBER OF CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 weeks</td>
<td>4</td>
</tr>
<tr>
<td>Between 2 weeks and 1 month</td>
<td>8</td>
</tr>
<tr>
<td>Between 1 month and 3 months</td>
<td>30</td>
</tr>
<tr>
<td>Between 3 months and 6 months</td>
<td>68</td>
</tr>
<tr>
<td>Between 6 months and 9 months</td>
<td>65</td>
</tr>
<tr>
<td>Between 9 months and 12 months</td>
<td>52</td>
</tr>
<tr>
<td>More than 12 months</td>
<td>149</td>
</tr>
<tr>
<td>Total</td>
<td>376</td>
</tr>
</tbody>
</table>

Source: Data provided by Families SA.

Garry Matschoss, Acting Manager of the PSU, observed:

> Sometimes, it gets very contentious, because having done the full assessment, and this is where I sign off ... we don’t recommend approval, which ... can be very problematic if the child has been in placement for some time, but it does happen.\(^{81}\)

A proportion of the overdue assessments might be awaiting a screening clearance. There is no point conducting a comprehensive assessment of a kinship carer until the clearance is available because they will not be approved without a screening clearance.\(^{82}\) Screening clearances must therefore be given a high priority within the Department for Communities and Social Inclusion, particularly where a child is being cared for in circumstances which may turn out to be unsuitable. An administrative arrangement should be established to provide priority screening checks for carers with whom a child has been placed pursuant to an iREG process.

iREG does not require a carer to present a current screening clearance, which is ultimately necessary to obtain full registration as a kinship carer. Some assessments lodged with PSU for consideration reveal serious issues with the suitability of the carers, which is particularly problematic when the child has been in a placement for an extended period of time.
The use of iREG processes requires urgent clarification. The longer a child remains in a placement which proves to be unsuitable, the greater the potential for further adverse impact on them. If issues arise during the course of assessment that cannot be overcome by working with the family, the child faces the uncertainty and disruption of a move from a placement with which they have grown familiar and carers to whom they may have grown attached. Placement of vulnerable children in alternative care which is not assessed to be safe or suitable also exposes the child to continuing risk.

Delays in full assessment arguably expose some carers (who are not related in the terms defined in the Family and Community Services Act but who are acting on the authority of the iREG) to liability under that Act. Section 41 prohibits a person from acting as a foster parent, unless they have been so approved. Section 42 requires that a carer be assessed according to a range of criteria:

In considering any application for approval as a foster parent the Chief Executive Officer must attempt to assess the capacity and willingness of the applicant to care for a child according to adequate principles and standards of child care, and must, in such manner as the Chief Executive Officer thinks fit, satisfy himself or herself as far as reasonably possible—

(a) that the applicant will have adequate interest in, and affection and respect for, a child placed in his or her care; and

(b) that the applicant will treat the child in a consistent manner and will provide a safe and stable family environment for the child; and

(c) that the applicant will understand adequately the developing personality of the child, and will provide opportunities to develop the abilities of the child; and

(d) that the applicant will provide adequate accommodation for the child and any other material provision necessary for the welfare of the child; and

(e) that, where appropriate, the applicant will provide opportunities for the child to maintain or recover his or her identity as a member of his or her own family and will allow the child reasonable access to his or her own family; and

(f) that, where appropriate, the applicant will assist the child to return to his or her own family; and

(g) that the applicant is in sound health and is able to withstand the demands of providing foster care; and

(h) that the applicant is otherwise a fit and proper person to provide foster care; and

(i) on any other matters that the Chief Executive Officer may consider relevant.85

A person is an approved foster parent if they have been approved as such, in writing, by the Chief Executive of the Department. The iREG process does not assess in detail the breadth of matters described in section 42,84 and it is unlikely that the Chief Executive would regard that process as an appropriate basis on which to grant registration as a foster parent. There is therefore a serious question about whether a proportion of kinship carers and SCO carers are regarded by the Department as registered foster parents under the Family and Community Services Act. If they are not, then there is a potential liability for acting as an unregistered foster parent. This issue does not apply to kinship carers who are step-parents, brothers, sisters, uncles, aunts, grandfathers or grandmothers.86

SPECIFIC CHILD ONLY CARE

Formal assessment of SCO carers is currently referred to foster care agencies for assessment according to the Step by Step program. Historically, there has been ambiguity about how these carers should be assessed. The requirement that SCOs be assessed according to the Step by Step tool was introduced because of a historically high rate of placement failure. Children were being rushed into placements with adults who had little understanding of the demands involved.86 The Step by Step assessment program over time focuses the adults on the significance of their undertaking.

However, unlike a foster care assessment, SCO carers are assessed with the child already provisionally in the placement under an iREG.

Provisional placement of the child can make it difficult to negotiate with carers about changes to the physical environment such as placing a pool fence or removing unsafe clutter. It can also be difficult to convince carers of the need to work cooperatively with the Department.87 Foster care agencies can be tempted to prioritise the assessment of carers who do not yet have children placed in their care (who are awaiting registration and are not eligible for iREG), to cope with the numbers of children awaiting placement. Some foster parents are working towards eligibility to care for more than one child, and there is an understandable desire to prioritise those assessments.

The Commission understands that the placement of children with SCO carers using the iREG process has been the subject of some discussion within the Agency. There are benefits to children being able to be placed, with full assessment following quickly. On the other hand, if full assessment does not quickly follow (the impetus for which can fall away once a child is placed) there is a risk that the child’s stability will later be disrupted.
One solution would be to fund foster care agencies where necessary to contract out SCO assessments to ensure their efficient completion. Experts in private practice could be funded to complete those assessments ‘as needed’. A panel of private practitioners authorised to conduct these assessments should be developed so that urgent assessments can be outsourced for priority attention where appropriate.

KINSHIP CARE
Kinship carers are not assessed according to the Step by Step program. They can be assessed by staff in the local office or by specialist assessment PSU staff. Kinship assessments are strength based and do not focus on the key competencies central to the Step by Step program. Assessment also focuses on identifying and mitigating risk to a child.86 Assessments are conducted against documentation which has not yet been approved at an executive level in the Department.87 There remains a level of uncertainty about the applicable policies and procedures.88

The Commission heard that in practice there is an inherent conflict in kinship placement assessment sitting with the local office. A worker faced with an emergency removal has a stark and difficult choice: place a child in emergency care which carries with it a high administrative burden and a great deal of pressure from management to move the child to a cheaper arrangement, or write up a substandard kinship care placement to justify placement in a family environment. An experienced social worker told the Commission of one environment:

It was like Steptoe and Son. There was rubbish from floor to ceiling; from the front fence to the back fence of the property. It was shocking. Inside the house wasn’t unhygienic per se, but there was so much clutter and stuff in it, there was no room for anybody, let alone for children. There was no yard space. There was scrap metal, car bodies, ovens and fridges and all sorts of stuff out there. Yet the staff had said that it was an appropriate house in order for the carers to be registered to care for these children. It was hideous. So that’s the sort of situation that can potentially occur when staff are desperate to place children.89

There is no doubt that kinship care placements are subject to a different standard of assessment than foster parent placements. There is an obvious case for adopting a flexible approach to account for the benefits of the child remaining in a familiar environment with connections to their family, but there is a danger that, on occasions, keeping the children with family has justified a placement which is inappropriate and potentially unsafe.

Inter-generational abuse1
‘Felicity’ is a teenager who was removed from the care of her mother Patricia in 2000, following a large number of child protection notifications about her and her siblings. Patricia had also been removed from the care of her mother as a child following allegations that she had been sexually abused by her stepfather, and that her mother had not been protective or supportive of her daughter. Criminal charges were laid, but were later withdrawn. Families SA recorded a finding that Patricia had been sexually abused by her stepfather.

In 2000 when Felicity was removed, she was placed with her grandmother and step-grandfather, against whom abuse had previously been substantiated by Families SA. This placement choice was by court order, and against the objection of Families SA.

By 2014 the placement was under considerable stress, with allegations that Felicity may now have been the victim of abuse at the hands of the step-grandfather.

Mr Matschoss the Manager of the PSU, observed that there was ongoing pressure to reduce the complexity and scope of the assessment of kinship carers, in an effort to address the growing backlog of assessments.90

In October 2013 amendments to kinship carer assessment processes were authorised at the executive level which removed the obligation on potential carers to provide a medical report from a general practitioner as to their capacity to provide care. The change was a response to the observation that medical reports could take months and delay the carer assessment process. The replacement medical self-assessment requires potential carers to self-report any medical issues for which they need support with or which might impede their capacity to provide care.91 This is especially concerning against the background that almost half of kinship carers are grandparents, many of whom have health issues affecting their capacity to care for children, especially in the longer term.92

Once a child is placed with a kinship carer and medical issues arise, Families SA has no power to insist on an independent expert medical report. The Commission heard of one situation where a grandparent kinship carer had an obvious serious medical condition, but refused permission for Families SA to obtain independent evidence about it. In those circumstances, Families SA regarded themselves as powerless.93 Conversely, foster parents in a similar position can be obliged to supply
medical information pursuant to section 47 of the Family and Community Services Act (under threat of a pecuniary penalty).

In November 2013 the Department introduced a priority response assessment (PRA) which further diluted the assessment process for some kinship carers. This short-form assessment is conducted when the carers are identified through initial triage as low or no risk. No documentation guides this triage decision, which relies heavily on professional judgement. The PRA does not assess parenting capacity, family history and environmental factors, all of which are part of a full assessment. When the abbreviated assessment was implemented, the potential risks of not covering parenting capacity and family history were identified. A requirement was then imposed to check potential carers on C3MS in order to identify issues. An internal audit of 43 PRAs found three cases of care concerns about potential carers which had not been identified through the PRA process.96

The same internal audit identified a number of carers registered on the basis of IREG documentation, with no evidence of police checks. There was uncertainty about the person responsible for conducting the police check and where the results should be recorded on C3MS.97 A high proportion also demonstrated evidence of only one referee check having been completed.98 There is no requirement that the referee have any standing or professional relationship to the child or carers. In some instances the referee was a close relative.99 Greater objectivity is needed in selection of referees, or a greater range of informants should be relied upon to build a picture of the carer’s suitability.

Helen Kay, Manager of the Families SA kinship care support program, told the Commission that some kinship carers have a history of adverse involvement with Families SA. Where such a history exists, the carer might be reluctant to engage with the Agency, and resist accepting intervention that might help them care for children.100 Some carers, the Commission was told, ‘prefer not to be contacted at all’.101 As with SCO carers, instances the referee was a close relative.99 Greater objectivity is needed in selection of referees, or a greater range of informants should be relied upon to build a picture of the carer’s suitability.

The Commission was told in clear terms of a feeling that in many circumstances a poor kinship care placement is a better option for a child than emergency care.102 Notwithstanding the risks inherent in some arrangements, the possible management of those risks is a pragmatic response to the current crisis in alternative care placements. It also acknowledges the benefits of a child being maintained within a familiar family structure. These observations highlight the need for comprehensive assessment, to achieve an informed balance between risk and the best interests of the child.

The existence of family ties is not a guarantee that a child will be safe in a kinship care placement. In Victoria in 2010, an Ombudsman investigation of out-of-home care concluded that less rigorous assessment standards, and the regular failure to check even those basic standards, had children remaining in dangerous placements for long periods of time.103 Departmental records were examined after two Victorian examples of children complaining of sexual abuse. There was no evidence that relevant assessments and criminal record checks had been properly done.104 Evidence before the Commission suggests that the same risk exists in this state.

**DECISION MAKING**

The Commission heard of inconsistencies in the level of decision making independence permitted to home-based carers. The departmental Consents and Decisions Practice Guide acknowledges that decision making in long-term home-based care will be delegated as part of a natural part of the parenting process.105 Section 80 of the Family and Community Services Act permits the Department to formally delegate in writing certain areas of decision making to foster parents who have cared for a child for three years or more.

Section 80 is rarely used. Rosemary Whitten, Executive Director for Metropolitan Services and Residential Care Services, was asked why formal delegations could not be made more frequently to enable families to make decisions about certain areas of children’s lives, such as health, education or travel. Ms Whitten believed that a barrier to greater delegation of decision making was the Department’s ongoing fiscal responsibility in some areas.106 This could be relevant where a child has high health needs, and decisions lead to significant financial implications. However, areas such as education and travel could be delegated to carers, with negotiation about financial responsibility dealt with as a separate issue. Section 80 provides a method for carers to be helped to gradually take over decision making, culminating in the making of Other Person Guardianship (OPG) orders in their favour. This is discussed further in Chapter 13.

Ultimately, a greater emphasis on OPG processes may render section 80 delegations of less relevance. However, it is a tool that must not be overlooked in considering ways in which home-based carers can be more empowered to care for children.

Amendments should be made to section 80 to repeal the current minimum requirement of three years and replace it with 12 months. To promote its use, a practice guide
should be developed to identify the types of delegations which might be made, and the circumstances in which they should be considered.

RELATIONS WITH THE STATUTORY AGENCY

Thirteen years ago the Layton Review observed that the state must acknowledge that it cannot itself parent, but it can facilitate and support parenting done by others. That report highlighted that the purchased services and contracts model often reduced foster parents to the cost of accommodation and nutrition of children without resourcing or acknowledging the role that these adults perform in developing children’s sense of belonging, sense of worth and self-esteem.109

Notwithstanding the force of this observation, foster parents and kinship carers continue to feel undervalued and sidelined in decision making about children they care for 24 hours a day, seven days a week. Carers seeking a voice in decision making about their child frequently reported having their status dismissed as ‘only the carer’.

Foster parents reported wanting to give a child in their care a secure sense of belonging, that they were part of a family with all the rights and responsibilities that entails. One foster parent explained, ‘I want my children to know they’re part of a family, not part of the system’.110 Many children in alternative care remain psychologically ‘caught between two families’ and foster parents and kinship carers play an important role in helping children to negotiate this.111 They do so uncertain about the security of their own emotional position. Foster parents in particular described the challenge of committing themselves to the care of a child who could be removed by the Agency at any point. One carer, who had cared for her now six-year old foster child since he was three-weeks old, described herself as living with the sword of Damocles hanging over her head.112 Many foster parents find themselves unable to function in that emotional environment. Good carers are pushed out, and the ones that remain are encouraged to care just a little less.113

‘I want my children to know they’re part of a family, not part of the system’

The Commission heard evidence from a large number of foster parents in hearings and considered the experience of others as part of three case studies: Abby, Nathan and Shannon McCoole (see Vol. 2). While there was some evidence of functional, consistent relationships between foster parents and Agency staff, overall carers were dissatisfied with the lack of respect shown to them, and lack of interest in their contribution to case management.

The case studies identified instances where foster parents had been poorly treated and the value of their contribution dismissed.

The best recruitment strategies for foster care might rely on word of mouth, but their success is very much dependent on the message being delivered by existing carers. Some foster parents told the Commission that although they loved their foster children, they would not recommend the experience to others. Overwhelmingly, the reason for this was the challenges they faced in dealing with the Agency.

One experienced social worker summarised the complaints consistently heard from carers114:

• they are not reimbursed for the real cost of providing care;
• they do not get enough information about children placed in their care;
• they are not automatically given a seat at the table when meetings are held, and their parenting role is not acknowledged in decision making;
• they are mistrusted for their motives, and normal advocacy for children in their care was made to seem abnormal;
• they get insufficient support to care for highly challenging children; and
• when they complain, the response is at best ineffectual, and at worst punitive.

These themes were consistently reflected in the evidence heard by the Commission, and in observations made in the course of case studies about the lack of respect shown to foster parents.

Registered agencies were also frustrated about the level of support available from the Agency. Aboriginal Family Support Services described a growing frustration with promises made at the start of placements, which were not made good. They said that expectations of carers were high, but at times the support to meet these expectations fell short:

Some of our placements can be really quite difficult, and we’re asking carers, who are volunteers, to take on very complex children at times ... and yet we are asking them to do this with little to no additional resources, and sometimes to keep this placement alive we have to put in the extra yards, and whether it’s the additional visits by support workers or some additional resources by Families SA, it keeps this placement in care, and stability for the child.115
The Commission is satisfied that if recruitment and retention of home-based carers is to improve, a shift in the way they are treated is essential. The child protection system cannot continue to exploit the goodwill of volunteers who turn their lives upside-down for children without giving them the respect and dignity that their position demands.

The Agency must clarify the role that it plays in caring for children who are in home-based placements. They must support the family to parent well, rather than intruding into every aspect of decision making as representatives of the Minister. This does not mean stepping away from the statutory responsibility, including the responsibility to develop a relationship of trust with the child and visit regularly. One submission argued that Families SA have confused their role, saying ‘the state can never be the parent, as the state is always a terrible parent and can never make up for the security of that daily care from a consistent, committed and loving caregiver … Foster families are often inappropriately intruded upon in terms of decision making, but abandoned in terms of support to deal with the child’s needs’.

‘Foster families are often inappropriately intruded upon in terms of decision making, but abandoned in terms of support to deal with the child’s needs’

INFORMATION SHARING

There is a high level of concern that the Agency does not freely share information which is relevant to the care of a child with potential carers. This concern is not isolated to the information required at the start of a placement; it applies to information relevant on an ongoing basis to the carer’s capacity to parent. In particular carers felt excluded from comprehensive information about children’s trauma histories. This left carers to their own devices to navigate the child’s special needs. One worker explained that in determining whether to share information with foster parents she was mindful of the confidentiality of the child’s family of origin. ‘It’s a fine line between providing them enough so as to not, you know, go against the family’s confidentiality’.

The balance of how much information is shared with carers, including potential carers, should be drawn in favour of more rather than less. Providing less than the full picture to carers is counter-productive and undermines carers’ capacity to deliver good quality care. It results in placement instability or the child’s needs not being met. Carers also may not receive sufficient information about case direction for the child, or about court dates and outcomes when a child is subject to ongoing proceedings.

An alternative approach which provides greater clarity about foster parents’ rights has been taken in NSW. The Children and Young Persons (Care and Protection) Act 1998 (NSW) sections 143-146 specifically refers to carers having a right to particular types of information, and rights to participate in decision making about children in their care. These provisions clarify the rights of carers to make informed decisions about placements and to receive the information they need to provide care. The provisions also emphasise a child’s entitlement to have information about carers before being placed with them.

Abby: Poor communication with foster parents

(The full case study of Abby is at Volume 2, Case Study 2: Abby—Intervening in high-risk families.)

In the case of ‘Abby’, her foster parent was made aware that the placement of the 18-month old child in her home might not be long term. Efforts to reunify Abby with her mother became increasingly futile. Abby’s caseworker made statements to the foster mother which gave her the impression that her family would be closely considered for long-term care if that need arose. However, the truth of the matter was that, at a very early stage, kinship carers interstate were being scoped. The complexities of an interstate transfer of orders meant that Abby remained in temporary foster care while reunification was attempted. Abby was in a critical developmental phase where satisfying her attachment needs was especially important, and home-based care was the best place for those needs to be satisfied.

Abby’s foster family hoped that she would become a permanent part of their family if reunification failed. When Abby was two-and-a-half years old her foster mother was asked to take her to a meeting at a playground with relatives who had travelled from interstate, which she did. At the meeting, Abby’s foster mother discovered that those relatives were being considered as long-term carers for Abby. She was not informed of this development by Families SA staff, but rather overheard it from one of Abby’s relatives. This was the first time Abby’s foster mother was made aware that other carers were being scoped for Abby.
FINANCIAL ARRANGEMENTS

Payments are made to foster parents and kinship carers in accordance with carer payment rates tied to the age and complexities of the child in their care. The payment is a reimbursement of the cost of caring for the child. It is not a wage and is not considered as income for the purpose of determining eligibility for federal income support payments or for tax purposes.

Table 11.2 shows that South Australia’s payment levels are among the lowest.

A direct comparison of these rates may be misleading because of the variety of ways in which loadings and additional costs are accounted for in different jurisdictions. A more useful guide to the adequacy of reimbursement is obtained by comparing the South Australian reimbursement rates to the foster care estimates, developed by the Social Policy Research Centre at the University of New South Wales. Foster care estimates represent the approximated costs associated with caring for a child or young person.

Table 11.2 shows that South Australia’s payment levels are among the lowest.

In South Australia, a series of loadings apply to recognise the higher cost of caring for a child with higher needs. The rate of carer reimbursement can be adjusted in accordance with the needs of the child at any particular time. However, this flexibility moves the rate payable both up and down. Good quality care which reduces psychological distress and the associated behavioural symptoms can result in carers having their payments reduced.

Some children attend school irregularly because of behavioural challenges that result in frequent suspension. Other children require regular medical and psychological appointments. Foster carers tasked with meeting these needs, especially where they have more than one child in their care, are prevented from or limited in engaging in the paid workforce. Foster care becomes a full-time occupation. Carers who register through specialist agencies including Life Without Barriers and Key Assets are more highly paid than general foster parents, and the fortnightly payment does not change according to the complexities of the child. Children who are placed with these carers have already been identified as having higher needs, and have often already endured at least one failed placement. Even across the specialist agencies the carer payments are inconsistent. Reimbursements across the specialist agencies vary by up to $200 per fortnight per child.

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The discrepancy between a foster parent receiving a base rate and one registered with a specialist agency is well understood in the foster care community:

That disparity is incredibly unfair, and for carers who talk to each other… well, I get $850 a week through Key Assets, and I’ve got this kid who actually looks like his behaviours are worse than yours, and I’m getting $200 per fortnight.
A carer who is registered as a general carer does not have access to the highest level of reimbursements available through a specialist agency, even if their child develops especially high needs. Only by transferring to a specialist agency and completing additional training will that carer be able to access the additional reimbursement. Additional benefits can encourage carers in that situation to take that course. Specialist agencies are funded to deliver more intensive support to carers, and are better equipped to deliver therapeutic support to those placements.

The Agency should address the discrepancies across general carer rates. Some flexibility is reasonable in the rates payable for children with higher needs, but the gap must be reduced by bringing basic payment rates upwards. In particular, there must be an acknowledgement that loadings which support a family’s ability to provide intensive and consistent care can prevent escalation of difficult behaviours and subsequent placement breakdown. The rates payable to specialist foster parents should also be standardised across agencies. Where general foster parents have children whose needs escalate and the care of those children would be better provided through a specialist agency, carers should be helped to move their registration to the specialist agency.

In addition to carer payments, Families SA is responsible for payment of other miscellaneous costs as they arise. An Alternative Care Support Payments: Manual of Practice guides decision making. Squabbling about financial responsibility for children’s hobbies and activities still causes tension between foster parents and Families SA staff. One carer reported that funding for a child’s music lessons was stopped after 18 months. Discretionary overrides could be paid. However, these guidelines are subject to the decision points of Practice and clearly sets out the circumstances in which fees will be paid. Where general foster parents have children whose needs escalate and the care of those children would be better provided through a specialist agency, carers should be helped to move their registration to the specialist agency.

Among the most contentious of these issues is payment for private school fees. Some families incur many thousands of dollars over a child’s schooling. The Manual of Practice provides guidelines for this decision making and clearly sets out the circumstances in which fees will be paid. However, these guidelines are subject to the circumstances of each child. Discretionary overrides of guidelines by senior executive staff asked to review particular cases become problematic when more persistent or assertive carers are treated more favourably than carers who accept a decision made at the local office level. Inequities become well known and promote resentment among carers.

Transparency is lacking about foster care entitlements and decision making. The two principal guides to decision making and entitlements, Alternative Care Support Payments: Manual of Practice and Consents and Decisions Practice Guide, are not available as a matter of course to foster parents. A version of the Consents and Decisions Practice Guide, which was specifically developed for release to carers, is available. An up-to-date version of the Alternative Care Support Payments: Manual of Practice should be produced and made freely available to registered carers, whether online or in hard copy. If a specific guide is produced for carers, it should contain the same information, to the same level of detail as the internal manual.

**ADVOCACY**

Connecting Foster Carers (CFC) is the peak independent body representing foster parents and kinship carers. It is funded through a service agreement with the Department, which requires CFC to provide a variety of services, including a newsletter at least twice a year, a telephone advice service staffed 9-5 with call back function after hours, and an internet site.

Funding, which for the 2015/16 financial year totalled $92,396, also covers: a small honorarium and reimbursement for excess mileage for CFC board members; training and information exchange forums; and corporate expenses such as the operation of a mobile telephone free-call service. CFC pays no wages, and the free-call line and other services are staffed by volunteers.

CFC has 560 member households and delivers newsletters three times a year. Board members rotate staffing the telephone service and answering enquiries via the internet site.

The objects of CFC include:

- assisting carers to provide a loving and stable family home environment to foster children;
- advocating, representing and lobbying on behalf of carers and foster children; and
- bringing greater recognition to carers and foster children.

Advocacy at a system level is well established, and CFC attends more than 30 meetings per quarter with government and non-government agencies. The service specifications in the agreement with the Department refers to advocacy, although it is not clear whether this refers to advocacy for foster parents and kinship carers as a group, or also on behalf of individual carers. It is difficult for CFC to offer an individual advocacy service to foster parents.

Many carers, especially kinship carers, are not used to dealing with large bureaucracies and lack the skills to assert themselves in dealings with Families SA. Other carers feel overwhelmed by the power imbalance between them and Families SA, which has the ultimate power to remove the child from their care.
CFC volunteers are carers themselves and many have good reason to be reluctant to develop an adversarial relationship with Families SA. They are also at a disadvantage in that they are usually not in possession of all relevant information.

An independent advocacy service that helps carers negotiate with the Agency should be established. CFC volunteers cannot be expected to provide an individual advocacy service in circumstances where their own relations with the Agency may suffer as a result. The appropriate site for such an advocacy service needs consideration. Such services might be provided through CFC, existing community legal centres or the Legal Services Commission. Educational materials for carers should be developed by the same service to clearly identify their rights to contribute to decision making in the Youth Court and in the Agency, and what rights of review exist inside and outside the Agency.

MANAGING RISK

PLACEMENT SUPPORT

Providing proper support to carers can reduce the risk of placement breakdown and improve stability for children in care. In a comprehensive survey in New South Wales, foster parents were asked to rate five statements for their relative importance in retaining foster parents. The three most important factors were:

- receiving more support from a caseworker;
- getting respect from workers; and
- getting regular respite from caring.

Financial considerations were viewed as much less relevant. These observations suggest that for carers the quality of the experience is much more important to them than the costs.

The level of foster parent satisfaction in their parenting role has been linked to them feeling competent in managing the behaviour of the children for whom they care. These feelings have been linked to an intention to continue to foster children in the future. Helping carers do their job well not only improves the current quality of care but could offer other benefits through improved carer retention.

Many foster parents are under the impression that an SOC will advocate on their behalf in dealings with Families SA. In practice, carers are often disappointed about a lack of support in this regard. Foster parents report that SOCs appear cautious about engaging in true advocacy because they are afraid to ‘rock the boat’ and feel constrained by the contractual relationship between the registered agency and Families SA. There are also occasions when concerns about the placement originate with the SOC, and advocacy by them would be a conflict of interest.

Mr Sandeman of Anglicare suggested one way of thinking about the role:

my view is more that we’re supporting a family, a family system, and that means somebody outside the family who is able to help that family resolve tensions and conflict. You’re not there to support ... the carers against the child, though that could be a construction. I think it’s much more about supporting families to function better, which means having the capacity to work both with the child, the other siblings, and the parents, and sometimes between the parents ... When it comes to investigation of a concern about abuse of that child within the foster family, that’s when the department needs to step in. That’s not our role ... If they’re case managing the child and they need to step in to decide whether to take the child away ... we do have a responsibility to report abuse if we see it, but the decision making about what happens as a result of those reports needs to be with the department.
There is an urgent need to clearly define the respective roles of the SOC and the child’s caseworker. Although it is critical that they work together, with the child’s best interests at the forefront of their working relationship, it is inevitable that their perspectives will not always align. Some caseworkers employed by Families SA complained that they were not permitted access to the service agreements which they believed would define the duties of the SOC. There is no reason why there could not be greater transparency about the terms of the service agreement (although aspects of costs arrangements might need to remain confidential). However, it must be understood that the service agreements also lack specificity. Families SA and the registered agencies must work together to develop clear specifications as to the respective roles of the SOC and Families SA caseworker. Such specifications must be freely available (including to carers) and must inform service delivery to families.

Foster parents must also receive accurate information about the precise nature of the SOC role. The current role title has a clear potential to mislead.

The Family and Community Services Act requires foster parents to be regularly reviewed. Reviews are conducted by registered agencies. Support and review of foster parents in accordance with these provisions is accomplished by contractual relationships with registered agencies. The Chief Executive of the Department has compulsory powers for managing foster parents. These include the power to enter any place or premises for the purpose of providing foster care support. It was described as ensuring that ‘some kinship carers are not being supported’. Kinship carers are supported by kinship care workers (SOC). When the Department places children in these arrangements, it does not have the statutory powers and obligations that would govern a foster care placement. This includes the power to delegate decision making under section 80. There is no logical reason to exempt related persons providing care to children from these provisions.

Kinship care by a step-parent, brother, sister, uncle, aunt, grandfather or grandmother is not subject to the requirements of the Family and Community Services Act. When the Department places children in these arrangements, it does not have the statutory powers and obligations that would govern a foster care placement. This includes the power to delegate decision making under section 80. There is no logical reason to exempt related persons providing care to children from these provisions.

Kinship carers are supported by kinship care workers who are non-social work qualified operational staff employed by the Agency (under the supervision of social work staff). Kinship care workers work with a child’s case manager to ensure that the placement is safe and appropriate.

Evidence indicated that kinship carers can be reluctant to engage with the program and accept support. For some kinship carers, contact must be negotiated. The Agency’s capacity to support and supervise the care delivered to children in the care of the Minister is not a matter for negotiation.

The Agency’s carer registration procedure requires that kinship carers be reviewed every 12 months to provide opportunities for mutual feedback about areas for development, or areas where further support is needed. Mr Matschoss, of PSU, which is responsible for the initial assessment, believed these reviews were the responsibility of kinship support workers or caseworkers from the local office. Ms Kay, of the kinship care support program, believed that responsibility sat with the PSU. What is clear is that kinship carers are not being reviewed on a regular basis in the same way as foster parents.

The kinship care program applies a workload management tool known as ‘differential service response’, which identifies workload priorities for kinship care support. It was described as ensuring that ‘some carers would receive more intensive support than others, depending on their current circumstances and need’. Some kinship carers do not have a support worker at all, and others only receive a minimal service.

Without legislative powers, Agency staff must negotiate to obtain the information for assessing and monitoring a placement. Mr Matschoss, talking about assertively pursuing a formal assessment of kinship carers, made the observation:

I guess about the closest we get is writing to them and saying that there will be a review … of the placement … which is, I guess, a veiled threat. We do things like looking at who’s got the relationship; is there a kinship care support worker involved; what’s the relationship there; is the local office involved? ... So we look at other avenues of how we can get in there. We also try to talk to the people, to find out what is the problem, and work around it, and accommodate. We are very, very flexible. In my time being involved, there is not one yet where we haven’t succeeded in actually being able to complete the assessment, but some, a couple of them, have been quite challenging.

A coercive approach is not suggested for securing the cooperation of reluctant kinship carers, but the existence of formal statutory powers to enable the Agency to keep children in care safe should provide clarity and boundaries in the relationship between the Agency and carers.
THERAPEUTIC SUPPORT

Children entering care in today’s environment have increasingly complex behaviours and medical needs. As the nature of care provision in home-based environments is changing, when carers are not adequately helped to deal with difficulties of children in their care, placements break down. Early support should be available to identify and address issues before placements are put at risk. Flexible support for carers is critical to identifying problems which might arise, and dealing with them in a timely way.

Home-based carers are not experts in trauma. They rely on the professionals to help them identify and deal with issues that emerge as the child grows. Two main barriers were identified to delivering therapeutic support: foster parents fail to communicate with support workers about the nature and severity of the problems; and professionals charged with supporting the placement do not refer them to appropriate support at an early stage.

The relationship between carers and the Agency is critical. A number of carers reported a reluctance to speak candidly to caseworkers about the challenges of caring, because they were afraid that their capacity to cope would be questioned. Some carers reported a reluctance even to seek reimbursement for property damage caused by their foster child because of a fear that their capacity to control the child’s behaviour would be brought into question.

Greater access to therapeutic support must be made available. This support can be delivered where it is most needed, only if the relationship of trust between carers and the Agency is improved.

TRAINING

The compulsory training delivered to foster parents for initial and continued registration is limited to:

- orientation training through the ‘Shared Stories, Shared Lives’ package;
- Apply First Aid (3 yearly);
- Safe Infant Care (for carers registered for infant care); and
- Child Safe Environments (3 yearly).

Ongoing training for foster parents is the responsibility of the contracted support agency. Barriers to attracting carers to complete more training include foster parents being put off by the poor quality training offered, or becoming frustrated by training being arranged then frequently cancelled because of a lack of interest. Staff from one registered agency observed a low uptake of non-mandatory training. Carers should be helped to develop their knowledge and skill. However, while foster care remains a voluntary undertaking, there is a limit to how much training can be legitimately imposed on busy carers.

A structured training program for general carers should be developed and skills recognised through a skills loading that acknowledges the preventative value of high quality therapeutic care. Carers with complex children, or children at risk of developing complex behaviours, could be targeted and helped to complete the program without needing to change their registration status to specialist therapeutic carer.

Foster care agencies currently deliver training independent of each other. There has been some local inter-agency cooperation, but more opportunities should be investigated. CAFWA is well placed to lead discussions for improved coordination, which could be supported by the government as a priority project.

RESPITE

Each agency enters into arrangements with carers to provide respite in the course of a placement. Respite can help carers who need a break from their caring role, and foster children who would benefit from different environments and a greater variety of role models.

Respite care can also be used between carer households to enable siblings in separate houses to enjoy weekends together. Children in care could thus develop a range of long-term relationships to their lasting benefit as they move into adulthood.

Foster care agencies recruit and register carers specifically interested in providing respite care only. Respite care is then provided to long-term carers on the basis of a match with a respite carer registered with that particular agency. There is no flexibility across agencies of access to respite care.

The need for respite care

Ms M is a 65-year-old retired woman who at the age of 60 decided to provide respite care to a child or young person in need. Soon after she was registered she was convinced by her registered agency to take on full-time care of an infant on an emergency basis. The infant remained with Ms M for 18 months while efforts were made to reunify him with his mother. In this time the child became attached to Ms M and a psychological assessment concluded that the child would suffer psychological damage if those ties were severed. Ms M was convinced to take on care of the child long term. Ms M lives in an area where the registered agency has no respite carers, but other agencies have carers in the area. Although Ms M was able to arrange some respite through personal friends, the lack of a respite carer in her local area who could provide respite during the school term puts pressure on Ms M.
Time for Kids is a not-for-profit service that provides respite carers for kinship placements. The fragmentation of services across different agencies, and between registered agencies and the Department means that kinship carers do not have access to respite carers who are registered with foster care agencies.

Greater coordination of respite care provision is urgently needed. The current fragmentation undermines the capacity of the system to respond adequately to carer needs. As with training, CAFWA is well positioned to lead greater agency coordination for respite, and should be supported by the government as a priority project.

RISK OF ABUSE AND NEGLECT

Just as children are at risk of abuse from their own families, so are they sometimes at risk in home-based placements.

Some children in care have particular needs and behaviours which make them especially vulnerable to abuse and neglect. A child whose psychological and emotional distress is expressed in behavioural dysfunction may test even the most patient carer. Carers who are not helped to manage these complexities may find themselves resorting to inappropriate and damaging methods to cope.

Foster parents may have allegations of abuse and neglect made about them because:

- abuse has occurred;
- children misinterpret actions because of a past history of abuse;
- foster parents are expected to deliver a higher standard of care than that expected of other parents; and
- the risk of emotional and physical abuse increases where carers are not trained adequately to cope with a child’s challenging behaviour.

South Australian data about the rate of substantiations of abuse in out-of-home care does not differentiate between home-based and residential care environments. The available evidence suggests that out-of-home care for some children continues to be unsafe. In the 2014/15 financial year 80 children were the subject of a substantiation of sexual abuse, physical abuse, emotional abuse or neglect in out-of-home care. This almost 400 per cent increase from the previous financial year suggests a dramatic change in approach to allegations of abuse (see Chapter 15).

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<th>Table 11.3: Number of children in out-of-home care who were the subject of a substantiation of sexual abuse, physical abuse, emotional abuse or neglect</th>
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<td>2012/13</td>
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<td>Number of children</td>
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<td>Proportion of total children in out-of-home care</td>
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The Commission obtained data from the Office of the Guardian for Children and Young People which monitors allegations of serious sexual abuse in care. Its capacity to do so is limited by the extent to which Families SA complies with its obligation to report all such matters to the Guardian. There is good reason to think the level of under-reporting from the Agency is significant. Between November 2008 and 31 October 2014 (six years) the Guardian received a total of 236 notifications, affecting 422 children and young people. Of that figure, 182 children (109 females and 73 males) affected were in home-based care, and 196 (140 males and 56 females) were in residential or commercial care. In drawing conclusions about the respective risk in each care arrangement, it is well to remember that 85 per cent of children in out-of-home care are in home-based arrangements (see Figure 11.2).

The risk of sexual abuse does not come from adults alone. Awareness is growing of the risk of child–child sexual abuse in out-of-home care environments, and the need for adults monitoring the environment to be vigilant to this possibility. Of the 236 total incidents reported to the Guardian, 95 were allegations of sexual abuse committed by another child.

Foster parents reported to the Commission that information about children’s history of sexualised behaviours was not always shared with them. Some carers felt this information was withheld at times to obtain a placement. The Commission was made aware of one case where children in a kinship placement exhibited difficult sexualised and trauma-related behaviours. These behaviours, including sexualised behaviours involving other children, were reported to the Agency and the kinship carers repeatedly sought support for the children. Ultimately the behaviours became unmanageable and the placement was at risk of ending. A request for an alternative placement recorded that the children’s behaviour was compatible with being placed with other children, and there were no
A scoping review commissioned by the Federal Royal Commission into Institutional Responses to Child Sexual Abuse identified 16 evaluations which considered the prevention of child sexual abuse in out-of-home care. The following practices were identified from the literature as contributing to the prevention of child–child sexual abuse in out-of-home care:

- providing adequate information to caregivers at the time of placement;
- strongly considering the appropriateness of placements at the outset;
- establishing a plan to maintain safety of all children in the placement;
- developing specific and well-articulated supervisions procedures; and
- providing effective treatment for children which specifically addressed their behaviour.

Where children are known to exhibit sexualised behaviours, this information must be shared openly with potential carers. Carers should have an opportunity to consider the appropriateness of the placement, and whether they are equipped to maintain the safety of all children in the placement.

Caregivers should also be offered training in how to address the needs of children who have been sexually abused, and to support them to keep their environment safe. Training should include how to respond to children who behave in inappropriate ways to minimise the risk that innocent conduct might be misinterpreted.

Factors identified as contributing to the prevention of carer–child sexual abuse are:

- completing rigorous screening checks, including having regard to information beyond criminal background checks;
- anticipating and checking applications for the use of pseudonyms;
- removing organisational features which can facilitate sexual abuse (power differential, unsupervised access to children, carers sharing bedrooms with children); and
- developing an environment where children feel safe enough to disclose.

Reforms to screening practices and organisational features are discussed in Chapter 20. Perhaps of greatest importance for children in home-based placements is creating an environment where they feel safe enough to disclose. This requires the maintenance of consistent and continuous relationships of trust with important adults outside the placement, such as the child’s caseworker or other trusted adults (see Chapter 10).

**RESPONDING TO RISK**

**DECISIONS TO REMOVE**

The media recently reported a number of removals of children from foster care placements. In these cases, Families SA needs to protect the privacy of the children concerned. Media reporting of these situations can present a picture of Agency operations which is incomplete or inaccurate. Reporting of that kind feeds the fear experienced by foster parents that their children might also be removed.

Removal of a child from a settled foster or kinship care placement is governed by a document described as a ‘Divisional Circular’. The removal of a child is controlled by section 51 of the Children’s Protection Act which provides a general power to the Minister to make arrangements for the care of a child under guardianship, including placing them in the care of an approved foster parent. The Agency’s discretion about where to place a child in care is unfettered, and carers have very limited rights of review.

Divisional Circular 131, issued on 29 July 2013, sets out a mandatory process of consultation and communication before a decision to remove. In particular, the circular requires that where concerns are serious enough to require placement termination to be considered, the caseworker must have communicated about those issues with relevant stakeholders, including anyone engaged to support the placement, professionals working with the child and, critically, the carer.

If the Agency considers that the matters of concern are unlikely to be resolved, and there is a high risk of placement breakdown, a case conference must be held and the carer must be invited. A decision to remove can only be made at that conference if all parties agree to that outcome. If consensus cannot be reached, the decision is made by a director or assistant director, taking into account all relevant information, and consulting with relevant experts.

The prescribed process, if followed, should leave a carer in no doubt about the seriousness of the situation before a decision to end the placement is made.
On occasions a removal must be undertaken in emergency circumstances, and it is not appropriate to engage the carer in a case conference. The circumstances include the Agency believing there is a real immediate risk to the child, and giving carers advance warning of the intended action may place the child at risk (for example, by being removed to an unknown location). Where such circumstances genuinely exist emergency removal is the only option. However, a very detailed assessment of the nature of that risk must precede any decision to proceed with an emergency removal. When a placement has to end, a cooperative and well planned process is to be preferred wherever possible. The impact of the removal on the child’s sense of security and wellbeing must be carefully considered. The impact of such action on the carer’s willingness to engage in a cooperative and planned transition process should also be weighed. These are not easy decisions, but evidence suggests that the balance has not been appropriately struck in recent times.

The Commission considered independent reviews of a number of decisions made by the Agency to remove children from placements. Some common themes were that:

- the Agency held genuine concerns about the quality of care being offered in the placements;
- the nature of the concerns made removal an appropriate response;
- the implementation of the decision to remove was poorly managed;
- there was a lack of consideration of whether the alternative available to the child would deliver a superior quality care; and
- the child’s perspective or view was not sought.

The seriousness of a decision to remove a child from a long-term placement, with the associated interruption to their security and attachment relationships, cannot be overstated. The Divisional Circular records:

the decision to remove children from families with whom they are living, including the removal of children who are settled with foster, relative or kinship carers, is a critical decision in the life of a child: removal of a child from placement may have a lifelong impact on the health, wellbeing and future of the child. The carer family may also be severely impacted. Such decisions must be made with the utmost consideration of the child’s safety, life-long security and future emotional wellbeing, as well as the natural justice rights of carers and their emotional wellbeing.

Decisions that have such wide reaching implications should be attended by a greater level of transparency and formality than is currently available. Foster parents must be supported to present their point of view and, where appropriate, participate in child-focused transition planning.

CARE CONCERN PROCESSES

Allegations that children in care have been abused or neglected, or that an appropriate standard of care has otherwise not been met, are referred to within the Department as ‘care concerns’. Management of these matters is described and analysed in greater detail in Chapter 15.

The management of care concerns has an impact on carers against whom such allegations are levelled. No doubt, the swift and rigorous investigation of such allegations is a fundamental safeguard for children living in out-of-home care. Some allegations are so serious that a child cannot be permitted to remain in the placement while the investigation proceeds. In some circumstances, that will require removal of the child without prior notification to a carer. These are situations which may arise with limited time to plan a response, and the safety of the child must be the focus of decision making.

However, if investigations are unnecessarily prolonged and conclude that concerns are not substantiated, or can be addressed without the removal of the child, then valuable security and continuity for the child will have been unnecessarily lost. For this reason, investigations must proceed as quickly as possible. Subject to investigational demands, carers must be given clear information about the allegations against them and how long investigations will take. Children also must receive appropriate and honest information about why their circumstances have changed, and what is likely to happen in the future.

REFORMING HOME-BASED CARE

Both the legislative and policy framework for home-based care needs significant overhaul. Governance has not kept pace with the growth in kinship care and this deficit should be urgently addressed. Carers need greater clarity about their rights to information and participation in decision making, and major decisions made by Agency staff that affect carers should be more transparent.

Legislative amendments are needed to ensure that all carers providing care to a child in the custody or guardianship of the Minister are subject to a consistent legislative regime, whether or not they are related to the child in their care. Legislative governance should therefore be expanded to include family members (including the groups currently excluded from the operation of the Family and Community Services Act) who care for children in arrangements where they receive a payment from the state government for that care.
This could be achieved by prescribing a second category of carer to which the provisions of Part 4, Subdivision 3 of the Family and Community Services Act would apply. This category would include step-parents, brothers, sisters, uncles, aunts, grandfathers and grandmothers who provide care for children who are in the custody or guardianship of the Minister, but who are currently excluded from the definition of foster parent. Amendments would also be necessary to section 80 in Subdivision 8 of the Family and Community Services Act to include reference to decision-making power being delegated to these relative carers as well as foster parents.

It is appropriate that kinship carers who care for children in private arrangements remain unregulated by the Family and Community Services Act.

The governance structures currently prescribed by the Family and Community Services Act are premised on a division of function between Families SA and registered agencies. The reforms to bring kinship care into alignment with foster care should extend to outsourcing kinship care assessment and support to appropriately qualified registered agencies. iREG processes would continue to be completed by Agency staff involved in the initial identification and assessment of the placement, but the final assessment would be delegated to the non-government agency tasked with providing ongoing support for the placement.

If possible the number of agencies delivering these services should not be expanded. Greater coordination and collaboration between agencies is valuable for providing training and respite care in particular. The recommendations made in that regard would be more easily achieved with the current modest number of agencies providing services.

The higher risks that may require management in kinship placements require highly skilled and knowledgeable staff helping carers to deliver quality care. Contractual conditions in service agreements with registered agencies must specify tertiary level qualifications for employed support staff.

Section 42 of the Family and Community Services Act sets out a range of matters the Department’s Chief Executive must consider before registering a foster parent. The Commission considers that these matters are equally appropriate to kinship carers. However, the Step by Step program used to assess foster parents is not designed to assess kinship carers.

A standardisation in the legislative regime does not assume standardised assessment. The criteria in section 42 are sufficiently broad to support a variety of assessment methods, appropriate to the circumstances of the particular carer. The current assessment tools have not been approved at an executive level, and remain in an unapproved form. There must be an investment in a rigorous evidence-based assessment tool to be used by registered agencies to assess kinship carers.

Standardisation of registration processes should deliver greater rigour to the current kinship registration processes. It would require regular reviews, and the Chief Executive of the Department would, if necessary, have the power to require compliance. It would also bring all carers within section 80, enabling decision making to be delegated to relative carers in appropriate cases.

The Commission acknowledges that there may be challenges in outsourcing kinship assessment and support in some regional and remote areas. This would need to be carefully monitored, and acted upon when an appropriate agency is able to demonstrate a capacity to provide a service at the required standard.

The Commission recommends that registration of kinship carers sit with CARU rather than the PSU, because of the anticipated standardisation of processes and stakeholders. CARU is in the best position to provide the comprehensive check of applications for registration that must apply to kinship carers.

The changes proposed would see a significant contraction in departmental kinship support services. However, it would bring a greater role for the CARU in reviewing and approving registrations.

CARU would need a significant injection of resources to deliver these expanded services. To assess the staff levels required, a service benchmark of a 14-day turnaround for completed assessments should be imposed (completed meaning that they do not need to be returned to the agency for further information). In considering how resources should best be deployed, emphasis should be placed on the analytical and professional, rather than administrative, aspects of the registration task.

The backlog in kinship carers who are caring for children without having been subjected to a comprehensive assessment should be addressed as a matter of urgency. A specific project team should be engaged to address the situation, and ensure that no kinship carer has a child in their care under an iREG process for longer than three months.

Practices that dilute the assessment for kinship carers, such as medical self-report processes and the priority response assessment, should be abandoned. There is a real danger that risks that remain unknown cannot be managed appropriately and children will be at risk.
PARTICIPATION IN DECISION MAKING

Foster parents at present have very little power to challenge decisions made which affect children in their care. Current practice in the Youth Court does not normally include contributions from children’s home-based carers. Section 47 of the Children’s Protection Act permits the court to hear submissions from a variety of persons who are not party to the proceedings. The range contemplated includes a person who care for the child under an administrative agreement with the Agency.

Section 47A permits the Youth Court to hear submissions from a variety of persons who are not party to the proceedings. The range contemplated includes a person who at any time has had care of the child.169

The right to make submissions does not give a carer the same rights as a party to proceedings. However, it does give carers a voice in the proceedings that is independent of the Agency. A carer’s ability to exercise this right is limited by the information they are given about the nature and timing of legal proceedings regarding the child. It also depends on them being made aware of the right, and being equipped with the skill and knowledge to present submissions. The independent advocacy service referred to earlier could help carers make submissions where appropriate, and promote awareness of this provision.

Currently, there is no legislative requirement that carers be permitted to contribute to decision making that affects children in their care. The evidence before the Commission suggests that the Agency has not always made their contribution a priority. The degree to which relevant information is shared also continues to be a source of dissatisfaction. It is appropriate that provisions for each of these matters be enshrined in legislation. The Commission recommends that the Family and Community Services Act be amended to include provisions for each of these matters be enshrined in legislation. The Commission recommends that the Family and Community Services Act be amended to include provisions in similar terms to section 143 to 146 of the Children and Young Persons (Care and Protection) Act (NSW), which refer to:

• a carer’s right to certain information to enable them to make an informed decision whether or not to accept a placement;
• a carer’s right to all information reasonably necessary for them to provide appropriate care to the child and keep other members of the household safe; and
• a child or young person’s right to information about a proposed carer before placement.

Section 146 provides that a carer is entitled to participate in decision making going ‘beyond those relating to daily care and control, concerning safety, welfare and wellbeing of a child or young person in the care of the authorised carer’.170

TRANSPARENT DECISION MAKING

The Commission considers that the seriousness of the decision to remove a child from a long-term placement requires a more transparent process than is currently available. Professional voices outside the Agency must be heard in these decisions. It is the view of the Commission that the quality of decision making could be improved by implementation of a panel process which considers all removal decisions where the Agency and carers are not agreed that removal is in the child’s best interests. An independent panel would consider not only the concerns about the placement, but the quality of the alternative placement on offer. The panel would also consider the plans for a sensitive and child-focused transition if a decision is made that the placement should be terminated.

Where possible, the panel should also consider in advance removals conducted without prior notice to carers. Such removals should be considered interim only, until the independent panel has considered any submissions made by, or on behalf of, the carer.

The panel should have at least three members, including an expert member independent of the Agency. Emergency decisions, when necessary, should be made on an interim basis, and reviewed within a fortnight by the panel. The panel should also obtain and consider the views of the children and young people involved in the most appropriate way.

COMPLAINTS MANAGEMENT

CFC reported that carers find making complaints about Families SA difficult. They are uncertain about the appropriate process, and fear the consequences to their relationship with the Agency and their position as carers.171 The Agency should develop a centralised complaints process for carers, to investigate complaints independently. It need not be a formalised investigation, but it should respond promptly in writing to complaints. The availability of the process should be well publicised.

The process should not require as a matter of course that the first approach with the complaint be to the local office or worker concerned. Although usually complaints should be raised initially at the local level, this should not be a prerequisite to raising the matter through a complaints office. The complaints office should however encourage, in appropriate cases, attempts to resolve issues through informal mediation between the parties.
Many contributors emphasised the need to give serious consideration to a move towards professionalising foster care. This is a concept that is gaining momentum in both research literature and across the out-of-home care sector. Two key drivers have been identified for this trend: children with increasingly complex needs entering care, and recruitment and retention challenges in home-based care. 

A key action from the Second Three Year Action Plan of the National Framework for Protecting Australia’s Children was to investigate barriers and opportunities for developing professional models of home-based care. A report by consultancy Acil Allen was commissioned to review these barriers and opportunities, and provides a basis from which further work can be undertaken.

The term ‘professionalisation’ is commonly used without clear definition. Across Australia, models of foster care already exist which aim to recruit skilled and qualified carers to foster children with high needs. These programs offer a higher reimbursement rate, sometimes with an expectation that full-time care will be available to the child. These have been described as ‘enhanced foster care models’.

A number of enhanced models currently operate in South Australia. Life Without Barriers, and Key Assets run the largest therapeutic service agencies which provide a higher level of support and reimbursement to carers who take on the care of children with high needs. These programs offer the expectation of full-time care available to the child. These have been described as ‘enhanced foster care models’.

Centacare was recently contracted to establish a specialist reunification foster care service. Carers are recruited specifically to care for children while work is done to support reunification with their families of origin. Kirsty Drew, Executive Manager, Family Outreach and Relationship Services at Centacare, told the Commission that carers recruited to this role are expected to deliver a more intensive service involving:

- a certain level of professionalism and commitment from the carers. So this is their job, they don’t have another job. The child doesn’t go to childcare, they are with the carer. With that acknowledgment around the payment, they are a lot more involved. 

Carers in this program are helped to engage on a more natural basis with birth families, to transport children to access, and build what can become a mentoring role for the birth family developing skills to regain care of their children. The foster parent is described as part of a care team.

The original model hoped to recruit foster parents who were interested in delivering the short-term therapeutic work, and respite carers who would be prepared to provide long-term care if reunification has failed. This has not proved successful, as it has not been possible to recruit carers who are interested in offering both respite and long-term care.

This means that where reunification is not successful, a child who may have formed attachment relationships with the reunification carer goes back into the system for placement with long-term carers. This disruption is unhelpful for the child’s psychological and emotional development.

The program shows promise in delivering a more holistic reunification service which puts the care of children at its centre. However, where reunification fails, there are potentially emotional and psychological consequences for the child.

The Centacare model inches closer to a professional model but does not meet the definition of a truly professional model.

The Acil Allen report describes professional foster care as:

- a model of home-base foster care whereby carers are employed in a professional capacity to care for children and young people with complex needs, who are unable to be placed in more traditional less intensive forms of out-of-home care.

Under professional care models, carers would be paid a salary that is commensurate with their level of skill; would be required to hold a relevant qualification and/or undertake ongoing competency based learning and development; and would provide, or have access to, therapeutic clinical support and other specialist services.

The key barriers to a true professional model arise from the fact that professional foster care sits at the intersection of the separate worlds of work and family. Negotiating industrial relations, occupational health and welfare, and tax implications of shifting a volunteer home-based endeavour to a professional remunerated model is complex.
Unintended consequences might also follow such a move. The following possible consequences are of concern:\textsuperscript{178}

- Professionalisation might drive up rates of payment for services traditionally provided on the voluntary model. Carers already caring for children with complex needs under the voluntary model may be understandably dissatisfied with the resulting disparity.
- If professionalisation does not result in the recruitment of additional carers, but merely shifts existing carers into the professional model, the overall cost of care would increase without changing the number of providers.
- It is unclear how a for-fee service relationship would impact on the development of stable attachment relationships between children and carers. This relationship might well be affected by the child being aware that their carers is being paid to care for them.

As at 2013 there was no precedent for a truly professional model of foster care being successfully implemented in Australia. Models developed in both Victoria and Queensland were not advanced into operation because of the complexities of shifting the underlying model from volunteers to employees.\textsuperscript{179}

In its interim report, the Select Committee on Statutory Child Protection and Care in South Australia recommended that the Agency establish a trial of professional foster care in an area of identified need.\textsuperscript{180} Against the background of the complexity of issues needing to be resolved to develop such a model, the Commission does not regard professional foster care as a current priority. To date neither Queensland nor Victoria has been able to negotiate these complexities, indicating caution is needed about this state expending significant resources in developing a model.

The Commission considers that at present there is greater potential for the expansion of enhanced models rather than attempting to negotiate and expend resources on developing a professional model with all its inherent complexities.

However, the Agency should closely monitor developments in other states, to identify successful models elsewhere that might guide future service developments in this state.
The Commission recommends that the South Australian Government:

97 Amend the *Family and Community Services Act 1972* to include relative carers within the regulatory provisions of Part 4, Subdivision 3 and section 80. The definition of relative carers should include the categories of relatives who are currently excluded from the definition of foster parent in section 4 (step-parent, brother, sister, uncle, aunt, grandfather or grandmother), who care for children in the custody of, or under the guardianship of, the Minister.

98 Amend the *Family and Community Services Act 1972* to provide approved carers with a right to information for the purposes of caring for children in the same terms as in sections 143–145 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

99 Amend the *Family and Community Services Act 1972* to provide for approved carers to be involved in decision making concerning a child in their care, in the same terms as in section 146 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

100 Amend the *Family and Community Services Act 1972* to provide a specific right to approved carers to contribute to a child’s annual review pursuant to section 52 of the *Children’s Protection Act 1993*.

101 Amend section 80 of the *Family and Community Services Act 1972* to repeal the current requirement that foster parents care for a child for three years or more before delegations of powers can be made, and instead prescribe a minimum period of 12 months.

102 Outsource assessment and support of kinship carers to appropriately qualified non-government organisations in accordance with the service models which currently apply to foster care.

103 Develop or purchase a comprehensive kinship assessment tool for assessing the safety and appropriateness of kinship placements.

104 Invest resources in the Department’s Carer Assessment and Registration Unit to expand services to include consideration of applications for registration by kinship carers. These registrations would be in accordance with an appropriate assessment tool, and would authorise the carer to provide care to a specific child or children only.

105 Establish a Families SA Carer Assessment and Registration Unit service benchmark for assessment and registration decisions of 14 days where the assessment is complete and further information is not required from the assessing agency.

106 Develop a process for carers seeking approval (foster parents and kinship carers) to provide preliminary information about themselves and other adults who frequent their home to enable comprehensive C3MS checks to be done before a full Step by Step or other appropriate assessment is completed.

107 Include in the service agreement with all registered agencies the requirement that Families SA Carer Assessment and Registration Unit be notified of any person who begins an assessment process for carer registration (by Step by Step or another appropriate process) who is screened out, or, for whatever reason, subsequently withdraws from the assessment.

108 Develop an approved panel of practitioners authorised to provide priority assessments of specific child only carers on behalf of registered agencies.

109 Create a project team to address the backlog in assessments of kinship carers and comprehensively review carers whose assessment is limited to an iREG assessment where the child has been living in the placement for more than three months.

110 Cease reliance on medical self-assessment forms and response priority assessments for kinship carers.

111 Enter an administrative arrangement with the Department for Communities and Social Inclusion to provide priority screening clearances for carers where a child has been placed pursuant to an iREG process.

112 Review initial orientation training for carers seeking approval to include training on recognising and managing trauma related behaviours, together with information as to availability of, and access to, therapeutic assistance if required.

113 Include Agency staff, children in care and existing foster parents and kinship carers in the delivery of preliminary information and training for new and prospective approved carers.
114 Develop a practice guide identifying the circumstances in which delegations pursuant to the amended section 80 of the *Family and Community Services Act 1972* should be made.

115 Develop a written document which sets out the role and duties of the supporter of carers (SOC), including their role if care concerns arise, and to whom various duties are owed. This document should be freely available to home-based carers.

116 Fund Connecting Foster Carers, or an appropriate alternative agency, to deliver an advocacy service with paid staff to support carers to access and exercise their rights.

117 Fund the advocacy service to develop education material which clearly describes foster parents rights to contribute to decision making, and their rights of review regarding decisions which affect them.

118 Create an expert panel within the Agency to consider the removal of children from long-term home-based placements.

119 Review reimbursement rates to bring general foster rates with loadings for children with complex needs closer to rates payable to therapeutic carers.

120 Develop a specific package of training for general foster parents which can lead to payment of additional skills based loadings.

121 Support carers who are registered to general agencies to transfer to therapeutic agencies where the needs of children in their care require it.

122 Conduct a review of contractual conditions and payments to registered agencies to promote greater consistency of payments to agencies which support foster parents.

123 Update the Alternative Care Support Payments: Manual of Practice and make it available to all approved foster parents and kinship or relative carers.

124 Monitor developments in professional models of foster care in other states with a view to adopting or adapting a proven model.

125 Engage and support the Child and Family Welfare Association to develop more coordinated provision of training to carers.

126 Engage and support CAFWA to improve the coordination of respite provision to carers.

127 Develop a centralised system for receiving and resolving complaints from carers, including informal mediation or escalation to executive staff where appropriate. Timely written responses should be made to complaints.
11 CARING FOR CHILDREN IN HOME-BASED CARE

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Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
CARING FOR CHILDREN IN HOME-BASED CARE

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Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
## Caring for Children in Other Environments

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OVERVIEW

Children for whom a home-based care environment cannot be found, or is not appropriate, find themselves being placed in a range of settings which can broadly be described as ‘rotational care’. This chapter considers the care that is available to those children, in terms of the quality of their experience and their protection from abuse.

Rotational care is a poor substitute for a loving family. It does not satisfy children’s attachment or developmental needs and for children who have experienced trauma and abuse, it rarely provides an environment which helps them to heal. Rotational care divides knowledge about the child across three shifts of workers a day, and fragments their childhood into observations recorded in a handwritten log.

Rotational care is provided to children who require care on an emergency basis (referred to as emergency or commercial care) or on a longer term basis in facilities which are either operated, or licensed by, Families SA (the Agency).

Residential care has traditionally been reserved for young people whose high needs make them unsuitable for a home care environment. However, recent growth in the number of children entering care has not been matched by a growth in home-based placements. Over the past decade the widening gap has been filled with rotational care arrangements which have developed in an unplanned and uncoordinated way.

The growth in demand for home-based placements has also seen young children and infants placed into rotational care, including children in their active attachment phase where consistent care supporting preferential attachment relationships is crucial to their development.

The plight of these children came to the forefront of public consciousness with the arrest of Shannon McCoole for sexual offences against the youngest and most vulnerable children (see Volume 2, Case Study 5: Shannon McCoole). The community was shocked and horrified about the extent of McCoole’s offending, and wondered how such depravity could have gone undiscovered for so long. The Commission’s inquiries into this question reveal a system of care that was failing children both in terms of the quality of care that was available to them and the protection from abuse that the system was equipped to provide.

One experienced former Families SA employee encapsulated the crisis in rotational care that preceded the arrest of McCoole, observing that:

*Having so few placement options for children who cannot return home that we now have babies and toddlers in residential care should be a scandal. The baby in residential care is the dead canary in the coalmine; and the baby sexually abused in care is the mine explosion.*

Drawing on evidence from the case studies of McCoole and ‘Nathan’ (see Volume 2, Case Study 4: Nathan), and other evidence, this chapter explores the reforms that are needed to the system of rotational care. It identifies systemic and operational deficiencies in facilities and considers the manner in which the system can be reformed to deliver a purposeful and high quality care environment, for children for whom home-based care is inappropriate.

The matters raised in this chapter are urgent and critical. Reforms discussed in this chapter must be prioritised to keep children in the care of the state safe.

This chapter principally relates to the Commission’s Terms of Reference 5(d), 5(e), 5(f) and 5(h), in the context of Terms of Reference 1 to 4.

ROTATIONAL CARE

In this chapter, the overall concept of rotational care describes any care arrangement that involves children being cared for by adults who are employees, and who work according to a shift structure which divides the day across three or more shifts, with changing staff attending to children’s care needs across each shift. Many of these arrangements have the same staff working on shifts, which gives children a greater sense of certainty and connection to those charged with caring for them. The Commission heard evidence that the number of carers varies between placements but could be as high as 30 over a week. The lowest number of carers in a placement reported to the Commission was three.

Rotational care of two main types is delivered in South Australia: emergency care (also referred to as commercial care) and residential care.

Emergency care is a response to an urgent situation and is provided in a range of settings, including homes owned by the Families SA (the Agency), short-term holiday rentals, hotel rooms, bed and breakfast establishments, and caravan parks.
Emergency care is delivered by casual staff, engaged via private agencies who maintain panels of carers. There are no minimum qualifications for staff engaged in this way, and they frequently care for children in unsupervised environments. As these arrangements are ‘established’ by the Minister, they are not subject to the registration requirements of the Family and Community Services Act 1972 (SA).³

Residential care is delivered by the Agency and by not-for-profit organisations. It is provided in a house or unit that is established on an ongoing basis for the care of children. As children move on, another child is placed. Facilities that are established and operated by not-for-profit organisations must be licensed, and the facilities are subject to 12-monthly reviews of their licence.⁴

Residential care is also staffed on a rotational basis, although there is frequently a greater level of consistency across the staff engaged at any particular site than is possible in emergency care.

**CHILDREN’S EXPERIENCES OF ROTATIONAL CARE**

The Guardian for Children and Young People (GCYP or the guardian) recorded various statements that children made about living in residential care during their 2013–2014 visits. Some children spoke well of the staff who provided care and were positive about their ability to listen and spend time with them. Others had concerns about the physical environment and the relationship challenges that can accompany living with a large number of other unrelated young people.⁵

A lack of familiarity with the staff can be especially challenging for younger residents. Children sometimes wake up in the morning to meet for the first time a carer who will be responsible for toileting, bathing and feeding them. Other children go off to sleep not knowing who will be there the next morning, and whether they know the person who will be there if they wake up during the middle of the night. One carer working in a rotational care setting described a child asking a senior worker, ‘Can you just come in and ... be there tomorrow morning so that I know that, when I wake up in the morning, there’s someone there that I know’.⁶

A number of children and young people who lived in rotational care attended the Commission’s consultation. They said the following about their experiences⁷:

- **One worker has been on night shift for three years. I trust her. The carers are always awake. There is an alarm around the house. There are certain rules—you have your own bedroom, it’s not a jail.**

- **In residential-care the night time carers are loud. They watch TV and wake you up, and then tell you to go back to sleep.**

- **Shift changes are hard—you wake up with a different person there. Not sure who will be there in the morning.**

- **When we went to the Royal Show we could only stay for an hour and a half because of the shift change. Other kids got to stay for the whole day.**

For children in rotational care the impact of trauma can be compounded by inconsistencies in their care environment and inconsistent oversight of their behavioural and emotional wellbeing. Rotational carers can struggle to manage these difficult behaviours. Disruptive behaviour and aggression in rotational care environments often receive the greatest attention because of the effect they have on others, while other important indicators about a child’s wellbeing may go unnoticed.⁸

‘People don’t want teenagers much, they want little babies and five-year-olds. All the people who aren’t picked go in a home together’

For some children, ending up in rotational care brings a connotation of not being wanted. One child told the Commission, ‘People don’t want teenagers much, they want little babies and five-year-olds. All the people who aren’t picked go in a home together’.⁹
INFANTS AND VERY YOUNG CHILDREN IN ROTATIONAL CARE

The Commission heard from a number of professionals with a high level of concern about infants and young children being cared for in rotational arrangements. Patricia O’Rourke, Advanced Clinical Practitioner with the CAMHS Infant Therapeutic Reunification Service, told the Commission:

“A healthy baby will be a wreck at the end of a week of rotational care, let alone our babies ... So never is rotational care okay. I don’t even think it’s okay for disturbed older children.”

There is a consistent body of evidence which establishes that rotational care is not an appropriate environment for the care of young children. A necessary condition for infant development is the availability of attachment relationships. Children who experience maltreatment in these relationships have reduced opportunities to develop trust, security and emotional regulation. At sensitive stages in brain development, the absence of healthy attachment relationships can undermine neurological development, potentially disadvantaging children throughout their lives. Disrupted care experiences may result in attachment insecurity including reactive attachment disorder, a serious disturbance in social and emotional relatedness and behaviour, or disinhibited attachment disorder, which is characterised by diffuse and non-selectively focused attachment behaviour, attention seeking behaviour and indiscriminately friendly behaviour.

Placing infants and very young children in rotational care restricts the opportunity for children to develop relationships with a confined group of caregivers who are consistently available and emotionally engaged. Dr Sarah Mares, an infant, child and family psychiatrist, explained:

“In a rotational care situation the child is having to adapt to the institutional environment whereas actually what children under three need is that the environment adapts to them.”

In this environment children miss out on the developmental benefit of emotional engagement and play in everyday activities:

“It is about the baby being enjoyed or the toddler being enjoyed, not just being cared for like a machine, like a body. They are not just a body, they are a person with an experience, a little person with an experience.”

The impact of rotational care on young children

(The full case study of Nathan is at Volume 2, Case Study 4: Nathan—Children with complex needs in out-of-home care.)

The Commission heard that Nathan was cared for in emergency care between the ages of six and eight, following a series of placement breakdowns. At the age of six it was clear that he had high therapeutic needs as a result of having experienced serious childhood abuse. Nathan was housed in rental premises and his care was provided by staff employed through a commercial agency. Nathan’s psychologist reported to Families SA, in the course of a regular report about his progress:

Notwithstanding his charming manner Nathan’s behaviour is no longer regulated by a concern for maintaining close emotional ties with significant people in his life. He is not being properly socialised ... In the absence of him being afforded the opportunity to form and maintain close emotional ties with a consistent caregiver or caregivers, he is almost certain to experience poor outcomes in most if not all aspects of his life. He is also a significant risk to the welfare and wellbeing of others. He is eight years old.

The psychologists who gave evidence in the case study agreed that Nathan’s time in rotational care contributed to his dysfunction. There is no doubt that the inability of the Agency to provide a placement setting which allowed him to settle and develop healthy relationship skills has undermined his recovery from a traumatic start.

1 Email to P Parkin, 12 January 2010.

Recently, there has been a growth in placement of infants and young children in rotational care. Data produced to the Commission by Families SA identifies the number of children in care aged three years and under accommodated in rotational care (residential care and emergency care) from 2011/12 to 2014/15:

- 2011/12—50
- 2012/13—63
- 2013/14—32

BARRIERS TO MONITORING CHILDREN’S BEHAVIOUR

Rotational care diminishes the capacity of an organisation to recognise changes in children’s behaviour which may indicate that they are experiencing distress.
Unexplained changes in the behaviour or development of a child should raise concern that a child is distressed by an event or a change in their environment. In children who are non-verbal the ability to stay attuned to their behaviour is especially important.16

In a home-based care environment, there is usually a very small group of people who are intimately involved in the care of the child and are attuned to changes in their child’s behaviours. When care of a child is shared between multiple carers, accompanying supervisory and management personnel, and a case manager, knowledge of staying attuned to changes and of acting upon that knowledge.

Procedures in rotational care facilities attempt to provide continuity in monitoring a child’s behaviour. Handwritten logs record daily activities and observations. A 10-minute changeover provides some opportunity for workers to discuss what is happening for the various children. Procedures require reporting of concerning observations to senior staff. However, the Commission heard during the McCoole case study that the effectiveness of these procedures is variable and dependent on a number of factors:

- an environment existing where carers are supported in the implementation of the procedures;
- consistent practices surrounding what should be recorded;
- a high level of knowledge regarding the significance of certain types of behaviours;
- competent oversight and analysis of the information reported;
- clear practices to escalate information to an investigation or other action where appropriate.

The Commission identified significant failings in the residential care directorate in all of these areas and observed that opportunities were lost to take action that might have prevented or detected offending by McCoole.

**EMERGENCY CARE**

Emergency accommodation was established to provide short-term care for children who could not be put in any other placement, in circumstances of pressing need.17

Children are placed in accommodation which is sourced by Families SA but staffed by carers employed casually by private agencies, according to service agreements. Three agencies currently provide staff under these agreements: nannySA, Hendercare and a for-profit arm of Baptist Care.18 Approximately 75 per cent of care is provided in premises that are leased or otherwise obtained by Families SA; the remaining 25 per cent occurs in houses that are owned or managed internally.19

In late 2015 a total of 31 houses were being used for emergency accommodation.20

Emergency placements are often established to respond to a demand at short notice, to remove a child into care at short notice, or to deal with the unanticipated breakdown of a placement. They can be established as well as cancelled at short notice. Families SA’s placement services unit (PSU) arranges the premises and contacts a commercial agency to arrange for staff. Approval is required from the Families SA executive to place a child on these terms.21 Children are collected from their social worker by the worker sent by the commercial agency, who then travels to the property and sets up the placement.22

**A LONGSTANDING PROBLEM**

Since the early days of placing children in motels and hotels, various bodies have agitated for the development of strategies to ensure that care of this kind is not required.

By 2007, children as young as 10 were being placed in hotels and motels, being cared for by agency staff on a 24/7 basis. This was the unplanned infancy of emergency care provision by commercial carers. Service contracts were then negotiated with the commercial care sector to staff these placements. Emergency care was only ever intended to be a short-term measure and there has been a lack of considered planning for its future use.23

From a figure of zero in 2002/03, the number of children in commercial care placements rose to four in 2004/05, then to 106 in 2005/06. This sharp increase was the result of many more children being placed in state care coupled with the failure of home-based care placements to keep pace.24 One witness told the Commission that in some cases, children’s extended stays in emergency placements were not because nothing else was available, but because other pressing priorities occupied the scarce time case managers had available: ‘Case managers would almost park the kids there while they tried to cope with the other load they had on board, so [the children] would, by default, stay there’.25

For a number of years attempts at planning have been made, without any significant inroads into the growing number of children in these arrangements. In 2011, the Agency released Directions for Alternative Care in South Australia, which promised a more robust out-of-home care system. However, the action plan which was to follow did not eventuate.26 The document proposed:

exploring a developmental and differential program of supported, residential and intensive group care environments providing a spectrum of residential care opportunities, including:
• emergency and short-term care
• respite and assessment options
• general group home care
• high support and special needs residential opportunities.

Building the out-of-home care system remains the overarching theme of contributions made to the Commission on addressing the high level of reliance on emergency care. One contributor commented that the challenge had remained the same for some years: to ‘build a sustainable alternative care system while concurrently managing the crisis’.27

WHO IS CARED FOR IN EMERGENCY CARE?

Figure 12.1 sets out the number of children who have been placed in emergency care in the 2012/13 to 2014/15 financial years, by placement type. The number of children who are placed in emergency care each year has fluctuated but there is an overall increase during the past three financial years.

This data corresponds with evidence heard by the Commission that there had been a steady drop in the number of children in emergency care, followed in 2015 by a substantial rise. It coincided with an increase in the number of children being removed coupled with a decrease in the number of available foster parents and residential carers—many of the latter being unavailable while a broad review of staff was under way following the Hyde review. The Commission heard that most weekends the service was close to running out of commercial carers who could care for the number of children who required placement.29

At one stage the situation was so dire that children were placed in other children’s rooms in residential care when that child was missing from their placement or staying elsewhere for the weekend.30

Although emergency accommodation developed as a mode of short-term care, the Commission heard evidence that children are spending extended periods, sometimes years, in emergency care. One emergency care worker said she could not think of any child with whom she had come into contact who had remained fewer than eight weeks.31 As a consequence, children live for extended periods in placements which are established at short notice with little regard to placement matching.32

Table 12.1 sets out the number of children placed in emergency care for three or more consecutive months, by placement type. It demonstrates some fluctuation in the number of placements, but no real decrease over time. Service agreements with agencies who provide staff in emergency care are structured on the assumption that the care is genuinely short term. The service model, budget and programming is not intended to provide long-term care and there is little consideration of anything more than basic 24/7 care.33

GCYP monitors the number of children placed in emergency care. In a January 2015 report, GCYP observed that at any one time, there are between 15 and 20 children in the state living in interim emergency care for extended periods. Many of these are children and young people who have complex needs.34

The reality of the current situation is that children who are easiest to place in other arrangements will remain in emergency care for the shortest periods of time. Consequently, it is children with high and complex needs who are likely to find themselves languishing for long periods of time in this poor quality care. Yet it is these children who require high levels of support and therapeutic assistance, which emergency care is not designed to provide.
WHERE DO CHILDREN IN EMERGENCY CARE LIVE?

Despite a strong recommendation against the practice from the Children in State Care (CISC) Commission of Inquiry, children in care continue to be housed in motels, caravan parks and bed and breakfast arrangements (see Figure 12.1). The majority of children in emergency care placements are housed in holiday houses. The term ‘holiday house’ does not refer to the facilities or the nature of the environment, rather the fact that the property is secured on a short-term, sometimes week to week, lease arrangement. In a report about emergency care in January 2015, GCYP noted that placement of children in settings like motels is rare in other states and territories. By contrast, in the 2014/15 financial year in this state, 38 children were cared for in motels, and 56 in caravan parks.

Children in commercial emergency placements can face unplanned and disruptive changes of residence in short-term rental accommodation. During busy periods, such as the Clipsal car race, the Fringe Festival and Christmas holidays, children are sometimes moved out to make way for other tenants. By contrast, in the 2014/15 financial year in this state, 38 children were cared for in motels, and 56 in caravan parks.

The fact that the properties are physically designed as family homes does not necessarily mean they are suitable for emergency care. They are not required to be routinely inspected in the same way as licensed residential care facilities.

The Commission has heard evidence that houses used by Families SA for emergency care are sometimes unfit for purpose and at times unsafe. One carer spoke of a placement arranged for a four-year-old boy in an area that was unsafe at night, had inadequate locks, no front fencing and no safe place for a child to play. In the same placement, a female child was required to share a room with carers. Families SA changed the location of the placement only after persistent complaints from carers.

In Volume 2, Case Study 3, Hannah’s emergency care placement ended when a complaint was made by staff to the Health Department which resulted in the placement being shut down.

The continued housing of children in inappropriate accommodation places the safety of children and carers at risk, and fails to provide an appropriate environment for the ongoing care of children.

The challenges of motel accommodation

A female carer was required to care for a 15-year-old boy in a motel located at a busy intersection. The boy had just been released from youth detention and had a history of psychological issues and violence against women. Another worker, who was rostered to work a passive shift (sleeping overnight), refused to sleep in the adjoining room to the child as the door did not lock. The substitute carer had little information about the young person: the placement was new and she could not access any information. The child was distressed and upset. He wanted to leave the motel room but knew he had to stay or he would be returned to detention. He repeatedly left the room to search for cigarette butts to smoke, with the carer attempting to supervise him from a safe distance throughout the motel premises. He left the placement the next day and was arrested.

Table 12.1: Number of children in emergency care for three or more consecutive months, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF CHILDREN</th>
<th>FEMALES</th>
<th>MALES</th>
<th>AVERAGE AGE</th>
<th>OLDEST CHILD</th>
<th>YOUNGEST CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>175</td>
<td>64</td>
<td>111</td>
<td>12</td>
<td>18</td>
<td>0–6 months</td>
</tr>
<tr>
<td>2012/13</td>
<td>114</td>
<td>49</td>
<td>65</td>
<td>10</td>
<td>17</td>
<td>0–6 months</td>
</tr>
<tr>
<td>2013/14</td>
<td>128</td>
<td>50</td>
<td>78</td>
<td>10</td>
<td>17</td>
<td>6 months to 1 year</td>
</tr>
<tr>
<td>2014/15</td>
<td>165</td>
<td>67</td>
<td>98</td>
<td>10</td>
<td>18</td>
<td>6 months to 1 year</td>
</tr>
</tbody>
</table>

Source: Data from Families SA.

1 Oral evidence: Name withheld (W40)
STAFFING EMERGENCY CARE PLACEMENTS

Placements are staffed by commercial carers from one of the three agencies contracted to Families SA. Staff are rostered over three shifts per day, usually of about eight hours each shift, with a 10-minute handover. An ongoing challenge in emergency care has been to develop consistent teams of carers for particular children. As the carers are engaged via an agency, and are employed on casual conditions, continuity can be challenging. In one instance, the Commission heard that a 13-year-old child in emergency care had seen 90 different carers rotate through her placement in 12 months.

Compared with residential care which is staffed by Families SA, emergency care has a much higher turnover of staff. This can be attributed to the casual conditions of employment offered by agencies (although some carers are employed on contract by Baptist Care), to the agency’s desire to share work equitably among staff, and to the emergency nature of the placements which are by definition created at very short notice.

That is not to say that stability cannot be achieved in commercial emergency care arrangements. The Commission heard of one placement in which a core group of five carers was rostered. This was achieved through careful carer selection and close monitoring by the agency manager. However, this example is the exception rather than the rule, and it must be noted that the child concerned has been in the ‘emergency’ placement for more than 1200 days.

RECRUITMENT AND TRAINING

Service agreements govern the relationship between Families SA and the commercial agencies providing emergency care. These agreements stipulate mandatory requirements for employment, including current child-related employment screening checks, police clearances and a range of training.

The selection process for staff engaged through agencies is unregulated. There is no standard job and person specification for the role and no minimum qualifications required, as evidenced in the McCoole case study. The processes adopted by the three agencies vary. nannySA conducts an interview and then checks references over the telephone.

Baptist Care recruitment involves a preliminary screening for prerequisite conditions, followed by the applicant’s attendance at an assessment centre to participate in an interview, role play and group scenario. Reference checks are then conducted. Baptist Care is presently considering introducing psychometric testing.

Prerequisite qualifications for commercial care agencies also differ. Baptist Care, for example, mandates that staff hold a Certificate IV relevant to the field, or equivalent tertiary study, before employment. nannySA does not require any qualification (see Volume 2, Case Study S: Shannon McCoole). Candidates who are unqualified to work in nannySA’s child care centres, where a Certificate III in Children’s Services is a minimum requirement, are nevertheless employed as emergency care workers deployed to care for the state’s most vulnerable children.

The processes used by commercial agencies are significantly less rigorous than those used in Families SA’s residential care directorate. However, applicants who fail to meet Families SA requirements often seek and obtain positions with private agencies. This is especially concerning where carers are engaged on anything but a very short-term basis, because commercial carers receive less training than Families SA employees as well as a lower level of ongoing support and supervision.

Training of commercial carers is delivered by the contracting agency. The level of training provided depends on the care agency. nannySA provides approximately two days of training, includes child-safe environments training and one day of training relating to Families SA practices. The training is delivered by employees who have attended ‘train the trainer’ courses provided by Families SA. The Commission heard that currently Baptist Care provides six days of training which includes non-violent crisis intervention training, and components relating to disability, positive behaviour support, confidentiality, information sharing, working with families, grief and loss.

While the Commission has heard evidence of commercial carers who are child focused and perform their duties in a diligent and skilled manner, the opposite is sometimes the case. One supervisor tasked with overseeing aspects of commercial care placements observed that ‘we … found very quickly that the agencies were often just getting anybody they could possibly find to come and work’.

SUPERVISION

The Intensive Placement Support Team, based in Families SA, oversees emergency care placements. This service, which is staffed by youth workers, aims to supervise and build the capacity of the commercial care team. It reports any deficiencies in the performance of individual carers to the commercial agency and consults with Family SA’s PSU about placements. The team also visits placements and tries to build relationships with children.

Emergency placements are administered by the local Families SA office, which is responsible for tracking and approving the necessary expenditure. Because of the high costs involved in maintaining emergency care placements, any approval to extend them is escalated to the executive level.
The guardian observed in her January 2015 report that the level of monitoring of emergency care placements appeared to depend substantially on the ‘availability and attentiveness of the social worker allocated to the child’.56 The variability in the quality of casework being delivered by the Agency, which is discussed in Chapter 10, gives little reason for confidence that an appropriate level of monitoring is being consistently sustained.

Families SA staff who engage with contract carers or agencies, including the Intensive Placement Support Team, are not provided with copies of the service agreements, nor do they have access to information about the terms of their engagement. Families SA employees complained that they were unable to identify whether carers or commercial agencies were adhering to contractual conditions or standards of care.57 In the McCoole case study it emerged that service agreements stipulated a carer to child ratio of 1:1. In practice, emergency care placements were being staffed at a carer to child ratio of 1:3, at the behest of local Families SA staff.

Unless a child has especially high needs, emergency care is currently staffed at a level of one carer to up to three children, or two carers to four children. Even with numbers of children higher than three, night shifts are generally staffed by a single worker. This undermines workers’ capacity to deliver the required quality of care to children who have high needs, and also regularly leaves emergency care workers alone with vulnerable children, increasing the risk of abuse.

The responsibility for supervision and performance management of commercial carers lies with the agency that employs them.58 Evidence heard as part of the McCoole case study revealed that the nannySA supervisors responsible for staff performance cannot maintain a consistent physical presence at houses. While they have some capacity to respond when complaints are raised, their capacity to identify issues is limited.59 nannySA is reliant on information being passed to it by other carers or Families SA, and supervision occurs only in reaction to complaints.

The consequences of a lack of rigour in recruitment processes

In May 2011, a commercial agency contracted to provide emergency care workers applied for a screening clearance for a potential employee, ‘Russell Yorke’. In assessing Mr Yorke’s suitability to work with children, the screening unit accessed his criminal and child protection history. A clearance was granted. Mr Yorke began work as an emergency carer in June 2011.

Unbeknown to the screening unit, Mr Yorke had worked with vulnerable children in Victoria, and Victorian authorities had recorded allegations that between 2005 and 2010 he had consistently engaged in inappropriate behaviour around children he accessed in a variety of care-giving roles. This behaviour including sexual grooming and sexual assault. None of these allegations had been substantiated, and no criminal charges had been laid. In August 2011, the Victorian Department for Human Services became aware that Mr Yorke was working in child protection in South Australia but did nothing to advise authorities in this state about his history.1

Two months after he began work as an emergency carer, Mr Yorke applied to be registered as a foster parent. A psychological assessment commissioned by the assessing foster care agency concluded that he was unsuitable to become a carer ‘in any capacity’.

These facts were reported to Families SA in September 2011. Notwithstanding that report Mr Yorke continued to deliver care to vulnerable children until 27 April 2012, when Families SA finally advised the private agency that Mr Yorke was considered unsuitable to work in emergency care.

In May 2012 Families SA were advised that Mr Yorke was in a romantic relationship with a young person who had formerly been in care, but had recently turned 18. The young person was now under the Guardianship of the Public Advocate because he had an intellectual disability and poor daily living skills. Mr Yorke had been engaged to care for this young person while he was still under the care of Families SA.

A 2013 review concluded that there was ‘prima facie evidence that [Mr Yorke] has engaged in sexual and other inappropriate behaviour with children in the Minister’s care’, and that there is ‘evidence that he presents an unacceptable risk to children’. The same review highlighted that five months had passed between the clear identification of concerns about Mr Yorke and the termination of his services. A national child protection warning has now been recorded against Mr Yorke.

1 Families SA, ‘Review into whether [Russell Yorke] has engaged in any inappropriate behaviour with children in the Minister’s care’, internal unpublished document, Families SA Statewide Services directorate, no date.
MOBILITY BETWEEN AGENCIES

Families SA does not provide any overall approval or registration process for agency staff who are rostered into emergency placements. Staff members may work casually for more than one agency at the same time, or, in some circumstances, for Families SA and for an agency. This means that no single organisation is responsible for monitoring the overall performance of that staff member. This can lead to circumvention of the requirements restricting the number of hours that carers work per week, and the number of consecutive hours that can be worked, provisions that are aimed at occupational health and safety considerations, but also the delivery of quality care to children.

Through an examination of documents produced in the McCoole case study, the Commission discovered that during one period McCoole was working shifts while employed by Families SA and shifts while also employed by nannySA. These shifts were sequential, leading to continuous shifts which lasted over 18 hours, and were sometimes as long as 24 hours. There was no oversight of the total hours worked continuously or the total hours worked over a week because of the split between shifts conducted through Families SA and shifts conducted through nannySA.

No senior staff member was able to provide a satisfactory explanation as to why a staff member who was employed by Families SA on their casual list would, at the same time, be engaged through an agency at substantial additional cost. The Commission was left with the impression that these arrangements had developed with little close consideration of the effect on the quality of care available to children, and the economic inefficiencies for Families SA.

Similarly, Families SA does not track the movement of emergency care workers from one agency to another. If a carer’s engagement with one agency is terminated or suspended, that carer may apply to another agency. Whether the agency to which the carer applies becomes aware of their history depends on the new agency conducting rigorous checks, and the willingness of the other agency to share information.

The Commission became aware of one instance where an emergency care worker was directed by Families SA not to work in Nation Building houses (small home-like residential care facilities) due to concerns about her interaction with children in care. The carer subsequently obtained a position with Families SA as a youth worker. It did not appear that her earlier poor performance was considered during the application process.

This systematic lack of oversight poses an unacceptable risk to the safety of children in rotational care.

PLACING CHILDREN AND CARERS AT RISK

The Commission is concerned that the amount of information given to emergency care workers about children who come into their care is frequently inadequate. This results in part from the nature of emergency care, where the emergency circumstances can mean that Families SA has little information to share.

In response to this, one commercial care agency exercised extreme caution about the developmental condition of infants coming into their care. Carers were trained to start all infants on formula, even those who were over 12 months, because they simply did not know whether or not the child could eat solid food. Requiring carers to apply this sort of caution because of a lack of basic information is unacceptable, and greater care should be taken to obtain such details at the time children are removed from their birth families.

The lack of information persists beyond the initial placement. The same carer said the following about the experience of older children:

“They’ve got to explain to every support worker who comes through the door what their deal is and why they’re here. Not that we ask that information but the kids have got their own rundown—they’re getting frustrated because the support workers don’t know where to take them to school or where to go with them next.”

This lack of information has placed carers at risk of harm. In one instance carers were not informed of a child’s history of self-harm and harming others. Absence of appropriate supervision within houses also contributes to the risk to children’s safety. One carer told the Commission that they had observed staff asleep on active night shifts and a number of carers spoke of inadequate support when first placed at houses, conducting their first shifts without adequate supervision. On some occasions, the police have been called to assist with the control of children. A review of C3MS records conducted by the Commission’s expert panel identified an occasion when emergency care workers called for police assistance to deal with a non-compliant seven-year-old.

An inability to access Families SA records regarding children via C3MS, infrequent visits by social workers to placements and a failure to update information exacerbate these problems (see Volume 2, Case Study 5: Shannon McCoole).
The challenges of caring for high needs children in emergency care

A sibling group entered a placement staffed by emergency care workers engaged through a private agency. Some of the children had wounds which required monitoring. The youngest child was still in nappies. Families SA staff mentioned to emergency carers that some of the children had MRSA, a bacterial infection which is resistant to many antibiotics, but gave no information about what that was or how carers ought to manage it. Carers did their own research and obtained some pamphlets to guide their approach.

Due to the size of the sibling group, the children were split between two adjacent houses. Children would frequently run to the other house to see their siblings. The residence was unsafe as the children could access the roof and jump between the roofs of adjoining properties.

At the direction of Families SA and the care agency, carers were required to separate the youngest child from his siblings to settle him to sleep. This resulted in the child screaming, scratching and biting carers. At one point his behaviour escalated to the point that carers barricaded themselves in a carers’ room and called the police to defuse the situation. The philosophy of the particular agency prevented carers from physically separating the children to calm them.1

This placement was staffed by only a single carer overnight.

1 Oral evidence: Name withheld (W40)

THE FINANCIAL BURDEN OF EMERGENCY CARE

Emergency care is the most expensive option in South Australia’s out-of-home care system.19 In mid-2013 the cost of caring for a child in emergency care was $322,600 per year, compared to residential care by Families SA staff which cost $180,500 per year.19

With emergency care now accommodating children for extended periods, these costs are a significant drain on the child protection budget. For example, Families SA spent over $460,000 in 2013/14 to provide 11 months of emergency care to one teenage girl. At that time, it had already spent more than $1 million on emergency care for that young person. These costs are considered normal for such packages of care.20 In recent times commercial care placements per child cost about $10,000 per week dependent on the level of service required, for example, whether one or two carers are on shift during daytime shifts, and whether an active (awake) or passive (asleep) staff member is required for night shifts.21

At present, the use of ‘emergency’ refers not to the need to accommodate children in any truly unforeseen situation, but rather to an inability of the current care structures to accommodate demand. The higher cost of emergency care corresponds with a lower standard of service provision and safety for children. As one social worker who supervised children in commercial emergency care placements observed, ‘You could buy a couple of houses and staff them with people with the amount of money [it costs for] these kids in rotational care—it makes no sense’.22

At present, the use of ‘emergency’ refers not to the need to accommodate children in any truly unforeseen situation, rather to an inability of the current care structures to accommodate demand.

Continuing reliance on such an expensive model of care has contributed to the very high average cost per night of providing out-of-home care in South Australia. As discussed in Chapter 11 (Figure 11.5), South Australia’s average cost per night in 2014/15 was $230.50, outpaced only by the Northern Territory which recorded an average cost per night of $287.29. The most economical service delivery was in New South Wales, which was paying only $143.23 per night.

Out-of-home care continues to consume the vast majority of child protection spending (see Chapter 8, Figure 8.4). Spending rose sharply after 2013/14 and continues to climb (see Figure 8.3). While such a heavy reliance on costly and poor quality emergency care continues, there is little chance of funds being available for investment in other important services.
THE AGENCY’S AWARENESS OF EMERGENCY CARE RISKS

Since at least 2011, senior executives in Families SA have been on notice that continuing to rely on the employment of emergency care workers on shifts where they work alone with vulnerable children carries a heavy risk.

In February 2009 brothers ‘Jake’ and ‘Nicholas Butler’ were placed in the care of emergency carers engaged through nannySA. On 21 February 2009 five-year-old Jake disclosed that he had been sexually abused by a worker by the name of ‘Colin Norton’.73

An investigation was launched which concluded that Jake had been sexually abused by Norton, and there were significant concerns that three-year-old Nicholas had also been abused. Norton denied the allegations but admitted masturbating once while he was working a shift caring for the boys.74

Criminal charges were laid but did not ultimately proceed to trial. The internal care concern investigation concluded that the allegation of abuse was substantiated.75

An adverse events review report was completed in October 2011. The reviewer emphasised that the current service model which commonly left poorly trained agency workers alone with vulnerable children was inviting a high level of risk. The reviewer observed:

> It has been shown that younger, more vulnerable children are entering Families SA’s care and staying longer. Notwithstanding developments within the Nation Building program, the use of emergency placements is unlikely to cease in the medium term. These circumstances would seem to create an even greater imperative to minimise the opportunities for child sex offenders. It is the judgement of the reviewer that emergency care arrangements necessitate a minimum of two staff for both overnight and daytime care. Not to do so is for Families SA to take a calculated risk which, as was seen with Jake and Nicholas, can have dire outcomes.76 [Emphasis in original]

The reviewer went further:

> It is the opinion of the reviewer that Families SA has little effective knowledge of or operational control of quality of staff that are provided by the commercial carers. In the absence of such oversight Families SA has little demonstrable evidence of carer competency to care for vulnerable children. Families SA is exposed to significant organisational risk in continuing arrangements which are clearly inadequate for meeting the needs of children in care.77 [Emphasis in original]

David Waterford became aware of these matters soon after commencing as Executive Director. He was concerned about the continued use of single-handed shifts. Mr Waterford observed that most systems in the developed world had moved away from single-handed models by the 21st century.78 Notwithstanding these remarks, the use of commercial care and staffing of using single-handed shifts has continued.

McCOOLE’S ACCESS TO CHILDREN THROUGH EMERGENCY CARE

Shannon McCoole began his career caring for vulnerable children through casual employment with the agency nannySA. He was recruited to the agency on the basis of a single interview and only cursory reference checks. Although McCoole had no experience caring for infants or young children, a half-day training session on infant care and child nutrition was considered sufficient to equip him to care for babies and young children, even on shifts where he worked alone.

Very soon after he started, McCoole was engaged to care for a sibling group of three children: ‘Kevin’, ‘Amy’ and ‘Ricky Jones’. Ricky Jones was three-and-a-half years old and suffered developmental delays which restricted his ability to communicate. McCoole worked a number of shifts which gave him unsupervised access to the children, access which he exploited to commit several sexual offences against Ricky.

These offences were committed at a time when the review into the circumstances of the abuse of Jake and Nicholas Butler had not yet been finalised. However, the review delivered in October 2011 did not result in any changes to the level of training required of emergency care workers, nor the practice of engaging them on single-handed shifts to care for children with very little oversight or supervision.

CEASING RELIANCE ON EMERGENCY CARE

The continued reliance in this state on poor quality emergency care is placing infants and young children in environments that are developmentally damaging and sometimes unsafe. Young children are being removed from the care of their parents following an assessment that they are at risk of harm or neglect, only to be placed in an environment which also carries a risk of harm. This risk is not restricted to the long-term harm of spending extended periods of time in rotational care, which undermines the development of critical attachment relationships, but extends to the risk of abuse at the hands of workers who are not adequately scrutinised when they are employed, and not adequately supervised while they have access to children.
There is conceivably a role for well supervised commercial care in true emergency situations or to fill short-term roster gaps. However, the current services are inadequate and should be reviewed as a matter of urgency.

Families SA is examining the viability of incorporating those emergency care placements provided from Families SA properties into the residential care directorate. There is some potential for extending that project to include emergency care being provided in other short-term sites, such as motels and short-term rentals. The Commission suggests the various functions of setting up placements, supervising and supporting them be consolidated in the directorate.

While these proposals would potentially deliver the structure and oversight that has been lacking, they would not address the high level of reliance on this form of care, which has arisen because of a crisis in more suitable out-of-home care placements. Resolving these matters requires a great deal more forethought and planning, including a high level of investment in improving home-based care options through the reforms discussed in Chapter 11, and preventing the movement of children into out-of-home care through greater investment in early intervention and protective intervention, discussed in Chapters 7 and 8 respectively.

The reforms proposed will take time. In the meantime, arrangements should be made to improve the quality of care being delivered in emergency care. Those arrangements should include:

- reviewing service agreements with private agencies to ensure that their recruitment and training requirements are appropriate for carers who are delivering emergency care;
- developing a job and person specification and selection criteria for emergency carers to be appointed to casual pools. Agencies should be contractually obliged to have such documents approved by Families SA;
- enabling Families SA staff who have contact with and supervise agency staff to examine the agency’s service conditions;
- registering emergency care workers with Families SA, identifying the agency with whom they are listed. Workers should not be permitted to register for work with more than one agency, or to register for agency work when they are a Families SA casual staff member. Prior to registration Families SA should review whether it holds any information which raises concerns about the suitability of the worker;
- terminating single-handed shifts in emergency care.

The Agency should aim to bring all emergency care in house. There are practical challenges to achieving this in the short term, including recruiting sufficient suitable staff and developing infrastructure to manage it. However, emergency care has long been neglected on the assumption that the heavy reliance on it is temporary and will resolve when other aspects of the system begin to work more efficiently. Greater investment should be made in bringing this form of care in the Agency’s structures, and it should be delivered by staff with a much higher level of skill than is currently available.

The guardian observed that reliance on emergency care will not reduce until other alternative options are established. She observed that this will not be achieved without substantial additional funds, at least on a temporary basis. The Commission agrees with this observation.

RESIDENTIAL CARE

Families SA runs a variety of residential care facilities, with varying physical configurations and staffing ratios. Residential care is also provided by not-for-profit, non-government organisations (NGOs) which are licensed by the Minister for that purpose.

South Australia relies more heavily on residential care than any other jurisdiction. Figure 12.2 shows the reliance on this form of care across the various Australian jurisdictions. Families SA reported that at 5 August 2014 there were 156 children being cared for in 64 residential care facilities. Usually an additional 65 children would be cared for in residential care facilities operated by NGOs.

THE GROWTH OF RESIDENTIAL CARE

The current state of residential care is the result of growth over many years without the necessary oversight and planning. As the former guardian observed of the current state of affairs:

Nobody would want this to happen. Nobody planned for it to happen. It was probably rather that the implementation of the good intentions from years past was lacking.

In the 1970s government policy focused on the deinstitutionalisation of residential facilities. Non-government providers were encouraged to close large institutions and offer cottage or foster care. A greater emphasis on family-like settings, with foster care being the preferred placement choice, saw residential care conceived as the placement of ‘last resort’ when other placement options had failed.

A shortage of placements in residential care arose as overall capacity could not meet demand. There was concern about inappropriate placement decisions and children being placed long term in units designed for short-term accommodation. Younger children were at risk from the behaviours of older children, and it was felt that units became a ‘dumping ground’ for children.
During the 1990s, the Campbelltown and Enfield community residential units and Gilles Plains and Sturt assessment units began operation. However, the accommodation shortage persisted, with children as young as eight being placed in units, and concerns about inappropriate placements remaining.86

In 2004 approval was granted to establish 10 transitional accommodation houses, which were designed to provide short-term housing to children who were hard to place in home-based care, with a view to reducing reliance on emergency care.87

In September 2009, Families SA underwent a restructuring which shifted the management of transitional accommodation and community residential care. At the same time, there was a growing tension between strategic planning for the growth of the sector, and managing the crisis of the increasing numbers of children entering care. There was a push in the Agency for competitive tendering, which was hindered by the absence of a procurement strategy.88

In 2010 the federal government’s Nation Building stimulus package made available a large number of new houses, providing a unique opportunity to transform the way residential care and emergency care were being delivered. The challenge was twofold: to develop a workforce strategy to staff the houses, and identify children currently in emergency care to transition into Nation Building facilities. At the same time, Families SA also planned to recruit sufficient youth work staff to take back the delivery of emergency care services from private agencies.

Families SA set up a Nation Building housing project to use the new housing stock to reduce reliance on emergency care. The project envisaged residential care being provided by Families SA youth workers in a proportion of the houses, supplying differentiated services to address children’s individual therapeutic needs.89 At the time, however, South Australia’s capacity to find appropriate foster care placements for children was decreasing. Based on the premise that, for the majority of children, placement in foster care remained the preferred option, there was concern that a focus on growing residential care would detract from the attention given to foster care.

The aim for the Agency, as described by the former deputy chief executive, was to ‘have the best residential care system on a very small scale and somewhere for most of those children in foster placements’.90

In mid-2011 the residential care directorate of Families SA was created. Later that year, the new Department of Education and Child Development was announced, which would include Families SA. In the same month the Nation Building houses became available. The plan to staff these houses with youth workers employed by Families SA was, however, stymied by delays in obtaining Cabinet approval to raise the full-time employment (FTE) cap, so premises were staffed entirely by commercial carers engaged at a premium cost through private agencies. The differentiated services for children with high needs that were originally anticipated were not provided.91

Figure 12.2: Percentage of children in care placed in residential care, 2014/15
By May 2012 the approval to increase the FTE cap had still not been granted. As a result of Cabinet concern about the increase in the number of public sector employees, Families SA was asked to consider a model that would run for no more than three years, during which time an assessment would be made about transferring residential care provided in Nation Building houses to the not-for-profit sector.92

The delay in progressing Cabinet approval for funding was felt acutely in the Agency. A high level of concern existed that continuing to care for children in settings that failed to meet their attachment and therapeutic needs would result in children being further damaged. In an internal communication, the Deputy Chief Executive noted that the number of highly complex children who could not be properly cared for in any of the existing service models, described as ‘unplaceable children’, had increased from six to nine during the period of delay in advancing the Nation Building proposal. This number was anticipated to increase further in the time it would take to implement change. In the meantime care for each of these children was costing the state between half a million and one million dollars per year.93

In the early phases of planning for the Nation Building project, the concept of developing a greater occupational mix in the residential care workforce was canvassed. Mr Waterford supported the development of a mix of professionally qualified staff (social workers, psychologists and other appropriately qualified professionals) and operational staff (staff focussed on operational care functions) to deliver a higher quality care than had been possible with a homogenous operational group. Ultimately this idea was not embraced, and recruitment to operational positions continued.

Between 2011 and 2013, the delay in Cabinet approval for the increase in FTE positions prevented the recruitment of new youth workers into ongoing positions, and employment was being offered on short-term contracts. Evidence available to the Commission supports the conclusion that the nature of the offering to the marketplace affected the quality of applicant that the recruitment processes were able to attract.94

In June 2013 Cabinet approval was finally granted to commence the recruitment of 369 FTE youth workers. Approval was granted on the basis that the Nation Building housing model would be built, owned and operated until an appropriate non-government agency could be identified to take over its operation. Between 2011 and 2013, while the approval was outstanding, the Nation Building houses had been staffed by carers engaged through commercial agencies, providing compromised standard of care at a premium price.95

In a media release issued on 11 June 2013, the then Minister, Jennifer Rankine, said:

Replacing commercial carers with professional, highly qualified Families SA staff means that our most troubled young people will get the long-term therapeutic and consistent care that they require … the positions will be three-year contracts and recruitment will be rolled out until 2015. There will be a specific recruitment campaign that will target potential staff in related employment and attract new workers.96

The release made no reference to the fact that the strategy was conceived as a temporary one and devolvement to the non-government sector was its ultimate aim.

Efforts still continue today to recruit adequate numbers of youth workers to the Nation Building houses. Lack of preparedness within Families SA to commence recruitment97, inadequate consideration of the overhead costs of recruitment within the Cabinet submission98, challenges resulting from the move to the Department for Education and Child Development (the Department), the arrest of Shannon McCoole and subsequent reviews of recruitment processes have all contributed to delay.99

To date, reliance on commercial care remains high and the demand for residential care placements remains strong.

RESIDENTIAL CARE DIRECTORATE

The residential care directorate sits within the Families SA Metropolitan Operations and Residential Care section of the Office for Child Protection.100 At March 2015, the directorate was responsible for 41 houses providing residential care, and five larger community residential units.101 Most facilities are located in the metropolitan area, with two properties in regional centres. The directorate is divided into regions and a manager is appointed to each. Each region or large residential care unit is managed by a supervisor employed at operational services (OPS) 5 level who provides oversight and management. Senior youth workers manage small groups of houses. The day-to-day care of children is delivered by child and youth workers employed at OPS2 and OPS3 classifications on rotating shifts and, where required, commercial carers engaged by Families SA.

Residential care is provided according to two main models: small houses caring for between one and four residents, and community residential units designed to house up to 12 residents. There are some variations on these two distinct models, including some facilities which are collocated small homes which can accommodate large sibling groups and maximise staff flexibility across the houses.
Children who enter care often have developmental disadvantages associated with being raised in abusive and neglectful environments. They have often been exposed to or witnessed physical or sexual abuse and have missed out on consistent and nurturing care. Their development may have been undermined by these experiences and they may present as challenging and confusing individuals to caregivers.

Children in residential care are more likely to suffer behavioural and emotional difficulties and experience problems in other areas, including physical health, learning and language and educational outcomes. Approximately 15–20 per cent of children in out-of-home care who exhibit significant behavioural and emotional difficulties are at high risk of repeated placement instability and further psychosocial harm and are more likely to be placed in residential care.

In 2008 Howard Bath, the then Northern Territory Children’s Commissioner, observed that:

> residential care is generally only considered after multiple foster care failures ... Unfortunately, these more needy and behaviourally troubled young people are placed into a care modality that has been run down and neglected and thus struggles to respond to the demands placed on it.

Bath noted that the behavioural, developmental and psychiatric problems of the population of young people in residential care were varied and complex. He emphasised the need for these complexities to be considered in the design of residential care environments. Drawing on other research, he made the following observations about the characteristics of young people cared for in residential care facilities:

- aggressive behaviour is often a defining characteristic of young people classified as ‘high needs’ whether or not those behaviours are identified by a formal diagnosis;
- the majority of children have some trauma related symptomology;
- between 14 per cent and 40 per cent have an intellectual disability, often in the ‘mild’ range;
- a significant proportion have neuro-development problems, including autism spectrum disorder, foetal alcohol syndrome, attention deficit hyperactivity disorder, Tourette’s disorder, and other chromosomal disorders and learning disabilities; and
- some young people have formally diagnosed mental illnesses, including mood disorders, anxiety disorders and early onset schizophrenia.

‘Chelsea’ and ‘Rose’ were both infants when they were placed in residential care houses. Both placements were inappropriate and the rotational style of care provided was not suitable for either child’s developmental or safety needs. Chelsea was initially placed in a house with one other infant before being transitioned to a placement with two teenage girls. The house where Chelsea lived did not even have a bath, and she was washed in a tub placed in the bottom of the shower.

Chelsea had entered care from hospital as an underweight child with developmental delay resulting from neglect, who had also been physically abused. Both Chelsea and Rose were sexually abused by Shannon McCoole when each was under two years of age. Neither of them was capable of making a verbal complaint, or protecting themselves from the abuse. In both instances there were observations by other carers in the house of concerning physical indicators of sexual abuse or sexualised behaviours that were indicative of abuse. These observations were either not acted on by the carers, or were not followed up by Families SA staff when reports were made.

A report to the Community Services Ministers Advisory Council in June 2005 concluded that adolescents with mental health problems are the least likely to display improved psychological adjustment in the care environment. The same cohort was the least likely to achieve the placement stability that appears to be a predictive factor in after-care success. In alternative care systems where some young people ‘fail their way into residential care’ it is frequently this cohort of complex high-needs young people who find their way to residential care.

1 See Volume 2, Case Study 5: Shannon McCoole.
In South Australia, the residential care population is expanding to include much younger children than has previously been the case. Often these children should be placed in home-based care, but this is prevented by a lack of options. The residential care population is no longer confined to older adolescents who cannot be accommodated in home-based care, but now also is being relied on to care for infants and young children. South Australia has a higher reliance on residential care for children aged four and under, and for children aged between five and nine than anywhere else in Australia, where placement of children under four in residential care is especially rare (see Figure 12.3).

Earlier in this chapter, the particular dangers associated with caring for infants and young children in rotational arrangements have been discussed. For these reasons the placement of children under 10 in residential care should cease. This is especially urgent with respect to children under three.

The CISC Inquiry recommended that adequate resources be directed toward placing children and young people according to suitability of placement rather than availability. Not unlike the present time, the state was experiencing a chronic shortage in home-based placements, and the inquiry was concerned about the growing reliance on emergency and residential care. There is no evidence that the Agency’s capacity to place children according to their needs has improved since that recommendation. Evidence rather indicates that a chronic shortage in available placements persists, restricting the capacity of placement services to choose according to the child’s needs, rather than to availability.

The importance of providing placements that address children’s needs has been emphasised throughout this chapter. The appropriate method of ‘matching’ is not to search for the least poor match of a child to an existing placement, but rather to tailor a placement to suit a child’s needs. The Commission accepts that this is not always possible within the present residential care environment within South Australia. Recommendations in relation to this process are addressed later in the section ‘Reforming residential care’.

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Figure 12.3: Percentage of residential care population by age, 30 June 2015

Note: Percentages may not add up to 100 due to rounding.

COMMUNITY RESIDENTIAL CARE UNITS

Community residential care, referred to as units, have been in use since the 1980s. There are five currently in operation.

At June 2014, between 62 and 66 children, or about one-quarter of children in residential care, lived in units. At that time, the youngest child placed in a unit was nine, although the primary focus is children and young people 10 and above. Recently, a new 12-bed unit was opened in the southern suburbs: it has the capacity to house sibling groups together in a wing, and has been used to place some children younger than ten.

In general, large units have bedrooms separated across three wings with an office and communal living area. Newer units have kitchens in each of the wings and each room has its own ensuite facilities. There is a greater emphasis on security in the larger units than in other placements: youth workers lock the doors to children’s bedrooms to prevent theft, and systems are in place that allow youth workers to isolate power to bedrooms as a behaviour management tool and lock kitchens. This increases the institutional feel of the environment.

During day shifts there are three OPS2-level carers rostered, one working in each wing caring for up to four residents. A fourth carer provides support across the unit. During business hours on weekdays a senior youth worker and a supervisor are also available. Care is provided solely by employees of Families SA. Over the course of a week, children will be exposed to a large number of carers rotating across the two-day and one-night shifts.

Until recently, units were staffed overnight by a single youth worker. However, the Commission understands that approval for two youth workers to work overnight has now been granted but Families SA has had difficulty filling the positions.

Twelve-bed units are the most economical method of providing residential care. By housing greater numbers of children in the facility, fewer resources are required. In particular, savings can be made in staffing levels compared to some smaller facilities. However, these cost-savings have been at the expense of the quality of care available.

WHO LIVES IN COMMUNITY RESIDENTIAL CARE

Over time, the kind of children being placed into larger units has changed. While these units were originally designed to accommodate children with comparatively moderate needs, they have gradually developed into a population of children with high needs. Often the residents are children or young people with complex behaviours and histories of failed home-based care experiences, who may often demonstrate highly traumatised behaviour. They may be violent towards carers and other children, take drugs, be truant from school and behave in inappropriately sexualised ways. Children with these high needs are placed in units because of the higher numbers of staff available on site at any time, compared to a smaller home. These changes have impacted greatly on the capacity of units to provide a safe environment for children.

The Commission heard almost universal condemnation of large units. Claire Simmons, a principal clinical psychologist with Families SA, told the Commission that the chronic placement shortage meant that once a child was placed in a unit, there was less chance of them being considered for a more appropriate placement. Under the ‘triage’ system, children in emergency care receive higher priority than those in large units.

Even design features such as the separation of children into separate wings, has not addressed the problem. The problem is exacerbated by the demand for beds, which gives little scope to consider whether the placement of a particular child is an appropriate fit for the child, or for other residents. One supervisor recalled objecting to placements on the basis of inappropriate matching, including the placement of a child on the autism spectrum at the unit. He was informed that the unit was the ‘best of all the worst options that there are’.

‘You have 12 kids who are all scared, confused and angry, and if the behaviour starts here, it just spreads around the unit and they’re just in a constant sort of state of fear and confusion and uncertainty’

Rosemary Whitten, the Executive Director of Metropolitan Services and Residential Care, was the only witness who identified any redeeming features of large units. She argued that large units allowed for a balance of caring for individual children, and some group environment so that the young children don’t get lonely, because that’s a significant issue, but it also allows for organisational systems and efficiencies so that Government gets good value for money. In the long term, the harm that is done to children in these environments does not support the contention that they are providing ‘value for money’.
Placing a child into a large unit carries with it a risk that the child is exposed to further trauma, or will develop antisocial behaviours, from their interaction with other residents. One experienced supervisor from a large unit observed that he often witnessed ‘cross-contamination’ of negative behaviours between children, as they spread through the unit ‘like a virus’:

“You have 12 kids who are all scared, confused and angry, and if the behaviour starts here, it just spreads around the unit and they’re just in a constant sort of state of fear and confusion and uncertainty.”

Ms Simmons made a similar observation:

“The ones I really worry about going into units are the kids who haven’t picked up the absconding or the sexualised stuff or the drug and alcohol. I always feel devastated, I think [this] is not overstating it, when we have to place a child in that environment who hasn’t got those behaviours yet, because it really does feel like the system’s just … adding … another problem for these kids.”

In addition to the spread of negative behaviours in the unit setting, there is a corresponding spread of high-risk behaviours among residents when outside facilities. When residents with volatile behaviours are collocated they persuade or coerce each other into engaging in high-risk activity away from the units. In a report provided to the Minister in 2007, the guardian drew attention to evidence that children residing in units frequently absconded and were at high risk of harm, including drug taking and prostitution:

“Young people are inviting or coercing other children in care to join them in their risky activity and associations. Adults are involved in recruitment and are adept at identifying vulnerable people.”

LIFE IN LARGE UNITS

The rate of critical incidents, and the degree of harm which results, are indicators of how safe a residential facility is for its residents. The guardian analysed critical incident data from eight units as part of a report on larger residential care facilities. While 20 per cent of children in residential care are housed in residential units, 33 per cent of the critical incidents considered by the guardian occurred in them. At least two-thirds of the occasions where physical restraint was used on children occurred in units. Over a six-month period, 266 critical incidents were reported within units, with almost half occurring within two particular units.

**Behavioural contamination**

In 2013, at the age of just 11, ‘Nathan’ entered a large residential care unit. Nathan had no history of being arrested by the police, nor any history of absconding from his home-based care placement. Every professional involved in Nathan’s care agreed that a large unit was an inappropriate placement to address his needs, but it was presented as a short-term option until something more suitable became available. Within the first six months of Nathan’s placement at the unit he had committed 22 separate criminal offences, had been incarcerated in youth detention on five occasions and had been missing from the unit on 40 occasions, the longest period for four nights. He was also the victim of a serious assault at the hands of an older resident.

The former supervisor at Nathan’s unit said:

“Personally, I’m totally opposed to large units. I believe that we shouldn’t be building them and if I could have permission to bulldoze my own I would do it tomorrow. If you think about it, you’re putting 12 highly complex young people under the same roof, and what do you expect is going to happen?”

1. See Volume 2, Case Study 4: Nathan.

The following issues were recorded as triggers for children involved in those incidents:

- dissatisfaction with where they live;
- intoxication by alcohol and other drugs;
- residents facing challenges at school;
- inactive supervision by staff and not intervening as tensions rose;
- bullying by other residents; and
- residents reacting to staff who they did not know or did not like.
The guardian’s report identified that critical incidents had an impact on children apart from those who were directly involved: other children who were present felt scared and missed out on positive engagement with staff who were occupied dealing with the immediate crisis. Workers experienced particular difficulty managing residents with disabilities and younger residents who were more vulnerable.126

For the purposes of a case study, the Commission examined monitoring reports prepared for a specific unit where Nathan was placed. The report was produced from residents’ self-evaluation surveys, a review of documentation, and a visit to the unit. One resident suggested that house dinners could occur where all 12 residents could eat a meal together. Residents associated such an event with being ‘more like a real family’.129 A dinner was arranged on the evening that a staff member from the guardian’s office attended. Residential care staff observed that the dinner would not be possible if all the residents had been home at the time because it would ‘not be safe to have them all together’.130

At Nathan’s unit each resident had their own ensuite bathroom and toilet facilities, which are accessed through their bedroom. Each resident’s bedroom is locked both when they are inside and outside the room.131 Residents must ask a staff member to unlock their bedroom if they wish to enter or use the bathroom or toilet facilities.132 Without this process valuables ‘go missing’ and residents’ safety and security can be undermined. One supervisor gave the Commission an example of how quickly adverse events can unfold when young people with complex behaviours are left unsupervised:

In this case, a staff member was in the kitchen in the wing and there’s a corridor and while she was cleaning the plates after dinner she sort of had a look and saw a young person sitting at the door, so half of his body was visible from the outside, his legs were sort of inside. She found that strange... So she had a look and this young person had... his pants down and was masturbating while the other person was in the room completely petrified watching TV ... So this is how quickly this can happen.133

If staff are busy dealing with a critical incident, or are otherwise engaged, residents must wait if they need their rooms unlocked including to use their bathroom. At the time of the monitoring visit conducted by staff from the office of the guardian, residents were observed knocking on the observation window to the office to get staff attention to access their bedrooms or go outside.

Staff have high levels of administrative responsibility. Everything that occurs is logged, including movement, telephone calls, and daily events both positive and negative. Food is stored in the kitchen of each wing. Kitchens are locked and food is not freely available to the residents. Many critical incidents occur in kitchens and the kitchens present many hazards during such incidents.134

It is clear that the processes which operate to keep children and young people safe also undermine the homeliness of the environment. Striking a balance between keeping residents and property safe and extending the freedoms that might be expected in a home environment is challenging. This conflict is very much a result of the collocation of children and young people with complex issues and the paucity of staff available to supervise their interactions.

The Commission heard evidence that within some community units youth workers use police intervention, criminal charges and bail conditions to control children’s behaviour.135 The use of police as a tool to deter children from engaging in particular behaviours is undesirable. It reflects the high level of routinely aggressive behaviour within units and the failure to equip carers with tools to manage children’s behaviour more effectively.

On some occasions, police are called when a young person or young people begin to act aggressively or in a way that might involve a danger to themselves, and there are insufficient numbers of staff in attendance to contain the situation. Calling the police is one strategy which results in urgent support for an escalating situation. But it is an approach that brings young traumatised children into contact with the justice system, which is not always helpful to the management of their behaviour in the long term.

This is a particular problem during night shifts when a single youth worker is expected to supervise and care for up to 12 children and young people across three wings of the unit. Many contributors argued for the rostering of a second night officer in larger units. The addition of a second staff member is not simply a question of preventing inappropriate or exploitative behaviours within the facility or having an extra pair of hands in the event of a crisis: it can help stabilise behaviour before a crisis occurs. Danijel Kevesevic observed that management of these complex children was all about relationships:

If you had another person, the kid would be reassured there’s enough people to take care of me, I’m not scared anymore, and it would be good to have people who actually saw Joe was to be the night officer instead of a revolving door of people they don’t even know ... So the kids usually ask you ‘Who’s on tonight?’ and if you say ‘Danijel’, ‘Oh, OK, I know where I’m standing, I know where the line is. I know this person will take care of me’. If you say ‘John’ who is casual, that creates another level of anxiety. ‘Who is John? He’s brand new. He doesn’t know the rules. Will he be able to protect me? Will he make this placement safe? Does he know the job?’136
GCYP monitors the investigation of sexual abuse allegations as a result of Recommendation 20 of the CISC Inquiry. In an unpublished memorandum to the Minister for Families and Communities in 2011, GCYP drew attention to the disproportionately high percentage of notifications of sexual abuse arising from units. Twenty-three per cent of notifications which were reported to GCYP involved a child in a unit when such children represented three per cent of the total care population. Peer-on-peer sexual abuse allegations were made 1.3 times more frequently in a unit than in other residential care, and 4.5 times more frequently than in home-based care.141 It is accepted that the rate of reporting of sexual abuse does not correspond to actual events of sexual abuse, and that concerns have been raised about the accuracy of data provided to the guardian by Families SA;142 nevertheless, this data adds more weight to the already overwhelming argument in favour of ceasing reliance on this form of care.

**ADVOCATING FOR THE CLOSURE OF UNITS**

Recommendations to the state government to close large 12-bed residential care units have been made repeatedly. Their continued use conflicts directly with the recommendations of independent inquiries and repeated recommendations made by the guardian. Families SA also recognises the inappropriateness of the model and would prefer not to further invest in it.

The 2003 Layton Review identified that children in care had expressed a need for ‘flexible accommodation that does not place two highly at risk adolescents together, in the same accommodation, particularly if there are drug and alcohol problems’.139 Since 2005 GCYP has advocated for the closure of units due to the high risk to safety and wellbeing of children placed therein.140 The CISC Inquiry recommended that adequate resources be directed towards placing children and young people according to suitability of placement rather than availability, and accommodating a maximum of three children in residential care facilities.141

Notwithstanding the unity of voices against the model, in the 2011/12 budget Families SA received funding to build and operate two more 12-bed units to address the growing need for out-of-home care placements. Mr Waterford told the Commission that the Agency did not support the model and did not want to invest in it, but that the view of Treasury was that this was the cheapest way of dealing with the issue.142

The placement of children in residential units operating in South Australia should cease. The environment is unsafe. The co-location of multiple high-needs children and young people spreads risk-taking behaviour, endangers children and fails to meet their therapeutic needs. No more than four children should be housed in any one residential care facility, except when necessary to accommodate large sibling groups. The decision to continue to invest in these facilities because of short-term economies of scale fails to consider the long-term cost to both the children being cared for, and society more generally, when the results of drug use, criminal behaviour, violence and sexual abuse of already disadvantaged children are considered. Economic rationalisation misses the point of child protection.

**SMALLER RESIDENTIAL FACILITIES**

Smaller residential care facilities are managed through two programs: transitional accommodation and Nation Building accommodation. The variation in description of these two programs reflects the historical origins of the properties in each, and the only difference that remains between the two forms is how they are staffed. In transitional accommodation, day-to-day care is provided principally by OP3 youth workers with staff from commercial agencies engaged only when Families SA youth workers are unavailable (see Volume 2, Case Study S: Shannon McCoole). By contrast, Nation Building houses were originally staffed entirely by commercial staff; however, Families SA has for some time been engaged in the process of moving towards staffing those properties with Families SA youth workers.143 Supervision is provided by departmental senior youth workers.

Transitional accommodation and Nation Building houses operate on a different staffing model to the larger units. This is possible because of the smaller number of residents and the lower complexity of their individual behaviours. Staff in smaller houses are responsible for cooking and cleaning as well as caring for children, while in the larger units cooks and cleaners are contracted for those functions.144 In transitional accommodation and Nation Building houses, staff to children ratios are set between 1:3 and 1:4. Where the young people in the house have high or complex needs, the ratio is more likely to be set at 2:3 or 2:4. That staffing level is augmented by a senior youth worker who circulates between four houses on a rotating shift basis. A supervisor is also responsible for four houses and is available during business hours.145

One experienced supervisor who had spent time in both the larger units and the smaller houses described the contrast he observed:

It [the smaller residential care facility] is a normal looking house among all other normal looking houses... So when you come in, you do get a feel of a house
... However, instead of 12 kids and 20 something workers, you have two to three kids that are ... matched properly, and you would have one or two staff members, depending on the dynamics that are happening. The staff member would be cooking with the kids literally rather than cooking the food and then staff ... heating it up and dishing it [up] ... you can’t compare it. It just looks like a home and feels like a home. And definitely the doors wouldn’t be locked ... It was a completely different experience for me, an eye-opening experience.\textsuperscript{142}

\section*{USE OF FORCE AGAINST CHILDREN IN RESIDENTIAL CARE}

The use of force against children and young people who reside in residential care facilities is permitted by Regulation 14 of the Family and Community Services Regulations 2009 in the following circumstances:

\begin{enumerate}[(a)]
\item An employee in a residential care facility may only use such force against a child placed in the facility as is reasonably necessary in any particular case—
\begin{enumerate}[(I)]
\item to prevent the child from harming himself or herself or another person; or
\item to prevent the child from causing significant damage to property; or
\item as a last resort after other strategies have failed—
\begin{enumerate}[(c)]
\item to ensure that the child complies with a reasonable direction given by an employee of the facility; or
\item to maintain order in the facility.\textsuperscript{147}
\end{enumerate}
\end{enumerate}
\end{enumerate}

This regulation applies to Families SA facilities, including emergency care, but not to licensed residential care facilities maintained by not-for-profit organisations.\textsuperscript{148}

The Agency trains youth workers in non-violent crisis intervention which is a behaviour management program that focuses on preventing disruptive behaviour. The program includes a model of physical intervention, which is used only as a last resort. The restraints involved are not intended to be painful, and are applied with the child’s dignity firmly in mind.

Commercial carers engaged through private agencies who work in residential care are not trained in the use of the physical restraint.\textsuperscript{149} In fact, in some cases, physical contact of any kind is prohibited by the commercial agency. This includes occasions when physical contact is needed to protect children from danger or harm, or to comfort or nurture a young child. Some commercial carers are directed that they cannot have any physical contact with children. Families SA staff have been obliged to instruct carers that certain contact, such as holding a child’s hand when crossing the road, is not only appropriate but necessary to keep children safe.

Evidence was also given that when children were at risk of harming themselves, agency staff were directed to lock themselves in the office rather than intervene.\textsuperscript{150}

Where force is used against a child in residential care, each employee involved must ensure a written report is made to the supervisor of the facility. The report must contain the name of the child and that of every employee who was involved in or witnessed the use of force; the date, time and location of the incident; and the nature of the force, its purpose and the circumstances in which it was applied.\textsuperscript{151} In practice, these obligations are satisfied by the completion of a pro-forma critical incident report which is submitted to a supervisor for approval.

The completion of written records documenting occasions involving the use of force is a critical safeguard for both the child and for workers involved. Written records provide transparency which permits others to review the incident. These reviews can help to improve skill and knowledge, with a view to preventing future use of force. Critical incident reports are also used by the guardian to monitor residential care environments, in particular to assess the safety of children in those settings.\textsuperscript{152}

\section*{ACCURACY IN RECORDING THE USE OF FORCE}

The Commission heard evidence during the McCoole case study that reports about the use of force were commonly prepared by one employee who was involved in an incident, without input from others who were involved or witnessed it. The pro forma used to record these incidents can mislead the reader into believing that other carers have endorsed the account when in fact they have neither seen nor considered it. The Commission viewed three critical incident reports prepared by McCoole in which he described the use of force against a child. On each occasion, the account provided by McCoole in the report conflicted with evidence from other carers who observed his conduct as well as that given by the children involved. None of McCoole’s colleagues had been asked to contribute or endorse the version being promoted by him in the report.

The supervisor who was asked to endorse two of the three reports, however, assumed that the witnesses named in the report had contributed to its preparation, and assumed that the account recorded was accurate. This meant that McCoole was able to avoid including dissenting voices about the use of force in the official record.

The regulations should be amended to require all witnesses involved in or present during the use of force to endorse the report as an accurate record of events, or, if they do not agree, to prepare and submit their own report. An electronic signature would be adequate to indicate agreement with the terms of the report.
THE CHILD’S ACCOUNT OF THE USE OF FORCE

Regulation 14 requires that along with the written record prepared by staff, a child must be given an opportunity to contribute their account:

(3) An account of an incident leading to the use of force against a child placed in a residential care facility must be—

(a) written, signed and dated by the child; or

(b) if the child cannot write—

(i) written on the instructions of the child, and

(ii) signed by the child,

(and such account must be kept together with the record required to be kept under subregulation (2)).

(4) A child may nominate any of the following persons for the purposes of subregulation (3)(b):

(a) the child’s case manager or caseworker;

(b) a lawyer;

(c) a cultural advisor;

(d) any other adult person,

(But any such person nominated may not be an employee of the facility nor have been present during the relevant incident that led to the use of force against the child). [Emphasis added]

Critical incident reports considered by the Commission in case studies have systematically failed to comply with Regulation 14(3). The manager of one guardianship hub had never seen a critical incident report which complied with Regulation 14(3). The Commission issued a summons for all records prepared pursuant to Regulation 14(3) for the 2014/15 financial year and received records which satisfied the requirements of Regulation 14(3). It is apparent that there has been a complete and systematic failure to comply with this critical safeguard on the use of force in residential care. The former guardian told the Commission that her monitoring had revealed a longstanding failure to comply, and she had raised her concerns at a management level within the directorate.

Nicole Stasiak, the Director of Residential Care, conceded that there had been a failure to educate carers about these obligations. After the matter was raised in Commission hearings, Families SA amended its procedures to reflect the legislative requirements and has begun to train supervisors and senior youth workers. An ongoing barrier to compliance has been the ability to identify a person within the categories of Regulation 14(4) who is not employed by the facility to assist the child.

The pro-forma critical incident report should be amended to make clear the regulatory requirement that the child’s perspective of events be obtained. Reports should not be signed off by supervisors where these requirements have not been met unless a sound and convincing reason is available to explain the deficit.

It is critical that children living in residential care are aware of their rights under Regulation 14. GCYP should develop an education campaign aimed at ensuring children and young people are aware of their rights and understand how to ensure their views are recorded in these circumstances.

LISTENING TO CHILDREN IN RESIDENTIAL CARE

GCYP monitors the circumstances of children in residential care to ensure that their voices and experiences are heard, and influence agency practice. GCYP has monitored residential care environments since 2004, and the current regime includes monitoring visits to selected facilities, visiting residents, and writing reports and summaries.

GCYP has the capacity to enquire into the circumstances of children in residential care and provide advocacy. The GCYP’s capacity to deliver this advocacy depends on children and young people knowing their rights, and having access to GCYP. In this regard, GCYP has observed significant variation in children and young people’s knowledge. It publishes the Charter of Rights for Children and Young People in Care as a means of publicising these rights. Within residential care facilities, children have varying levels of understanding of the charter.

The GCYP’s monitoring noted that few residential care houses have formal complaint or feedback processes and residents are not aware of how to raise complaints. Within some, an informal complaints process is in place, but residents hold varying views about its effectiveness. Some children told the guardian that they did not feel listened to and questioned the value of speaking up. All children agreed that a more formal process which required complaints and responses to be documented would be a good idea.

GCYP made a similar observation about house meetings. Meetings did not occur in houses where children under 10 lived, and while some carers reported that meetings occurred informally, children in those houses did not always agree. Within community residential units, most supervisors reported that fortnightly meetings took place. Residents expressed conflicting views about the usefulness of the meetings.
generally complained to GCYP that there were limited opportunities to participate in decisions that affected their lives.161

COMMUNITY VISITORS SCHEME

The Layton Review recommended that functions be included within GCYP162 similar to the ‘community visitors’ that were then provided for in Queensland within the Commission for Children and Young People Act 2000.163

South Australia has not legislated for a community visitors scheme for children in care. Community visitors schemes operate within the state providing services to other vulnerable groups. Since 2011 there has been a community visitors scheme for people with mental illness who are admitted to treatment centres, including emergency departments and forensic settings.164 This service was recently expanded to include people with a disability and now provides support to those living in state-funded disability accommodation or supported residential facilities.165 It is an independent statutory scheme with reporting lines to the relevant Minister and includes a Principal Community Visitor and an advisory committee. The scheme’s volunteer community visitors must undergo role-specific training.166

A Bill to implement a Training Centre Visitor Scheme has passed both Houses of Parliament. It provides for the creation of the Training Centre Visitor, an independent statutory position, who is equipped with powers of visiting, inspecting, advocacy and promotion of residents’ best interests. There is also a power to inquire into and provide advice on matters referred by the Minister. GCYP can be appointed to this role, in addition to its present functions.167

These community visitors provide important services for vulnerable populations who are accommodated in out-of-home environments. They provide a range of services that include inspecting facilities, advocacy, improving the patients’/residents’ experiences, identifying gaps in service provision, increasing accountability and transparency within service provision, helping resolve complaints, and acting as a link between frontline service delivery and policy and service development. Their aim is to ensure the consistent delivery of best practice services, and improve overall health and wellbeing outcomes.168

The former guardian supported the development of a targeted community visitor scheme for children in residential care, recognising that although social workers did their best to visit children regularly, they faced competing organisational demands. A business case put forward by GCYP in 2014 proposed that a community visitor scheme target children who were new to care—the time of greatest instability and uncertainty. The business case also supported extending the service to all children in non-home-based care, in view of their position of particular disadvantage.169 The former guardian expressed the view that whereas a community visitor could focus solely on the child’s views and interests, a social worker had to balance other interests.170

The estimated cost of a scheme which targeted services to all children who had newly entered care (including those in home-based placements) exceeded $2 million a year; providing the service to children in residential care only was estimated at $1.7 million.171 The preference for a targeted model—that is, providing a community visitor service for the first years of a child’s time in care—was based on the cost. The cost of a community visitor service to all children in care was calculated to be at least $11 million per annum.172

In contrast with the mental health and disability model, the former guardian recommended the paid employment of community visitors, in order to recruit individuals with a background of engaging and working with children, and thereby achieve high quality reporting and advocacy.173

The Commission supports the implementation of a community visitors scheme for all children in residential care. The powers that community visitors will require to effectively perform their function will depend on the model adopted. Any scheme should grant community visitors the ability to access the children to whom they provide a service.

COMPLAINTS MECHANISMS

Section 56 of the Family and Community Services Act requires the Department’s Chief Executive to hear and investigate complaints made by a child with respect to their care or control. However this section applies only to children residing in licensed residential care facilities. There is no corresponding obligation on the Chief Executive in relation to children in facilities established by the Agency.

Ms Stasiak told the Commission that she supported the inclusion of Families SA facilities in this regime. She observed that some staff in residential care feared that helping children to make complaints about their circumstances would encourage them to make false allegations which would result in staff being removed from the workplace. Workers with this attitude express caution about improving complaints mechanisms. Ms Stasiak’s view was that children usually have an underlying reason for making a complaint, even on the occasions where it is not well founded, and processes must allow children to do so.174 Ms Stasiak’s evidence reflected a sophisticated awareness of the challenges which face the residential care directorate and a child-focused view of the potential solutions.
Section 56 of the Family and Community Services Act should be amended to require the Department’s Chief Executive to also hear complaints from children residing in their own facilities. A clear pathway to this mechanism should be available to children and young people in residential care. In order to track the effectiveness of the mechanisms established, quarterly reports which describe the number of complaints received and any emerging themes should be made to the Minister and GCYP.

Earlier reference is made to GCYP developing an awareness campaign for children and young people in residential care regarding their rights pursuant to Regulation 14. This campaign should also include promoting rights according to section 56, and how to access these complaint pathways.

STAFFING

Working in residential care is a difficult job. Carers must demonstrate understanding and empathy towards children of differing ages, ethnicity, culture, socioeconomic background and development. They must have an extensive knowledge of children’s psychological and emotional difficulties, and a high level of skill to address them. The challenge for workers was encapsulated by Mr Waterford, discussing the difficulties of recruiting workers to the role:

*For [some children] within this population, the level of trauma they had experienced I think necessitated a higher level of expertise. The challenge ... is that a lot of the work is cleaning, cooking, bottom wiping, and getting the right mix of operationally classified staff and professionally classified staff is vexed.*

Child and youth workers are employed under the OPS stream, with salary ranges from $49,576–$53,661 for OPS2 to $57,738–$61,822 for OPS3. Applicants must hold a child-related employment clearance, a current first aid certificate and full drivers licence.176 The process by which McCoole was recruited to Families SA was typical of the practices in operation at the time. A merit-based selection process was undertaken by a panel comprising the recruitment coordinator, who was employed within the residential care directorate, and two youth workers. The process included the following steps:

• initial application via a web-based site;
• shortlisting of applicants on the basis of their written application;
• the administration of an employment suitability test package offered by the Australian Institute of Forensic Psychology (AIFP), rebranded in 2013 as the Safeselect® Psychometric Testing System. Safeselect is a later version of the AIFP test suite;
• exclusion of some applicants on the basis of the test results;
• an observation shift in a residential facility;
• a medical assessment; and
• a face-to-face interview by the panel.

Safeselect testing includes an IQ component as well as a literacy, numeracy and writing component and a series of personality measures which are said to produce a result indicating the applicant’s potential suitability for the position. The test did not make a specific claim to test for a risk that the applicant would commit abuse against a child. The tests were administered by the recruitment coordinator, with results processed interstate by the AIFP, who produced a series of documents describing the results for all candidates.

This documentation provided to the Agency included results for each candidate for the IQ, reading, writing and numeracy assessments. Safeselect also identified whether candidates were recommended for further evaluation and an interview, and whether caution should be exercised in advancing a candidate when results indicated they were ‘high risk’. Candidates might be advanced notwithstanding their test scores where, for example, English was not their first language, and the test may have unfairly discriminated against them.

The panel was required to interpret the test results as part of the shortlisting process before the interview and during the interview process.

THE HYDE REVIEW

Following McCoole’s arrest, Mal Hyde, the former Commissioner of the South Australian Police, was appointed by the Minister for Education and Child Development to conduct a residential care workforce review. Its purposes were to:

• assess whether the residential care workforce was fit for role by conducting a full evaluation of the recruitment and selection process for each employee;
review and make recommendations to improve the effectiveness of the selection policy and processes and assess the operational risks in staffing residential care facilities; and

- identify strategies to maintain adequate staffing levels.

Mr Hyde worked with departmental staff and psychologists from Broomhall Young Psychology to complete the review in September 2014. A number of deficits within Families SA policies and practices were identified.

Before the review could begin its work evaluating individual employees, the available records had to be gathered. There was no simple and accurate way to identify all residential care directorate employees. Inconsistent information was obtained from payroll records, databases and onsite records provided by managers. Eventually after cross-checking the data from a number of sources, 467 employees were identified.

The review then faced challenges gathering documents relating to the employment and supervision of each employee including their initial application, psychometric test results, observation shift reports, evidence of valid child-related employment screening, supervision reports and performance plans. No single file contained all relevant documents about an employee’s recruitment and performance. Paper records were scattered throughout the Department, and psychometric tests for some employees had to be obtained from Safeselect. The review was obliged to recreate its own employee files from available documents.

These challenges highlighted an ongoing failure by the Department to establish basic human resources (HR) systems and processes. The capacity to effectively monitor the conduct of employees, particularly in a workforce of this size, requires systems that permit the employer to readily access corporate information. At its most basic, an employer should be able to identify who is working for the organisation. The effect of this systematic failure is further described in the McCoole case study, where his performance deficits were never fully understood by any single person in the directorate as he moved between areas which were separately managed.

The review observed that management within residential care was not fully integrated into the broader Department for Education and Child Development, resulting in ineffective and inefficient duplication of policies and procedures, siloed systems and a reduced level of support from that which had been available when the Agency had been part of the Department for Families and Communities. Processes and arrangements reflected a reactive management style, concentrating decision making in key executives and managers, with no business plan. A number of broad reforms were under way with few completed, and policy documents did not reflect the reality of Agency practice.\footnote{179}

The review examined how the recruitment process used the Safeselect test results. It observed that understanding the test results and interpreting them in a recruitment process required expertise and training. Panel members involved in recruitment between 2011 and 2013 were not trained in the interpretation of the tests and the review found evidence which suggested that they took little notice of the results.\footnote{160}

This conclusion is consistent with evidence before the Commission. Panel members who were asked to consider the Safeselect results recognised that they were untrained and therefore unable to properly understand test results. This, it seems, led to the results that were available being disregarded.\footnote{181} A number of applicants who returned high-risk ratings were advanced, as the interview process either failed to highlight areas of concern, or if concerns were identified and an attempt made to follow them up, panel members were not qualified to interpret the candidate’s response\footnote{182} (see Volume 2, Case Study 5: Shannon McCoole).

The findings of the review included that:

- the selection process had not been applied reliably, consistently and effectively, leading to significant weaknesses;
- recruitment and selection had not been planned and managed in a structured way at senior levels and there was no workforce plan;
- the selection process was being managed without expertise, resources and capability; and
- there was a lack of rigour applied to the selection process generally, and the quality control, performance management and accountability for the recruiting and selection processes were inadequate.

The Commission agrees with these findings.

The review concluded that the residential care directorate had no workforce management plan with a strategic approach to recruitment, selection, training and retention. The directorate’s systems could not even identify the number of vacancies.

Of the 467 employees examined by the review, 102 workers were identified as being of high or very high concern.\footnote{183} The review could not locate sufficient information on which to make a suitability assessment for 86 employees, or 18 per cent of the workforce. These results reinforce issues raised about recruitment and selection processes, and how the Agency assesses an employee’s ongoing suitability for the role.\footnote{184}
The review made a total of 49 recommendations, and an implementation project commenced in early 2015. The project team was staffed by employees outside the Office for Child Protection but within the Department. It was intended that the project team would complete the work necessary to embed the responses to the recommendations within the practice of the Agency.\textsuperscript{185}

The issue of the 102 employees identified as high or very high risk had to be addressed as a matter of priority. A panel worked through those employees to consider the viability of their future employment. Each employee was interviewed by a panel which included an organisational psychologist, a senior residential care directorate employee and a senior HR professional. As a result of these interviews, 25 employees were directed away from the workplace, pending further action.\textsuperscript{186}

The project team then took on responsibility for recruiting and selecting youth workers\textsuperscript{187} given the urgent need to fill vacant positions. Approximately 100 youth workers employed on temporary contracts were transferred to ongoing contracts\textsuperscript{188}, vacancies were identified and a recruitment process commenced. This initial recruitment process utilised the Safeselect suite of tests with two additional tests added to secure information identified by registered psychologists as important.\textsuperscript{189}

The project developed systems and processes that should be incorporated into Families SA standard processes. Dr Jane Richards, the Project Director, expressed a level of concern that the Agency does not currently have the expertise needed to manage the systems required, and that no plan existed to address or resource this.\textsuperscript{190}

The Deputy Chief Executive, Office of Child Protection, Etienne Scheepers, gave evidence before the Commission in October 2015. He told the Commission that he had only recently received a copy of the Hyde review. When asked if he had read it, he said:

\begin{quote}
I skimed it. I have an idea what’s in there. I have not read it in-depth because the world has moved on significantly from then.\textsuperscript{191}
\end{quote}

The Commission is concerned that these comments demonstrate a lack of understanding of the entrenched issues facing the Agency and the extent to which these will continue to challenge the Agency in the immediate future. While improvements have been made through the work of the implementation project, ‘given the previous history on selections and the management approach, there is no guarantee that the changes will remain’.\textsuperscript{192}

CURRENT RECRUITMENT PROCESSES

In 2016, recruitment for residential care was placed within a dedicated Families SA team. The current process is coordinated by a recruitment officer with HR expertise. This officer chairs the selection panel which also comprises two supervisors from the directorate. The panel report is prepared by another HR specialist.

The panel prepares an initial shortlist, after which a suitability test is conducted by a clinical psychologist. A series of psychometric tests, approved by the review implementation steering committee\textsuperscript{193}, are conducted by the psychologist in a one-to-one setting, and the applicant is either screened in or out. There is no follow-up of this assessment in the panel interview.\textsuperscript{194} The Safeselect testing regime is no longer used by Families SA as part of its recruitment of youth workers.

The Commission supports the continued use of the 2016 recruitment processes. The utilisation of HR expertise in conjunction with highly experienced operational staff provides necessary experience on the selection panel. It is appropriate that a suite of psychometric tests is utilised which reflect the specific role of youth workers within South Australia, and reflect the characteristics sought in applicants for this role. Both the Hyde review and the McCoole case study identified that a crucial failing of previous recruitment processes was the use of untrained and unqualified staff to interpret Safeselect test results. It is important to acknowledge that while Safeselect asserts that its reports are designed to be read by non-psychologists, it also asserts that at least one person on a selection panel should be trained in the use of the system.\textsuperscript{195} Even though Safeselect offers training to selection panel members, this was not utilised by the Agency.

The Commission is satisfied that individual testing conducted by qualified experts in organisational psychology is an appropriate and necessary strategy. This method is key to undertaking a holistic assessment of an individual to properly assess their potential suitability for a role in the residential care setting. The Commission emphasises that psychometric or psychological assessment should only be conducted by experts with appropriate qualifications.

The Commission does not recommend a return to using the Safeselect tool as part of the recruitment process. Experience in this state has demonstrated that expecting people without expertise in the field of occupational psychology to interpret test results, and ask questions of applicants in an interview which requires further interpretation of test results, has led to a misuse of the tests and leaves the Agency open to significant errors of interpretation.

In addition, the Commission is of the view that the Safeselect tests are not appropriate for use in residential care recruitment.
Safeselect asserts it provides clients with ‘a group of tools designed to assess the risk associated with hiring staff who will work in a public safety role’. The term ‘public safety officer’ is used by Safeselect to ‘refer to anyone working in a job where the decisions they make will affect the safety of other people’. Under this wide descriptor, Safeselect provides psychological assessment services for roles such as police, correctional services, fire, ambulance, fisheries and security officers. Working in child protection is viewed by Safeselect as a public safety role.

Further, the complete suite of tests is not viewed as reliable for Aboriginal and Torres Strait Islander (ATSI) applicants. Advice to Families SA from Kenneth Byrne, the Managing Director of the AIFP, was that reliance on the test results could unfairly disadvantage such applicants. While the test was administered to ATSI applicants, they were automatically recommended to advance.

The Agency has been reviewing the appropriateness of using the Safeselect suite of tools in its selection of residential care workers since at least 2010, and the need to use a psychological screening test that identified desirable characteristics and core competencies of the actual role in the Agency has been highlighted.

The use of the Safeselect profiling system in the selection of residential care workers has not been specifically evaluated. There is no evidence which establishes that the suite of tests is an appropriate measure of risk or indicator of desirable personality traits in relation to the specific role of youth workers employed in residential care. It is questionable whether the Agency should have viewed its residential care workers, who care for children with trauma histories in a residential environment, as working in a public safety role.

Assessment of the suitability of an employee for the youth worker role should not cease at the point of employment. Evidence given during the McCoole case study consistently demonstrated that carers working with McCool had concerns about his personality fit and style of care, and that they observed inappropriate interactions by him with children and carers. To a degree, senior staff were aware of these concerns. An ongoing process of assessment of the suitability of carers should continue past initial employment. It is recommended that the employment of all new employees be subject to an initial probationary period of at least six months. A comprehensive review of performance should occur immediately before the conclusion of the probationary period and an assessment made about the suitability of the employee for continued employment.

It is important to note that commercial carers are not subject to the same standards of engagement required of the directorate’s youth workers. People who are viewed as unsuitable for employment according to standards set within Families SA may nevertheless work within Families SA by gaining entry through commercial care arrangements, either within Families SA housing or in emergency care.

**TRAINING**

When skilled care is delivered by qualified and committed carers, children and young people can do well in residential settings. However, evidence suggests that there are significant gaps in training provided to carers in Families SA facilities, which leave children at risk of physical and emotional harm.

The demands of the youth worker role require a high level of knowledge. This demand can be met either by recruiting appropriately skilled people or by intensively training employees once they are engaged. While there is an argument that the basic level of knowledge might be improved by requiring applicants to hold a formal relevant qualification prior to appointment, such a requirement would restrict the pool from which selections are made. In view of the pay structure and the operational aspects of much of the work, it is unlikely that sufficient numbers of applicants with appropriate qualifications would be attracted to the position in the long term. The Commission also heard that personal characteristics such as resilience and life experience can be as important as formal qualifications in the selection of good child and youth workers.

The Commission accepts that mandating qualifications at a degree or certificate level, prior to employment, is inappropriate. The quality of training offered to employees after their appointment therefore becomes particularly important.

Youth workers currently undertake a full-time six-week course upon commencement, which includes class-based teaching and practical experience shadowing other youth workers (see Volume 2, Case Study 5: Shannon McCoole). Workers are then required to complete a Certificate IV in Child, Youth and Family Intervention within 12 months. This training is funded by the Agency. The certificate requirement has not always been a condition of employment and there is a proportion of the workforce who hold no formal qualification. The Agency is in the process of consultation about how to now engage these employees in training towards the certificate.

Training should continue beyond the basic matters covered in the six-week course and the Certificate IV. The Commission is aware that a number of carers felt ill-equipped to respond to the basic needs of young children in their care. Workers who were rostered to care for infants were not provided with training specific to infants’ needs or development. While some had experience caring for their own children, this was not always the case. One youth worker said that when an infant was first placed at the house where he was employed only one worker within his team had previous personal experience caring for infants. No-one in the team had any training or employment experience caring for infants.
Child and youth workers should be engaged in compulsory professional development which acknowledges the importance of their role in delivering therapeutic care to children and young people—one that transcends caring for the basic physical needs of a child. This professional development should endeavour to ensure that these workers gain the skills needed to contribute to a healing environment which is responsive to children in care.

THE CARE OF YOUNGER CHILDREN AND INFANTS

With the exception of circumstances where it is in the best interests of children to keep sibling groups together, the Commission does not support the placement of children under 10 in residential care. The reality is that until the home-based care sector can be expanded to accommodate the number of infants and younger children coming into care, or the number of such children requiring placement decreases, younger children will continue to be accommodated in these environments.

It is therefore necessary to consider how the directorate will provide quality care to those children. Youth workers who care for young children and infants must acquire the skills that are needed for that task. One option would be to develop a specific class of residential care worker with specialist training in early years care and child development. In view of the long-term aim of removing that group of children from the residential care population, recruiting specific workers for that purpose is short-sighted. In order to improve skills of the workforce in early years care, but retain the flexibility in the workforce to accommodate anticipated changes in the residential care population, suitable workers within the directorate should be identified for specific training in early child development and early years care.

SUPERVISION

In addition to appropriate ongoing training, workers should receive regular professional supervision. Evidence from the McCoole case study indicated that supervision was predominantly used as a means of addressing undesirable behaviours. Treating supervisory practices as relevant only to correcting workers’ conduct contributes to the perception that supervision is a pejorative process: it misses entirely the positive uses of supervision as a means for staff to raise topics of concern in their observations of children, to discuss their own development, and relay the observations of other staff.

Youth workers may operate in an isolated environment, without close oversight by their immediate supervisors. Supervision can provide an opportunity for supervisors to assess their wellbeing. Workers should have regular supervision which reviews their behaviour and performance and identifies learning opportunities. In some instances group supervision will be appropriate to raise common issues and constructively address team functioning. The supervision should be conducted by someone who has a high level of knowledge about child development and trauma, and can contribute knowledgeably to discussions about particular children.

Supervision notes are an important record of the Agency’s assessment of staff members’ performance. They should be kept in a manner that enables continuity of supervision across a worker’s engagement in different areas and different houses. The McCoole case study highlighted that as McCoole moved between different areas of the directorate, his supervision records were not accessed by his new supervisors, and a consistent knowledge of his performance deficits was never gained.

SEXUAL ABUSE IN RESIDENTIAL CARE

There is no doubt that children who are cared for in institutional environments (including residential care) are vulnerable to abuse, including sexual abuse. The reasons for this are attracting research attention as the disturbing rate of child abuse in religious and secular institutions is uncovered. In 2013 the National Crime Agency in the United Kingdom published a paper identifying themes in the sexual abuse of children by adults in institutions. The analysis considered residential care homes and secure units, among other institutional settings. An examination of the data gathered led the authors to observe:

Learning from institutional sexual abuse cases indicates that there is something about institutions, as environments for child sexual abuse, which appears to aggravate the vulnerability of potential victims and amplifies the power over them that abusers can exercise. This means that institutions are high risk environments for children, young people, and indeed other vulnerable people. Such a high risk, coupled with the vulnerability of potential victims, requires a higher investment in mitigation.

The analysis concluded that:

(Institutional child sexual abuse) is a product of a malign culture within an organisation which colludes with an offender’s propensity to abuse. The culture is set by poor leadership with rigid and closed structures; ineffective and unmonitored policies where staff are reluctant to report or discouraged from reporting their concerns; and where the interests of the institution are valued above the interests of the child.

A child who has been the victim of abuse is more vulnerable to being re-abused. Children who enter care already have developmental disadvantages associated with being raised in abusive and neglectful environments. When they are removed from their families to rotational care settings these disadvantages are compounded.
Children who have been abused sometimes become accustomed to these experiences and may also become used to their experiences not being given any priority. Children have the capacity to learn from a very early age to manage this in a way that enables them to remain close to their caregiver who is also the source of the abuse. The ability to manage and mask their own needs is then taken into subsequent relationships. These children do not assume adults will be interested in, or believe, what they have to say. They may learn to lie as a coping mechanism in their flawed care environment.

Some children who have been maltreated or neglected are especially vulnerable to adults who pay them particular attention and make them feel special. Children become attached to their abusers, and when abuse is also associated with attention, it can feel special for a child who is detached from other relationships that should be sustaining them. One of the challenges for identifying and addressing this risk in the residential care environment is that the creation of a special relationship with a vulnerable child can, in most circumstances, be highly beneficial: ‘many people have had a special relationship with a teacher or other adult that has been hugely beneficial, raising their ambition, confidence and skills’.

Some children who have been abused before coming into care develop behaviours which a potential offender can interpret as provocative. This is, of course, a self-serving interpretation. Nevertheless, it does render those children more vulnerable to a repeat of the abuse that might have brought them into care.

GCYP collects data relevant to allegations of sexual abuse in care. The data collected relies on reports being forwarded from the Care Concern Investigations Unit, and the data gathered must be considered with the caveat that GCYP may not receive all relevant notifications from the unit. There is good reason to think not all reports were forwarded to GCYP. A total of 236 reports of allegations of sexual abuse made between November 2008 and October 2014 were received, including a small number of reports from the Adelaide Youth Training Centre (AYTC), the secure care facility for children and young people serving periods of detention or remanded in custody.

Of the 236 total, 116 related to children living in family-based care, and 79 to children in residential care. The remaining 41 related to children in respite care, emergency care or the AYTC. Approximately 10 per cent of children in out-of-home care during the relevant period lived in residential care settings, and yet 79 (34 per cent) of the 236 reports came from children in that environment. Children in residential care are significantly over-represented in the rate of sexual abuse allegations being made.

GCYP observed that the higher rate in residential care may result from a number of factors: a greater external scrutiny of residential care; the higher needs of children in those settings; and a greater vulnerability in residential care to sexual abuse, including abuse from other children and young people.

While the focus of the Commission’s inquiry has been the risk of sexual abuse of children in residential care by carers (Volume 2, Case Study 5: Shannon McCoole), statistically there is greater risk to a child in residential care of sexual abuse by people outside the care facility as well as by other children within. A report of the Victorian Commission for Children and Young People identified that external predators committed 63 per cent of the sexual abuse identified within the period of the Inquiry. It was of equal significance that 31 per cent of the acts were committed by children against other children.

Residential care environments should acknowledge the risk of sexual abuse of all forms to children and actively protect children against such offending. This is of particular significance in considering the future for the 12-bed community residential units.

**WHO ABUSES CHILDREN?**

**DEFINING PAEDOPHILIA**

Paedophilia is a term that is commonly, and often inappropriately, used to describe adults who engage in sexual behaviour with children who are under the statutory age of consent. Properly applied, however, the term ‘paedophile’ has a far more restricted meaning. The clinical definition of paedophilia is a person who has [a] sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age. The diagnostic criteria for paedophilic disorders, as set out in DSM-5, require that:

1. Over at least six months, there have been recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child or children (generally aged 13 years or younger);
2. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty; and
3. The individual is at least age 16 years and at least five years older than the child or children in criterion 1.
As is evident from these criteria, ‘not all paedophiles commit sexual offences and not all people who commit child sexual offences are paedophiles’. The research supports the conclusion that there are adults who experience paedophilic urges who do not offend against children and many adults who offend against children but do not satisfy the diagnostic criteria for paedophilia. It is a dangerous and pervasive stereotype that all adults who offend against children have a specific and exclusive sexual interest in children.

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PREDATORY, OPPORTUNISTIC AND SITUATIONAL OFFENDERS

Researchers Stephen Smallbone and Richard Wortley conceive child sex offenders as falling into one of three types: predatory, opportunistic or situational offenders. Predatory offenders are stereotypical paedophiles and can be described as ‘high-frequency, chronic offenders’. They indulge in more frequent and extended sexual contact, suggesting they are interested in forming a relationship with the child. They are persistent and calculating in identifying vulnerable children to pursue.

Not all child sexual offenders are predatory in their approach. Professor James Ogloff told the Commission that ‘most child sexual offences have been found to be opportunistic, situationally determined, or involve victims who, while still being children, are post-pubescent’.

Opportunistic offenders may or may not satisfy the diagnostic criteria for paedophilia. Their offending generally exploits existing circumstances. Opportunistic offenders:

will tend not to actively create opportunities to abuse children, particularly if doing so would require any sustained effort. In simple terms, where the committed offender is the opportunity-maker, the opportunistic offender is the opportunity-taker.

Situational offenders offend in circumstances where the situation amplifies the level of temptation. The environmental circumstances create an impulsive decision to offend to satisfy a sexual need that does not necessarily originate in an attraction to children. Situational offenders are generally law-abiding citizens with no other criminal involvement. Their sexual offending will be relatively isolated. They are unlikely to create an opportunity to offend. The offending may result from environmental stressors:

While they are generally able to exercise self-restraint, a momentary lapse may be enough to turn what is probably at first a sense of emotional congruence with a child into a sexual incident.

Situational offenders are likely to be older at the time of the first sexual contact with a child, and they usually select female victims and victims within their family circle. A situational offender is more likely to be a person in a caregiver role or an authority figure who abuses their position of trust.

Child sex offenders are a heterogeneous group and it is not possible to identify any particular features that mark out a person who is more likely to sexually offend against a child. Frequently, even people who have the closest relationships with child sex offenders have no knowledge they are so inclined and are even less likely to know they have acted on the inclinations.

There are many adults whose potential to offend against children can be controlled by making changes to the environment in which they operate. That is, an opportunistic offender who is not presented with an opportunity to access a child will not manipulate circumstances to create such an opportunity. A situational offender who is not placed in a high risk situation may never commit an offence.

MANIPULATION OF ENVIRONMENTAL FACTORS

Institutional settings have generally concentrated on screening to exclude unsuitable adults from working with children. Modern approaches emphasise that the manipulation of environmental factors has the potential to be a much more powerful way to protect children from sexual abuse. It is important to acknowledge, however, that predatory offenders, who manipulate their environment to create opportunities to offend, will not be completely deterred by changes to their operating environment.

Wortley and Smallbone nominate four strategies for changing operating environments: increasing effort, controlling prompts, increasing risk and reducing permissibility.
INCREASING EFFORT
The ‘increasing effort’ strategy relies on the assumption that offenders will usually choose a victim who requires the least effort and deviation from their usual routine. Increasing effort for potential child sex offenders involves making access to victims more difficult. This strategy includes screening and recruitment processes that exclude high risk people.

Increasing effort also requires ‘target hardening’. This focuses on strategies such as teaching children protective strategies. This might include prevention programs that provide generalised upskilling in protective strategies. This might include teaching childrenassertiveness and self-confidence for vulnerable children rather than education about adult concepts such as sexuality or sexual acts.

CONTROLLING PROMPTS
For some offenders, the situations in which they find themselves may prompt them to offend. Some sexual offences are committed in circumstances where the child has been in a ‘provocative’ (from the point of view of the offender) or vulnerable situation. In residential care settings, tasks such as bathing, nappy changing or changing clothes may present prompts which tempt offending.

INCREASING RISK
In child sexual abuse, the presence of a responsible and alert parent or caregiver plays a central role in protecting the child from abuse. In institutional settings, effective supervision of employees combined with protocols that govern the way in which employees engage with children are critical.

Protocols such as prohibiting workers from being alone with children or modifying the physical environment to increase natural surveillance opportunities may be necessary. Ambiguity in rules and regulations as to what interactions are and are not prohibited provide fertile ground for exploitation by a potential child sex offender, who will push boundaries to engage in grooming behaviour.

In a residential care environment the presence of other staff members who are well trained and attuned to behaviours which raise concern is potentially one of the most powerful strategies to reduce the risk of child sexual abuse.

The effectiveness of the supervision of other adults, however, depends on the ability and willingness of those adults to recognise problematic behaviours. This can be challenging. Professor Ogloff explained in evidence that the starting point for most adults is that they experience no sexual attraction to children. It is easy to assume adults who appear in other respects to be like us also have the same absence of sexual attraction to children.

This is particularly so for adults who are part of our own social or friendship groups. This thinking supports the pervasive and dangerous belief that a child sex offender will be so different to us they will be easily identifiable. The more the community perpetuates the stereotype that sex offenders are sleazy predatory strangers, the more the real danger to children is overlooked. The real danger often lies with people who seem most like us: ‘monsters don’t get close to children, nice men do’.

To recognise problematic behaviours, people working in an environment with children must understand that people who are motivated to offend against children will not always fit their preconceived notions of what an offender looks like.

REDUCING PERMISSIBILITY
For some offenders, a psychological capacity to justify their offending enables them to overcome the community message that sexual behaviour with children is unacceptable. This may be through distortions of thinking such as ‘I was educating the child’, ‘the child was not harmed’ or ‘the child enjoyed the act’. Distortions might include thinking about children in sexual ways or considering children’s behaviour to be deliberately provocative.

In institutional settings, justification of behaviours of this kind may be achieved by a de-personalisation of the victims, divesting them of human qualities and individuality. Staff anonymity and collective responsibility can minimise the staff member’s sense of personal responsibility. Institutions that have firm rules and expectations of staff (including clarity of behavioural standards and expectations), and which personalise and individualise the children they care for, can address the distortions that offenders might employ to justify their offending.

Smallbone and Wortley set out the following features of institutional environments that minimise the risk of sexual abuse:

Strategies include ensuring that residents receive adequate levels of physical care that affords them human dignity; minimising institutional features of the environment and unnecessary regimentation; introducing explicit codes of conduct and induction procedures for staff that clearly spell out acceptable and unacceptable behaviour and leave no room for the exploitation of ambiguity; provide formal opportunities for residents to make complaints if abuse occurs; and opening the institution to outside scrutiny, including instituting a process of regular independent inspections and reviews.
The National Crime Authority report referred to earlier drew a number of conclusions about improving the conditions in institutional settings to prevent abuse:

**Children in institutions are at risk not only from the offenders who seek to exploit them, but also from adults who fail to see or fail to report abuse:**

- **Organisational culture, structure and processes can be used to manage situations where offenders might be tempted to abuse.** There is greater capacity for the protection of children through the management of opportunity and situations, than through the exclusion of potential offenders from the environment;

- **Rigid hierarchical organisations and closed organisations can operate to de-personalise staff and children within them.** This dehumanises children in their relationships with adults and staff in their relationships with managers. Staff who see signs of abuse and report them are often ostracised and excluded; and

- **Quality leadership and strong governance in an organisation which has the safeguarding of children as a high priority, and which regularly monitors and evaluates relevant policies and processes, influences the development of a healthy, open culture which supports the reporting of concerns.**

These observations resonate heavily in the Commission’s consideration of the organisational dysfunction that was the background to McCoole’s offending. These matters are discussed in greater detail in that case study (Volume 2, Case Study 5: Shannon McCoole).

**RECOGNISING THE SIGNS OF SEXUAL ABUSE**

Sexual abuse can have both an immediate and long-term impact on a child’s physical, emotional and mental wellbeing. Children who are too young to retain a narrative memory of the abuse perpetrated upon them may nonetheless retain the experience in procedural memory, such that the associated distress and anxiety can be later triggered. It is a misconception to think that abuse a child does not remember will not have an effect on their psychological wellbeing and development.

The impact of child sexual abuse depends on a range of factors including the age of the child, the age of the perpetrator, and the frequency, duration and type of abuse. Infants and young children are particularly vulnerable to the impact of abuse as the early years are a critical period for biological, psychological and social development. It is a time when infants and young children are completely reliant on their caregivers for emotional and physical protection. The younger the child the more likely the impact of abuse will be inscribed on neurological processes, affecting memory, attention span, self-regulation and physical health. Infants and young children are also especially vulnerable to abuse as they are unable to understand or communicate the nature of their experience in a way the adults around them will understand.

For these children, the existence of a close and consistent caregiver who is attuned to small changes in their behaviour and wellbeing is critical to their protection. In a traditional family environment with a small number of consistent caregivers, behavioural issues are more easily identified and addressed in a timely way. For children in rotational care, the impact of trauma can be compounded by inconsistencies in their care environment and inconsistent oversight of their behavioural and emotional wellbeing.

**BEHAVIOURAL INDICATORS**

There are a range of behaviours that may indicate past or current abuse or trauma, but which do not specifically indicate sexual abuse. In the short term, infants and young children may respond to trauma with non-specific distress such as being more unsettled or demanding. Trauma also manifests in language delay, regression in previously achieved developmental goals, clinginess, sleep difficulties and toileting issues. Specific phobias related to the abuse might develop such as a fear of bathing, toileting or being in the dark. Some children may re-enact frightening events during play, with toys or sometimes with other children, or in drawings.

Children may also internalise symptoms, becoming withdrawn, anxious or stressed, or exhibiting a number of behavioural changes all at once. Other children may externalise symptoms, becoming upset and displaying tantrums and aggression. The child may self-harm through behaviours such as head banging, excessive rocking, rubbing hair off their head or risk taking.

A number of children who have experienced trauma will develop behaviours which can be described as ‘self-soothing’. For children who have been abused the usual methods of self-soothing, such as thumb sucking, may become persistent or extreme. Some children will develop genitally focused soothing behaviours or begin to deliberately defecate or urinate in socially unacceptable locations. They may engage in faecal smearing outside normal toileting mishaps. Where these behaviours are persistent, or develop after continence has been achieved, they indicate that the child is experiencing an extreme level of distress. Children may also play with faecal matter to distract them from their distress or replicate their trauma in some way.

Toileting issues of this kind, particularly if they are persistent, raise questions of sexual abuse and should be closely assessed with other contextual information including the existence of other specific trauma behaviours.
MORE SPECIFIC INDICATORS OF SEXUAL ABUSE

There are some behaviours which raise a specific level of concern about sexual abuse rather than other kinds of abuse or trauma. In younger children, any penetrative behaviour (inserting things into their own or other children’s genitals) raises a high level of concern about sexual abuse.254 Any behaviour that has coercive features, including pressuring other children into sexual acts or exposing themselves, is of particular concern. Behaviours that mimic adult sexual behaviour should raise serious questions about the origin of the knowledge on display. Touching the genital areas of others outside what is incidental or accidental should also raise concerns.255

Some behaviours raise a level of concern about sexual abuse, but need to be closely examined in their particular context. These include a child persistently or provocatively exposing their body to others beyond what is contextually appropriate, and masturbating in a way that has a driven or compulsive aspect to it and appears to be motivated by something other than exploration.256

APPRECIATING THE SIGNIFICANCE OF A CHILD’S BEHAVIOUR

Assessing the significance of behaviours exhibited by children who have been removed from their birth families can be complicated by their sometimes unknown trauma histories. The extent and type of trauma a child in care has been exposed to in their past may never be fully understood. The identification of behaviours, and the assessment of their significance, is further complicated by inconsistencies in the rotational care environment and the lack of knowledge held by staff about the potential significance of the behaviours they observe.

Traumatic behaviours can intensify in the rotational care environment because there is no consistent adult in the child’s life. A carer’s capacity to perform their role can also be impaired by an absence of information about the child’s background before coming into care. This, combined with inadequate logging and reviewing of child behaviours at a supervisory level, results in a lack of careful and detailed tracking of behavioural changes.

NOTICING THE BEHAVIOUR OF ADULTS

In a paper prepared for the federal Royal Commission into Institutional Responses to Child Sexual Abuse, Professor Eileen Munro and Dr Sheila Fish analysed the failure of adults to identify and report child sexual abuse in institutions.257 This analysis accepted as a starting point that a worker’s judgment about the behaviour of other adults in their environment is subject to cognitive biases. Organisations have a major part to play in addressing these conditions to make adults more sensitive to the behaviours they observe that might indicate child sexual abuse.258

Confirmation bias is a concept that describes the human tendency to be slow to revise an opinion once it has been formed. When a point of view or opinion has been reached, we more easily notice evidence confirming it, and tend to explain or interpret other evidence in a way that supports our original thinking.259 The overwhelming majority of workers in residential care are well intentioned in their interactions with children, and when faced with an example of concerning behaviour, they are likely to apply an explanation for the behaviour which is consistent with their existing opinions and biases.

Sexual abuse of a child in the workplace is rare. In circumstances where workers do not expect or anticipate the occurrence of a rare event, child sex offenders may be more easily able to convince their colleagues they are overly suspicious or have misinterpreted an individual incident.260

The ability to identify problem behaviours can also be challenged by the need to bring together a large number of minor pieces of information to give them meaning.261 If each individual piece of information is interpreted benignly, it is unlikely to be reported or be available for analysis in any holistic way. This may be particularly problematic when a worker is frequently moved across various sites working with different people, such that a pattern in their behaviour is never identified with certainty by their colleagues.

Finally, it must be remembered that it is far easier in hindsight to attribute behaviours to grooming when it is known they led to abuse. In hindsight, behaviours can be divorced from the environment in which they occurred, and from sometimes competing indications of good behaviour, which may have influenced the interpretation at the time.262

ORGANISATIONAL CULTURE

Organisational factors have a powerful part to play in helping workers make the best decisions when they observe concerning behaviours. The underlying organisational culture is a critical factor in determining how people behave within the workplace. It transcends policies, procedures and training and informs how people behave. Some aspects of organisational culture can be created by the perception of a matter which becomes so pervasive that it informs the behaviour of the workers within the organisation.
Professor Munro and Dr Fish make the following observations about the significance of organisational culture in keeping children safe:

Culture is partly created by explicit strategies and messages from senior managers but is also strongly influenced by the covert messages that run through the organisation and influence behaviour. Workers need not only a formal mechanism for making reports but some guidance on the threshold for action. Thresholds are rarely explicitly put in writing; workers tend to develop an understanding of them through the feedback they get themselves or the feedback they see given to others who report concerns. The feedback can either encourage or discourage workers to report concerns.

Their report identified examples of workers declining to make complaints about behaviour because they did not trust managers and believed nothing would be done, or because they were concerned that a colleague who was the subject of the complaint would learn that it had been made. Some workers fear being ostracised by colleagues if they report concerns. Resolving to allege inappropriate behaviour is regularly tolerated fosters an environment where children is a difficult decision, particularly when workers fail to report or because they were concerned that a colleague who was the subject of the complaint would learn that it had been made. Some workers fear being ostracised by colleagues if they report concerns.

Workers might also be dissuaded from making reports because of an absence of clear reporting pathways or a lack of clarity about who is responsible for raising concerns. An organisational environment in which concerns do not appear to be listened to, or actioned, will discourage workers from making a report, as well as lead them to believe they will be ostracised or punished, rather than supported, for doing so.

The policies and procedures of an organisation, in particular the rigour and consistency with which they are applied, are important to the prevention of child abuse in institutional settings. Where behavioural expectations are clear and consistently enforced there is less room for an offender to groom their environment to normalise breaches of acceptable boundaries with children and young people. Ambiguity in behavioural expectations in an environment can allow potential offenders to exploit situations to their own advantage. Offenders can build an identity as someone who regularly flouts the expected behavioural norms, leading their colleagues to ignore occasions when their interactions with children cross appropriate boundaries. A workplace where inappropriate behaviour is regularly tolerated fosters an unwillingness to report and act on concerns.

Evidence given in the McCooe case study highlighted gaps in carers’ knowledge of child development, sexualised behaviours and indicators of distress, and an underdeveloped understanding of the dynamics of child sexual abuse. It also revealed a dangerous naivety about the risk of sexual abuse in the residential care environment. This was particularly concerning, given the rapidly developing knowledge base about the risks to children in institutional care.

Evidence also exposed an inconsistent understanding of policies and procedures. Guiding policies were difficult to locate and applied inconsistently, even by those at senior levels. The enforcement of clear boundaries and standards in the workplace has been identified as an important strategy to reduce the risk of sexual offending. The Agency should clearly identify operational policies, and train the workforce in their operation. Senior members of staff should model and enforce strict adherence.

Carers should be provided with training to help them understand and respond to children who exhibit behaviours that may indicate trauma or sexual abuse. This is a complex task when caring for children who will commonly have experienced serious abuse or neglect in their past, and causal conclusions might be difficult to draw. Case study 5 notes that carers received insufficient training in the identification and understanding of these behaviours; furthermore, when these behaviours were observed, their significance was not understood, or when they were understood, they were not actioned. Identifying and understanding these behaviours is not just about preventing sexual abuse in care, but is also critical to identifying children who need additional help or professional intervention.

Training should be accompanied by opportunities for workers to discuss the application of theory to their own practice. They should be encouraged to discuss children in their care whose behaviours are of concern and regularly review learning through applied discussions.

Carers should understand and accept that children in residential care are vulnerable to sexual abuse and should be vigilant in monitoring the conduct of others. Training should be provided to address dangerous assumptions and stereotypes of child sexual offenders, and provide information about the complex dynamics of grooming. This training should be designed not to alarm, but to challenge the current stereotyped thinking and encourage workers to have an open mind about the risks to children.

Training should be delivered by experts in the field and be followed by opportunities to openly discuss the application of learning to the residential care environment. The provision of such training would be
in line with Recommendation 17 of the CISC Inquiry, which recommended that all carers receive training in aspects of child sexual abuse.271 All employees should acknowledge their responsibility for reporting matters that raise concerns about the conduct of colleagues towards children as part of the conditions of their employment. This should extend to observations and information which do not meet the threshold for mandatory reporting. Their responsibilities in this regard should be discussed and workshopped through training.

Some carers have been discouraged from enquiring into and addressing behaviours which are trauma based, or indicate the possibility of abuse. They were told that enquiring into such matters was inappropriate because they were not sufficiently trained, and that any exploration of such issues would need to be undertaken in the context of an expert forensic interview. This approach potentially denies children opportunities to share their concerns and worries, and talk about their experiences in a way that promoted a better understanding. It could also emphasise the institutional nature of the environment and undermine the development of healthy nurturing relationships.

Residential care workers should not be prevented from engaging with children to explore the meaning behind children’s statements and behaviours, in a way that is supported by their training. The child and youth worker job description requires workers to ‘sensitively ascertain information from children or young people about their health, education, family and cultural background, and their understanding of their situation’.272 This aspect of the role is critical, and the workers should be equipped to do it. The role description for their position should also include (in addition to the matters referred to above) ascertaining information about the child or young person’s feelings of safety in the residential care environment. Additional practice guidance and training should be provided to ensure workers understand the limits of their responsibilities in this regard.

The capacity of good workers to provide effective monitoring is reduced if they are overworked and unable to spend quality time engaging with children.

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The DANGERS OF SINGLE-HANDED SHIFTS
Inadequate staffing creates a risk to child safety. A number of youth workers and carers told the Commission that they were concerned that they would not be able to safely care for children because too many were being placed in their care, or because they were unable to manage children’s behaviour. Staffing a shift with a single carer magnifies that risk.

The risk of sexual abuse posed by single-handed shifts has been addressed within the McCoole case study. While working double-handed shifts does not remove all opportunities to offend, and there are necessarily times when a child will be alone with a carer, the physical presence of another staff member on a shift would plainly deter most offending.

In addition, engaging carers who are well trained and attuned to behaviours which raise concern is a potentially powerful strategy to lessen the risk of child sexual abuse.274 The capacity of good workers to provide effective monitoring is reduced if they are overworked and unable to spend quality time engaging with children.

The risks to children of single-handed shifts have been well known at a senior level for some time. The Agency’s capacity to deliver any higher staff to child ratio has however been undermined by a lack of funding.275

A move away from single-handed shifts is needed to aid in crime prevention and to provide workers the time and space they require to attend to children’s basic care needs. Such a move would call for a substantial investment to expand the workforce, and it is accepted that this cannot happen quickly or without thorough planning. However, removal of single-handed shifts should be a serious medium-term aim for Families SA.

SUPPORTING AND SUPERVISING CARERS
Support to carers is provided during working hours by senior youth workers, with on-call support available overnight. A mobile night team offers additional support, but this resource is as yet unable to provide thorough supervision or monitoring due to the multiple houses and units it services, which are spread across large distances within metropolitan Adelaide.276

A large proportion of youth workers who gave evidence during the McCoole case study raised concerns about the level of support and supervision they received from a particular cohort of senior youth workers and supervisors who were operating in the southern area. The Commission observed inconsistent supervisory practices and a toxic workplace culture which, at least in part, can be attributed to poor relationships and a chronic lack of trust between senior and operational staff.
The capacity to monitor children’s behaviour in a rotational care environment, where observations are split between carers, is undermined where carers fail to communicate with one another, either because they do not get along or because the culture does not support it.277

The combination of a toxic workplace culture and inconsistent operational practices within residential care properties affected the willingness of carers to raise concerns about the behaviour of children and staff, to the extent that carers were deterred from reporting for fear of personal repercussions. These concerns were not unfounded. In the course of the McCooле case study, the Commission heard of numerous instances when senior staff responded inappropriately to complaints.

The directorate’s organisational culture has led to a situation in which obtaining accurate information about children and workers is compromised. The culture of mistrust deters many good workers from speaking out about concerns they have about the safety of children and the behaviour of their colleagues. These factors contributed to McCoołe’s conduct going undetected for so long. The inconsistent approach to standards similarly enabled McCoołe to take advantage of lax practices to normalise some of his inappropriate conduct.

It is critical that the Agency remain vigilant about the risk of child sexual abuse. While the scope and frequency of McCoołe’s offending marked it as especially heinous, his arrest did not mark the end of risk to children in rotational care. The Agency is in need of substantial reforms to its structures, organisational culture, staffing and policies in order to reduce the risk of abuse in the future.

REFORMING RESIDENTIAL CARE

CAN RESIDENTIAL CARE BE GOOD FOR CHILDREN?

Residential care is not the first choice of care for many children. Because it is depicted as an unattractive, last chance option, it implies to children that their placement there is their fault and removes any sense that it might be a positive option.278

Such a characterisation fails to recognise that residential care can be the right option for some children. The challenge lies in developing a system that reflects the different needs of children who come into residential care, as the provision of homogenous service models will almost invariably fail to meet the needs of some.

In his book *Pain, normality and the struggle for congruence*, Professor James Anglin identifies situations in which residential care might be recommended:279:

- to accommodate children who do not want to be placed in home-based care, or for whom home-based care is not appropriate. This may be due to previous abuse in such environments, or a child’s behaviour posing a risk to their own safety or that of others;
- to keep family groups together, when siblings would have to be separated to obtain a placement in home-based care;
- to maintain stability of a home-based placement by providing respite care;
- to provide intensive therapeutic services; and
- to assess a child’s needs, in preparation for a long-term placement.

A single service model will be incapable of meeting all of those needs. A differentiated system has the capacity to better address individual needs, both in relation to the nature and duration of care.

An important aspect of a reformed system is a clear understanding of the purpose of the placement. For every child, care provision should be informed by that purpose, with strategies in place to achieve it over the timeframe identified.

Despite the potential benefits of targeted and well-resourced residential care, there are many children for whom it will not be an appropriate placement option. It should not be a dumping ground for children in the absence of better options. Strategies that improve the recruitment and retention of foster parents and other home-based options remain essential to the development of a healthy out-of-home care system.

Residential care is not a replacement for a child’s family or their home. It should however provide a home-like environment that is nurturing, supportive and stable. It should develop the child’s sense of culture and community, and encourage, where appropriate, ongoing contact with birth families and other important people. Children should not be isolated, but have access to social, sporting and educational opportunities. They should be encouraged to express their views about matters that affect them, and have these views heard.

Given the length of time children reside within residential care, there should be capacity to plan for the future, including after care. Children should be encouraged to be aspirational about their futures, and should have someone walking beside them in planning for the future, providing guidance and helping to shape their goals. Children and young people need carers who they can relate to and trust, and systems that can help them to achieve their goals.
Above all, the residential care environment should provide a safe place for children and young people. This principle is recognised in the National Framework for Protecting Australia’s Children, which identifies as one of its six supporting outcomes that ‘Children who have been abused or neglected receive the support and care they need for their safety and wellbeing’.280

The concept of safety includes an environment that is physically safe for a child to live: that is, facilities that are safe, in locations that are safe, with adequate staff who are equipped with the knowledge and skills to provide appropriate care. Safety also extends to providing an environment that is free from physical and sexual abuse and neglect.281

**REFORMING STAFFING**

Professor Anglin, conducting research about best practice in residential care settings, observed that there is a tendency for the philosophies and practice orientation of supervisors to permeate the conduct of carers, and affect the experiences and thoughts of children in their care.282 This observation underlines the need for management and supervisory staff to embody best practice in their endeavours. This includes adopting practices which reflect a philosophy of care, adhering strictly to operational standards and procedures, and leading and modelling a healthy and cohesive working environment.

Currently senior staff in residential care are appointed to the OPS classifications, which focus heavily on operational requirements. Supervisors play a strong hands-on role in everyday decision making, including approval of expenses, and staffing.

Supervision of youth workers should stem from a greater professional knowledge base and have a greater emphasis on child development and wellbeing, to promote the care of vulnerable children as a professional endeavour. To achieve the shift the Commission recommends the appointment of allied health professional (AHP) or professional officer (PO) stream employees as supervisors, above senior youth workers. The AHP stream is the one used by Families SA to employ social workers and requires a degree qualification. The PO stream is not widely used within Families SA but is utilised to employ people with a broader range of qualifications, although it also requires at the minimum a degree. If this recommendation were implemented, senior youth workers would be required to assume a greater responsibility for operational tasks such as rostering and administration to permit supervisors to engage with the development and care needs of the children.

Supervisors appointed at the AHP or PO classifications should be able to demonstrate a knowledge of child development. The McCoole case study identified significant gaps in the capacity of the Agency to understand the significance of information about the behaviour of children in residential care. The primary focus of supervisors should be the therapeutic care of children, including tracking information about their experiences and behaviour in care. Their purpose should be to obtain an accurate picture of the child’s psychosocial status, to identify any behavioural concerns and coordinate their observations with the district office, psychological services and youth workers to tailor a consistent, cohesive response. Where concerns held by residential care staff about children are not being addressed, supervisors should raise the issue with the district office, and where necessary, with other services.

The change in the supervisor function would mean additional responsibilities for senior youth workers, including the authority for some routine decisions. In long-established care teams, where youth workers understand a child’s care needs and background, it would be appropriate to reflect their greater understanding by granting them authority to make decisions about certain day-to-day activities. This would help overcome delays in decision making which can cause children to miss out on opportunities.

The McCoole case study demonstrated significant distrust and organisational dysfunction within the residential care directorate. Evidence heard by the Commission about the conduct of some senior staff cast doubt on their ongoing suitability for employment in a role caring for vulnerable children. While the behaviour of a number of staff members failed to meet the standards that should apply to such important work, the Commission is obliged to refer in particular to the conduct of Katherine Decoster, Shane Sterzl and Lee Norman, and recommend that the Agency consider their conduct, as described in the case study, against the relevant ethical standards and consider what, if any, action should be taken with respect to them.

Apart from these individuals, the Commission observed a number of occasions when staff were discouraged from raising concerns. There was a pervasive perception held at a senior level that concerns about inappropriate conduct by one staff member towards another, including bullying, racist jokes and sexist conduct, could be dealt with by ‘mediation’. This meant the staff member making the complaint had to come face to face with the other in an attempt to resolve the issue. This was applied even in situations where significant power imbalances existed, and had the effect of dissuading staff from voicing complaints when they were not prepared to engage in such a process. This was especially so where concerns were genuinely performance or disciplinary matters, and not appropriate for a ‘mediated’ response.
An open door policy should be promoted at all levels of management to encourage staff to raise legitimate concerns about the behaviour of colleagues and the wellbeing of children. While there is a role for mediation, it is an unsuitable mechanism for dealing with allegations of inappropriate workplace conduct. Policy and procedure should make it clear that raising concerns about the conduct of other carers is a condition of employment, and that staff should err on the side of reporting. There should be a clear process for a worker to make a complaint or report the conduct of other workers. Such a process must support workers who wish to complain to senior staff outside their usual reporting lines.

**TRACKING THE BEHAVIOUR OF WORKERS**

During the course of the McCoole case study it became apparent that there are a number of ways in which information about the conduct of a worker is recorded, but there is no system to bring together or analyse that information. Observations about McCoole’s conduct were potentially available from care concern reports, supervision records, complaints about him from fellow workers to supervisors, and critical incident reports. Had all these sources been formalised and analysed, it is possible that the themes identified by the Commission might have been identified during the time he was employed.

This chapter has already considered the need to ensure that workers report observations of their colleagues that concern them, and the need to reform the quality of recording critical incident reports. Information from all sources should be compiled in a single location, with staff specifically tasked with tracking and monitoring workers who are identified as potentially problematic, or who justify close enquiry.

The Commission recommends that a unit be established either within the residential care directorate or in the HR services unit to bring together information about employees and contracted staff working in rotational care (both emergency and residential). This unit must also be freely accessible to staff and contracted carers who wish to share concerns but who feel constrained from doing so within their direct lines of management. Evidence in the McCoole case study highlighted the existence of multiple barriers to workers raising complaints, not the least of which was a lack of clarity about the appropriate pathway.

This unit should track matters relevant to employees of the Agency and workers who are contracted through commercial agencies. The registration of these workers discussed earlier should simplify this process.

To bring together all the different information which should flow into this unit, the Commission recommends that the Agency invest in software that facilitates the capture of care concerns, critical incident reports, concerns reported by colleagues and other sources of information. As an example, a program currently in use by SA Police, IA Pro, provides suitable recording, tracking and reporting functionality. The Commission was impressed by the functionality of this program, and its potential applications in child protection.

In the course of analysing data, this unit should also conduct regular audits of reports on the use of force against children in residential care facilities, to ensure compliance with the Family and Community Services Regulations.

**THERAPEUTIC CARE**

The CISC Inquiry recommended that therapeutic and other intensive services be developed as a matter of urgency for children in care who abscond. It further recommended the establishment of a group of care workers with suitable training and experience to deliver intensive therapeutic services for children with complex needs who frequently abscond from placements, and the engagement of a team to examine the benefits of establishing a specific therapeutic intervention program to identify, assess, assist and treat children at high risk.

At the time, it was recognised by the government that there were children in care with complex needs who required greater therapeutic support. The development and implementation of initiatives which expanded the therapeutic component in care services, such as residential care, were also under consideration at that time. The CISC Inquiry noted the need to adequately resource, monitor and evaluate such programs, in order for them to be effective:

*Evidence to the Inquiry establishes, without question, that there should be a range of placement options for each child and young person in state care. Each should be placed in the most suitable option available.*

Notwithstanding this recommendation, therapeutic services have not been developed consistently. Families SA has attempted, with varying success, to provide intensive therapeutic care to a small number of children with high needs. This has included establishing a relatively stable workforce in some placements, and locating a social worker at the house where care was provided. Training and support was provided by psychological services and psychologists attended meetings to discuss progress. Care has been provided to one or two children at a time, with variable
outcomes. Some children found the process intense and frightening.\textsuperscript{287} Despite this model having been used in the past, its current availability, and how such a placement might be obtained for a child or young person with high needs, was not clearly apparent (see also Volume 2, Case Study 3: Nathan).\textsuperscript{286}

**THEORIES AND MODES OF THERAPEUTIC RESIDENTIAL CARE**

Care provision within Australia can be generally categorised as ‘standard’ and ‘therapeutic’. The distinction lies in the ideology of care and the practical aspects of the daily care of children. There is no single model or mode of therapeutic residential care. A definition which continues to inform practice is that therapeutic care is:

*intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.*\textsuperscript{291}

What is meant by working ‘therapeutically’ with children is not well defined and is left to the interpretation of those who work with children.\textsuperscript{290} There is also debate on the reference to the care being ‘time limited’ given the length of time many children and young people remain in residential care.\textsuperscript{291}

A report prepared by the Australian Centre for Child Protection (ACCP) for the Commission provides an analysis of overseas and Australian use of therapeutic care and a review of relevant literature. This report has informed much of the Commission’s consideration of therapeutic care.

The bulk of published research has been conducted in international residential treatment programs, which are generally delivered very differently to therapeutic care in Australia. Residential treatment programs in North America, in particular, tend to be delivered in large facilities or clusters of satellite homes, supported by multidisciplinary services and guided by a program of intervention. The focus is generally on time-limited interventions, and services aim to support the child and their family or wider network. Australian models of therapeutic residential care relate to models of group care, which are tailored to meet the needs of children who have experienced trauma, abuse and removal from family of origin. Practice frameworks in Australia which guide services are not strictly ‘models of care’; rather, they are broad therapeutic frameworks which address organisational culture and guide individual practice.\textsuperscript{292}

Notwithstanding the differences in the models, adoption of some of the characteristics of residential treatment care models would improve the quality of care being delivered in residential care. Relevant literature supports the following conclusions:\textsuperscript{283}

- Success of residential care is related to matching interventions to properly assessed needs; however, much more work needs to be done to determine what works for whom.
- Long-term effectiveness appears related to the capacity of the service to engage with the child’s support network. Consideration of how to engage with a child’s family and other supports, including those situations where returning the child to their biological parents is not contemplated, will be a challenge in residential care settings, particularly where parental abuse or neglect has occurred.
- The impact of any residential program may be time limited, unless ongoing support is provided. Program design should therefore consider ongoing contact with program staff and post-care support.

The ACCP suggests that exploring the potential for larger congregate care models, as opposed to houses, may help to develop a broader range of models for children in out-of-home care.\textsuperscript{284} The Commission cautions against developing such models based on the present structure of large units within the state. While it is conceivable that, in the future, such models might be appropriate to meet the therapeutic needs of specific groups of children, add-on therapeutic care under the present structure would not resolve the present issues experienced in large residential care units.

**THERAPEUTIC RESIDENTIAL CARE IN AUSTRALIA**

Since 2008 Victoria has provided therapeutic residential care to children with intermediate or complex needs. In contrast to South Australia, non-government organisations provide the majority of residential care in Victoria. Additional funding is provided to NGOs for each therapeutic residential care placement to fund additional staff, and published guidelines set out comprehensive practice expectations. Carers are required to have or obtain minimum qualifications and receive core training. Therapeutic specialists are employed in the residential environment and provide assessment and therapeutic plans for children and support for staff in maintaining therapeutic responses to children. Therapeutic plans provide for the involvement of the service provider and other government agencies. Referrals to placement are initiated by a panel process.\textsuperscript{285}
The Victorian system is worthy of consideration as it appears to be the only Australian model that has been evaluated against standard residential care. A review of therapeutic care pilot sites in Victoria conducted in 2011 suggested that the presence of a therapeutic specialist and increased staffing were important in developing quality relationships with children. The report noted positive signs for improved placement stability and engagement with community, as well as progress towards case planning goals, when compared with standard residential care. A reduction in risk taking and secure care admissions was also noted.296

The report’s cost analysis indicated that the additional cost involved in a therapeutic residential care placement was likely justified when considering longer term outcomes for children. A report of the Victorian Auditor General in 2014 came to a similar conclusion.297

In Australia two frameworks have been most influential in shaping practice and policy: the Sanctuary® and Children and Residential Experiences Model (CARE) models. There is limited evidence evaluating either model. The Sanctuary model aims to create a trauma-informed and sensitive organisational environment within which specific trauma-focused interventions can be delivered. Importantly, it aims to develop an organisational culture in which staff teach important skills, but also model those skills in their interactions with children.298 The CARE model is a practice framework which focuses on organisational competencies and consistency across team members in the way in which they understand and respond to children’s behaviours. It aims to strengthen attachments, build competencies, involve families in children’s care, enrich environments, and enable staff to adjust their expectations to take into account children’s development and experience of trauma.299

Thus while there is an absence of comprehensive evaluative data establishing the effectiveness of intensive therapeutic care service provision within the Australian context, there are indicators that therapeutic care can achieve positive outcomes. There is currently insufficient evidence to distinguish between the two models in terms of their effectiveness. It may be that having a clear model of practice is as important as the particular model that is selected.300

Both models301:

- address organisational culture and advocate agency wide change in knowledge, attitudes and behaviour towards children;
- recognise that children have suffered a variety of traumatic experiences, and focus on staff developing a common understanding of the reasons behind behaviour, rather than simply responding to the behaviour itself;
- focus on the development of competencies through strategies that are developmentally appropriate; and
- offer extensive training to develop common understandings of children’s challenges.

CONSIDERATION OF THERAPEUTIC CARE IN SOUTH AUSTRALIA

The Layton Review recommended that a range of flexible care options be developed for children and young people who were in care. Recommendation 14 stated that ‘placement services must include specialised professional care options particularly for children and young people who have significant needs’.302

In 2012, when therapeutic residential care was a relatively new concept, the Agency proposed a specialised residential care model that involved a focus on tailored care, with service provision delivered according to individual needs. It was considered particularly appropriate for children with physical, mental or intellectual disabilities. The proposal noted that ‘the number of children and young people with complex and/or extreme levels of need entering out-of-home care is escalating and therefore the need to develop more effective and proactive specialised delivery models is increasing’.303

Provision of therapeutic services also formed part of the Agency’s planning for residential care in the Nation Building program. A differentiated system was envisaged comprised of an assessment unit as well as streamed services that included therapeutic residential care offering clinical support from experienced practitioners and youth workers. The streamed system recognises that children will have variable durations of care depending on the identified aim of their stay: for some the targeted support would allow children to return to their family; for others long-term care will be appropriate. This model was strongly supported by Dana Shen, the former director of residential care.304

A 2014 recommendations paper which considered the future of residential care built on these ideas. It proposed reducing commercial care, creating induction and assessment units for short-term care, and subsequently matching children with home-based placements. Where longer term placement within residential care was appropriate, a streamed model of care was proposed. The model anticipated differentiated services matched to the needs of children with physical health, mental health, disability and behavioural problems.305

THE NEED FOR A THERAPEUTIC FRAMEWORK

The absence of a model or framework of therapeutic care in South Australia has resulted in carers relying on their own experience and preferences, or learning on the job from other carers. As many carers do not have...
a high level of knowledge about caring for children with trauma behaviours, variation in styles with disparate and inconsistent practices within and between facilities is evident. In the absence of overarching principles it can be difficult for staff to assess the appropriateness of some conduct towards children. Differences of opinion can arise, which are adjudicated by senior staff based on their own personal preferences or styles of care. Inconsistency is confusing for children and undermines stability. Inconsistency can also be exploited by abusers who seek to normalise conduct which is questioned.

A therapeutic framework should provide a theoretical background for all care decisions, to improve consistency and reduce reliance on individual philosophies. The framework should provide the added benefit of establishing a solid basis for the supervision and performance management of workers who do not follow the endorsed approach.

A framework should be applied in all facilities providing residential care to children in care: its application should not be restricted to facilities which care for children with high needs. A framework which promotes consistency, a growth in knowledge, and a more sophisticated understanding of, and response to, behavioural challenges is relevant to the entire directorate.

A model of therapeutic care should provide:

- services within a homely environment;
- multidisciplinary staffing at a level that permits effective application of therapeutic principles;
- structures to promote interdisciplinary engagement, including caseworkers, psychological services and external services such as education, police and health;
- consultation and engagement about the construction, implementation and review of a child’s therapeutic plan;
- strategies to engage other adults who are important to the child;
- a means to evaluate the service’s effectiveness.

STREAMED SERVICES

The Commission understands that the Agency is currently considering a restructure of the residential care directorate, including the development of specialised therapeutic care facilities which house small numbers of complex young people. 306 Three streams of care are proposed:

- short-term assessment over eight weeks. Assessment would include the viability of reunification with parents where appropriate;
- care for children on long-term guardianship orders, who are assessed as complexity levels 1 and 2 (according to the complexity assessment tool which is described in greater detail in Chapter 10); and
- care for children with high needs, whether physical, psychological or behavioural.

The current proposals do not rely on large residential care units as long-term homes for children and young people. The new model envisages no children under the age of 10 housed in residential care.

These proposals are appropriate and well informed. However, it will take a great deal of commitment and political will to implement the model.

To ensure that children and young people in residential care are kept safe it is most important to match them to the facilities, including the other residents. Children should not be placed in homes on the basis of the staffing levels that are available; rather, staffing levels should be determined on the basis of the needs of the children in that facility. The current situation which exists in large residential care units, where complex young people are grouped together for ease of management and efficiency of staff deployment, should not be permitted to continue.

A therapeutic framework, once selected, should be applied across all three streams of care. The Commission recognises that all children and young people living in residential care facilities will benefit from a consistent therapeutic approach.

STRUCTURAL REFORMS

The management and supervision of residential and emergency facilities is currently spread across different divisions of the Agency. Control of all residential facilities, and the management of emergency care placements, should be centralised within the residential care directorate to allow consistent management, oversight and supervision of all forms of rotational care.

In the course of the McCoole case study, evidence was given about a ‘build, own, operate and transfer’ model (BOOT), which was a condition of the approval which was granted to hire residential care staff to the Nation Building project. The BOOT proposal required the Nation Building service to be built, operated, and then transferred to the non-government sector once an appropriate candidate had been identified. The Commission does not support this plan. The residential care directorate requires extensive reform to stabilise and upskill the workforce. It needs substantial attention to address the toxic organisational culture and establish enforceable and consistent performance requirements. The serious process of reform cannot be accomplished if the endeavour is seen as temporary. The provision of residential care requires skill, experience and close oversight. For the foreseeable future, this should be done from within government.
A necessary corollary of this position is that the directorate should continue efforts to build a stable long-term workforce in residential care. The implementation of differentiated services, and the adoption of therapeutic models of care and secure care, will continue to require a highly skilled, stable and knowledgeable workforce.

MEASURING OUTCOMES

The Agency should also commit to developing and implementing outcome measures for children who live in residential care. The Commission recommends that the Agency consult with a credible research body to identify appropriate criteria against which to measure the effectiveness of reform efforts. These measures should concentrate on outcomes for children who live in residential care. In particular, consideration should be given to achieving consistency between outcomes measured by the Agency and those measured as part of monitoring the ‘Outcomes Framework’ and any interstate residential care services which engage in similar monitoring, to permit data to be compared across populations. This process would place the Agency in a better position to monitor the wellbeing of children in residential care and to assess the efficacy of programs.

ACHIEVING HIGH RELIABILITY

The arrest and prosecution of Shannon McCoole highlighted the vulnerability of young children in residential care to sexual abuse. The Commission’s enquiries have demonstrated that no single failing enabled McCoole to offend in such a devastating way. There is no simple remedy to address the overall risk of sexual abuse in residential care. The system should be structured and staffed by people who understand the importance of ongoing, vigilant observation, informed by knowledge about sexual abuse, trauma, child development and child behaviour.

The problems facing children in residential care go far beyond the risk posed by McCoole. Some two years after McCoole’s arrest, and despite attempts by the directorate to address a number of the issues identified, children in residential care are still at risk of harm in the system that has been entrusted to care for them.

While the reforms discussed in this chapter should improve the safety of the residential care environment, ultimately it is the quality of staff who are engaged to care for children that will provide the greatest deterrent to adults who seek to prey on vulnerable children in their care.

Organisations that are structured and managed so as to prioritise the safety of children have been referred to as ‘high reliability’ organisations. They:

share a fundamental belief that mistakes will happen and their goal is to spot them quickly. They encourage an open culture where people can discuss difficult judgements and report mistakes so that the organisation can learn. Organisations seeking to be safe places for children must encourage frequent, open and supportive supervision of staff to help counteract the difficulties people face in making sense of ambiguous information about colleagues. A shared acknowledgement of how difficult it can be to detect and respond effectively to abuse contributes to a culture that keeps the issue high on the agenda.

Organisational change to recast the residential care directorate as a high reliability organisation should be prioritised. It is essential that this occur to protect those most vulnerable children who the state has taken into its own care. The offending by McCoole was of a gravity beyond what could have been contemplated by the Agency. However, it cannot be assumed that it was a one-off. The system must protect against its reoccurrence.

SECURE THERAPEUTIC CARE

Secure therapeutic care is a model of care that generally involves the statutory confinement of children in care who are at significant and substantial risk of harm either to themselves or others. This form of care aims to address the therapeutic needs of such children where they are unable to be addressed in a less intensive environment. Children are placed in secure therapeutic care for a period of time during which they receive intensive therapy to address their underlying issues.

The model is generally aimed at children and young people in care with complex needs who:

• place themselves and/or others at significant risk of harm;
• abscond on a regular basis, placing themselves at risk;
• have complex trauma symptoms and behaviours;
• undertake risk taking behaviour that results in serious abuse and exploitation, in particular sexual exploitation; and
• abscond from placements, meaning it is not possible to address their underlying trauma or attachment problems with therapy.
The needs of this group of children vary. They may include issues such as mental health concerns, cognitive impairment, neuro-disabilities (such as foetal alcohol spectrum disorder), communication disorders and learning disabilities, or any combination of these.

The key feature of secure therapeutic care as opposed to other forms of therapeutic care is the restriction of a child’s liberty. This aspect of it has made the use of secure therapeutic care a controversial topic in South Australia for some years.

In 2003 the Layton Review recognised a cohort of ‘young people caught in a vicious cycle of drug addiction, sex abuse and prostitution ... [who] needed a place where they could be taken to have a chance to ‘dry out’ and assess their future lives with professional assistance’. The Layton Review identified a need for therapeutic safe-keeping with secure short-term accommodation and appropriate services, acknowledging that ‘safe-keeping arrangements are a significant and intensive interaction’ but for some young people, there were no other effective options. As a result, secure therapeutic care was recommended. This recommendation was not implemented.

In 2008, the CISC Inquiry identified a similar need. In considering the question of a secure facility, the views of the Agency were sought. The Agency informed the CISC Inquiry it had considered such a model at different times but was currently ‘working to identify a suite of services and system changes required to provide stability and certainty for children who may be an ongoing risk as runaways’. The response further stated that:

once an adequate suite of prevention-focused therapeutic support and placement options is in place, we will be better positioned to consider any potential role that an intensive short-term mandated treatment model could play as a part of a continuum of responses.

The Agency’s preferred option was to ‘enhance and improve current systems, inter-agency accountability, service delivery models and multidisciplinary approaches to address the complex needs of the children’. Nonetheless, the CISC Inquiry recommended a secure therapeutic care facility. The recommendation was initially supported by the government. In 2010 a change of mind followed advice from GCYP and the development of a secure therapeutic care facility was abandoned.

Instead the government indicated that a number of other strategies would be developed to protect children, including:

- improved intensive therapeutic services for children in existing residential and home-based care, including those in youth training centres;
- protective behaviour training and sexual health education available to all residents of residential facilities; and
- an amendment to the Summary Procedure Act 1921 (SA) to restrain adults who exploit children by offering them shelter, drugs or other goods in return for sexual services.

Of these three strategies highlighted by the government only the legislative change to provide for written directions has been actioned. Protective behaviours training and sexual health education have not been provided. While a small number of places have been created for intensive therapeutic care, therapeutic care services have not been improved to the required level.

In South Australia children and young people are held in a secure setting only for youth justice and mental health purposes.

The Adelaide Youth Training Centre (AYTC) is a facility for the detention of children and young people who have come into contact with the criminal justice system. A sentence of detention can only be imposed in very limited circumstances, such as where the child or youth is a recidivist offender, a serious firearm offender, or one for whom the court is satisfied a non-custodial sentence would be inadequate because of the gravity or circumstances of the offence, or because the offence is part of a pattern of repeated offending.

Boylan Ward (part of the Women’s and Children’s Hospital) is a 12-bed mental health facility for children and young people. While it is not a secure unit, a young person subject to an involuntary treatment order may be held securely. The ward’s focus is to provide inpatient services for young people who are experiencing the early stages of a psychotic illness, suffering severe mental disorder (including depression) with a suicidal component, or have complex and coexisting disorders requiring multiple assessments and specialised care.

Secure therapeutic care models currently operate in New South Wales, Western Australia, the Northern Territory and Victoria to meet the needs of children whose safety and therapeutic needs cannot be met in any other way. Each of the models operates slightly differently although there are some common themes.

While Queensland does not operate a secure therapeutic facility, the 2013 Child Protection Commission of Inquiry in Queensland recognised the need for such a facility and recommended the development of a model when finances permitted.
THE NEED IN SOUTH AUSTRALIA

Evidence before the Commission indicates that the need for secure therapeutic care, identified by the Layton Review in 2004 and the CISC Inquiry in 2008, still exists.\textsuperscript{319} Witnesses reported that the needs of a particularly complex group of children remain unmet.\textsuperscript{320}

The evidence suggests that the size and complexity of this cohort of children has increased since the CISC Inquiry.\textsuperscript{321} The Agency’s Director of Quality and Practice, Sue Macdonald, acknowledged that the danger is ‘off the scale’ for some children. The inability to contain these children and young people is an ongoing challenge to the system, not only for Families SA but also for SA Health.\textsuperscript{322}

INAPPROPRIATE USE OF THE ADELAIDE YOUTH TRAINING CENTRE

The Commission understands that high-risk children sometimes engage in offending behaviour with the aim of being detained in the AYTC. Some children feel safer in the contained environment that it provides.\textsuperscript{323} In the opinion of Claire Simmons, a principal clinical psychologist, this was because he knew he could not keep himself safe and wanted someone else to take that responsibility.\textsuperscript{324}

It is a matter of concern that children are indulging in criminal offending to find safety. These children are at risk of developing recidivist criminal behaviours and becoming institutionalised. Detention of children in AYTC provides short-term safety, but no long-term solution, nor does it help a child to resolve underlying issues. Failure to provide more appropriate alternative environments for these children perpetuates the disadvantages they face.

CHILDREN IN NEED OF SECURE THERAPEUTIC CARE

Some children desperately need intensive therapeutic care, but the intensity associated with that process is challenging. Ms Simmons described:

\textit{[a] cohort of children [who] ... abscond because they are frightened ... of a relationship with anyone, so ... [without] the capacity to contain them, you can’t work with them because they’re simply not there.} \textsuperscript{325}

Children who have experienced significant abuse in their home environment can find being in a home-type placement painful and run away.\textsuperscript{326} One child who was placed in intensive therapeutic care remained four nights out of 65. While therapeutic services were available, her persistent absconding prevented her benefiting from services to address her underlying trauma issues. While absent the child was placing herself at risk through drug taking, prostitution, association with outlaw motorcycle criminal gangs, and engaging in criminal activity including threatening to harm others. Staff were at a loss as to how to keep the child safe when no alternatives were available.\textsuperscript{327} This child’s circumstances are not unique.

A CAUTIOUS APPROACH

Secure therapeutic care is not without controversy. While some witnesses identified the need for secure care in carefully identified circumstances as a last resort, others were not convinced.\textsuperscript{328} Many people highlighted the need for caution and careful consideration. Some emphasised that if a secure therapeutic care service were developed it would need to be well resourced and purpose built, and provide adequate therapeutic services as well as a suite of step-up and step-down services (flexible levels of care according to need). One witness thought that ‘entry, maintenance and exit of children with the facility should sit separately to Families SA’.\textsuperscript{329}

In terms of step-up and step-down services, the Commission heard evidence highlighting the lack of services for the drug and alcohol problems experienced by children and young people in care. In particular there is no drug and alcohol detoxification service available to adolescents.\textsuperscript{330}

A cautious approach is needed. Secure therapeutic care is resource intensive and without a planned and structured approach, with clear guidelines and principles, it could easily be abused.

Ms Macdonald told the Commission that any secure therapeutic care model would need to be chosen carefully, with oversight which ensured that children were not allowed to drift. Further, it would need to admit children for a sufficient time to be able to address entrenched issues. It should not be used simply as a circuit breaker and it should deliver an appropriate therapeutic service.\textsuperscript{331}

SECURE THERAPEUTIC CARE IN SOUTH AUSTRALIA

A report prepared by Dr Sara McLean, based at the Australian Centre for Child Protection has informed the Commission’s consideration of secure therapeutic care in the child protection system. Dr McLean concludes that there is a ‘paucity of evidence about the effectiveness and the practice parameters of secure care, despite anecdotal support for its use’.\textsuperscript{332} While acknowledging the paucity of evidence, the Commission is mindful of the urgent circumstances that a number of children and young people find themselves in, and the absence of any other effective options.

The Commission recommends that a secure therapeutic care model and facility be established in South Australia for children in care. The Commission is mindful of the costs involved, but considers there is a demonstrated need for such a service.
The service’s creation and implementation would require careful consideration. It should be flexible enough to meet the needs of children who are at risk from a variety of factors and should be part of a suite of options available for children in care, with appropriate and well-resourced step-up and step-down services. These may include semi-secure care, mental health facilities and outreach programs, and specialised flexible foster placements. The aim is to help children to reintegrate without overwhelming them.

Secure therapeutic care would provide the most intensive model of care available and be supported by streamed residential care services, all operating under a consistent therapeutic model of care.

A number of key messages are highlighted in Dr McLean’s report that should guide the design of a model:

- Children placed in secure care are likely to have complex needs, including communication disorders, mental health disorders, post-traumatic stress disorder, neuro-disabilities and learning disabilities.
- Its effectiveness will depend on the quality of therapeutic input, skilled interactions with staff and transition planning.
- The model should include:
  - positive relationships between staff and young people;
  - an ability to match therapeutic input to client needs;
  - significant input from mental health services;
  - the capacity to engage children with services for long enough to benefit; and
  - appropriate and comprehensive transition planning.

In addition to these considerations, the Commission has also identified a need for a drug and alcohol service for adolescents as part of the streamed model of care (including detoxification services). 

**GOVERNANCE**

There is potential for abuse of a secure therapeutic care model, and strong external oversight is necessary. The best way to achieve oversight is to place decision making in the hands of the Judiciary. In New South Wales, applications must be made to the Supreme Court, while in Victoria and Western Australia the Children’s Court determines applications.

The commission favours the NSW approach. An application is made to the Supreme Court and the length of the stay is determined by the court. Typically a one-week order is initially made, allowing time for more intensive assessment and the gathering of additional evidence. The decision to restrict a child or young person’s liberty in these circumstances is one that should have high level oversight. It is not appropriate to place oversight with the Youth Court jurisdiction which also hears and responds to criminal charges, and may lead children and young people to think the process is a punitive one.

The legislative framework for this state should require application to the Supreme Court of South Australia before an admission. The length of admission should be governed by the court (subject to a maximum prescribed by legislation), with regular judicial reviews to oversee the effectiveness of the orders.

As part of the application process evidence should satisfy the court that a service is available to meet the needs of the child while in secure therapeutic care. A case plan should outline the following matters:

- the reason and purpose of admission;
- the case plan; and
- the plan for transitioning the child back into the community using step-down services.

**TIMING AND DURATION OF SECURE THERAPEUTIC CARE**

Careful consideration should be given to the circumstances in which a child is placed in secure therapeutic care. In some jurisdictions it is used as a last resort. However, this approach raises the risk of dangerous behaviours continuing while other inappropriate options are explored, and may mean the opportunity to provide worthwhile therapeutic intervention is lost. The appropriate test should be whether secure therapeutic care is the most appropriate option available to the child, weighing up the risk of harm to the child if there is no intervention versus the seriousness of restricting the child’s liberty.

The available length of admission varies across Australia. Longer term programs are often required to respond to such issues as mental health, disability and social needs. Children should be admitted for a sufficient time to address any of these underlying concerns.

**CHILD’S RIGHTS**

Secure therapeutic care must grapple with the tension between a child’s right to freedom and self-determination and the need for the state to take appropriate steps to protect them from danger and aid their psychological recovery.
If a child elects or wishes to be placed in secure therapeutic care and this is supported by the Agency, the application process should follow the same path as an involuntary application. The Supreme Court should make the decision and provide continuous oversight.

The representation of children subject to an application should also be considered. Children should be provided independent legal representation which is free of charge throughout the period of the order. They should also be able to contact their legal representative and/or GCYP at any time during the period of the order.

OTHER CONSIDERATIONS
Delivering therapeutic services is a crucial part of the secure therapeutic care model. A high level of inter-agency cooperation between the Agency and service providers such as SA Health and Education is required to deliver services.

Dr McLean reports that staff who adopt a wellbeing oriented approach to working with young people are more likely to be effective than those who adopt a punitive approach. She maintains that knowledge about child development, family dynamics, conflict resolution and responses to challenging behaviour arising from trauma and disability are important. Staff should have specialist skills in these areas. A model of secure care should in no way be conceived as a punitive response.

Staff should be able to draw on the expertise of others as required. Youth workers will need to be highly trained with regular ongoing professional development and supervision. They will need to work closely with and be supervised by professionals across a variety of areas, including mental health, trauma, social work and education.

EVALUATION OF THE MODEL
Any secure therapeutic care model which is established should be regularly evaluated against key performance indicators that measure outcomes for children. The model should be constantly assessed against evidence provided by such evaluations.
The Commission recommends that the South Australian Government:

128 Phase out the use of commercial carers in any rotational care arrangements except in genuine short-term emergencies.

129 Review service agreements with commercial agencies who supply emergency care staff to:
   a require the commercial agency to develop job and person specification and selection criteria which must be approved by Families SA;
   b prohibit workers from undertaking shifts through more than one commercial care agency at a time when engaged by Families SA to look after children in care. This includes a prohibition on undertaking shifts for a commercial care agency at the same time as undertaking shifts for Families SA;
   c require commercial care workers to be registered and approved by Families SA before their employment begins; and
   d require commercial agencies to report any information that reflects on the suitability of a care worker, to initiate tracking via the system outlined at Recommendation 142.

130 Provide Families SA staff who work with commercial carers with access to relevant portions of service agreements to clarify work expectations and specific conditions of engagement.

131 Provide the residential care directorate with sole responsibility for engaging, supervising and supporting emergency care placements.

132 Forthwith abandon single-handed shifts by commercial carers engaged through commercial agencies.

133 Reform the manner in which the use of force against children in residential care facilities is recorded and tracked by:
   a amending regulation 14 of the Family and Community Services Regulations to require any worker who participates in or witnesses an incident involving or leading to the use of force against a child to verify the accuracy of the written report of the incident or, in the alternative, where the accuracy of the written report is not verified, provide an independent written account with respect to the incident;
   b amending the pro forma of the report to clarify the requirements of regulation 14(3);
   c requiring supervisors to reject any report that does not comply with regulation 14(3) in the absence of any adequate explanation for non-compliance. If a non-compliant report is accepted, the supervisor should specify the reason for acceptance in the absence of compliance; and
   d regularly audit reports to ensure compliance with the regulations.

134 Amend section 56 of the Family and Community Services Act 1972 to extend the operation of the section to children in all facilities (including emergency care) established by the Minister, and develop a specific and identifiable pathway to enable a child to make a complaint to the Chief Executive pursuant to that section.

135 Require the Chief Executive to provide a quarterly report to the Guardian for Children and Young People (GCYP) and the Minister with respect to the number of complaints received, and any recurring themes which emerge from those reports.

136 Request GCYP to develop an education program for children in facilities run by the Agency or non-government organisations (emergency and residential) to explain and promote their rights pursuant to regulation 14(3) of the Family and Community Services Regulations 2009 and section 56 of the Family and Community Services Act 1972.

137 Request GCYP to develop an education program for children in facilities run by the Agency or non-government organisations (emergency and residential) to explain and promote their rights pursuant to regulation 14(3) of the Family and Community Services Regulations 2009 and section 56 of the Family and Community Services Act 1972.

138 Recruit child and youth support workers in accordance with the 2016 recruitment model, including a requirement that all applicants for those positions undergo individual psychological assessment.

139 Require all new child and youth support workers to complete a minimum six-month probationary period, to be followed by a rigorous performance review before approval for further employment.
RECOMMENDATIONS

140 Require all child and youth support workers to complete ongoing professional development and training, particularly in the following areas:
   a the dynamics of abuse in institutional environments;
   b understanding children who are at risk from institutional environments;
   c the way in which children react and respond to abuse;
   d how to respond to children whose behaviour or statements may indicate the possibility of abuse; and
   e the early years child development, and caring for infants and young children (for selected workers).

141 Review and clarify policies that guide the behaviour of workers, particularly in relation to:
   a physical contact with children (to provide clear and unambiguous guidance);
   b recording observations in observation logs; and
   c reporting lines for information about the wellbeing of children.

142 Develop a clear process for workers in the residential care directorate which:
   a obliges workers to report any concerning behaviours from other workers, including those behaviours that do not necessarily meet the requirements for a mandatory report;
   b obliges workers to report concerning behaviours from children in the absence of action by case management staff; and
   c clarifies the availability of reporting pathways external to workers’ immediate line of supervision.

143 Create a specific unit and database to receive and track information about the conduct of staff from:
   a care concerns;
   b critical incident reports;
   c information from other staff; and
   d complaints made by children.

144 Review the conduct of the specific staff identified in Volume 2, Case Study 5: Shannon McCoole and consider their ongoing suitability for employment in their role.

145 Develop a streamed model of residential care with the following elements:
   a short-term assessment;
   b long-term care for children who are not suitable for home-based care;
   c care for children with high therapeutic needs; and
   d built-in measures of outcomes that can be used to evaluate performance of the model on a regular basis.

146 Identify and adopt a model of therapeutic care which is sufficiently flexible to be applied across all categories of residential care, and which promotes a consistency of approach and standard of care for all children.

147 Replace operational services (OPS) 5 supervisors in residential care with allied health professional (AHP) or professional officer (PO) degree qualified staff, and recast the job and person specification to focus on the provision of staff with high level expert knowledge.

148 Ensure that all youth workers in residential care have regular supervision as a means to promote their professional development and, where necessary, manage deficits in their performance.
149 Apply the following standards across residential care:

   a. no child under 10 years to be housed in a residential care facility except where necessary to keep a sibling group together; and
   b. no child to be housed in a facility with more than four children, except where necessary to keep a sibling group together.

150 Recruit a sufficient complement of staff to:

   a. cease using commercial carers in residential care facilities;
   b. develop a casual list to provide staff who are available on a flexible basis; and
   c. abandon single-handed shifts.

151 Abandon any plan to outsource any residential or emergency care service that is currently delivered by the Agency.

152 Develop a secure therapeutic care model, supported by legislation, to permit children to be detained in a secure therapeutic care facility but with an order of the Supreme Court required before a child is so detained. The model should include regular evaluation of outcomes for children.
Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.

12 CARING FOR CHILDREN IN OTHER ENVIRONMENTS

NOTES

1 Submission: Name withheld (S84).
2 Oral evidence: Name withheld (W61).
3 Family and Community Services Act 1972, s. 51(6).
4 ibid., s. 51(4).
6 Oral evidence: S Goss.
9 GCYP, What children say about child protection and out of home care, p. 32.
10 Oral evidence: P O’Rourke.
11 Oral evidence: S Mares.
12 ibid.
14 Oral evidence: S Mares.
15 ibid.
18 Oral evidence: L Kelly.
19 Oral evidence: G Matschoss.
20 Oral evidence: N Stasiak.
28 Submission: J Walker.
29 Oral evidence: G Matschoss.
30 ibid.
31 Oral evidence: Name withheld (W40).
32 Oral evidence: J Walker.
33 Submission: J Walker.
34 GCYP, Report on interim emergency care, p. 3.
38 Oral evidence: Name withheld (W40).
39 S McDougall et al., The implementation of recommendations made by independent child protection inquiries in South Australia: A report to the Child Protection Systems Royal Commission, Australian Centre for Child Protection (ACCP), Adelaide, April 2016, www.agd.sa.gov.au/child-protection-systems-royal-commission. This report records that the government response largely satisfies the intent of the CISC Inquiry recommendation. The report does not refer to the continued placement of children in motels, serviced apartments and B&B accommodation. It is likely that the Commission has access to additional data not considered by the ACCP.
40 Oral evidence: N Stasiak.
41 Oral evidence: S Turvey.
42 Oral evidence: D Shen.
43 Oral evidence: J Creek; T Santillo.
44 Oral evidence: J Creek.
45 Oral evidence: S Turvey.
46 Oral evidence: A Abela.
47 Oral evidence: T Santillo.
48 ibid.
49 Oral evidence: Ms L (Vol. 2, Case Study 5: Shannon McCoole).
50 Oral evidence: S Turvey; L Kelly; T Santillo.
51 Oral evidence: T Santillo.
52 Oral evidence: S Turvey.
54 Oral evidence: G Matschoss.
55 ibid.
57 Oral evidence: S Turvey; name withheld (W67).
58 Oral evidence: S Turvey.
60 Oral evidence: D Shen; P Cross.
63 Oral evidence: Name withheld (W40).
64 ibid.
65 ibid.
66 ibid; S Goss
67 For the methodology of the Commission’s usual practice review see Appendix C.
68 Oral evidence: Name withheld (W107).
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140 GCYP, ‘Closure of the large residential facilities’, p. 3.


142 Oral evidence: D. Waterford.

143 Oral evidence: N Stasiak; J Richards.

144 Oral evidence: J Lamont.

145 ibid.

146 Oral evidence: D Kevesevic.

147 Family and Community Services Regulations 2009, r. 14.

148 Regulation 14 applies to residential care facilities, which is defined in regulation 3 as a residential care facility established under section 36 of the Family and Community Services Act 1972 (SA), Section 51 of this Act provides a separate power to the CEO to issue licences to operate children’s residential facilities, as defined in section 6.

149 Oral evidence: J Creek.

150 ibid.

151 Family and Community Services Regulations 2009, r. 14(2).

152 For example, GCYP, Monitoring report 2013-14: Larger residential care environments, pp. 6–7.


154 Oral evidence: P Simmons.

155 Oral evidence: N Stasiak.

156 ibid.


161 GCYP, Monitoring report 2013-14: Larger residential care environments, pp. 15–16.

162 RA Layton (Chair), Our best investment: Recommendation 4, p. 2.4.

163 Commission for Children and Young People Act 2000 (Qld), Part 4; In 2014 the Office of the Public Guardian took on the role of conduct of the Queensland Community Visitors’ scheme: see the Public Guardian Act 2014 (Qld), Chapter 4.

164 Mental Health Act 2009 (SA), Part 8, Division 2.

165 South Australian Community Visitor Scheme (SACVS), ‘Principal Community Visitor annual report: Disability accommodation services 2014/2015, Government of South Australia, 2015, p. 5; see also Disability Services (Community Visitor Scheme) Regulations 2013.

166 SACVS, Principal Community Visitor annual report: Mental health services 2014/15, Government of South Australia, 2015, p. 65.

167 Youth Justice Administration Bill 2016 (SA), ss. 11(2), 14.

168 SACVS, The South Australian Community Visitor Scheme, brochure, no date.


170 Oral evidence: P Simmons.

171 Costing for employed visitors provided. GCYP, A community visitor program, pp. 9, 13-14.

172 If staffed by fee for service employees, the cost of engaging volunteers was greater. Oral evidence: P Simmons. GCYP, A community visitor program, pp. 9, 13-14.

173 Oral evidence: P Simmons.

174 Oral evidence: N Stasiak.

175 Oral evidence: D. Waterford.


177 Families SA, Role description, OPS2 Child and Youth Support Worker, approved March 2015, review date February 2015; Families SA, Role description, OPS3 Child and Youth Worker, approved March 2015, review date February 2015.


179 ibid., p. ii.

180 ibid., p. iv.

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183 ibid., p. 49.

184 ibid., p. vi


186 Oral evidence: J Richards.


188 Oral evidence: J Richards.

189 ibid.

190 ibid.

191 Oral evidence: E Scheepers.


193 Oral evidence: N Stasiak.

194 ibid.

195 K Byrne, ‘Information to assist readers of these materials’, letter to the Child Protection Systems Royal Commission, 8 December 2014, p. 3; Safeselect, Safeselect user manual version 4.0, September 2014, p. 6.

196 K Byrne, Safeselect, ‘Information to assist readers of these materials’, p. 2.

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199 Mr F, internal memorandum to D Shen, 20 September 2012 (Vol. 2, Case Study 5: Shannon McCoole).

200 T Bailey, internal memorandum to the Executive Director of Families SA, doc. no. 10TDFC/407, 2010; Families SA, ‘Australian Institute of Forensic Psychiatry feedback on the AIPF profiling system, internal unpublished document, September 2013.

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Commission for Children and Young People, ‘... as a good parent would ... Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care, Commission for Children and Young People, Melbourne, 2015, p. 48.


J Ogloff, Clinical and forensic psychological report regarding the Shannon McCoole case study, report to the Child Protection Systems Royal Commission, 1 February 2016, p. 3.

Oral evidence: J Ogloff.


Oral evidence: J Ogloff.


S Smallbone et al., Preventing child sexual abuse, p. 23.

Oral evidence: J Ogloff.

Oral evidence: S Mares.

Oral evidence: S Mares.


E Munro & S Fish, Hear no evil, see no evil.

E Munro & S Fish, Hear no evil, see no evil.

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Oral evidence: S Mares.

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Oral evidence: S Mares.

Oral evidence: Name withheld (W29).

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Oral evidence: S Mares.

Oral evidence: S Mares.

Oral evidence: S Mares.

Oral evidence: J Ogloff.

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272 Families SA, Role description, OPS2 Child and Youth Support Worker, approved March 2015, review date February 2015; Families SA, Role description, OPS3 Child and Youth Worker, approved March 2015, review date February 2015.


274 Oral evidence: G Curyer.

275 Oral evidence: D Waterford; D Shen.

276 Oral evidence: D Kevseveci.

277 Oral evidence: S Mares.


281 National Crime Agency (UK), The foundations of abuse.

282 JP Anglin, Pain, normality and the struggle for congruence, p. 72.


284 ibid., Recommendation 42, p. 462.

285 It is noted that ACCP report on the implementation of recommendations made by independent child protection inquiries in South Australia records the CISC recommendation or recommendations in relation to therapeutic responses as implemented in full based on the Parenting Research Centre’s Data (see p. 14). It is likely that the Commission is considering additional data not considered by the ACCP.

286 Oral evidence: C Simmons.

287 ibid.

288 ibid.


291 ibid., p. 18.

292 ibid., p. 6-7.

293 ibid., pp. 7-10.

294 ibid., p. 6.

295 ibid., pp. 25-27.


299 ibid., pp. 10–14.

300 ibid., p. 14.

301 ibid., p. 15.

302 RA Layton (Chair), Our best investment, Recommendation 14, p. 2.8.


304 Oral evidence: D Shen.


308 As considered within the Child Development and Wellbeing Bill 2014, s. 10.

309 E Munro & S Fish, Hear no evil, see no evil, p. 7.

310 RA Layton (Chair), Our best investment, p. 13.8.


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314 Minister for Families and Communities, Second annual report by the Minister for Families and Communities to the Children in State Care Commission of Inquiry Report, Government of South Australia, Adelaide, November 2010, p. 87.

315 Written directions are discussed further in Chapter 10.

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320 Oral evidence: P Miller; name withheld (W59); R Ali & C de Crespigny.


323 Oral evidence: Name withheld (W94); S Macdonald; name withheld (W14).

324 Oral evidence: C Simmons.

325 ibid.

326 ibid.

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ADOPTION AND OTHER PERSON GUARDIANSHIP

OVERVIEW

ADOPTION RATES

The Hallahan report
Best interests are paramount
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OTHER PERSON GUARDIANSHIP

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PARTIAL DELEGATION OF AUTHORITY

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FIGURES

Figure 13.1 Percentage of children in third-party guardianship across Australia, 30 June 2014
Figure 13.2: Proposed process for applying for Other Person Guardianship
OVERVIEW

The importance of children being provided with stable and nurturing family relationships to support their wellbeing and future development is emphasised throughout this report. This chapter specifically examines the role and function of adoption and Other Person Guardianship (OPG) as options for the permanent care of children who cannot be safely cared for in their families of origin.

In South Australia, many children in care remain in foster, kinship or residential care placements long after it is clear that there is no chance of returning them to the care of their parents. In some instances, for example where a child’s parents are deceased, acknowledgement of this will be swift. In other situations tension may arise between the child’s best interests and a birth family’s desire for reconciliation.

There is no doubt that care arrangements which provide stability, certainty and normalcy give children the best chance to meet their full potential. Placing decision-making power with families who know the child best, and who have day-to-day care for the child should be pursued wherever possible and safe.

In South Australia, there are two legal provisions that clarify family relationships and decision-making power and increase feelings of stability and belonging for a child. These are orders for OPG and orders for adoption.

It is evident that both options have been seriously neglected in South Australia. As a result, Families SA (the Agency) continues to retain responsibility for the monitoring and case management of some children who have become, for all intents and purposes, part of a new family. Many contributors to the Commission expressed disappointment that the Agency had not embraced these options to advance the interests of children in care.

In August 2015, the release of the Coroner’s report into the death of Chloe Valentine brought the issue of adoption of children from the child protection system to the forefront of public debate. This debate has proceeded, at times, on the mistaken belief that the need to provide children requiring care with a loving and stable family can be met by matching those children with those families who wish to adopt a child. This fails to understand adoption as a mechanism to advance the best interests of the child by recognising and negotiating the relational complexities of their situation, as opposed to a means to satisfy the desire of adults to create or expand their families.

Adoption and OPG mechanisms should be engaged in a more systematic way to meet the needs of children for stability and certainty. Although these arrangements will not be suitable for every child, greater consideration should be given to their potential to provide a safe home for those children who would benefit from such an opportunity.

This chapter principally relates to the Commission’s Term of Reference 5(d), in the context of Terms of Reference 1 to 4.

ADOPTION RATES

Since the 1960s, adoption Australia wide has decreased steadily. In 2014/15 there were 292 adoptions registered across Australia, the lowest number on record, and a 74 per cent fall from 1142 in 1990/92.1 The neglect of adoption as an option for children in care undoubtedly relates, at least in part, to issues arising out of the Stolen Generations as well as past practices of forced adoption.

Notwithstanding this general trend, in recent years there have been a growing number of adoptions of children from care. In particular, legislative changes in Western Australia and New South Wales have elevated the status of this kind of arrangement. During 2014/15 across Australia there were 94 adoptions by carers, the highest figure in a decade. Of these, 87 occurred in New South Wales.2

Amendments to the NSW Children and Young Persons (Care and Protection) Act 1998 provide what has colloquially been described as ‘fast track adoption’. The legislation states that where there is no realistic possibility of restoring a child to their biological parents within a period of six months for a child under two or 12 months for a child over two, then the permanency plan for that child’s long-term placement must consider whether adoption is the preferred option.3 Those amendments did not receive universal support. Although Aboriginal children are exempted, concerns were expressed by some health, legal and community groups that making adoption easier risked creating a new generation of Stolen Children.

In South Australia only one ‘known child adoption’ occurred in 2014/15. That adoption was not necessarily by a carer, as ‘known child adoption’ includes adoptions by step-parents and other relatives outside the child protection system.4

Patricia Rayment and Claire Simmons, experienced clinical psychologists employed by Families SA, confirmed that adoption as a permanency option had been neglected in South Australia for many years. They argue that this neglect has: effectively robbed children under the guardianship of the Minister of an option which would see them exit state care and be given the opportunity to belong to families throughout their life spans.5
They estimated that if adoption were supported in South Australia at a rate equivalent to that observed internationally, some 200 non-Aboriginal children in care might be able to leave the system."6

THE HALLAHAN REPORT
In January 2015 the South Australian Government commissioned Professor Lorna Hallahan to undertake an independent review of the Adoption Act 1988. She was tasked with considering the following issues:7:

- adoption information vetoes
- adoption of a person over the age of 18 years
- retention of the child’s birth name
- same sex couples adoption
- single person adoption
- discharge of adoption orders in certain circumstances
- adoption of children in care
- inter-country adoption.

Professor Hallahan’s report (the report) makes a number of recommendations for changes to the Adoption Act and to consequential policies and practices. This chapter is only concerned with that part of the report which relates to the adoption of children in care.

The wide range of views on this topic that are cited in the report mirror submissions received and research undertaken by this Commission, with the dominant theme being that the rights of the child must be paramount, and the needs and best interests of the child must be prioritised.8

Section 9(1) of the Adoption Act (which defines ‘adoption’ in South Australia) provides that:

> where an adoption order is made, the adopted child becomes in contemplation of law the child of the adoptive parents and ceases to be the child of any previous birth or adoptive parents.

In considering the relevant issues, Professor Hallahan applied a broader definition of adoption, taken from the Report of the Senate Committee into the Commonwealth Contribution to Former Forced Adoption Policies and Practices:

Adoption is a legal process by which a person becomes in law, a child of the adopting parents and ceases to be a child of the birth parents. All the legal consequences of parenthood are transferred from birth parents to the adoptive parents. The adopted child obtains a new birth certificate showing the adopters as the parents, and acquires rights of support and rights of inheritance from the adopting parents. The adopting parents acquire rights to guardianship and custody of the child. Normally the child takes the adopters’ surname. The birth parents cease to have any legal obligations towards the child and lose their rights to custody and guardianship. Inheritance rights between the child and the birth parents also disappear.9

BEST INTERESTS ARE PARAMOUNT
In discussing the issue of adoption generally, Professor Hallahan makes the point that adoption does not exist primarily for family formation, so the selection of adoptive parents cannot be based on the desire of some people to have children. It must be based on a profound understanding of the rights, needs, best interests and welfare of the child or children.10

Her report emphasises that in any adoption process the paramount consideration must be the best interests of the child. Professor Hallahan refers to Article 21 of the United Nations Convention on the Rights of the Child (UNCRC), which states that:

> Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorised only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child’s status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary.11

Professor Hallahan comments that adoption is:

one of the possible options available to ensure that children receive the care to attend to their needs, interests and well-being… In adoption, Article 21 specifies that the best interests of the child must be ‘the paramount consideration’ whereas in Article 3, the best interests of the child is ‘a primary’ consideration. The paramountcy principle in Article 21 ‘establishes that no other interests whether economic, political, state security or those of the adopters should take precedence over, or be considered equal to, the child’s’… Archard (2003) elaborates on the distinction. A consideration that is to be paramount ‘outranks and trumps’ all other considerations and, in the context of adoption it means that the child’s welfare and best interests are the most important consideration and must determine the outcome.
Within the UNCRC 1990 while the best interests of children are the paramount consideration there is a presumption that children’s best interests are served by the following:

- Living with their biological parents where possible; however, adoption can only occur if parents are unwilling or unable to discharge their parental responsibility;
- Each potential adoption requires proper assessment with full reports by independent professionals to the authorities considering the adoption application;
- Children’s rights must not be violated;
- Child’s views must be inclusive of the process where possible which is in the spirit of the Convention; and
- Adopted children have the right to know that they are adopted and to know the identity of their biological parents.\(^\text{12}\)

Professor Hallahan discusses the research into outcomes for children adopted from care and those that compare adoption with other permanency options. She says that:

the studies suggest, unsurprisingly, that children fare better when they do not have prolonged exposure to highly inadequate parenting, poor living conditions, sustained neglect and abuse. They also fare better when their living arrangements are safe, stable and maintained over their childhood. Whether or not adoption adds that bit more that really helps a child settle and belong is not entirely clear. Early action is important, especially to reduce the impact of poor attachment, and cumulative harms and trauma along with birth-related developmental issues.\(^\text{13}\)

and:

Any decision to proceed with adoption from care needs to be made with intensive assessment, a commitment to explore and exhaust other options without allowing drift to occur in the child’s life and providing an opportunity for key family members, including the father if he is known, to have input into the decision. All this must occur within a commitment to preserve the safety of the child.

This approach to planning for long-term stable care and belonging for a child requires an approach to case recording, data keeping and sharing an internal communication within the child protection authority (Families SA) that is an expectation of professional practice, and facilitated within the department. An integrated case management approach that has highly trained social workers involved with the child and his/her world (including school), the child’s family, foster carers, and other child and family support services could produce a comprehensive plan to which all parties agree. This builds on the notion of surrounding the parent, child and foster carer with pre- and post-placement resources that enhance every opportunity for a placement to survive and thrive.\(^\text{14}\)

**PARENTAL CONSENT**

The Act provides that an adoption order will not be made unless each person who is a parent or guardian of the child has consented to the adoption (whether the parent or guardian is present in Australia or not).\(^\text{15}\) While there may be some parents who are prepared to relinquish their rights and consent to the order for adoption, there are others who will be reluctant, even if the children have been removed from them due to their abuse or neglect. The Act provides for the dispensation of consent where it appears to the court:\(^\text{16}\):

(a) That the person cannot, after reasonable inquiry, be found or identified; or
(b) That the person is in such physical or mental condition as not to be capable of properly considering the question of consent; or
(c) That the person has abandoned, deserted or persistently neglected or ill-treated the child; or
(d) That the person has, for a period of not less than one year, failed, without reasonable excuse, to discharge the obligations of a parent or guardian of the child; or
(e) That there are other circumstances by reason of which the consent may properly be dispensed with.

In South Australia, therefore, there is no legal impediment to the adoption of a child who is in care, even in the absence of parental consent, where any of the preconditions above are satisfied.

Professor Hallahan referred to these existing provisions, noting that in the course of consultations she was ‘struck by the number of practitioners in the field who were not aware that these provisions exist in the Act and confidently asserted that adoption from care is impossible’.\(^\text{17}\) She thought this reflected a long-standing policy suggesting that adoption from care may not be the solution for many children who come to the attention of the child protection system.

**REASON FOR CAUTION**

The Guardian for Children and Young People (GCYP) in a submission to the Hallahan review emphasised that in most cases children in care want to identify with both their family of origin and the family that provides care to them.\(^\text{18}\) The Charter of Rights for Children and Young People in Care underscores the right of children in care to maintain a connection with their families, culture and community, including contact with people who help them
feel good about themselves.20 These rights, the GCYP reminds us, should apply equally to children who have been in care and are subsequently adopted. Adoption should not be considered where there is doubt about whether these rights will continue to be respected.

Professor Hallahan refers to adoption of children from care as a ‘last resort option’. Specifically, she indicates that adoption is not to be approached as the solution to solving immediate issues of safety for a child, at the potential expense of their ‘longer term needs around belonging and identity formation’.21

The report observes that children in the care system are not uncomplicated. They may have developmental issues and complex family circumstances; they may have siblings who are an important part of their identity and sense of belonging.22

The Commission is concerned that some of those who advocate adoption as the solution to the lack of suitable long-term placements for guardianship children may underestimate the extent of trauma and consequent complex behaviours of children who have been mistreated by their biological parents. Foster parents who undertake the care of such children need not just financial support but help from a range of relevant services to manage their problems. Many foster parents are reluctant to contemplate adoption because of the associated loss of these supports.23

Further, the Commission heard evidence about long-term placements with caring and loving foster families which broke down as a result of the extreme behaviour of children relating to their earlier mistreatment. In some cases, the children had to be removed because their behaviour placed the safety of the foster parents at risk. The removal of these children from a caring foster placement to yet another placement, possibly into residential care, is distressing for carers who have become attached to them. It also has an obvious adverse impact on already traumatised children and is likely to reinforce their belief in their lack of worth.

Adoption is no panacea for the current shortage of suitable care placements for children who cannot remain with their families of origin. The fact that there is a cohort of families who are interested in starting or growing their families through local adoption, and who may relieve placement pressure in the care system, is irrelevant to the question of a child’s best interests.

By keeping the child’s best interests at the centre of all decision making, it is apparent that there is currently another option available in South Australia that will satisfy a child’s need for permanency and stability. This is Other Person Guardianship, commonly referred to as OPG. This form of guardianship delegates greater decision-making power to the family that is caring for the child without affecting the legal status of the birth parents. It anticipates the continuity of some assistance from the government for a child’s special needs.

Professor Hallahan supports the use of OPG and observes that the government has not made wide use of this provision to date. She urges the allocation of additional resources, together with a comprehensive evaluation of the program over a period of about 10 to 20 years.

Professor Hallahan concludes that existing arrangements in the Children’s Protection Act 1993 (SA) relating to OPG are adequate in terms of ensuring security and stability without undermining long-term identity formation, and further considers that the court should be satisfied that OPG is not an option for a child before proceeding to adoption.

The Commission considers that greater use should be made of OPG. Many families will be content with the security that OPG provides; for others, a successful OPG placement will provide strong support for a subsequent application to adopt. However, OPG should not be used to exclude the possibility of adoption in appropriate cases, nor should it be treated as a mandatory prerequisite to an application for the adoption of a child in care. In every case, the option exercised must be that which is in the best interests of the child.

ADOPTION AND ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

The long-term negative ramifications of forced adoption on Aboriginal and Torres Strait Islander families cannot be overstated. However, the possibility of adoption should not be denied to Aboriginal children as a result. The adoption of Aboriginal children is not excluded by the Act, but is subject to the following important conditions set out in section 1121:

1) The Court will not make an order for the adoption of an Aboriginal child unless satisfied that adoption is clearly preferable in the interests of the child to any alternative order that may be made under the laws of the State or Commonwealth.

2) Subject to subsection (3) an order for the adoption of an Aboriginal child will not be made except in favour of a member of the child’s Aboriginal community who has the correct relationship with the child in accordance with Aboriginal customary law or, if there is no such person seeking to adopt the child, some other Aboriginal person.
The more contentious issue is where adoption by a non-Aboriginal person of an Aboriginal child is contemplated. The Act does not prohibit this, but sets out conditions that must be satisfied before such an order may be made under section 11(3):

(a) that there are special circumstances justifying the making of the order; and
(b) that the child’s cultural identity with Aboriginal people would not be lost in consequence of the adoption.  

The GCYP, in a submission to the adoption review, pointed out that there is no requirement in section 11 of the Act to consult with an Aboriginal organisation in relation to adoption of Aboriginal children: this is at odds with the consultation requirements in the Children’s Protection Act. The Commission considers it appropriate to include such a provision in the Adoption Act to reflect the Aboriginal placement principle and its underlying philosophies.

The Commission otherwise considers that the current legislative framework strikes an appropriate balance in terms of the adoption of Aboriginal children.

**OTHER PERSON GUARDIANSHIP**

Other Person Guardianship is assigned by order of the Youth Court, which appoints up to two persons as the legal guardians of a child. In practice, orders are made until the child attains the age of 18 years, although the court has the power to make shorter orders if appropriate. OPG is an alternative to adoption for a foster or kinship carer with respect to a child who is placed under the guardianship of the Minister. In cases in which a child is already under the guardianship of the Minister, the guardianship is transferred from the Minister to the child’s carers.

The aim of OPG is to provide a child with a normal care environment that is stable, consistent and loving, in which the child has the opportunity to fulfil their developmental potential. Placing decision making about the child within the family that is caring for them promotes an environment that is more consistent with that of a traditional biological family and empowers carers to make decisions based on what they perceive as being in the best interests of the child. The responsibility of an Other Person (OP) guardian is greater than that of a foster or kinship carer who is obliged to act according to the prescriptive decision-making authority given to them by the Minister.

OP guardians are able to make decisions about most aspects of a child’s life, such as education and schooling, haircuts, medical procedures, and school excursions. They can also make decisions about interstate or overseas travel, provided that such arrangements do not contravene any fixed contact arrangements with birth parents. Any continuing involvement with Families SA is on a voluntary or as-needs basis.

Legal arrangements similar to OPG exist in other jurisdictions within Australia and internationally. In the United Kingdom, the nearest legal equivalent of OPG is called a Special Guardianship Order. It is a private law order made under the UK Children Act 1989 and is intended for children who do not live with their birth parents who would benefit from a legal and secure placement. That order does not end the legal relationship between the child and their birth parents. Those who can apply for Special Guardianship Orders include anyone with whom the child has lived for at least three years out of the last five, and a local authority foster parent with whom the child has lived for at least one year preceding the application.

In South Australia there are three entry points to OPG:

- variation of a long-term guardianship order to an OPG order;
- application for OPG as an alternative long-term guardianship order following unsuccessful attempts at reunification; and
- application for OPG without prior long-term guardianship or Custody of the Minister court orders.

The most common entry point for OPG is variation of an existing long-term guardianship order.

Although an OP guardian is not obliged to acquiesce to the Minister’s ultimate authority when making decisions that affect the child, the OPG order is not unconditional and the OP guardian must comply with the conditions that are affixed to the order of the court. These are most commonly articulated in what is referred to as the ‘care plan’. The court can revoke the OPG order if there is failure to comply.

The OPG practice guide sets out the areas which Families SA considers should be covered in the care plan. They are:

- how the child’s health, educational and social needs will be met;
- how the child’s special needs (trauma or disability) will be met;
- how the child’s identity as a member of two families will be developed;
- how the child will maintain connection to their family of origin, community and culture. In particular, for Aboriginal children:
  - how the child will gain knowledge and understanding of their Aboriginal history;
— how the child will be assisted to learn, understand and build their Aboriginal identity;
— how the child will gain more knowledge and understanding of their extended family and community;
— how the child’s cultural expression will be developed;
— how the child will gain more knowledge and understanding about their Aboriginal cultural values, beliefs and practices;

- how the child will have regular family contact/access visits and how this will be facilitated by the new guardian, birth family and, where necessary, Families SA;
- what level of Families SA financial support (i.e. alternative care support payments, loadings and incidentals) will be needed and when/how such payments will be reviewed;
- what level of ongoing Families SA support and/or services are required and how these services will be reviewed;
- how any future disputes between the parties will be resolved; and
- how and when the child’s care plan will be reviewed.

The practice guide also provides that:

- Aboriginal and Torres Strait Islander children must be appropriately assessed for OPG arrangements in accordance with the Aboriginal and Torres Strait Islander Child Placement Principle. Initial assessment for such children will be based on the criteria outlined in the OPG practice guide with particular focus on the carer’s demonstrated commitment to maintain the child’s connection to their family of origin, community and culture;
- All assessments for OPG involving Aboriginal children will require consultation with the Regional Principal Aboriginal Consultant and, where appropriate, extended family and community members; and
- OPG assessments must also consider individual cultural issues relating to culturally and linguistically diverse communities as an integral part of the formal assessment planning process.

RATES OF OTHER PERSON GUARDIANSHIP

The Commission was advised that all OPG applications finalised by the Youth Court between July 2011 and December 2014 were granted. However, in recent times, there appears to have been a dramatic drop in the number of applications made. The number has dropped from 27 in 2012/13 and 29 in 2013/14 to three in the first six months of 2014/15. The Commission has not been provided with any explanation, although it understands that there is a large backlog of OPG applications awaiting assessment by Families SA. Whatever the reason, South Australia lags substantially behind other states with respect to OPG, as demonstrated in Figure 13.1 below.

Figure 13.1 Percentage of children in third-party guardianship across Australia, 30 June 2014

(Note: Data for Northern Territory unavailable).
WHAT DOES OPG MEAN FOR A CHILD?
Through OPG it is hoped that children will develop a stronger sense of belonging and personal identity by being connected with a family that they can call their own. The order demonstrates the guardian’s permanent commitment to the child—recognising the child as part of their family and promoting feelings of safety and security. The Commission was told of one case in which an OPG order was sought by Families SA three weeks before the child turned 18 to recognise the child’s place within the family and to foster a greater sense of belonging.33

A shift to OPG, with reduced contact with Families SA, should also help remove the stigma of a child being labelled as someone in state care. Research that shows the improved developmental outcomes of adopted children, as compared to those who have been maltreated by biological parents or have been in simple foster or residential care, also supports the benefits of an OPG order.

WHAT DOES OPG MEAN FOR A CARER?
The making of an OPG order acknowledges the contribution a carer has made to a child’s life. It grants them greater decision-making capacity and responsibility than that which can be exercised by simply being a foster or kinship carer. OP guardians have the benefit of exercising their decision-making power free from regular oversight by Families SA caseworkers.

However, children subject to an OPG order have usually experienced abuse or neglect in their early lives and are likely to have ongoing needs that can render parenting difficult. It is therefore important that such children and their guardians are afforded some continuing support by the state, if it is required.

It is expected that access arrangements between the child and the biological parents existing before an OPG order will continue while the child is in the care of an OP guardian. Those arrangements should be included in the care plan.34 In some instances there is need for support by Families SA, such as where there are complicated internal family dynamics: this may be the case when kinship carers become OP guardians or where the birth parents of a child have behavioural or psychological problems which make unsupervised access inappropriate.

An OP guardian also benefits from a greater degree of certainty that the child will remain in their care over the long term. The fear of a child being removed is a significant issue for some foster parents. A Families SA worker said that potential foster parents were dissuaded from taking on the role by the perception that ‘at the end of the day the biological family have all the rights. Families SA make all the decisions and you are simply a volunteer’.35 An OPG order has the potential to reduce that anxiety and assist the carer to make a long-term commitment in which they can permit themselves to love and care for the child unreservedly:

(‘You care for a child) with a guarded heart because there is always a risk that the child could be removed.’36

WHEN IS IT APPROPRIATE FOR AN OPG ORDER TO BE MADE?
The practice guide sets out five conditions identified by Families SA for a carer to be eligible to be appointed the child’s guardian37:

• The carer has demonstrated capacity to provide a high level of care for the child;
• The carer has sufficient personal and professional support and resources to provide care for the child now and into the future;
• The carer family is committed to the child maintaining connection to their family of origin, community and culture;
• The carer has made a lifelong commitment to the child; and
• A preferential relationship exists between the child and the carer.

These are appropriate matters to be considered with respect to an OPG application, but they should not be inflexibly applied. They are not mandated by legislation nor by direction of the court. For example, notwithstanding these criteria, OPG may be appropriate for a child who is particularly traumatised and is unable to develop a preferential relationship, but the OP guardian recognises and understands the situation and provides high quality care for that child’s special needs.

THE CURRENT APPLICATION PROCESS
The current application process generally starts with a referral to the OPG Assessment Panel (the Assessment Panel) from a Families SA worker and/or a carer (who may be assisted by their support agency).38 The Assessment Panel is located within the Placement Services Unit of Families SA. In some instances carers have directly approached an Executive Director of the Agency when their application has not been endorsed by Families SA at the local level.39 For an OPG application to be successful, however, it generally requires the support of Families SA.40
The Assessment Panel meets on a monthly basis and usually consists of two principal social workers, an Aboriginal Family Support Services (AFSS) representative, a representative of the Child and Family Welfare Association (CAFWA) plus any professional person that the panel deems to be relevant to an assessment. For example, when the application relates to a child with a disability, the panel may engage the help of a disability services expert.41

A worker in the Placement Services Unit undertakes an assessment of the application by applying the five criteria. The worker must consider the child’s long-term prospects up to and beyond the age of 18.42 The Commission heard evidence indicating that this particular aspect of the assessment was potentially complex as it required the assessor to look at a child’s life well past the age of 18. For example, a worker assessing a toddler must consider the impact of issues which might arise in adolescence—a complicated task which becomes even more difficult with children who have a background of trauma.43

About half of all applications are referred back to the initiating caseworker with a request for more information. The Assessment Panel will then either approve or refuse the application. If the application is approved, the child’s caseworker prepares a care plan which then serves as a ‘roadmap’ of the child’s care needs over the short and long term.

**TIMING OF THE APPLICATION**

There is no timeframe prescribed by legislation with respect to an OPG application. In practice, the decision to apply for an OPG order is based on the needs and circumstances of the individual child rather than the length of time in which the child has been in a particular placement.44 However, there is clearly a large degree of uncertainty surrounding the time at which an application can be pursued.

One carer said she had been advised that she would have to wait for two years before the issue was raised and another mentioned a period of at least three years.45 Garry Matschoss, Acting Manager of the Placement Services Unit, identified a ‘rule of thumb’ for the Placement Services Unit of the child having been in the placement at least a year.46

The level of confusion regarding the time at which an application for OPG can be made should be resolved. The Commission recommends an amendment to the Children’s Protection Act to permit applications for OPG to be made for a child who has been in the care of a foster parent under a long-term order for not less than two years. However there will be some situations in which the best interests of the child will dictate a lesser period of time in care. Accordingly, the legislation should also provide the court with an unfettered discretion, in appropriate circumstances, to make an OPG order for a child who has been in care for less than two years.

**DELAYS**

The Commissioner heard a number of complaints about delays in the processing of OPG applications. The Commission was told that at one stage, the waiting list was between 18 months and two years.47 Mr Matschoss said some assessments were completed in as little as four months but generally took more than six. In some cases Carers opted not to proceed when they fully understood the responsibilities.48 The delays may in part be due to the restricted number of workers assigned to undertake OPG assessments: currently there are only two staff dealing with applications. Mr Matschoss estimated that there were about 36 cases on the waiting list.49

There is also the complex and time-consuming nature of the assessments themselves. These are especially difficult when complicated access arrangements or other disputed matters need to be resolved for inclusion in the case plan. The process is further complicated by the need to refer the final decision to the Executive Director of the Agency for approval.

**THE APPLICATION TO THE YOUTH COURT**

The application is then forwarded to the Crown Solicitor, as the legal representative of the Minister, to make an application to the Youth Court.50

The child’s biological parents are parties to the original guardianship order and are therefore served with a copy of the application. Although there is no legislative requirement for them to consent to the application, the Act requires the court to be satisfied that before making an OPG order there is no parent able, willing and available to provide adequate care and protection for the child.51 As discussed in Chapter 9 this provision is problematic and should be repealed. It has the potential to stand in the way of a long-term order in the best interests of the child.

Evidence suggested that there were delays in listing OPG applications for hearing in the Youth Court. The Commission has not investigated that aspect but it may be that OPG applications are regarded as less urgent than other applications made to the Court in which the safety of a child is at risk. It is also possible that neither the applicant/carer, nor the child, has a particularly strong voice in presenting such applications and that may be a factor in the lack of expedition.
BARRIERS TO OPG

Evidence given to the Commission suggested that OPG placements were not a priority for the Agency from a case management perspective. Ms Rayment and Ms Simmons commented that:

Practitioners seem to be resistant to transfer children’s guardianship from the Minister, possibly due to factors including historical concerns regarding OPG, lack of parental consent, concerns regarding the quality of care provided by foster carers or a carer’s ability to manage issues such as contact with birth families. The vexed issue of children being placed under the guardianship of carers from a different cultural group has also led to delays in progressing OPG.

A foster parent told the Commission that some 18 months earlier carers had been undertaking the assessment process but it was stopped without explanation. On 19 October 2015 an article in the Advertiser under the heading ‘More stability for children in state care’ reported the Education and Child Development Minister, Susan Close, as saying that she wanted to raise awareness of OPG among those who had long-term care of children. The article advised that the Agency would be writing to 788 families who had been caring for a foster child for two years or more, encouraging them to consider OPG, which would give them more control over everyday decisions. A sum of $475,000 a year in the state budget was mentioned to fund the initiative.

Mr Matschoss was asked about the matters contained in this article (which had been published just a few days before he gave evidence). The article had apparently taken him by surprise. He was unable to assist with any detail as to how the sum of $475,000 would be allocated and he was concerned about whether the staff could cope with a substantial influx of applications.

Mr Matschoss thought there would be fewer than the 788 families mentioned in the article but that 150 to 200 families would be eligible. However, he cautioned that some of the carers most eager to apply were not necessarily the most suitable. The unsuitability appeared to relate principally to difficulty with access arrangements with birth parents. There was also some confusion about the level of ongoing financial support that would be available, but Mr Matschoss’s personal view was that financial reasons alone would not justify rejecting an application for OPG.

The proposal contained in the announcement by the Minister is consistent with the recommendation in the Hallahan report for greater use of OPG. It suggested a change of attitude by Families SA and was welcomed by foster parents who had been advocating for this form of legal permanency for many years.

On 19 April 2016 the Commission wrote to the Department to ascertain progress with respect to the OPG applications foreshadowed by the Minister. The Commission sought the following information:

- how many families were contacted;
- how many families responded;
- how many families indicated they would like to pursue an OPG application; and
- what progress has been made in relation to those applications.

By letter dated 28 April 2016 the Commission received a reply under the signature of the Deputy Chief Executive for Child Protection as follows:

In October 2015 the Growing Other Person Guardianship project was still in its early planning. The number of carers to be contacted depended on the determination of preliminary screening criteria which were not yet established. The figure provided to the Advertiser was based only on the number of children in foster care placements for two years or more and did not consider any other relevant factor relevant for OPG.

The preliminary screening criteria used to identify the carers to receive an invitation to attend to the OPG information sessions were:

- carers who have been caring for children for longer than three years
- carers who have no current care concerns
- carers who are a fully registered carer
- carers who have not accessed payment other than carer payments aligned to the child’s age and complexity
- carers who are caring for children under the age of eight.

Using the above criteria as a guide, 213 families were contacted and 84 families responded.

A total of 59 families and four non-government organisations’ representatives attended the sessions as follows:

- Northern location, Mawson Lakes: 20
- Central location, Hindmarsh: 11
- Southern location, Marion: 20
- Port Augusta: 4
- Whyalla: 8.

Of the 63 families who attended the sessions, four were neither sent an invitation letter nor made previous contact to advise of their attendance.
The information sessions were intended to provide information to carers about the OPG process and not to gauge or seek opinions of those attending about their interest to pursue OPG.

The OPG process begins when carers express their interest in OPG with their caseworker at the office or hub. This may occur during the child’s annual review, or as part of casework case management practice. Information recorded in case notes cannot be extracted for reporting. Therefore at this stage the number of people interested in OPG is not possible to ascertain and report on. Following discussions about the criteria and process for OPG with the carer, if the hub/office and carer feel that OPG is the appropriate path to take, a referral is made to the OPG team and discussed with the OPG panel that approve the commencement of the OPG assessment.

The OPG project is reviewing how each step in the OPG process can be improved to capture information for the purpose of improving reporting. Currently, based on those who attended the information sessions, referrals have come through as follows:

- One family has been referred and approved for assessment; this carer is caring for three grandchildren.
- One other family is in the process of being referred.

The information contained in this letter raises several matters of concern:

- The criteria for consideration as an OP guardian are set out in the Department’s OPG practice guide and do not include any of the matters used by the OPG project team to identify those carers who were entitled to receive an invitation to the proposed information session.
- There is no explanation for limiting the invitation to those carers who had been caring for children for longer than three years. Section 80 of the Family and Community Services Act 1972 allows the Minister to delegate powers to a foster parent who has had the care of a child for three years or more, but that is different from OPG. In any event, the statement by the Minister as reported in the press contemplated those who had been caring for a child for two years or more, and Mr Matschoss mentioned a period of one year.
- Reference to ‘carers who have not accessed payment other than carer payments aligned to the child’s age and complexity’ suggests that carers who are receiving anything more than the basic subsidy were to be excluded. The OPG practice guide sets out the areas that Families SA considers should be covered in the care plan and states what level of Families SA financial support may be required. If Families SA considers there is a need to monitor such payments to avoid misuse, appropriate provisions can be included in the care plan.
- The limitation to carers of children under eight years of age is curious. There is no apparent rationale for this criterion, which may exclude many families, including some whose children may have passed that age while they were waiting for the Agency to consider and/or process their application. There is no reason to exclude a child from OPG on the basis of age if the OPG placement is in the child’s best interests. Some applications may in fact be facilitated by the ability of older children to more readily express their views about the application.
- The letter sent to families who were not excluded by the preliminary screening advised that it was for an information session only. That may account for the relatively low number of persons who responded to the invitation. It appears that there was no attempt at these sessions to gauge or seek opinions from those attending about their interest in becoming an OP guardian. The Agency indicates in its letter that there is difficulty in extracting relevant data from the case notes to ascertain the number of people who might be interested in OPG. It would have been helpful to use these sessions to ascertain the level of interest from those present and give them some clear direction on how to advance an application.
- Although some carers might have decided not to proceed once the responsibilities had been explained to them, it is unlikely that reluctance accounts for the alarmingly low level of assessments that followed the promising announcement by the Minister.

The Commission can only conclude that the intransigent attitude of Families SA identified earlier continues. The intention of the criteria applied on this occasion appears to have had more to do with limiting the number of applications flowing into the Department, rather than making a concerted effort to increase the numbers of carers who might be suitable OP guardians.

THE RIGHTS OF THE BIRTH PARENTS

Although there is no requirement that birth parents consent to an OPG application, they are entitled to be notified and, where appropriate, their views obtained with respect to it. This process can cause delays. In one case the Commission was told of efforts to locate a child’s parents being so thorough that a birth parent was found who was unaware that he was the father of the teenage child concerned. Mr Matschoss observed however that many birth parents did consent: they may say, ‘I hate your Department, but I know it’s best for my child.’ Others, despite their relationship and history, struggled with the idea that they might be seen to be giving their child away.
Although dealing with such issues was the responsibility of the workers in the Placement Services Unit, Mr Matschoss thought there might be an advantage in having someone independent who had not been previously involved working through issues with the child’s parents. Some foster parents refrain from pursuing an OPG application to avoid stirring up issues with birth parents who were having minimal, if any, contact with the child.

The Commission considers that the rights of birth parents with respect to an OPG application should be clarified. Although they are not required to consent, they do have a right to be heard. However, if they wish to oppose the order, the onus should be upon them to establish on the balance of probabilities why the order should not be made. This may be a less confronting position for birth parents, and remove a level of anxiety associated with ‘giving the child away’.

**PROMOTING OPG**

Families SA should make a genuine commitment to OPG as part of permanency planning for children in care. The suitability of an OP arrangement should be identified as early possible in a child’s placement, with records maintained about the progress of the child, and the carer’s suitability for OP guardianship. That information should be readily accessible at the time of the OPG application and assessment.

There is a need to clarify and expedite the current procedure with respect to OPG assessments. Where a child has been in care under a long-term order for a period of not less than two years (or in other special circumstances less than two years), a foster parent should be entitled to make an application to the OPG Assessment Panel to be appointed the OP guardian of that child. The application should usually be made with the support of the Families SA caseworker or the foster care support worker, but that support should not be a prerequisite to the foster parent or kinship carer making the application.

The application should briefly address the five relevant conditions. The applicant may wish to nominate a person or persons to assist with the assessment of their suitability, such as a caseworker, teacher, disability support worker, therapist or other expert concerned with the care of the child. In that case, the application should include a written authority for information to be made available to the panel.

The Assessment Panel’s membership should be reviewed. It should be composed of members with appropriate expertise who are independent of Families SA, although Families SA should be represented, provided the person concerned is not connected to the case in question. Depending on the case, the Assessment Panel could include representatives from CAFWA or AFFS, a disability support worker and a psychologist or other professional. For administrative convenience, this panel could be the same one that is constituted as the Case Review Panel to consider disputed issues of family contact, which is discussed further in Chapter 9.

When an application is lodged, the Assessment Panel should conduct an initial screening. If the application is ‘screened in’ (as having the capacity on the face of it to satisfy the five criteria), it should then be referred for formal assessment and preparation of a care plan. The person preparing the assessment and developing the care plan would need to consult with the child, the carers, the birth parents and other professionals. In the case of Aboriginal and Torres Strait Islander children, the principal Aboriginal consultant and AFSS would need to be consulted.

In some cases, the Assessment Panel might consider the child’s caseworker to be the best person to perform the assessment. Where the caseworker has maintained a close relationship with the child and the foster family and has kept the required records, the assessment and care plan should be able to be completed in a timely manner. Otherwise, the application should be referred to a practitioner within the Placement Services Unit. If there is no-one available to perform the assessment in a timely way, it should be outsourced to a private practitioner. Any costs incurred as a result of outsourcing should be offset by the advantages and potential cost-saving of moving a foster parent to OP guardianship. Figure 13.2 shows the suggested process for applying for Other Person Guardianship.

Following the assessment and preparation of the care plan, the matter should then be referred back to the Assessment Panel for final determination. Upon approval by the panel the application should be referred to the Crown Solicitor to prepare the requisite application to the Youth Court. There should be no need to refer the matter to the Executive Director for final approval, as that will be given by the Youth Court on the hearing of the application.

The OPG application should then be served upon the birth parents with advice that if they oppose the making of the order they will be required to prove to the court on the balance of probabilities why the order should not be made.
Figure 13.2: Proposed process for applying for Other Person Guardianship
STANDING TO MAKE AN OPG APPLICATION
Evidence was given by some carers that they would like to act on their own behalf with respect to lodging an OPG application in the Youth Court.65

The ability to initiate proceedings in court would assist those persons whose applications are not currently supported by Families SA. However, such applications are likely to have limited chance of success and have the potential to result in protracted proceedings by creating an adversarial relationship with the Minister as the guardian of the child. There is also a danger that granting carers the ability to take their own action could have a number of unintended consequences. It could lead to a change of practice whereby carers were encouraged and/or expected to make applications on their own behalf, saving the resources of Families SA. This would be a significant disadvantage to carers, particularly those who do not have the intellectual or financial ability to deal with complex court procedures. Carers are unlikely to be well placed to undertake potentially difficult negotiations with biological parents with respect to access or other arrangements, which must be included in the care plan. It could also make it difficult for the court to obtain properly sourced objective evidence as to the suitability of the proposed OP guardian, which would inevitably result in further delays to the application.

The wish to act in person appears to be borne out of frustration with the current attitude of Families SA to OPG applications as well as the extended delays in processing. The question of delay can be resolved by Families SA promptly addressing the current backlog. The Commission believes that the ability of a carer to make an application to an independent panel, as outlined above, should allay the concerns of those carers whose applications, for whatever reason, are not supported by their caseworker. If an application is not approved by the Assessment Panel, it is unlikely that it would succeed in court. The Commission does not therefore currently support carers being permitted to apply directly for an OPG order. However, this issue may need to be revisited if the current problems persist despite the recommendations contained in this chapter.

POST-OPG SUPPORT
The strength of the relationship between the child’s carers and the biological parents is an important part of the success of any OPG arrangement.66 The transparent exchange of information between parents and carers should be encouraged whenever it is possible.67 In the long term, fostering good relations between birth families and carers may result in a reduced need for resources to support contact. A more natural relationship between the birth family and carers is also good for the children.

In the Commission’s consultation with children, one child said, ‘Where I am now we organise the access ourselves—without Families SA being involved. It is great’.68

‘Where I am now we organise the access ourselves—without Families SA being involved. It is great.’

Mr Matschoss told the Commission that it was initially intended that post-OPG support to families would be provided by a non-government organisation such as the post-adoption support service provided by Relationships Australia. Many families would benefit from continuing support after OPG, although at a much reduced intensity. It is appropriate that a continued needs support service be made available to them. In line with recommendations in Chapter 11 about extending the role for the non-government sector in supporting home-based placements (specifically kinship care), the Commission recommends that post-OPG support also be provided by non-government agencies. There is no reason that support could not be provided, at a reduced level, by the registered foster care agency responsible for originally placing the child in the care of the family. Where no agency has previously been involved (kinship carers are supported by the statutory Agency) a referral should be made to a non-government agency providing services in the appropriate region.

PARTIAL DELEGATION OF AUTHORITY
Section 80 of the Families and Community Services Act 1972 provides that where a child who is in care has been in the care of a foster parent for three or more years, the Minister may delegate to the foster parent such powers as the Minister thinks fit. A delegation under this section may be revoked by the Minister at any time. The power is limited to delegation to approved foster parents and does not include kinship carers who fall outside the definition of a foster parent.

A gradual and sequential delegation of powers pursuant to section 80, to transfer decision making to carers who have been identified as potential OP guardians, should occur as part of day-to-day case planning. The manner in which carers then exercise those powers will be highly relevant to the later assessment of their suitability as an OP guardian.
This delegation of power could also occur during the period in which the OPG application was pending and would help to allay some of the present anxiety about delays in processing those applications.

The barriers to greater reliance on section 80 are discussed in greater detail in Chapter 11. Recommendations are made in that chapter to amend section 80 to expand its operation to include relative carers (according to the definition suggested in that chapter), and make section 80 delegations available when the child has been with the carer for 12 months or more. These amendments should provide greater flexibility in the use of section 80 delegations as a tool to work towards OP guardianship applications.
RECOMMENDATIONS

The Commission recommends that the South Australian Government:

153 Amend the Children’s Protection Act 1993 to enable carers to apply to be appointed an Other Person guardian where children who are subject to long term orders have been in their care for a minimum period of two years, or such lesser period as the court in its absolute discretion determines is appropriate in the circumstances.

154 Amend the Children’s Protection Act 1993 to provide that biological parents who oppose an application for the appointment of an Other Person Guardian bear the onus of proving to the court on the balance of probabilities why the order should not be made.

155 Establish an independent assessment panel to consider applications for Other Person Guardianship, in accordance with the following procedures:

   a the application to be made by a foster parent in person or by a caseworker or foster care support worker on behalf of the carer;

   b an initial review be carried out by the Assessment Panel to determine the utility of referring the application for a full assessment;

   c the application to be referred to the caseworker or such other appropriate person as is available to carry out the assessment and prepare the case plan in a timely manner;

   d when the assessment has been completed and case plan prepared, the application to be referred back to the Assessment Panel for final determination;

   e all decisions of the Assessment Panel are to be final.

156 Promote the use of section 80 of the Family and Community Services Act 1972 for the delegation of decision making to support potential applications for Other Person Guardianship.

157 Consider the question of adoption where that is in the best interests of the child and an Other Person Guardianship order would not be appropriate.
NOTES

2 ibid., p. 2.
3 Children and Young Persons (Care and Protection) Act 1998 (NSW), s. 83.
4 AIHW, Adoptions Australia 2014–2015, p. 27.
5 Submission: P Rayment and C Simmons.
6 ibid.
8 ibid., pp. 57–60.
9 ibid., p. 19.
10 ibid., p. 37.
12 ibid., pp. 57–60.
13 ibid., p. 19.
14 ibid., p. 37.
15 Adoption Act 1988 (SA), s. 15(1).
16 ibid., s. 18.
17 L Hallahan, Adoption Act 1988 (SA) review, p. 53.
18 Guardian for Children and Young People (GCYP), submission to the L Hallahan review of the Adoption Act 1988 (SA), February 2015, p. 2.
19 ibid., p. 3.
20 L Hallahan, Adoption Act 1988 (SA) review, p. 54.
21 ibid., p. 55.
22 ibid.
23 Adoption Act, s. 11.
24 ibid., s. 11(3).
25 Children’s Protection Act 1993 (SA), s. 38(1)(d).
28 Children’s Protection Act, s. 38(1)(f).
30 ibid., p. 3.
31 Families SA, data provided to the Child Protection Systems Royal Commission.
32 ibid.
33 Oral evidence: G Matschoss.
35 Oral evidence: T Hutson.
36 Oral evidence: K Ryan.
38 Oral evidence: G Matschoss.
39 ibid.
40 ibid.
41 ibid.
42 ibid.
43 ibid.
44 Families SA, ‘Other Person Guardianship practice guide’, p. 3.
45 Oral evidence: S Lane.
46 Oral evidence: Name withheld (W10).
47 Oral evidence: G Matschoss.
48 Oral evidence: Name withheld (W59).
49 Oral evidence: G Matschoss.
50 ibid.
51 ibid.
52 Children’s Protection Act, s. 38(2)(a).
53 Submission: P Rayment and C Simmons.
54 Oral evidence: J Jarvis.
56 Oral evidence: G Matschoss.
57 ibid.
58 ibid.
59 ibid.
60 E Scheepers, letter to the Child Protection Systems Royal Commission, 28 April 2016.
61 Families SA, ‘Other Person Guardianship practice guide’.
63 ibid.
64 ibid.
65 Oral evidence: K Ryan; J Jarvis.
67 ibid.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
OVERVIEW

CHALLENGES FOR YOUNG PEOPLE LEAVING CARE

Education and employment
Life skills and housing
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The CREATE Foundation
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POST-CARE SERVICES

Relationships Australia SA
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RECOMMENDATIONS

TABLES

Table 14.1: Young people under the guardianship of the Minister entitled to transition planning and who had a current transition-from-care plan
OVERVIEW

In order to conduct a thorough analysis of the child protection system it is necessary to examine how the state prepares and plans for a young person’s exit from the system and how it supports their transition to an independent life. The manner in which they are supported through this transition is a measure of the success of those who have been charged with raising them.

Children and young people leave the child protection system in a number of ways, often depending on why and how they were initially placed in care. This chapter focuses on young people whose case is closed on the expiry of their guardianship order at the age of 18, or who, before reaching the expiry of their order, are transitioned into independent living arrangements.

Leaving care is ‘a major life event and process that involves transitioning from dependence on state accommodation and supports to so-called self-sufficiency’. It can mean significant changes to caring relationships that have sustained young people throughout their childhood. Turning 18 marks the beginning of an expectation that the young person will be responsible for their own pathway, negotiating the government systems and services that might be available to support them, and bearing responsibility for the consequences of the decisions they make.

Unlike young people in the general population, care leavers embark on the challenges of adulthood without the safety net offered by a traditional family structure. While reaching the end of their care journey is a highly anticipated occasion for some, for others it can generate a sense of abandonment and anxiety.

Preparation before transition and support after it are critical to care leavers if they are to develop the skills needed to reach their full potential. Previous reports concerning the South Australian child protection system have identified gaps and advocated for the state to provide young people leaving care with appropriate resources and recognition. The Layton Review discussed the need for:

- specific legislation for young people leaving care;
- transition planning that involves all key agencies and stakeholders including significant others and the young person; and
- a reorientation of existing systems and policies towards a model that incorporates permanency planning.

Despite the acknowledged need for a more comprehensive approach, major challenges persist for young people leaving care. The end of their care journey represents an opportunity to transition into adulthood on their own terms. A supportive transition that nurtures their independence in a way that parallels parental care should be regarded as a central component of a quality child protection system.

This chapter principally relates to the Commission’s Terms of Reference 1 and 2.

CHALLENGES FOR YOUNG PEOPLE LEAVING CARE

Young people leaving care represent one of society’s most vulnerable and socially excluded groups. By comparison to the general population, care leavers are more likely to suffer disadvantages in several key areas as a consequence of their out-of-home care experience.

For any young person, the transition from adolescence to adulthood can be a challenging period marked by changes across many aspects of life. For children leaving care, it can present greater obstacles than those experienced by other young people in the general population. Transitioning to independence requires already disadvantaged young people, who are coping with a greater number of life stresses, to enter adulthood at a far younger age and over a shorter timeframe than their peers.

The circumstances leading to placement in the child protection system, such as a parent’s mental health issues or substance abuse, violent family relationships, poverty, neglect, and physical, sexual or emotional abuse, all leave their mark. Irrespective of the period of time a child spends in out-of-home care, the loss, interruption or absence of secure caregiver relationships usually makes the experience a traumatic one and can contribute to ongoing difficulties with social adjustment and challenges maintaining stable and adaptive relationships. Children and young people in care very often develop problems with behavioural and emotional regulation arising from traumatic experiences or disruptions in early attachments. They are more likely to have developmental delays and intellectual or physical disabilities compared to the general population. These difficulties all impact on their ability to engage effectively with the adult world.

Children and young people may encounter a range of inadequacies in out-of-home care including poor quality care; abuse; a constant shifting of placements, schools and social workers; and a lack of stability and security over time. This lack of continuity and consistency is likely to undermine their social and educational progress and hinder their capacity to successfully move towards independence.
Any transition that occurs abruptly at a critical stage of a young person’s development brings another experience of loss and abandonment. Young people frequently leave care without stable family support or a well-established social circle on which to rely. Some may return to the support of their birth families, but not infrequently those families are still experiencing the challenges and behaviours that led to the child being taken into care. Such young people are reluctant to seek out services, engage in therapy or develop community networks because their experiences in out-of-home care have led them to distrust the system. Many young people perceive the system as a source of instability and frustration, and seek to distance themselves from it. Those who have experienced trauma and abuse may also find it difficult to articulate their problems and feel uncomfortable engaging with conventional service models. This in turn leads to them feeling disconnected from society and becoming even more isolated. 

Internationally, research consistently reports that care leavers are more likely to:

• not complete high school;
• be unemployed or underemployed;
• earn low wages if employed;
• become parents at a young age;
• be incarcerated or involved with the criminal justice system;
• be homeless at some stage;
• live in unstable living arrangements;
• be dependent on social assistance;
• experience mental health issues; and
• be at higher risk of substance abuse difficulties.

EDUCATION AND EMPLOYMENT

Australia-wide data obtained from an extensive survey of care leavers found that of the respondents who had left care (and were over 18 years of age) only 35.3 per cent of them had completed Year 12 studies. The figure for the general population of 19-year-olds who had completed Year 12 studies was 74 per cent. In the same population, 28.5 per cent of care leavers were unemployed, compared to 9.7 per cent of youth in the general population. 

When young people leave care with an inadequate education they have a lower prospect of obtaining employment, which is an essential step towards securing independence. A variety of factors may contribute to young people in care suffering poor educational outcomes. One factor is likely to be that young people in care are required to complete their final years of schooling at the same time as they are moved out of the care system.

Claudine Scalzi, the state coordinator of the CREATE Foundation, observed:

Children and young people …17, 18, doing Year 12 … have to work out where to live. It’s near impossible. But … that’s probably why children and young people don’t go on to further education, because it’s stressful to be completing that, trying to work out where to live. 

A young person who has the commitment and intelligence to succeed academically and engage in higher education is hardly well served by balancing the demands of Year 12 with managing a household, a budget, independent living, and the fear that support will soon cease. Young people living in care through their final years of schooling and striving for a place in higher education are simply not competing on a level playing field with their peers.

LIFE SKILLS AND HOUSING

Many young people leaving care do not have the developmental maturity or life skills to allow them to live independently. For example, few know how to budget to meet periodic payments, and built-up debt can prevent them from meeting their daily living expenses. Gaps in life skills such as accessing transport can limit employment opportunities, which in turn contribute to financial problems. 

Finding and retaining suitable housing is difficult for care leavers. Apart from the limited supply of accessible housing, many young people lack the skills or maturity to live alone and find it difficult to tolerate the social isolation. If they are placed with others, they may lack the skills to live harmoniously. Care leavers are at a heightened risk of homelessness: CREATE’s 2009 survey found that 34.7 per cent had experienced periods of homelessness in the first year of leaving care. 

RELATIONSHIPS AND SOCIAL CONNECTION

Some care leavers experience difficulties forming relationships and gravitate towards negative peer groups. Keeping such company can increase the risk of offending and set the young person on a path towards the correctional system. 

Lacking adequate social supports, information about their rights and access to services, care leavers are at risk of exploitation. They are also more likely to experience low self-esteem, increasing their vulnerability.
Alice Thompson-Francis, the manager of a non-government run independent living program providing supported accommodation to care leavers, told the Commission:

*I think … it’s a case by case basis for each client, but what runs through them all is just their need to be loved and their need to be wanted, and they will risk that for anything, no matter how unsavoury these people are. … Part of our job with all of our clients, and this is male and female, is how we build that self-worth, how we use praise and positive reinforcement, making sure that no matter what they do, there is success in everything, to build that self-esteem, (which) will then hopefully also build that self-worth. That being said, sometimes the self-worth of our kids … is that … it takes more than … praise and nice words sometimes to fix what’s happened. And our kids are taught from a really young age attention—positive or negative, it’s still attention, so sometimes that’s one of the hardest things … to really … move on from."

‘It takes more than praise and nice words sometimes to fix what’s happened’

**HEALTH**

Young people leaving care are more likely to have health problems than those in the general population. In South Australia, the demographic profile of young people accessing post-care services indicates that, compared to the general population, nearly two-thirds meet the criterion of psychologically distressed. A 2010 investigation of 77 care leavers aged between 18 and 25 concluded that 53 per cent had a problem with substance abuse. These issues are frequently related, and some young people may consume substances as a way of dealing with psychological issues. This in turn contributes to the development of antisocial behaviour.

With health services delivered separately for adults and children, and not well integrated, care leavers can find the journey to adulthood complex and difficult to negotiate.

**INTER-GENERATIONAL CHILD PROTECTION ISSUES**

Young people who leave care are significantly more likely to become parents at a younger age. Unfortunately, for some care leavers, a history of trauma and unstable or poor quality out-of-home care compromises their parenting capacity.

A survey conducted by Relationships Australia Post Care Support Services in South Australia found that nearly half of a 40-parent sample reported facing significant impairment in this regard.

Young people who have left care are also far more likely to have children who are placed in out-of-home care. Helping young people to transition successfully out of care can circumvent the inter-generational nature of child protection issues. Preparing young people for their future parenting role can act as a form of early intervention to protect future generations of children from risk of harm.

As one witness observed:

*It should never be assumed that [children with a history of out-of-home care] … know how to make good and healthy choices about when they want to be parents, about what they need to provide for their children, about how many children they can care for at the one time, and there are such simple steps that can be taken to support children under guardianship so that they can make good choices about their own health and their own circumstances that will lead to better outcomes for their children.*

**SMOOTH TRANSITIONS MAKE SOCIAL AND ECONOMIC SENSE**

A holistic and accessible system of support for young people transitioning out of care has the potential to interrupt patterns of disadvantage and help young people develop the foundation for greater wellbeing. In the 2009 CREATE Report Card, *Transitioning from care: Tracking progress*, Dr Joseph McDowall observed:

*Many acute issues must be addressed within the system; but it is effectively the young people in care transition to become valued and productive members of the community that is the benchmark of success … For far too long young people transitioning from care have been ‘invisible’, largely absorbed into the disadvantaged sector of the nation. While they may wish to be treated ‘like everybody else’, they should occupy a special place in the collective mind of their ‘corporate parents’ who need to be sure that their young people have realised their maximum potential as human beings.*
SOCIAL CONSIDERATIONS

Individualised, aspirational transitions from care empower young people to move into adulthood on their own terms and in a manner that allows them to best take advantage of their individual skills and talents.

Care leavers are not a homogenous group. A 2008 study grouped care leavers into three clusters, each of which required a different type and amount of support. The ‘moving on’ young people welcomed the challenge and made effective use of help they had been offered. The ‘survivors’ tended to include younger care leavers who had experienced disrupted placements and higher levels of homelessness and unemployment after exiting care; they benefited from specialist caseworkers and mentors. The most disadvantaged group, the ‘strugglers’, required the most post-care support, despite the fact that they seemed to benefit the least from it.26

Transition planning should be flexible enough to cater for individual needs and circumstances. A successful transition for some young people will be measured by the achievement of stable housing, an income, and reliable social supports which enable them to engage effectively in their community. For others, a successful transition will be measured not only by having basic needs met, but by having opportunities provided for engagement in higher education, and the private housing and job market.

Researchers have observed that many care leavers display remarkable resilience in recovering from trauma.27 The quality of the care provided in out-of-home environments correlates closely with the development of this resilience. In particular, placements that promote secure attachment, provide good educational experiences, advance living skills and career plans, are supportive of social experiences and nurture a positive identity have been found to be associated with higher levels of resilience.28

Stereotyping care leavers around concepts of disadvantage, unemployment and poor levels of education has a tendency to lead to a one-size-fits-all policy which overlooks the potential of care leavers who do not fit this model. When low expectations are held of them, and reduced outcomes are considered acceptable, care leavers come to behave as disadvantaged because they believe that to be inevitable.29

A study conducted of care leavers who had gone on to higher education, or aspired to do so, noted a series of common themes, which included30:

• the existence of a person to support educational aspirations, and to overcome the pessimism of others; and
• preparation in transitioning from care, including financial support for higher education.

Faced with such a diverse population, it is incumbent on the state to ensure that care leavers have a transition out of care that is individualised and aspirational, and which gives each young person their best chance of fulfilling their life potential.

ECONOMIC CONSIDERATIONS

There is a powerful economic argument for investing in a system that provides support to young people so that they may successfully transition out of care. A study conducted in 2006 tracked the pathways of 1150 young people who left the child protection system in Australia between 2003 and 2004 and assessed the extent of their service usage over time. The research found that there are substantial potential cost savings to government if care leavers are helped to achieve more aspirational pathways.31

The research assigned care leavers to one of five pathways, according to their level of usage of eight service systems (alcohol and other drugs; employment support; family support; income support; health; housing support; justice; and mental health services). Those in Level 1 had similar service usage to the general population, while those in Level 5 had very high and complex patterns of service usage, including frequent use of mental health crisis services and hospitals, drug detoxification, income support, terms of incarceration and long-term income support.

The report estimated that 55 per cent of care leavers fell into high cost service usage pathways and that the children of people leaving care were also likely to end up on that pathway. By tracking the combined cohort of young care leavers, the research estimated the net cost to government over the course of 44 years from age 16 to 60 to be $1.9 billion, or $43 million per year. The net cost was calculated as the gap between the estimated costs of a cohort in the general community and this cohort.32

The analysis suggested that even if no more than 10 per cent of individual care leavers in each service usage level were supported so they could move to the next less intensive level, gross savings in the order of $128 million over the course of 44 years could be realised. Even a conservative level of additional support, aimed at improving the pathway of a modest proportion of care leavers, has the potential, over time, to result in substantial savings, not to mention the improvement to the lives of those individuals.
Jodie: A promising student set up to fail

Jodie was under the guardianship of the Minister from the age of 14. She lived initially with friends of her family, but that arrangement broke down when she was 16. At the age of 16, Jodie was placed in an independent living program run by a non-government organisation which provided supervision and support. She was attending high school and had goals to pursue higher education.

One week into her Year 12 studies, Jodie was informed that she would be moving to an independent living unit. The prospect of living on her own frightened her. She told the Commission:

On the day that they told me that I had to move out, I was hysterical … what 17 year-old girl wants to live on their own, how am I supposed to afford it. I’m starting Year 12, how the hell do you think I’m going to get my good grades, and then I kept saying, ‘This is why everyone in Families SA fails’.

The unit was located in a troublesome neighbourhood and was not close to Jodie’s high school. Jodie was required to cover rent and all living expenses, including the internet which was necessary for her studies, from a Centrelink youth allowance. Jodie said that it was not uncommon for young people to live by candlelight or to go without food because they could not make ends meet on their youth allowance. However, Jodie managed to find a part-time job and saved the money to buy herself a car to drive to school.

As a result of the pressures of independent living, she cut back her studies to four days a week. Families SA offered no additional assistance such as tutoring to help her complete Year 12. She obtained a laptop computer through the non-government organisation which provided supervision and support. After multiple requests to Families SA brought no action.

Jodie told the Commission that the decision to move her into independent living had:

set me back in Year 12, having to worry about paying bills, having food to eat, having a car to get to school, paying insurance, and still achieving high grades in school. This is nearly impossible … I feel I have not been prepared and they have failed to do their job completely.

Jodie reported that it took her over 12 months to obtain her birth certificate from Families SA, when she needed it to apply for a tax file number. During a Year 12 retreat run by her high school, parents wrote letters of encouragement to their children; all Jodie received was a very short letter from a social worker.

Despite these barriers Jodie displayed remarkable resilience and ambition. She told the Commission in evidence that she had not abandoned her dream of going on to higher education and she had a clear path in mind of how she would achieve this. She knew this would become even more difficult once Families SA withdrew its support altogether.

After moving into her independent living unit, Jodie was told that Families SA intended to close her case on her 18th birthday, which fell in the middle of her Year 12 exams. Jodie negotiated with Families SA to keep her case open until after her graduation from Year 12, but no support, including financial support, would be provided after that time. Jodie enquired about the possibility of leasing the second bedroom of another young person’s independent living unit for a short period after her lease ended, hoping this arrangement would provide her with short-term accommodation and would assist the other young person financially. However, she was told that this was against policy.

Jodie told the Commission she felt let down by Families SA. She said:

The day [my 18th birthday] hits I have nowhere to live as they have said I will no longer ‘need’ their help. I feel that they have failed me and really set me up to fail. I will do the best I can; however I have no financial, physical, emotional help at all from any adult figure … I feel I am just a number on the system who gets ticked off and then they move on to the next number.

I really believe this is why the per cent of children under the guardianship of the Minister who do not achieve … in life is significantly high, as the support they received while in care was very minimal. Social workers only ‘care’ between the hours of nine to five.

Turning 18 is meant to be a highlight of your life and be an exciting time … however for me it is not that at all. I am worried about what is next for me, where I go next, how I continue to live and pay for everything.

The Commission has recently learnt that Jodie managed to gain a scholarship to help fund her further studies.

Given Jodie’s personal drive and motivation, adults around her might have assumed her capable of handling the challenges of independent living. But the resources of the state should stretch beyond basic assistance. Care leavers who are high achievers and have aspirational goals should not be neglected, but should be celebrated and given help to achieve their goals.

Jodie needed a transition-from-care plan that provided stability and support during her critical senior school years. She needed ongoing financial assistance after she turned 18 to help her find accommodation and meet the costs of tertiary education. Jodie would have benefited from tutoring to help her fulfil her educational goals as well as mentoring and guidance appropriate to her individual needs.
MODELS OF TRANSITION CARE

THE NATIONAL APPROACH

The importance of transition planning has been recognised through a priority project established under the National Framework for Protecting Australia’s Children.33 Transitioning from out-of-home care to independence: A nationally consistent approach to planning (the National Approach) was published in 2011.34 Also published in 2011 were the National Standards for Out of Home Care, which refer to standards for young people transitioning out of care. Standard 13 requires that these young people have a transition-from-care plan from the age of 15 that details the level of support to be provided after leaving care.35 Performance against Standard 13 is measured by:

- the proportion of young people aged 15 and over who have a current leaving care plan; and
- the proportion of young people who, at the time of leaving out-of-home care, report they are receiving adequate assistance to prepare for adult life.

The National Approach to transitioning from care seeks to produce broad consistency across the states and territories as to how the transition planning is achieved, as well as promote stronger links and better coordination of government and non-government services. The vision for the National Approach is described as follows:

All young people transitioning from out-of-home care to independence receive support from governments, non-government organisations, family members and/or carers, business and the community to experience an effective transition and reach their full potential for social and economic participation.36

The National Approach offers a holistic perspective, requiring the following needs to be considered37:

- housing/accommodation;
- health (physical, emotional—including self-esteem, mental, sexual and dental);
- education and training, employment or other suitable activity;
- financial security;
- social relationships and support networks;
- life (and after care) skills; and
- legal matters.

It endorses the inclusion of all relevant participants in planning, including the young person, their caseworker, foster parents, family members, other agencies and significant others in the young person’s life. It sets out a three-phase approach which assumes a continuity of effort from the preparation phase through transition to after care, with the key goals for each phase building on and consolidating work from the previous one.

At each phase essential elements are identified which have their origins in the evidence base relating to transition planning.38

Preparation

- A transition plan is in place that meets the needs of both the young person and the agency.
- The young person knows their entitlements and how to access them.
- Personalised support is in place.
- Practical support is in place.
- General and preventative health needs are being addressed.

Transition

- The transition plan is implemented, is being overseen by a key person and is modified when required.
- The young person is accessing specialist and mainstream services for ongoing assistance.
- Personalised support is in place and information is being shared across agencies as appropriate.
- Practical support is in place and is ongoing as needed.
- Ongoing needs are being addressed to support participation, relationship building and stability.

After-care independence

- Independent living skills are consolidated.
- Support is ongoing.
- The individual is participating socially and/or economically.

The National Approach provides a best practice standard from which states and territories are asked to develop their own service models. It is expected that adherence to a broad, evidence-based approach will result in an improvement to the outcomes of care leavers across the nation.

INTERSTATE APPROACHES

In Australia, post-care support is legislated in New South Wales, Victoria, the Northern Territory and Western Australia.

In New South Wales the Children and Young Person’s (Care and Protection) Act 1998 mandated that the Minister provide or arrange for assistance for young people in care and care leavers between the ages of 15 and 25. The Minister is to provide such assistance as he or she considers necessary, having regard to their safety, welfare and wellbeing.39
Assistance includes:

- the provision of information about available resources and services;
- based on an assessment of need, financial support and help with finding accommodation, setting up house, pursuing education and training, securing employment, and accessing legal advice and health services; and
- counselling and support.

Ministerial guidelines for the provision of assistance after leaving care were published in 2008. They state that a leaving-care plan should be informed by a needs assessment, and that designated agencies must be involved in the transition planning as well as offer follow-up support at regular intervals in the years after the young person’s exit from care. The guidelines also recommend extra assistance based on an assessment of the person’s needs and consideration of whether they are at risk of not successfully transitioning to independent living. The young person should where practicable be referred to an existing service which may include a funded specialist after-care service.

In Victoria, section 16(1)(g) of the Children, Youth and Families Act 2005 provides that the secretary of the relevant department has a responsibility to help young people under the age of 21 make the transition to independent living. However, this is a non-enforceable obligation on the relevant department to prepare for transition to adulthood. There is no obligation imposed on the Minister to continue supporting young people past the age of 18, nor is there any prescriptive explanation of what this assistance might entail. At present, the legislation does not adequately reflect the attention that should be given to this critical aspect of a young person’s journey from care.
Neurological research indicates that achievement of the legal age of majority does not coincide with complete maturation of the frontal lobes of the brain—the part of the brain responsible for high-level decision making and reasoning. Rather, these structures appear to fully mature in early adulthood, after the age of 20. Research also suggests self-regulatory competence is not fully developed until early adulthood. The functional modern family structure implicitly accounts for this, and is usually flexible enough to respond to the various rates at which a young person will be ready to take on the responsibilities of adulthood.

In the current social environment, it is a rare family that requires a child to leave home and relinquish family support at the age of 18. Educationally, socially and financially, many young people benefit from receiving the support and guidance offered by caring adults well beyond this age.

The lack of a prescriptive obligation on the Minister to provide support past the age of 18 stands in stark contrast to the approach taken in modern families. The current legislative regime remains a ‘surgical cut at age 18’, which occurs irrespective of the young person’s readiness for independence. Research conducted in South Australia found that almost all service providers interviewed believed that care leavers were not developmentally mature enough to independently negotiate the adult world without the support of a caseworker. Many considered it unreasonable that these young people were expected to face these challenges much earlier and more abruptly than their peers. Comments in the submissions received by the Commission reflected similar concerns:

‘Young adult care leavers are often without any form of safety net to soften their inevitable falls and guide them through the challenges that independence presents’

Data from Families SA indicates that 269 of the 301 young people who transitioned from care in the two years between 1 January 2013 and 31 December 2014 had their files kept open for a period of 30 or more days following the expiry of their court order. Of this cohort, approximately 10 per cent had cases that remained open with Families SA as at 23 April 2015. These relatively low figures are not surprising given the Commission found that the Agency has a very limited capacity to deliver meaningful post-care services to young people. In the absence of a legislative mandate, any work after the young person turns 18 is ad hoc and is at the discretion of the individual caseworker and the district centre manager who must approve it. The Commission was advised that while there was evidence of local managers being prepared to extend services to young people beyond 18, executive level approval was infrequently given, meaning very few young people were supported beyond 18 for more than a short three-month period.

TRANSITION PLANNING POLICY

The Standards of Alternative Care in South Australia recognise the need for transition planning. Core Standard 7 of that document requires that transition planning for young people leaving care begin when they are 15 years of age and ‘gain clarity and intensity’ as the young person approaches 18 (or the time of their planned exit from care). The Redesign process in Families SA has resulted in a number of policy changes to the way in which young people transitioning out of care are being supported. It has also changed the way in which cases are managed in local offices.

Transitioning from care in South Australia is governed by the Transition from Care Service Model and the Transition from Care Work Instruction. The service model records its objectives as follows:

- to provide case management services to young people who meet the eligibility criteria;
- to maximise young people’s capacity to live independently in the community;
- to assist young people to obtain and retain accommodation; and
- to improve social, emotional and economic outcomes for young people leaving care.

It records desired outcomes as follows:

- Young people experience a well-planned gradual transition to independence.
- Young people are adequately prepared with the full range of practical skills they need to live independently.
- Young people are better informed of community services/supports available post care.
- Young people transition from care to stable accommodation and are able to meet the obligations of a tenancy agreement.
Neither the service model nor the work instruction make any reference to the National Approach, nor do either appear to be modelled according to its underlying principles, which endorse a holistic approach to transition planning with continuous assessment of the young person, identifying strengths and goals in each of their life domains. The worker is required to refer back at all times to the life domains, including health, education, training or employment, and identity and culture. This ensures that the focus is wider than simply the development of practical skills, and challenges young people to consider a more aspirational trajectory.

This wider focus is missing from the service model and work instruction currently operating in Families SA. The service model is focused on the attainment of practical goals. It makes no reference to the three phases of transitioning (planning, transition and after-care) nor does it consider how those three phases might be translated into practical case management. In order to improve the trajectory for care leavers, a service model should be developed that is consistent with the National Approach and incorporates its principles of best practice.

The service model also requires that on reaching the age of 15, all young people with a complexity assessment rating (CAT) of 1 or 2 will have their case management transferred from a case manager (generally a qualified social worker) to a transition-from-care youth worker. This model replaces the previous one where the child’s existing caseworker would be responsible for supporting the child’s transition.

ROLE OF TRANSITION-FROM-CARE YOUTH WORKERS

The service model requires the following:

- Adequately qualified and trained staff will provide a Transition from Care service that supports the achievement of the objectives and outcomes as stated above. All staff will be required to have a qualification (i.e. Certificate III, IV, Diploma, Advanced Diploma(s) or Degree) in a relevant field.74

Transition-from-care youth workers are employed at an OPS3 classification. Appointment to the position does not require any minimum qualifications.75 The OPS3 classification is remunerated at an annual salary of between $56,330 and $60,314. By comparison, a base level social worker employed at the AHP1 classification would be remunerated at an annual salary of between $57,127 and $70,111.76 The employment of OPS3 youth workers in a case management role is inconsistent with the requirements of the service model.

The policy decision to employ OPS3 workers to case manage young people at a critical phase in their care journey is short-sighted. Built into the process is a change of caseworker at a critical time for the young person. For many, this will be another in a long series of changes that mar their out-of-home experience. Continuity of relationships throughout a child or young person’s care journey is frequently ruptured by workers moving on, by young people changing placements to different geographical areas and by other events which may be unavoidable. Good service planning works to minimise those changes as much as possible.

As different circumstances arise, an adolescent may move rapidly from being a low complexity case to one of higher complexity, due to complications such as drug taking, or other risky behaviours.77 This highlights the dangers of allocating case management responsibilities to less qualified workers on the basis that their skills will be adequate to manage cases of lower complexity. The current service model for transitioning from care places young people entirely in the hands of workers who lack the level of skill and knowledge that is acknowledged in the Allied Health Professional (AHP) classification, which requires social work qualifications as a minimum standard. This strategy gives little weight to the importance of continuity of case management relationships for young people, particularly at a very difficult and potentially complex time in their lives.

The transfer of the whole case management responsibility to transition-from-care youth workers at the age of 15 also sends a potentially frightening message to a young person: the focus of work will now be on moving them out of care, rather than incorporating the transition service as an add-on to standard case management relationships.72

INTER-AGENCY COLLABORATION

The fragmented nature of services for young people leaving care was a consistent theme throughout the Commission’s investigations. In South Australia services appear to be siloed, and impeded by compartmentalisation.78 The lack of integration, particularly between children and adult health care services, makes the transition difficult for care leavers with mental health problems or disabilities. There is a disparity between the services offered by the Child and Adolescent Mental Health Service (CAMHS) and the services available in the adult mental health system. The Commission also heard that attempts are occasionally made to coordinate or share the management of young people who might have a combination of problems. A young person may be deemed eligible for only one service based on an assessment of that being the more pressing problem, when in fact a wrap-around approach from a combination of service providers would be more useful.79
A collaborative approach would help provide care leavers with efficient and effective support.75 A more integrated system for transitioning from care should be developed which allows for better service coordination and information sharing among government agencies and the non-government sector. While it is beyond the Commission’s terms of reference to make recommendations regarding the manner in which the state’s health care services are coordinated, it is noted that there should be a greater focus on the needs of the individual over time so that the same agency can provide a continuous service from adolescence into adulthood.76

CASE PLANNING

In line with the National Standards, the Transition from Care Service Model requires that planning for a young person’s transition commence at the age of 15.77 As noted above, a key indicator against which performance is measured is the proportion of young people in out-of-home care aged 15 and above who have a current leaving care plan.

Table 14.1 sets out the percentages of young people in the care of Families SA who were entitled to transition planning according to the National Standards and who had a current transition-from-care plan for the relevant financial year:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ENTITLED TO PLANNING</th>
<th>RECEIVED PLANNING</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>611</td>
<td>199</td>
<td>32.6</td>
</tr>
<tr>
<td>2012/13</td>
<td>645</td>
<td>213</td>
<td>33.0</td>
</tr>
<tr>
<td>2013/14</td>
<td>617</td>
<td>206</td>
<td>33.4</td>
</tr>
</tbody>
</table>

Source: Data from Department for Education and Child Development.

The fact that fewer than one-third of young people who were entitled to transition planning actually received that service demonstrates that insufficient attention is being paid to it.

Young people more generally report receiving limited career planning and little information about what training and employment options may be available to them.79 All too frequently, young people approach the age of 18 without a clear understanding of how they will access adult services and accommodation.79

The Commission examined one young person’s transition from care in Vol. 2, Case Study 3: ‘Hannah’. It found that Hannah’s planning lacked acknowledgment that ‘independent living’ is a multifaceted concept, and its attainment requires more than securing a house and an income and developing the skills to manage each of those things. There was limited consideration of Hannah’s goals, and the skills she would need to achieve those goals.

Hannah was not provided with adequate opportunities to participate in case planning, or identify the goals of the transition plan. There was little evidence that the case planning by Families SA sought input from other significant adults or service providers in Hannah’s life, including the independent living program in which she was involved. Hannah’s voice was also excluded from consideration of planning for her future. Hannah’s experience highlighted the need to prioritise the engagement of young people in planning their future. Not only does such an approach reflect best practice, but it also reflects the important expectation that young people will start to take responsibility for their own life paths.

Standard 4.1 of the Standards of Alternative Care require that a young person be an active participant in all decision making that relates to them.80 This is reflected in the Transition from Care Work Instruction which requires that case management engage the young person in developing their plan and working towards achieving their goals.81 The case study of Hannah revealed that in practice she was not consulted sufficiently about important decisions that affected her transition.

The lack of planning for young people’s transition from care is unacceptable: it is an area in which South Australia should work to meet the National Standards. It is hoped that Families SA’s recent introduction of a transition-from-care plan template and a checklist of actions to be completed prior to a young person’s exit from care will lead to an improvement in this area. However, a more fundamental shift is required—from the current case management approach which is reactive, piecemeal and crisis focused, towards one that is forward thinking, holistic and person-centred.

LIFE SKILLS

Before the changes imposed by Redesign, teams of youth workers specialising in supporting young people transitioning out of care delivered life skill development programs in money management, food management, safety in the home, tenancy training and accessing community resources.82 Under the new service model these programs are no longer operational.
The Commission heard evidence that residential care units and commercial care settings are particularly poor at equipping young people with the skills required for self-sufficiency. A former youth worker in a residential care facility told the Commission that a culture shift in combination with a change to service principles has led to young people not being encouraged to take responsibility for themselves:

“When it came to going to school, going to medical appointments, keeping money aside so you’ve got bus tickets to get around—all of that changed ... they weren’t being set up with the right skills because we were just doing everything for them, and there was no accountability if they didn’t do anything for themselves. So they go from literally one extreme to the other, of being in a unit with fulltime staff, there’s always food there, there’s always a warm bed; everything is there for them ... to moving into a house on their own with no budgeting skills, don’t know how to cook a meal, don’t know how to wash their clothes, don’t know how to keep the room tidy, and then they’re expected to just live there with a worker that will come and see them every two to three times a week.”

One residential care unit supervisor spoke about the limited capacity of residential care facilities to cater for young people developing skills such as driving. There was no clearly identified process about how lessons would be funded, and who would be responsible for taking the young person out to achieve the necessary driving hours. The Commission also heard evidence about commercial care environments where young people approaching their transition from care are being cared for around the clock with no consideration given to the need to develop their life skills.

There is scope for life skills programs to be outsourced to the non-government sector. Existing programs run by the CREATE Foundation as well as several independent living programs are discussed below. The key role for the specialist transition-from-care youth workers in that case would be to ensure that young people are engaged in the program that is best suited to their overall goals.

In addition to formalised programs, however, a young person’s progress should be tracked to ensure that they are being helped to develop the necessary life skills in their out-of-home care environment. For many young people in stable foster or kinship care environments, this may involve the transition-from-care youth worker helping the main carer with a range of tools for modelling independent living skills.

FINANCIAL ASSISTANCE
The Families SA Financial Counselling and Support Program has the capacity to provide a range of financial support services for young people over the age of 15 who are transitioning from care or moving into independent living and for adults who have spent a period of six months or more in care.

In practice, this generally involves helping young people to set up a bank account and tax file number, and apply for Centrelink payments and any transition to independent living grants that may be available. It might also involve paying for driving lessons for the young person. While there is potential for financial counsellors to work with young people to develop their financial planning and budgeting skills, this is an ad hoc service which relies on a referral being made by the young person’s caseworker.

Post-care financial services are provided on the basis of self-referrals and vary depending on individual needs, but may include help managing utilities bills, for instance.

Young people moving from care to independent living are eligible for adolescent community brokerage money which is funded from the Commonwealth/State National Affordable Housing Agreement. The payment is not available for young people who remain in home-based care at the time of their exit. Brokerage is paid to a maximum of $5000 for purchasing furniture and household items. Although it is intended that the funding be “innovative and flexible in meeting the specific and individual needs of the young person” there are restrictions on what can and cannot be bought. An itemised account including quotes for goods to be purchased must be provided to Families SA. A young person cannot use brokerage funds to purchase furniture informally, although second-hand goods can be purchased as long as the vendor has an ABN.

The transition to independent living allowance (TILA) is an allowance of up to $1500 funded by the federal government, which may be used in a variety of ways. The TILA is available for young people aged between 15 and 25 and can be applied for in addition to any other assistance that may be available from other sources.

Carer subsidy payments made by Families SA cease when a young person turns 18, making many foster parents unable to continue looking after young people due to additional financial pressures. To address this issue, the Layton Review recommended that funds be made available to extend care payments to foster families if the young person remains in their care.

In 2006, Families SA introduced a limited subsidy for carers when a young person is over the age of 18 and still engaged in secondary education. It does not continue if the young person goes on to tertiary education, nor is it sufficiently flexible to support the variety of other
to recognise that frequently these young people: considered good practice for adulthood, it is necessary including TAFE and apprenticeship-based qualifications. are pursuing post-high school education or training, to help them continue to care for young people who extension of payments to foster and kinship carers assistance provided should include, in appropriate cases, should be articulated in ministerial guidelines. The NSW model, the specific details of the assistance training and employment; and access to legal advice, and other assistance to obtain housing, education, financial grants and assistance for care leavers); financial and other assistance to obtain housing, education, living expenses, and education and training costs. Some improvements in service accessibility for care leavers may also be accomplished by reinvigorating Rapid Response prioritisation policies, and extending their application specifically to people leaving care up to the age of 25.14

The current service model and work instruction do not give sufficient emphasis to the best practice elements clearly set out in the National Approach. The service model and process documents should adopt a more sophisticated approach to transition planning, consistent with the National Approach. Specific reference should be given to how to support young people who wish to engage in post-high school education and training.

Transition-from-care youth workers should not be used as case managers. Instead, they should be developed as an add-on service, available to support a young person’s transition from care throughout the planning, transition and after-care independence phases. The service should be offered to young people for whom continuous support by Families SA is likely to be appropriate. This would enable caseworkers to access the specialised knowledge and community networks of the transition from care youth workers, while maintaining the high standard of case management that is expected of tertiary qualified case workers. Young people may also be encouraged to engage with services if they can turn to the youth workers for additional support and consultation:

Often when you’re doing casework there’s conflict between the caseworker and our young people from time to time. The ... major role of a youth worker should be engagement with young people and, if they’re not doing the case management, it’s a lot easier to engage with young people, even at that complex level, over a period of time starting at 15.101

So, depending on the young person, that could be as simple as initially starting more of a mentor role, really, until you’ve engaged, and then start setting goals with that young person towards independence.102

All young people transitioning from care should receive sufficient help from the Financial Counselling and Support Service to enable them to develop their financial management skills and take advantage of any financial support to which they are entitled. Following the lead of other jurisdictions, the Minister’s capacity to provide financial assistance after a young person leaves care should be expanded to include contributions towards accommodation, living expenses, and education and training costs.

Financial assistance available for young people transitioning from care lacks a cohesive delivery strategy. The benefits of the Financial Counselling and Support Program are gained only by young people whose caseworkers proactively seek it out. By contrast, jurisdictions such as New South Wales, Western Australia and the Northern Territory have legislated the responsibility of the Minister to provide broad ranging financial assistance to care leavers. The CREATE Foundation’s Ms Scalzi advised the Commission that in this state it remains the case that many care leavers are simply not aware of their entitlements under grants such as TILA and the Dame Roma Mitchell Fund.97

Once a young person is moved into an independent living arrangement, they are expected to manage their finances with minimal support, including negotiating complex systems such as Centrelink.98 While this approach may be considered good practice for adulthood, it is necessary to recognise that frequently these young people:

come from a trauma background ... and quite often there can be intellectual delays, so ... they wouldn’t have the mental capacity to be able to deal with someone at Centrelink. And they haven’t got the resources to be able to provide the information Centrelink want at the time, like tax file numbers, and things like that, at that age.99

A NEW APPROACH TO SUPPORTING CARE LEAVERS

The Commission recommends that the Children’s Protection Act be amended to impose a specific obligation on the Minister to provide or arrange assistance to care leavers up to the age of 25 years. Such assistance should specifically include the provision of information about services and resources (especially financial grants and assistance for care leavers); financial and other assistance to obtain housing, education, training and employment; and access to legal advice, health services, counselling and support. Consistent with the NSW model, the specific details of the assistance should be articulated in ministerial guidelines. The assistance provided should include, in appropriate cases, extension of payments to foster and kinship carers to help them continue to care for young people who are pursuing post-high school education or training, including TAFE and apprenticeship-based qualifications.

legitimate pathways that young people may wish to pursue, such as vocational traineeships or entry to the job market. Importantly, the subsidy ceases in the case of young people who are arguably the most in need of ongoing support and stability—those who are disengaged from education and at risk of choosing less desirable pathways.
SUPPORT SERVICES FOR CARE LEAVERS

There are a number of non-government agencies which provide support to young people leaving care, and which have contractual relationships with Families SA.

THE CREATE FOUNDATION

The CREATE Foundation is the national peak consumer body representing children and young people with out-of-home care experiences. In South Australia it is funded by Families SA to provide a number of programs and services that support young people transitioning from care.

The CREATE Your Future program delivers a series of practical workshops to support young people aged 15 to 25 across seven life domains: education, training and employment; identity; relationships; health and wellbeing; finance; housing; and life skills. The program aims to provide young people with ‘that stuff you miss around the kitchen table’ as a consequence of growing up in care. The workshops are held alongside recreational activities, including camps, to encourage attendance. Young people can attend as many of the modules as they like, and can consolidate their skills through advanced sessions.

The program includes an annual scheme providing grants of up to $3000 to members of clubCREATE for items such as laptops, driving lessons, educational resources, and accommodation and living expenses.

The running of such programs is not without challenges. Running camps in particular is a costly exercise which is encumbered by the difficulty of finding suitable volunteers to assist. The ability to offer such programs to children and young people living in rural regions is especially limited by budgetary constraints. These programs also have a limited capacity to cater for young people with high or complex needs. Group-based activities that bring together young people who have complex trauma and abuse histories can be challenging and require a high degree of risk management.

Despite their limitations, programs such as CREATE Your Future offer young people ‘an opportunity to connect ... with other young people with the care experience, make them feel that they’re not alone, and connects them with their community’. Importantly, these programs are not restricted to those under the age of 18, meaning that care leavers can continue to benefit from these programs after transitioning to independence. Additional funding to allow programs to cater for young people with a range of needs, through one-on-one sessions where necessary, would ensure that all young people leaving care are properly equipped with the life skills required for independence.

Research by the CREATE Foundation has found that information and resources about transitioning from care are fragmented and difficult to navigate. The CREATE Go Your Own Way kit is a recently developed resource for young people aged 15 and above who are starting to plan their transition to independence. The kit includes information across the seven life domains covered in the CREATE Your Future program and is supported by a website where young people can find further resources. The kit is currently being piloted in South Australia, with an evaluation under way of 84 kits that were distributed to young people turning 17 in 2014.

CREATE is also interested in developing a smartphone application for care leavers. The relevant department in Queensland has piloted such a tool, and in Victoria care leavers have access to a dedicated leaving care helpline which they can call for social support, for advice or for a referral to local support services. Many children and young people respond to strategies that use social media and technology based tools to keep them informed of available services. Research suggests that the use of smartphone applications has the potential to enhance social networks and ‘give young people an opportunity to engage in their own time and at their own speed, and help resolve distrust in services or organisations’. Innovations of this kind, where supported by an evidence base, should be embraced.

CREATE’s Speak Up program is available to young people aged 14 to 25 who are interested in becoming CREATE young consultants. Participants learn about the care sector, and develop advocacy, leadership and public speaking skills through a three-level training program. As young consultants, they use their stories and experiences to represent CREATE at local, state and national events and forums. Aside from the obvious benefit of giving young people the opportunity to have their voices heard, the program builds participants’ confidence and provides them with skills that will empower them into adulthood.

Ms Scalzi told the Commission of one young person who:

was unaware of CREATE while being in care, but postcare, she was engaged in education at TAFE, and needed to do a community module, and found out about CREATE that way. And since then, she’s done all levels of Speak Up; she’s been to Ministers’ meetings; she’s been to CREATE conferences. She’s applied for grants. She’s kind of cofacilitated on camps. She’s highly engaged—it’s given her a purpose.

In South Australia membership of clubCREATE is not automatic on a child or young person’s entry into care. The organisation is obliged to spend its limited resources on locating and attempting to engage children and young people. Reaching out to care leavers who may be interested in participating in programs such as Speak Up...
is particularly challenging as neither Families SA nor the post-care services provider, Relationships Australia, are able to share the contact details of young people.

Young people should be signed up to clubCREATE as a matter of course on entering care, with the choice of opting out should they choose. This would ensure that all children and young people in care are made aware of the programs on offer and would free up resources to be utilised where they are needed most.

The CREATE Foundation provides a unique service and has established credibility with young people with an out-of-home care experience. They should be assisted in utilising their funding in the most efficient way. The Commission recommends that the Department reach an administrative arrangement with the CREATE Foundation to provide details of children when they enter care. This arrangement should strictly control the use to which such data can be put, and also require CREATE to provide an easily accessed exit option from membership.

The Commission also recommends funding the development of a smartphone application to provide young people with up to date information about programs and services.

SUPPORTED INDEPENDENT LIVING PROGRAMS

Families SA has contracted with non-government agencies including The Salvation Army, Anglicare and Baptist Care (SA) Inc. for the provision of programs that support young people transitioning from care. These services are generally bundled with independent living accommodation.

Young people are referred to these programs through the Families SA Placement Services Unit. Once a referral is received, program managers meet with the young person and their caseworker to identify whether the young person wishes to engage with the program. They also assess the suitability and readiness of that young person to move towards independent living.

However, it appears that many young people are referred to independent living programs not because they are ready to take that step, but because it is the only viable placement option once home-based care and residential care are no longer suitable for them (see Volume 2, Case Study 3: Hannah).

Each program offers a range of practical supports for young people including, but not limited to:

- developing life skills such as cooking, cleaning, budgeting, shopping or accessing public transport;
- applying for and engaging in education or employment;
- managing and maintaining health;
- developing community and social connections;
- addressing legal issues;
- developing and maintaining positive relationships; and
- learning to access long-term housing options.

As the approach adopted and the capacity to provide support vary somewhat across the programs, each service model is outlined briefly below.

MUGGY’S ACCOMMODATION SERVICES, THE SALVATION ARMY

The Salvation Army runs three Muggy’s programs servicing the north and south metropolitan areas, as well as multiple north-western country locations, which are managed from offices at Port Pirie and Whyalla. Each program has the capacity to work with 20 young people.

Each program leases houses to young people transitioning from care. Some properties are owned by Families SA, some by The Salvation Army and others by Housing SA. A young person can be referred to the program from the age of 15, but they will not usually be allocated a property until they are at least 16 years old, which is when they become eligible for a youth allowance payable through Centrelink. Young people in the Muggy’s program agree to pay for food and $85 a week in rent from that allowance, although the costs of utilities are paid by the program. They are able to furnish the home using brokerage funds available to care leavers, and the goods purchased remain theirs to keep when they leave the program.

Staff are available 24 hours a day at a centrally located office which is also equipped to provide temporary accommodation and intensive support to a young person prior to their transition into a property or during times of crisis.

In order to remain in Muggy’s accommodation, the young person is expected to engage with workers and maintain regular attendance at appointments. These may take place two to three times a week at either the Muggy’s office or, more commonly, at the young person’s home. The appointments are scheduled in accordance with a case plan, renewed every three months, which incorporates goals that the young person, in conjunction with their key workers, wishes to work on based on identified support needs and interests.
YOUTH 180, ANGLICARE

Anglicare’s Youth 180 program offers nine independent living placements throughout metropolitan Adelaide in properties owned by Housing SA. These properties are usually available to young people once they turn 16. While the program does accept referrals of young people older than 16, the fact that participants must transition out of their placement at the age of 18 means that any young person referred after the age of 16 will have less time in which to develop independent living skills in a supported environment. Youth 180 can continue to offer outreach support up to the age of 19.

Young people have an individual care plan which is developed around eight independent living skills domains. The care plan is updated monthly by the youth caseworker following consultation with the young person, their youth carers, their Families SA case manager, and any others who may be involved in the care team.

It is not an essential requirement of the Youth 180 program that young people be in receipt of a youth allowance from Centrelink. However, if they do receive an allowance, a contribution of $40 a week towards rent is expected. Groceries and utilities are covered by the program because these are shared with the youth carers. Youth 180 properties are furnished, although Youth 180 provides the young person with some financial support to decorate the property.

STABILISATION AND TRANSITION SERVICE AND SUPPORTED INDEPENDENT LIVING PROGRAM, BAPTIST CARE SA

Baptist Care SA (Inc.) is contracted to offer two transitioning-from-care services to young people under guardianship.

The Stabilisation and Transition Service (SATS) assists young people from the age of 14 to 18 to build independent living skills in a congregate care environment. The program operates at two properties, one of which accommodates up to four males and a second which accommodates up to six females. The properties are split into units, each with two bedrooms, their own living area and kitchen. The facilities are staffed 24 hours a day by one or two support workers who assist young people with the development of independent living skills. Each young person is assigned a case manager who is tasked with tracking the young person’s progress.

The SATS program is commonly used as a stepping stone to programs such as Muggy’s or Youth 180. Young people may start out in the SATS program at age 14, and after developing their independent living skills in a supported congregate care environment for two years, will transition into one of the independent living programs. The SATS program has limited outreach capacity once a young person has left the program.

The Supported Independent Living Service (SILS) can accommodate up to seven young people aged between 15 and 18. The program is an extension of the SATS program with an added independent living component. There are four properties in Murray Bridge and three in Mount Gambier where young people live independently and receive case management support. A fourth property in Mount Gambier which acts as a stabilisation house, can accommodate up to two young people. The properties are owned by Housing SA but are allocated to Families SA and provided to Baptist Care for use in the SILS program.

Baptist Care has an arrangement whereby Junction Australia, under the supervision of Baptist Care, administers the lease of the independent living unit to a young person. This is intended to separate the support provision role undertaken by Baptist Care from Junction’s tenancy management function, encouraging a more collaborative approach between the young person and Baptist Care. Once a young person is eligible for a Centrelink youth allowance, they are expected pay for their living expenses as well as $50 a week in rent. However, there is a degree of flexibility whereby Baptist Care can instruct Junction Australia not to collect rent for a certain period if, for example, the young person is waiting for their youth allowance to be approved by Centrelink. Similarly, as with the Muggy’s program, young people must furnish their independent living unit using their brokerage funds.

Young people in the SILS program can remain in their independent living unit for as long as their file remains open with Families SA. In practice, this generally means that young people are transitioned out at about the time of their 18th birthday.

A NEED FOR GREATER PROGRAM FLEXIBILITY

Each program offers a slightly different service model, with variations in the level of support offered. The Muggy’s program, for instance, suits young people with a higher level of independence because there is not the live-in support available in some other models. The availability of a variety of service models makes it more likely that a young person will be able to be matched to a program that suits their particular needs. Some programs, however, have been criticised for expecting too much of young people who are trying to live independently for the first time.

Some witnesses believed that some programs had rules that were too rigid for the needs of young people. For example, different programs had different rules about young people sharing accommodation. In some cases, housing together those with complex needs may
be detrimental to their successful transition from care. For some, having their own space is a welcome change from congregate care arrangements. Others, however, may be highly fearful of living alone. Service flexibility is needed to ensure that the varied needs of young people are appropriately met.

The principles of the Muggy’s program require young people to experience the natural consequences of their actions. This means that if a young person consistently fails to meet their rental obligation, or fails to abide by tenancy rules or program expectations, their housing lease will be at risk, and ultimately may be terminated. However, these expectations are balanced with a high level of staff persistence, and a high degree of flexibility in service delivery. As the program operates on a 24-hour staffing roster, appointments are scheduled around young people’s commitments. The fact that appointments are usually held in the young person’s own home is consistent with research suggesting that meeting young people in their own environment can help to facilitate engagement and alleviate levels of discomfort and anxiety.131

Services should be wary of imposing expectations that ignore the underlying trauma history of some young people which may impact on their willingness or capacity to engage, particularly where services operate on traditional appointment structures. As in a modern family, services should be sufficiently flexible to help young people learn from mistakes by not closing the door on assistance and by offering multiple chances for re-engagement.132 The Muggy’s program has a strong commitment to continuity of care, which means that even if a young person loses their tenancy, Muggy’s remains open to working with them towards another tenancy.133

The Youth 180 program uses a trauma focused therapeutic approach that is strengths based.134 This is particularly relevant when working with adolescents, which is often the age at which the complexities of a trauma background become more evident. Youth 180 emphasises relationship building and providing young people with a sense of belonging.135 Ms Jo Press, the Manager of Anglicare’s residential care programs, told the Commission that:

The best opportunities for young people to be able to have the best outcomes they can have … is really primarily not through whether or not they know how to budget or they can wash dishes or they can go grocery shopping. These things are important, I’m not meaning to dismiss them, but it’s more about how they feel a sense of worth and a sense of belonging and how they understand how to have, you know, healthy relationships. So my primary concern in Youth 180 is that it always comes back down to the relationship and maintaining the relationship with the young person over and above all the other things that fit into that. You do those alongside it, but the relationship’s got to be central to everything that you do.137

In line with research highlighting the importance of stability and positive relationships in building resilience, independent living programs should aim to do more than just equip young people with basic life skills. Building relationships with young people needs time and flexibility but requiring young people to transition out of independent living programs at the age of 18 limits the capacity of the programs to develop these links. This becomes particularly problematic when referrals are received after the young person’s sixteenth birthday, and the time available to work together is reduced:

We don’t have as much luxury to nurture them in their homes, because it’s … kind of all business when they come in … later … we do have to try and move them on a little bit quicker.136

The Commission heard of only a few examples where contractual conditions with service providers had been relaxed so they could keep working with young people after the age of 18, when circumstances required continued support. However, there are strong arguments in favour of the state funding independent living programs run by the non-government sector to provide formalised support and accommodation to young people beyond the age of 18.

In accordance with best practice principles, transition to independence should occur at a pace determined by the young person. Extending the support offered by these programs past the age of 18 may remove the pressure to make the initial referral before the young person is ready. It would give programs greater flexibility to work with young people for as long as required to ensure a successful transition.

The non-government sector may be better placed than Families SA to continue working with young people after this age.138 One witness observed:

What I do notice in Youth 180 is that young people in care are jumping at the bit to get themselves out of care once they turn 18. So I think that we would need to think about how we do that. I don’t think that young people want to be stuck in care, or they would consider to be stuck in care, until they are 25. My preference would be that the guardian was able to perhaps step aside at 18, but those services that held a relationship with those young people … could continue to provide services mostly again of an emotional and relational support for that young person up to a much greater age.139
There may also be an advantage in spreading the responsibility and accountability across sectors and services. Positive experiences with non-government services could be used as the vehicle to develop trust and gradually introduce mainstream government services.\(^{141}\)

One of the primary criticisms of the current system is that young people lose relationships they have formed with carers and caseworkers on turning 18, leading to renewed feelings of abandonment and rejection.\(^ {142}\) When relationships constantly change it becomes difficult for consistent plans to be developed. The young person is more likely to lose trust in services and relationships, making them reluctant to seek out services in future. The ability to maintain continuity of care and relationships is all the more important for young people who have difficulty with building trust and relationships in the first place.

A working model exists in New South Wales, where designated agencies that supervised the young person’s last placement must provide follow-up support at regular intervals in the years following their exit from care.\(^ {143}\) Such a model should be considered as an alternative, in appropriate cases, to Families SA’s approach in which a transition-from-care worker extends their supports to a young person beyond the age of 18.

If such a model is to be workable, existing independent living programs would need to expand. Both Youth 180 and the SILS programs have waiting lists for a limited number of placements.\(^ {144}\) Although the Muggy’s program has greater capacity with funding for 20 young people in each of its north, south and country programs, a waiting list still applies. All the programs are limited by the discrete locations in which they operate. Greater investment in such programs is likely to make economic sense. Evidence suggests that these sorts of programs are more cost effective than commercial or residential care.\(^ {145}\)

The Department should review its contractual conditions with independent living programs with a view to developing a more flexible approach to the age of admission and the circumstances in which a young person leaves. Particular consideration should be given to continuing accommodation support for young people who wish to engage in higher education or after high school training.

**HOUSING SA INITIATIVES**

In recognition of the difficulties that care leavers face in securing accommodation, Housing SA has committed, under its Rapid Response–Whole of Government Services policy\(^ {146}\), to provide eligible young people leaving guardianship with timely access to housing advice and assistance.

Where public housing is identified during transition planning as the most suitable option, young people should be given priority allocation, most commonly through the Direct Lease Youth Priority Scheme. This scheme offers short-term housing (typically for a period of two years) to young people aged between 16 and 25 who have had difficulties accessing other accommodation.

Despite the Rapid Response policy, securing suitable housing remains one of the biggest challenges for young people transitioning from care.\(^ {147}\) The waiting time for an allocation can be so long that referrals must be put in to Housing SA around a young person’s sixteenth birthday.\(^ {148}\) Too often housing and accommodation options are not explored early enough, resulting in limited housing options at the point of transition. This places increased pressure on Housing SA and creates a high level of anxiety in young people about where they are going to live.\(^ {149}\) The shortage in public housing also places pressure on Families SA to move young people as soon as they are allocated a property, irrespective of the readiness of the young person to make that move.\(^ {150}\)

Inter-agency collaboration is not always as effective as it should be. Referrals provided by Families SA to Housing SA can lack critical background information. This means that Housing SA is unable to fully assess risk or put in place appropriate supports for young people moving into public housing.\(^ {151}\) There has also been a lack of active support from Families SA once a young person moves to a Housing SA property. The manager of the Southern Region of Housing SA, Danielle Bament, told the Commission that a lack of support can result in young people getting ‘into trouble with their tenancies early on, whether it’s debt, or disruption, or just putting their tenancies at risk’.\(^ {152}\)

Housing SA data showed that, as at 30 June 2014, 20.3 per cent of active public housing tenancies in South Australia contained at least one occupant who was currently, or had previously been, under the guardianship of the Minister.\(^ {153}\) Once in the public housing system, a large proportion of young people become entrenched and go on to some other form of public housing at the end of their direct lease.\(^ {154}\) Young people who transition from care can face challenges in breaking this pattern.\(^ {155}\)

Public housing is not always the best option for vulnerable young people exiting guardianship: it often groups together in one area people with a variety of complex needs\(^ {156}\) and it is often located in low-income, high unemployment areas.\(^ {157}\)
Public housing lease conditions, which permit only one leaseholder, also restrict young people from entering share housing arrangements. Although tenants can apply to have another person live with them, they retain responsibility for maintaining the tenancy. This can be difficult for young people to manage if the person with whom they are sharing causes problems or disruptions.\textsuperscript{159} Ms Bament said:

A lot of the tenancies in public housing among young people were going badly because ... they wanted to be more social. They reported to [Housing SA] and Families SA they don't like living by themselves, it's the first time they've ever lived by themselves, so they have friends around, and get into a bit of trouble.\textsuperscript{155}

Young people seeking to enter the private rental market face a number of barriers including a lack of a rental history, and most pertinently, housing affordability.\textsuperscript{156} An analysis conducted by Housing SA found that there were 'virtually no opportunities to live independently in private housing' for young people on a Centrelink income.\textsuperscript{157}

In light of the significant housing issues that continue to confront young people leaving care, Housing SA has trialled a series of initiatives in the southern Adelaide region to find ways to better support them. A new assessment form to accompany the referral to Housing SA has been developed to gather more detailed information about the young person's needs, including risk factors and what supports exist or are needed.

The southern region of Housing SA has also been trialling an approach in which young people who have a long-term chronic condition that prevents them from accessing or maintaining other forms of housing are offered a Category 1 lease as opposed to a direct lease when a property becomes available.\textsuperscript{152} The advantage of a Category 1 lease is that it is a long-term lease which extends for a period of five to ten years, potentially providing greater stability to young people who are unlikely to be able to access other options.

The Commission understands that Housing SA is intending to roll out the initiatives trialled in the southern region across the whole state in the coming months. A memorandum of understanding\textsuperscript{161} and an updated operational protocol\textsuperscript{162} are being finalised to set out agreed agency roles and responsibilities.

The Southern Region Housing SA office, in collaboration with the Southern Guardianship hub of Families SA, has also been developing a model that provides more aspirational pathways for young people leaving care. The intention is to replicate the pathways that most young people in the general community take when moving out of home, which involves entering the private rental market through shared housing, while also engaging in study, training or employment:

This model aims to set up a more common—a more mainstream pathway that most young people experience, and provide those opportunities for young people exiting care, so that they can live in a household with reasonable amenities, certainly higher than public housing, and ... live with their peers, but in a way that ... they are receiving support.

There will be households of two or three young people sharing, and ... each young person would have their own case manager. That case manager would be common to the household, and as well as providing one-on-one support, that case manager will provide support to the household to maintain, you know, good household relationships.\textsuperscript{161}

The model envisions young people being housed for six to 12 months, ensuring continuity of care and intensive support from Families SA in the early stages of living independently. As a young person approaches the leaving care age, a case conference would be held and a plan put in place for transitioning them to Housing SA supports.

The project is still in its infancy. Through the 90-day change program run by the South Australian Government, an intensive team has been brought together from Housing SA, Families SA and the Department of State Development to refine the details of the service model.\textsuperscript{164} Housing SA and Junction Australia have also committed to providing high amenity houses in good transport corridors. A funding source is now being sought to support a two-year pilot project in the southern metropolitan region.

The initiatives taken by Housing SA in collaboration with other agencies reflect an acknowledgement that approaches under the Rapid Response policy were failing to produce the desired outcomes for care leavers. There is a need to re-emphasise the objects of that policy. There is also a need to develop, pilot, evaluate and promote innovative services that specifically address the trajectory of transience that is too common among care leavers. Research also supports the use of lead-tenant models such as the Ladder St Vincent Street program to assist care leavers in their transition to independence.

The Government should support the innovations being developed by Housing SA that involve expanding the range of housing options for independent living past the age of 18, and which attempt to model more closely the natural journeys of young people moving gradually towards independence. Housing SA is a vital partner in these reforms.
LEAVING CARE

POST-CARE SERVICES

RELATIONSHIPS AUSTRALIA SA

Since July 2012, Families SA has contracted Relationships Australia SA to provide post-care services. Support is available to anyone over the age of 18 who has spent six months or more in out-of-home care in South Australia. The services are offered out of an office called Elm Place, which concurrently runs the Commonwealth-funded Find and Connect program.

The services available through Relationships Australia are limited by funds and staffing. With a current annual budget of $326,104 and 2.58 fulltime equivalent staff to provide support services to meet the multitude of needs of care leavers across the entire state, Relationships Australia faces issues that appear to be the result of a lack of funding for post-care services, as opposed to a lack of skill in the organisation.

At present the service relies on clients self-referring. Since the service’s inception in 2012, only 9 per cent of clients have been under the age of 20, with the highest percentage of clients waiting until their mid-twenties to seek support. The longer care leavers wait to access services, the more entrenched their issues tend to become. There is a lack of clear referral pathways between Families SA and post-care services, and there are concerns that not all care leavers are made aware of post-care services.

CREATE Foundation’s Ms Scalzi told the Commission:

“Relationships Australia postcare services are underfunded to be able to provide a decent postcare service for children and young people in care … from 18 to about 26, they’re not engaging, and they’ll come back, [in their] 30s, 40s, to postcare services, so … there’s that big gap, where we … lose them.”

Although some recent improvements have been made in links between Families SA and post-care services, there remains a need for a more integrated referral system, where young people are systematically referred to the service by Families SA at an earlier age, and with an accompanying risk assessment.

The current method of promoting the post-care service is by way of a brochure. Post-care services require resourcing to support an assertive outreach program targeting individuals who are not currently engaged. The service would also benefit from strategies of engagement that are based on feedback from young people and utilise social media and other methods that appeal to this particular cohort. This is consistent with research which recommends a greater focus on outreach programs and the use of social media and technology to engage vulnerable care leavers.

The smartphone application referred to earlier would help here.

The current funding for post-care service delivery is not enough to address the complex issues faced by care leavers, which include major health, dental and educational disadvantages. Where Elm Place was initially able to offer a drop-in service, resource limitations have now reduced the service to an appointment-based one. Many young people in this cohort find appointment keeping difficult and conversations in an office setting intimidating.

Relationships Australia SA should be funded to deliver innovative and flexible post-care services which engage young people at times and in locations where they are more likely to be receptive. Several interstate examples of mobile youth outreach services exist that would provide suitable models for South Australia. The Chatterbox Bus run by Open Family Australia, for example, amalgamates outreach with drop-in services and links longer term support to informal frontline assistance including access to the internet as well as food, clothing and health supplies.

Ladder St Vincent Street

The Ladder St Vincent Street program is an innovative youth housing and support program, located in Port Adelaide. It was developed by Housing SA, St John’s Youth Services and Ladder to provide sustainable housing for young people who have experienced or are at risk of homelessness. Ladder is a not-for-profit organisation established by Australian Football League players to tackle youth homelessness.

The program applies a model of service provision which draws together access to secure housing, an expectation of engagement in education, training and employment opportunities, and participation in community. Young people are provided with independent apartments in the one purpose-built complex which is staffed 24 hours a day. They are provided with case management, which includes a focus on training and employment, and receive mentoring from former and current elite sportspeople and others associated with sport.

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There is a long overdue need for service provision to shift away from compartmentalised programs to an integrated approach that both prepares young people to transition from care and assists them after the age of 18. Such an approach would also build and capitalise on relationships formed with a child prior to them leaving care:

My thinking is that, really, it is the ongoing emotional support as any other family would provide for their young people that is needed for young people post 18. As I said before, my preference for that would be that that service is tied in to the service where that young person already has strong relationships.176

BEST PRACTICE IN POST-CARE SERVICE

An example of a comprehensive leaving care program that incorporates best practice principles is the Stand By Me pilot program developed by Berry Street in Victoria. The program is based on the UK’s personal adviser model and provides intensive general casework support. Recognising that trust is a major issue for these young people, the program emphasises continuity of worker–client relationships throughout the pre- and post-care phases. It offers medium to long-term support after care through an assertive outreach model that follows the young person and matches resources to their identified need at the time.

The program is adaptable and flexible, appreciating that the first few years after leaving care can be a time of multiple crises and evolving needs. A key focus is on activities likely to reduce homelessness such as working with young people to plan their accommodation, helping to negotiate retention of foster care or kinship care placements, and establishing and maintaining transitional or independent living options. The program also works with young people to address trauma, improve access to mental health supports, facilitate access to financial assistance, and establish links to employment, education and training services.

An interim evaluation of the first year of the pilot program that ran from December 2012 to December 2013 was recently conducted.174 The review found that the program was developing effective ways of working with care leavers and that the program’s approaches and methods were consistent with research into effective practice for supporting young people leaving care who have complex needs, and who are at risk of homelessness.180 Significant positive outcomes have been found as a result of180:

- the program’s focus on building relationships over time while the young person is still in care;
- work done to re-establish and support young people’s contact with family; and
- assistance with maintaining links with out-of-home care supports including foster parents or residential carers in order to reduce the possibility of further trauma and disrupted attachments.

Similar programs have been funded in New Zealand. Young people can be allocated an adviser from two non-government service providers at the age of 15 to assist with planning the transition from care, empowering them to make informed decisions and modelling positive social behaviours. The service providers can then become the lead agency supporting the young person in the community after they leave care.182

There is a need to move away from the notion that post-care services are an ‘add-on’ to the core work of the child protection system. The Commission recommends the piloting of an intensive post-care support service for those young people who are identified as especially vulnerable in the post-care period. Preference should be given to an agency that currently provides support services to this group.

Greater effort needs to be made to integrate post-care service provision to the agencies supporting young people during care, to capitalise on relationships and connections which should be well established. The Commission recommends the piloting of an intensive post-care support service for those young people who are identified as especially vulnerable in the post-care period. Preference should be given to an agency that currently provides support services to this group.

For other generic post-care services, there should be a significant injection of funds to enable services to be delivered more flexibly, and more assertively. A review of the needs of the population currently accessing Relationships Australia services should be conducted to identify areas of specific need.

FAMILIES SA PROVISION OF ACCESS TO RECORDS

Families SA responds to requests from care leavers for access to records held by the Department. Items such as birth certificates, immunisation records and other legal documents may be required in adulthood, but for many care leavers, accessing the information held in their file is also an important aspect of developing a sense of self and piecing together memories that they are unable to clarify from other sources.
In order for care leavers to access their file, they must complete a freedom of information request. This presents a hurdle for many young people who are often also dealing with the stress of negotiating with a number of other bureaucratic processes. Once a care leaver is granted access, they are given a brochure for Relationships Australia should they require counselling to help them review their file. Providing support to care leavers to access their records is essential given the potentially confronting material that they may encounter. A brochure with contact details for a service that the care leaver may not otherwise have any connection with is unsatisfactory.

Other jurisdictions have specific legislative provisions giving care leavers the right to access a range of documents, without charge, relevant to their care journey (including birth certificate, school reports, medical reports and personal photographs). New South Wales has the most generous provisions, granting care leavers a right to access any personal information that relates to them from the departmental files, his or her authorised carer or carer agency. The care leaver can elect to have the requested information orally or in writing. The care leaver is also entitled to original versions of documents held on a file, free of charge. The carer agency is required to provide an appropriate person to support and assist the care leaver in seeking access to the information.

The Children’s Protection Act should be amended to permit care leavers to access, free of charge, original and copy documents relating to them which are held by the Department, registered carers, registered care agencies (foster or kinship care), or non-government organisations who have been contracted to provide them with out-of-home care. Support should be provided to any young person so accessing their records to help them make sense of the records and understand their implications.
The Commission recommends that the South Australian Government:

158 Amend the Children's Protection Act 1993 to require the Minister to provide or arrange assistance to care leavers aged between 18 and 25 years. Assistance should specifically include the provision of information about services and resources; financial and other support to obtain housing, education, training and employment; and access to legal advice and health care.

159 Expand financial counselling services to manage access to post-care financial support from the Agency provided in accordance with Recommendation 158.

160 Amend the Children's Protection Act 1993 to permit care leavers to access, free of charge, original and copy documents that relate to them from the Agency, approved carers, and any non-government agencies contracted to provide care to them.

161 Continue to make modified payments to foster and kinship carers where the care leaver is engaged in tertiary education, apprenticeship, or any post-high school training, and where their best interests would be served by remaining in foster or kinship care until the qualification is completed.

162 Review the Rapid Response policy to identify opportunities to expand priority services to care leavers up to the age of 25.

163 Prepare a new service model and work instruction for leaving care that incorporates the relevant elements of the National Approach, including specific reference to supporting care leavers who want to access further education and training.

164 Redeploy transition-from-care caseworkers to provide an add-on service for young people planning their move to independence.

165 Reach an administrative arrangement with the CREATE Foundation to provide it with the names and contact details of children entering care and/or their carers (as appropriate).

166 Fund the development of a smartphone application that provides young people with up-to-date information about services and entitlements when leaving care.

167 Review contractual conditions governing service specifications for non-government independent living programs to develop greater flexibility in the age of admission and the age of discharge from programs.

168 Fund Housing SA to develop innovative housing models, particularly those that use supported share housing where appropriate for care leavers.

169 Fund a pilot program of intensive case management assistance for vulnerable care leavers, to be delivered by an agency with established relationships with vulnerable children in care.

170 Conduct a review of the needs of the population currently accessing Relationships Australia’s services to identify the specific needs of service users.

171 Make a significant injection of funds into post-care services currently provided by Relationships Australia, to enable these to be delivered more flexibly and more assertively.
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OVERVIEW

Children who have been removed from their families and placed in out-of-home care have the same right to be safe as all other children. It should be expected that children in the care of the state will be given a higher standard of care than they would otherwise receive in the community. Despite safeguards, the perpetration of abuse against children in the care of the state, and deficits in care standards, are unfortunate realities. The child protection system must be equipped to respond to these challenges.

It is essential that the system investigate abuse and neglect in care for it to evaluate and improve its standards of service delivery. Appropriate and transparent mechanisms for reporting, investigating and responding to allegations of abuse are integral to this goal. These need to be complemented by sophisticated monitoring practices that evaluate responses and inform necessary system change, not only to respond to children who experience abuse in care, but also to prevent such abuse recurring.

An allegation that a child has been abused or neglected in their care environment, or that there is a deficit in their standard of care, is referred to as a care concern. After securing the immediate safety of the child, the purpose of responding to a care concern should be twofold: first, to identify the contribution of an individual's actions (or inactions) to any deficiencies in the standard of care, or any abuse or neglect experienced by the child, and second, to identify whether any systemic issues contributed to the child’s adverse experiences.

This chapter discusses how the abuse and neglect of children in care is reported, investigated and responded to by the child protection system. The Commission has examined the challenges faced by the Department in fulfilling these responsibilities and identified improvements that should be made to this important aspect of service delivery.

The chapter principally relates to the Commission’s Terms of Reference 5(g), in the context of Terms of Reference 1 to 4.

WHAT THE RESEARCH TELLS US

At the outset, it is important to acknowledge that the majority of care environments are safe. Most carers and employees are committed to providing safe care. However, there may be occasions when a child in care is maltreated, or the care provided falls below an acceptable standard. The reasons for this may be varied, and the result of the interaction of a number of factors. For example, poor recruitment practices and training, inadequate support and monitoring of placements, and the high care needs of a child may all contribute to abuse or neglect in care.

The child protection system must have in place robust mechanisms that support the identification, reporting and investigation of these care concerns.

There is no clearly defined model of best practice for investigating the abuse and neglect of children in care. However, research identifies a number of themes or principles that receive relatively widespread approval as ‘good practice’, summarised as follows:

- the need for a specialist independent investigations unit;
- the need for the child’s voice to be heard before, during and after the process;
- the need for accurate record-keeping during investigations;
- the importance of adequate training and support for staff; and
- a recognition that resource limitations can influence decision making during investigations.

Research highlights the need for investigators to have a diverse range of skills, which may be broader than those held by child protection practitioners. This should be considered when designing job descriptions and training. Investigators should also have no prior relationship with the carers or staff members they are investigating. Clear, specialised procedures, policies and guidelines should be developed and shared with stakeholders. It is essential that this includes guidance in relation to coordination and cooperation between government agencies and other stakeholders. In particular, there should be close coordination between investigators and law enforcement such that investigations can be conducted jointly or in parallel where appropriate. Clear definitions are also critical. Variable and ambiguous definitions of maltreatment and risk undermine an investigator’s ability to make findings about abuse or neglect.

Research also suggests that one of the best predictors of child maltreatment is a prior history of child maltreatment by the carer or staff member. As part of the investigation, the investigator should therefore have access to, and review, all previous reports of child abuse and neglect.

Timely investigations are essential, not only to protect the child but to capture evidence before it is compromised or memories fade. Findings need to be promptly made and communicated to those responsible for managing change and to other stakeholders, to ensure corrective actions are taken.
Significantly, research suggests that the availability of services or resources can affect the substantiation of an allegation. If resources are not available to respond to the child’s needs, maltreatment may not be substantiated even if it exists. The workload of an investigations unit can also be a major barrier to appropriate analysis and decision making, and the completion of investigations.9

THE DUAL PURPOSE

When responding to allegations of abuse or neglect in care, a properly functioning care concern system will identify both inappropriate conduct by an individual and failings of the system. This is because the state owes a particular duty of care to children who have been removed from their families and placed in the care of the state:

Incidents or situations of harm to a child in care need to be viewed and responded to not just as an abusive action by an individual, but as a breach or dereliction of the duty of care at individual, program and agency levels. The concept of extended responsibility involves seeing beyond the individual to the range of individuals, agencies and departments involved in the care of the child or young person.

Harm to a child or young person in care will be seen as different to intra-familial abuse. The operational definition of harm and risk of harm for children and young people in care is expanded to include the state’s duty of care, and thus will have a dual focus on the action or inaction of an individual and the systemic context in which it occurred.10

Identifying and responding to systemic issues is an important mechanism through which the experience of children in care can be improved. Understanding how the system has failed one child should allow for changes to be made to prevent or minimise the recurrence of abuse or neglect to other children.

While in some circumstances the outcome of an investigation may apportion blame to an individual, the actions (or inactions) of an individual should not overshadow possible system deficits as contributing to the issue. It is of critical importance that every investigation is viewed as ‘an opportunity to educate others about prevention’.11

In addition, a care concern investigation should not be viewed as a mechanism to punish an individual carer or staff member. The findings of an investigation may lead to consequences for an individual, such as deregistration as a carer or the termination of their employment. However, an investigation should not be aimed at giving effect to those consequences or be distracted by them. The overarching aim should be to keep children in the care of the state safe.

ESTABLISHING AN INDEPENDENT INVESTIGATIONS UNIT

The Layton Review in 2003 recommended an accountable, independent and transparent review mechanism for complaints about case management and allegations of abuse or neglect of children in care. It proposed the establishment of a specialist review and investigations unit, independent from the statutory agency Families SA (the Agency).12

Independence was an important aspect of this recommendation. Investigation of its own decisions could leave the Agency open to criticism of bias or cover-up. However, a unit in the same department as the Agency, but removed from its operations, was considered sufficient to provide independence, transparency and integrity. The unit was to afford a high level of procedural fairness, have database recording capabilities to ensure appropriate tracking of allegations and scrutiny of the system, and be subject to an external appeal process.13

A specialist unit was established in the Department for Families and Communities and tasked with the investigation of abuse and neglect of children in care. The unit reported directly to the Chief Executive, and sat within the Office of the Chief Executive. It also undertook investigations into care concerns arising in the context of disability services and youth training centres.14

In 2012, the unit in part moved with the Agency to the newly formed Department for Education and Child Development (DECD, or the Department), and became known as the Care Concern Investigations Unit (CCIU). Since that time, the Department has struggled to find an appropriate place for CCIU within its organisational structure.15 Apart from the Office for Child Protection, the Department had little experience or expertise in statutory child protection, and more specifically the investigation of abuse and neglect in care. The CCIU was initially located in the Office for Corporate Services (formerly the Office for Resources, Operations and Assurance), a section of the Department that had never undertaken statutory child protection work.

In mid-2014 the Chief Executive of the Department approved the move of CCIU into the Office for Child Protection, in the Agency’s Service Accountability Unit.16 This arrangement would have provided a direct reporting relationship to the Deputy Chief Executive responsible for Families SA, while maintaining the independence of CCIU from the Agency’s day-to-day operations. It was intended that this would better enable any system deficits identified through investigations to be fed into practice and policy improvement.17
The move of CCIU into the Office for Child Protection never eventuated. The destabilisation in the Department that occurred following the arrest of Shannon McCoole (see Volume 2, Case Study 5: Shannon McCoole) and the subsequent focus on the functioning of CCIU in that matter may have contributed to this.

Eventually, the Department opted to shift responsibility for conducting serious care concern investigations to the Department’s Incident Management Division (IMD). All investigators in the IMD have a law enforcement background. Concerns had previously been expressed that the approach of the IMD was ‘more focused on individual culpability, which although not the priority for the management of care concerns in the child protection context’.21

The lack of clarity about the placement of CCIU has been accompanied by confusion as to the scope of CCIU’s role and its limited integration with associated functions in the Department. This has been particularly evident in circumstances where the care concern has involved allegations of employee misconduct. Within the Department, the investigation of employee misconduct was generally the responsibility of the Special Investigations Unit (SIU). Despite the potential for the overlap of responsibilities, no planning took place and no document existed governing the respective roles of the two investigative bodies. They operated independently of each other. At times this led to an ineffective use of the Department’s investigatory resources. The efficacy of the relationship between CCIU and the human resources functions of the Department has also been questionable.

CCIU has continued to rely on outdated and unendorsed practice manuals developed before the Department was formed in 2012. It has mostly been left to its own devices without strategic guidance. Consequently, the day-to-day functioning of CCIU has been largely subject to the professional judgement of whoever happens to be the unit’s manager.22

A report commissioned by the Department to review CCIU in March 2015 found there was ‘an inconsistent understanding of the purpose, objectives and role of the CCIU’.23 This finding is consistent with those of the Commission.

During the past four years, the functioning and relevance of CCIU have been compromised by its instability and lack of integration into the Department. There appears to have been an insufficient understanding of the important role of CCIU in the child protection system. Much work of CCIU has been delayed. The outcomes of its investigations have made little contribution to improving systems issues facing Families SA and the experiences of children in care.24

The lack of understanding of CCIU’s role and purpose extends to many stakeholders in the child protection system, including Families SA staff, foster parents and residential care workers. The Commission was told ‘the whole area of care concerns is just a nightmare … people are not necessarily very clear on all the processes’.27 The procedures and practice surrounding care concerns were described as a ‘minefield’ and the lack of documented guidance available to Families SA staff is a huge gap in the field.28 Many carers were completely unaware of the care concern process, not knowing what CCIU was, what care concerns were or how investigations were conducted.29

The investigation of abuse and neglect in care is a function that the proposed new department would need to perform. While independence is important, it is equally important that there is sufficient clarity regarding the purpose and integration of the investigative body within the department to ensure its dual purposes are effectively achieved.

REPORTING CARE CONCERNS

A care concern arises when a child who is in the care of the state:20

- is allegedly abused or neglected; or
- there is allegedly a deficit in the standard of care provided to the child; and
- the allegations relate to the care provided by a Families SA employee or volunteer, an out-of-home care employee or volunteer, a foster parent, a kinship carer or a Specific Child Only (SCO) carer.

Care concerns are raised with the Department through a report to the Families SA Call Centre (commonly known as the Child Abuse Report Line, or CARL). They are received in the same way as other child protection notifications. If the notification meets the above criteria, it should be classified as a care concern referral (CCR) and referred to the manager of CCIU.

Unlike notifications relating to children who are not in care, the Call Centre practitioner is not required to assess whether a notification should be screened in for a response. The practitioner is also not required to give a response priority (tier) rating to the concern: at the point of intake, the level of concern or seriousness expressed by the notifier is irrelevant.22

The guidance given to Call Centre practitioners about receiving care concern notifications is limited and outdated. The care concern criteria are not clearly set out in their practice manual, and there is no definition of what amounts to a care concern. Consequently, Call Centre practitioners sometimes incorrectly classify care concerns as a general child protection notification (referred to a Families SA local office) or an extra-familial notification (referred to South Australia Police). As a result, they are not referred to CCIU.
The reporting of a care concern may also be frustrated by limitations in the functionality of C3MS, the Agency’s electronic case management system, which leads to ‘inaccurate, inconsistent or absent case recording’.36 The Commission was told a care concern may not be recorded on C3MS, and therefore not referred to CCIU, if the notifier can only provide the name of the carer or employee, and not the name of the child. This is because C3MS requires notifications to be recorded against a child’s name. If the functionality of C3MS is obstructing the recording of care concerns in this way, it is a significant gap in the reporting system.37

LISTENING TO CHILDREN IN CARE

Children in care may report concerns regarding their care, or that of another child, to the Families SA Call Centre. However, there is no special mechanism to support this, and in reality few children self-report abuse or neglect concerns to the Call Centre. From 2011/12 to 2014/15 there were more than 190,000 notifications to the Call Centre but only 200 (0.1 per cent) of those were from children making a report about their own circumstances (see Chapter 7, Tables 7.6 and 7.7). Less than half of those (89 notifications) were screened in for a response from the Agency.38 It is unknown if any of the 200 notifications came from children in care.

Children in care are particularly vulnerable to abuse or neglect by a carer. They may have limited support networks beyond their primary carers. In particular, children in rotational care do not have the advantage of a consistent caregiver who will listen to them and advocate on their behalf. Due to their past experiences, children in care may be reluctant to build trusting relationships with other adults, and may feel further isolated by their adverse experiences in care.

Perpetrators of abuse may target children with a history of dishonesty as they are less likely to be believed by adults if they complain. If an organisation, or the broader system, does not value the voice of children, they are especially vulnerable.39 Unfortunately, children in care are less likely to be believed if they make a disclosure than other children in the community.40

This was demonstrated in the McCoole case study. A senior youth worker was faced with an accusation made by a 13-year-old girl in residential care that McCoole had walked into the bathroom without warning when she was on the toilet with her pants down. She called McCoole a paedophile. The senior youth worker dismissed her complaint about McCoole’s behaviour and accepted his explanation of innocence, partly because the young person had a history of telling lies.

Children who have experienced abuse and neglect may develop unhelpful behavioural habits such as telling lies. However, it is dangerous to systematically prefer to believe adults over children when the respective versions of events collide.

There should be formal and informal mechanisms in place to ensure a child’s experiences of care are both heard and understood. Children should feel able to report concerns about their circumstances and believe that their complaints will be heard and responded to appropriately.

It is also important for a child to have trusting relationships with adults other than their primary carer: they need regular contact with both their caseworker and other caring adults.41

ADULTS’ FAILURE TO REPORT

It is likely there is an under-reporting of abuse and neglect in care42, not only because children feel unable to report, but also because adults fail to report.

A child in care may raise an issue with a carer or another adult. If that person is a mandated notifier, they are obliged to report the concern. However, this does not always occur. Some people may believe a report is unnecessary because the child is already in care and they assume that those in the Department who are involved in the child’s case management will already be aware of any such concerns.

The Commission was told that if a concern was raised directly with a Families SA office, rather than the Call Centre, it was possible the issue would be addressed locally instead of through CCIU.43

There is a lack of clear guidance as to the circumstances in which a person who is in contact with a child in care must make a notification. This has contributed to Agency staff and other stakeholders having a varied understanding about when such a notification should be made.

However, the value of any reporting guidelines, or the reinforcement of mandatory notification obligations, will be directly influenced by the way in which the system values the voice of children in care:

> Unless the organisational culture supports the power of children and young people, emphasises their rights and has a positive child-focused orientation, any obligatory procedures such as complaints mechanisms are tokenistic and ineffective.44
Unless the organisational culture supports the power of children and young people, emphasises their rights and has a positive child-focused orientation, any obligatory procedures such as complaints mechanisms are tokenistic and ineffective.

While supporting children to disclose concerns and report them is of fundamental importance, the Commission’s inquiries into McCoole’s conduct demonstrated that organisational culture can also create a barrier for adults, silencing potential notifiers. How the system responds to a child or adult who makes a notification can affect their willingness, and that of others, to report in the future.

**PRACTICAL STRATEGIES TO IMPROVE REPORTING**

Within the Agency, staff must be able to identify a care concern and understand their obligation to report it. The Commission was told that there was little contact between CCIU and front-line staff, impairing CCIU’s ability to perform an educative role. Providing guidance to staff should be a responsibility shared by CCIU and the Agency. Staff, including residential care workers, should be trained to identify and notify any conduct that may amount to a care concern, and should be supported by clear, easily accessible documentation.

A better understanding of responsibilities on the part of staff should help foster an environment in which children see value in disclosing or reporting concerns about their own circumstances. There is also scope to consider how technology can help provide children in care with a voice. It is unlikely that a child in care would telephone the Call Centre, wait on the line for their call to be answered and then disclose their concerns to a stranger. Although there is an online notification system (eCARL), it does not have a user-friendly interface for children.

A number of local authorities in England and Northern Ireland use a computer application (accessible through the internet, and on smartphones and tablets) to help children communicate their circumstances or concerns to people involved in their care. The application, Mind of My Own or MoMo, is described as a ‘self-advocacy app’. It is not an application dedicated to the reporting of child protection notifications. Rather, it facilitates engagement between a child and their caseworker, and gives them a tool to express their views. There is merit in exploring such technology to ensure children in care feel able to voice their views and, importantly, know how to engage with a concerned adult if they experience abuse or neglect, or are concerned about the standard of care being provided to them.

It is also necessary to ensure adequate guidance and training are provided to carers who are engaged through contracted service providers (whether in a home-based setting or a rotational care setting) about their role in identifying and reporting conduct that may amount to a care concern, and the process that follows. While there is a general contractual requirement to this effect, the Department appears to have provided little guidance as to the content or expected outcomes of this training.

### DETERMINING THE CATEGORY

All care concern referrals are sent from the Call Centre to CCIU, where they are determined to be one of four categories: serious, moderate, minor or no action. This determination is made by either one of the two most senior staff, namely the manager or the principal investigations officer. The category determines the response pathway, as shown in Table 15.1. Minor and moderate care concerns are referred from CCIU to Families SA, where it is expected that front-line staff would undertake an appropriate response.

<table>
<thead>
<tr>
<th>DETERMINATION CATEGORY</th>
<th>RESPONSE</th>
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<tr>
<td>Serious care concern</td>
<td>Serious care concern investigation conducted by the CCIU, and more recently the Incident Management Division</td>
</tr>
<tr>
<td>Moderate care concern</td>
<td>Families SA inquiry</td>
</tr>
<tr>
<td>Minor care concern</td>
<td>Families SA case management</td>
</tr>
<tr>
<td>No action</td>
<td>No further action taken</td>
</tr>
</tbody>
</table>

Table 15.1: Care concern response pathways

Serious care concerns are serious breaches of accepted care standards, where the child is suspected to be in immediate danger, has already suffered serious harm or is at significant risk of serious harm, as a result of the carer’s or staff member’s actions, inactions or impaired capacity to act in their designated role. The investigative response—a serious care concern investigation—should involve evidence gathering and an assessment of individual culpability and the contribution of systemic factors.
Moderate care concerns are moderate breaches of accepted care standards, which give cause for concern that the child is at risk of harm, and their safety and wellbeing would be in jeopardy if intervention did not occur. The response should focus on the attitude, behaviour, skills and capabilities of the carer or staff member and the supports and resources available to them. This process is conducted by way of an inquiry and a formal outcome should be recorded.

Minor care concerns are minor breaches of accepted care standards that pose a minor risk to the safety and wellbeing of the child. The response is expected to be part of general case management, with attention given to the supervision, development and training of the carer, staff member or volunteer by way of discussion.

If, despite the referral, a child was not in care at the time the concerns were raised, or they involved a person other than a caregiver, CCIU will not take any action. It may also be determined that no further action is required if, for example, there is insufficient information in the referral, no breach of a standard of care is identified, or the allegations are already being addressed by Families SA or a service provider.

RELYING ON PROFESSIONAL JUDGEMENT

The determination process on occasion leads to inappropriate decisions and an underestimation of potential risk.

In making a determination as to category, the manager of CCIU and the principal investigations officer rely on their professional judgement. Other than the broad definitions described above, there are no clearly defined assessment criteria to guide this process or help the decision maker to weigh the various factors.

Professional judgement is important, but making determinations on that basis alone can be fallible. Decision making may be straightforward when a child is ‘clearly safe or clearly unsafe’. However, care concern referrals often do not present a definite picture of a child’s circumstances and safety.

Difficulties in applying a consistent approach to decision making seem inevitable. The absence of articulated thresholds for each of the categories has led to a situation in which:

the same allegations or concerns could go to one worker and be assessed as serious, and go to a different worker and be assessed as moderate, or even ... as no action.

THE INFORMATION-GATHERING PROCESS

During the determination process a range of information is considered, including:

- the age of the child and their vulnerability;
- the effects of the alleged abuse or neglect on the child;
- whether the child sustained any injuries;
- the behaviour of the child in the context of the notification;
- whether there is more than one child involved;
- the credibility of the notifier or any witnesses;
- actions already taken in response to the care concern referral (CCR);
- prior notifications or care concerns relating to the child or the person who is the subject of the concern, and if so whether they are similar in nature;
- whether there are any supports in place for the person who is the subject of the concern; and
- whether the allegations are criminal in nature.

Some of this information will be available on the face of the referral. Some of it will not.

Depending on complexity, determinations may take as little as an hour or as long as two weeks. Timeframes extending beyond 48 hours to determine the response pathway for an allegation relating to the suspected abuse or neglect of a child in care are unacceptable. Initial delays only serve to contribute to the more extensive delays experienced in care concern investigations. Lengthy determinations are also indicative of the inappropriate processes for gathering and assessing information during this early stage.

INVESTIGATING, NOT DETERMINING

CCIU’s intention in gathering more information than is presented on the face of the referral is to help the decision maker reach the most appropriate determination.

The initial task of CCIU is to determine an appropriate category based on the seriousness of the allegations contained in the referral. While there is a role for gathering limited basic and incontrovertible information, caution must be taken not to give undue weight to information received from other sources. For example, it is appropriate for the decision maker to confirm an employee was on shift at the time of the allegations, or that a child was in a particular placement. It may also be appropriate to review prior care concerns relating to the person who is the subject of the concern. However, having regard to information beyond these basic details can lead to a quasi-investigation being conducted before a determination is made.
To develop an understanding of the circumstances surrounding the child’s care, CCIU will often consult with Families SA senior staff who are involved in the child’s case management, who are supporting the placement or responsible for managing the employee who is the subject of the concern. However, this process can undermine the independence of CCIU and compromise good decision making.

For example, about 12 months before McCoole’s arrest, a care concern was raised regarding his conduct involving a six-year-old female child, ‘Mikayla Bates’. The observations of the notifier led to the circumstantial inference that McCoole had sexually assaulted Mikayla. Nevertheless, this was determined to be a minor care concern. This was inappropriate and a gross error. Before the determination was made, Catherine Harman, who was then the manager of CCIU, consulted with a manager and supervisor in Families SA’s residential care directorate. Ms Harman was advised that McCoole was an agency supervisor in Families SA’s residential care directorate. Ms Harman acknowledged that this advice may have influenced her decision to categorise the matter in a way that would not require a comprehensive CCIU investigation.

The information gathering that occurs before a determination is made is indicative of CCIU conflating what should be clearly defined stages of determination and investigation. The tendency to seek further contextual information blurs the distinction between assessing the seriousness of the care concern based on the information in the CCR and assessing the veracity of the allegations.

The Commission reviewed a number of determinations that, on the basis of the information provided in the CCR, appeared serious in nature. Nevertheless they were classified as minor or moderate following extraneous information being taken into account.

For example, CCIU may allow information regarding the notifier’s circumstances to influence determinations. Families SA may advise CCIU that the notifier is experiencing drug or mental health issues, or is involved in court proceedings to have their child returned to their care, or there is an acrimonious relationship between the notifier and the carer or employee who is the subject of the care concern. Some determination rationales highlighted the identity of the notifier as being ‘significant in relation to the matter’. A determination rationale relating to allegations of emotional abuse in a foster care placement questioned ‘the agenda of the notifier’. In another matter, information from a Families SA caseworker indicating they had no concerns regarding the placement, led CCIU to determine that ‘no action [was] required’.

By placing weight on the identity and credibility of the notifier during the determination phase, determining the seriousness of the allegations is conflated with investigating the veracity of the allegations.

**CONDITIONAL SAFETY**

The raising of a care concern does not shift responsibility for the immediate safety and wellbeing of a child in care from Families SA. It is for Families SA to decide if a child will be removed from their placement, or whether an employee will be shifted to another position, placed on alternative duties or suspended.

At the time a determination is made, it is expected that Families SA will have already acted to ensure the child’s safety. This can result in undue emphasis being placed on the fact that the child is already out of harm’s way, and therefore conditionally safe. The determination may be influenced by the level of response thought necessary given the child’s or carer’s current circumstances, rather than focusing on the seriousness of the allegations. An otherwise serious incident may be categorised as minor or moderate because the child is conditionally safe.

Conditional safety does not mean a child’s experiences do not warrant proper investigation. A failure to investigate could lead to the child being returned to an unsafe care situation, or another child in the future being placed in the same unsafe environment.

The Commission reviewed a CCR that alleged the child’s foster parents took him outside and made him jump on a trampoline without stopping when he would not sleep at night. While he was jumping, the carers cracked a whip underneath his feet. This was determined to be a moderate care concern. However, at least nine prior CCRs had been raised in relation to this child’s placement with the foster parents. On a previous occasion, one of the carers had broken the child’s arm when attempting to discipline him. Efforts by Families SA to address the behavioural management techniques of the foster parents had failed.

The rationale for the determination concluded by noting the child no longer resided in the placement and called for Families SA to investigate the appropriateness of placing a child with those foster parents in the future.

Given the previous CCRs and the failed attempts by Families SA to address the concerns, an independent investigation was warranted. Requiring a child to jump on a trampoline at night while cracking up whip is at the very least emotional if not physical abuse. The allegations suggested the foster parents had intentionally jeopardised the child’s safety and wellbeing. The conditional safety of the child should rarely be given weight in the determination, particularly against a significant history of CCRs.
THE RELEVANCE OF ACTION TAKEN BY FAMILIES SA

The Commission was told that if Families SA advises CCIU that the matter is already being addressed, a determination may not reflect that which would be appropriate based on the information in the CCR alone. Concerning examples of this practice include the following:

- It was alleged a child residing in a kinship placement had not attended school regularly for three years, was not fed enough food, was constantly presenting as dirty and smelly, and was not having his medical needs met. This was determined to be a minor care concern. The issues were said to be longstanding, but being addressed by case management. If issues of persistent neglect had not been resolved after three years, despite case management efforts, it is difficult to view the allegations as being anything other than serious. The minor categorisation simply sent the concerns on the same ineffective response pathway. This case required an independent investigation with consideration of broader issues including whether the placement had been appropriately supported and whether the placement should have continued in the face of such ongoing issues.

- Concerns were raised about the physical and emotional abuse and neglect of a child in a kinship care placement. Before the carers were registered, 35 child protection notifications had been made relating to the care they provided to their own children. The CCR was categorised as minor. It was noted that “there [was] a comprehensive management strategy in place to which an investigation by the CCIU is unlikely to “value add”’. There were a number of ways in which an investigation could have added value to the child’s experiences or contributed to broader systems issues. CCIU could have reviewed the effectiveness of the approach to put in place a management strategy. An investigation could have shed light on any deficiencies in the process that led to the persons becoming kinship carers despite their significant number of child protection notifications.

- It was alleged that a child was forced to jump on a trampoline while it had bricks on it. A number of previous care concerns had been raised against the child’s foster parents in relation to both abuse and deficiencies in their standard of care. On a previous occasion, the foster parents had openly stated that they did not want to care for the child. Nevertheless the child remained in the placement. It was determined no action was required because, after the trampoline/brick event, the child no longer had any contact with the foster parents and the foster care agency was likely to recommend deregistration. However, no follow-up action was taken to ensure they were deregistered. An investigation may have identified systems deficits that had enabled the foster parents to continue in their role, despite their inability to provide a safe care environment.

- Allegations of sexual abuse by a carer were categorised as minor. It was noted that although the allegations were serious, appropriate supports were in place for the child and the carer had been deregistered.

Having regard to actions taken by Families SA in these sorts of cases can result in CCIU missing important opportunities to inform future practice improvements. It also does little to address the risk to other children who may be placed in such adverse care environments.

RESOURCE CONSTRAINTS

CCIU’s capacity to undertake investigations is limited by its staffing complement of only four investigators.

Philip Adams, Manager of CCIU, acknowledged that resource constraints in CCIU should not be considered at the determination stage. However, it appeared that in some matters they had led to a lower than appropriate categorisation. This was evident in a referral involving the neglect of an Aboriginal child by a kinship carer in a remote community. Concerns about the care of the child had been prevalent over a significant period of time. Families SA’s previous attempts to address the issues had not improved the child’s circumstances. It was a matter that required independent investigation. Nevertheless, it was categorised as a moderate care concern, citing, among other considerations, distance and timing.

CCIU should respond appropriately to concerns in all regions across South Australia, not only those that are financially or geographically convenient.

The capacity to resource an investigation may be a factor that is difficult for CCIU to ignore at the determination stage. It raises the question of whether the determination of care concerns should be undertaken independent of CCIU as the investigative body.
THE CONSEQUENCES OF AN INCORRECT DETERMINATION

The determination of serious allegations as minor care concerns has broad implications. A departure from an appropriate categorisation of conduct because of influence from extraneous information or by persons who are not independent leads to a lack of clarity and common understanding of the process. Families SA staff and other stakeholders are left without a clear understanding of the criteria to be applied when determining a CCR or the rationale for a decision.75

The use of the term 'minor' can be misleading. Those who rely on a determination that does not accurately reflect the seriousness of the concerns are unlikely to give the matter the weight it deserves. Staff or other agencies who are asked to respond to the care concern may not believe it is necessary to gather further information because they are mistakenly reassured by the minor label. It may also send conflicting messages about what conduct is considered appropriate and what is not.

As revealed by the McCoole case study, categorising serious allegations as minor or moderate can lead to the mismanagement of care concerns and inadequate responses to legitimate concerns. For example, no inter-agency strategy or planning meeting will be held, investigative tasks may be allocated to staff lacking appropriate skills, efforts may be made to manage serious matters collaboratively with service providers, and processes and outcomes may be influenced inappropriately by staff who have a vested interest in the matter. Some of these topics are discussed below.

IMPLEMENTING THE STRUCTURED DECISION MAKING® TOOL

Determinations must be made in a way that is transparent and accountable, and not undermined by external influences or idiosyncrasies of the decision maker.

In 2013, in response to deficiencies identified in the determination process, a project was undertaken to develop a Structured Decision Making® (SDM) assessment tool to provide criteria and thresholds for assessing care concern notifications. The SDM care concern screening criteria tool was developed by Families SA in partnership with the Children’s Research Centre in the United States, the creators of the SDM system. It was anticipated that this tool would ‘offer the same objectivity, consistency, validity, transparency and rigour that SDM has been demonstrated to deliver for intra-familial child protection’.76

A very troubling determination

The care concern referral (CCR) alleged a residential care worker (the carer) entered Oliver’s room yelling and Oliver accidentally slapped the carer in the face. The carer dragged Oliver by the feet into the hall, where, using Oliver’s own hands, he hit Oliver in the head 10 times. The carer laughed and put washing powder in Oliver’s mouth. This was witnessed by two other children. It was alleged that this was not the first time the carer had hurt Oliver or other children in the house. Oliver was reportedly scared of the carer.

This was categorised as a minor care concern. CCIU consulted with the carer’s manager, who advised that the carer had experienced stressful events in his life, but there had been no cause for concern during his employment. Further, the carer was to be moved to another residence and would no longer provide care for Oliver. CCIU concluded that ‘given the consistent account provided by the boys and [the manager’s] response to this CCR to date there is little value a formal investigation by the Office or the CCIU can add’. The residential care directorate and human resources were to respond to any specific issues identified regarding the carer’s behaviour.

This is a troubling determination. The allegations were serious and potentially criminal in nature. It is difficult to comprehend how the alleged physical abuse of a child in residential care, particularly when deliberate and degrading, could be determined to be a minor care concern. The discussions with the carer’s manager appear to have resulted in the CCR being determined as less serious than it should have been. While Oliver was conditionally safe from the carer, the intention was to expose another group of children to the risk of having him care for them. There was no independent examination of the circumstances surrounding the incident or whether broader systems issues contributed, such as carer training, the use of behaviour management techniques or lack of managerial oversight.1

1 Department for Education and Child Development, Care concern documentation, internal unpublished documents, Government of South Australia.
It was proposed that the care concern screening tool would be used by practitioners in the Families SA Call Centre to assess notifications of alleged care concerns and classify them into one of three response pathways: investigation and review, standard of care review or response not required. This proposal was a marked change from the system of relying on professional judgement alone, and would replace the unhelpful minor, moderate and serious categorisations.

The care concern screening tool includes clearly defined criteria as to what constitutes a care concern, the circumstances under which a care concern response is required and, as shown in Table 15.2, defined thresholds for practitioners to assess the notification against.

The tool applies the same thresholds to abuse or neglect, and risk of harm, for children in care as for other children in the community. This ensures that abuse in care is not measured differently, and that there is not a greater tolerance of inappropriate conduct or unsafe care environments.

Recognising the high duty of care owed by the state to children in care, the standards of care assessment criteria include a broad range of circumstances, such as:

- minimum case management requirements are unsupported or unmet;
- the child’s health care, emotional wellbeing or therapeutic needs are unmet;
- the child’s indigenous, cultural, spiritual or religious identity is unsupported;
- confidentiality or the privacy of the child are breached;
- negative behaviour is directed towards the child;
- the child’s problematic sexual behaviour is normalised or minimised;
- appropriate relationships between the child and his or her family or kin are undermined; and
- the child’s participation in decision making is inhibited or refused.

Testing of the care concern screening tool demonstrated that it produced consistent assessment decisions, and would have a negligible effect on the workload of Call Centre practitioners, who were familiar with the application of structured decision-making tools, and accustomed to interpreting and applying definitions. While the tool reduced the scope for individual interpretation and unusual or inappropriate assessments, the practitioner would still be required to apply professional judgement to determine if the concerns raised in the notification met the clearly defined criteria. This is to be expected. As discussed in Chapter 7, SDM tools support but do not replace professional judgement.

A constructive care concern response is one that not only promotes the wellbeing of the child, but also improves the quality of out-of-home care service delivery, strengthens care team relationships and helps conserve valuable foster care resources. The screening criteria tool puts renewed focus on program and system level concerns and recognises that:

Care concern responses cannot contribute to the improvement of [out-of-home care] until they move from a focus on individual culpability in causing harm to a child to a focus on the total care system and its expected standards of care.

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>THRESHOLD</th>
<th>RESPONSE PATHWAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or neglect, or significant risk of serious harm</td>
<td>Same threshold as for intra-familial child protection. Relies on the definitions of abuse, neglect and risk in the <em>Children’s Protection Act 1993 (SA)</em>.</td>
<td>Investigation and review</td>
</tr>
</tbody>
</table>
| Standard of care unmet | Different threshold to intra-familial child protection to acknowledge the higher standard of care expected for children in care. The standards are informed by:
  - the Standards of Alternative Care in South Australia (revised 2009)
  - the National Standards for Out-of-Home Care (2011)
  - a literature review. | Standard of care review |
| Criteria unmet | Case management consideration | |

The investigation and review response pathway emphasises that a care concern response must be holistic, not only investigating individual culpability, but also reviewing the context in which the conduct occurred and identifying the contribution of program and system deficits.

In August 2014, the care concern screening tool was approved by the Families SA Executive for use in the Call Centre, with endorsement from the Chief Executive of the Department. Nevertheless the tool was not implemented. At October 2015, CCRs continued to be determined in the same manner, punctuated by confused and flawed processes. Several possible reasons were put forward, including a change in leadership in the Office for Child Protection, the likelihood that the tool would screen in more care concerns for an investigative response, and the approval coming at a time when the Department was in significant crisis.82

The Commission asked a qualified and experienced Families SA practitioner to use the care concern screening tool to assess the care concern referral raised against McCoole that had been determined to be minor. This assessment identified that the allegations raised the suspicion of a sexual act with, or exploitation of, a child in care, and a significant risk of sexual abuse of the child: all grounds for screening in the notification for an investigative response and referral to CCIU. However, at the time and in the absence of the tool to guide professional judgement, the McCoole care concern was incorrectly classified. Consequently, an investigation did not occur.

The care concern screening tool should be implemented, and screening decisions regarding notifications of care concerns should be made by Call Centre practitioners. Determinations as to the categorisation of care concerns should no longer be based only on professional judgement. However, before implementation, the care concern screening tool should be reviewed, particularly in light of what has been learned from the McCoole case study. For example, a defect in the tool is that it may not give weight to new suspicious indicators of sexual abuse if the child has been sexually abused in the past, which could lead to an inappropriate screening decision.83 A history of sexual abuse should not be used to discount current concerns. The review should also ensure the tool does not allow for allegations that demonstrate relevant facts circumstantially to be overlooked.

INVESTIGATING A SERIOUS CARE CONCERN

When investigating a serious care concern, CCIU will attempt to gather information from a range of departmental, government and non-government sources. CCIU has access to C3MS and other records held by the Agency, such as carer registration files. Records may be sourced from other government agencies with the cooperation of the Agency as the child’s guardian or, if they relate to another person, with that individual’s consent. CCIU investigators may also interview witnesses, including Families SA staff members, carers, the child and the person who is the subject of the concern.84

THE POWER TO INVESTIGATE

The authority, including any statutory power, for CCIU to conduct investigations is uncertain, even within CCIU.85

A DELEGATION FROM THE CHIEF EXECUTIVE

The Chief Executive of the Department purported to delegate authority to individual CCIU staff to conduct, manage and plan investigations for and on behalf of the Department, by sending letters to them. The letters did not refer to any legislative powers. Nor did they indicate what an investigator was actually authorised to do in the conduct of an investigation.86

The Commission sought clarification of this issue. The Chief Executive advised the Commission that the letters were not intended to act as a delegation of statutory powers or authorities. Rather they served as evidence of his authorisation to CCIU staff to conduct investigations. The letters were subsequently reissued. The concept of delegated authority was removed.87

POSSIBLE STATUTORY POWERS

The 2015 report commissioned by the Department to review aspects of CCIU suggested that the unit acted according to the authority of section 19 of the Children’s Protection Act 1993 (SA).88 The Interagency Code of Practice: Investigation of Suspected Child Abuse or Neglect also states that according to section 19, ‘CCIU has legislated authority to access relevant information as articulated under [the Act].’89 However, CCIU Manager Mr Adams told the Commission that CCIU did not rely on this section as a source of authority or power to conduct a care concern investigation.90 With an appropriate delegation, section 19 could provide a basis for the conduct of some care concern investigations.

Section 45 of the Family and Community Services Act 1972 (SA) empowers authorised officers to enter premises for the purpose of ascertaining whether a child in foster care is being adequately cared for. However, Mr Adams said that this section had not been applied directly while he was manager of CCIU.
Section 47 of the Family and Community Services Act requires foster parents to provide the Chief Executive with information about themselves, or a child in their care. These two sections currently provide a source of power in relation to the investigation of foster parents. Proposed legislative reforms (discussed in Chapter 11) would result in all relative or kinship carers (who are caring for a child on a care and protection order) also being subject to these provisions.

Reliance on sections 45 and 47 would give investigators more scope to gather and obtain information, and result in better informed findings.

**CONTRACTUAL OBLIGATIONS**

Contractual arrangements with foster care and emergency care agencies require service providers to cooperate with care concern investigation processes and to follow up assigned tasks. These arrangements should provide very effective support to CCIU when gathering information during an investigation.

Mr Adams thought that there was a need for a much closer relationship between CCIU and those areas of the Agency responsible for licensing, contracting and service accountability, to complement the role of CCIU. That is clearly desirable. If investigation processes are being compromised because of a lack of cooperation from service providers, the Agency should address these issues through contractual mechanisms.

**LIMITED POWERS OF INVESTIGATION COMPROMISE OUTCOMES**

The scope of CCIU’s investigatory powers is limited. Apart from contractual obligations, and information obtained from within the Department and through inter-agency mechanisms, investigators cannot compel persons or organisations to provide information, nor speak with them. Consequently there will be cases where key witnesses decline to provide information, and other potentially relevant evidence cannot be obtained. This can result in findings based on an assessment of incomplete evidence.

At the conclusion of an investigation (putting aside the identification of systemic issues), the outcomes that may be reached are:

- abuse or neglect is substantiated or not substantiated; and
- a deficit in the quality of care is substantiated or not substantiated.

When an investigation is constrained by a lack of evidence, the appropriateness of recording a definitive outcome of ‘substantiated’ or ‘not substantiated’ is questionable.

For example, an investigation was conducted into sexual abuse allegations levelled against a kinship carer who was providing care to his teenage step-granddaughter. It had been substantiated that a number of years earlier the carer had sexually abused the teenager’s mother. Information gathered during the investigation revealed that there was evidence potentially supportive of the present allegation of abuse. However, key witnesses declined to speak with the investigator and did not cooperate with the investigation. The outcome of this investigation was then recorded as ‘abuse not substantiated’. In the circumstances the more appropriate result should have been the recording of an inability to resolve the allegation due to an insufficiency of evidence.

The Commission considers an outcome such as ‘undetermined—insufficient evidence’ should be available to investigators and would make it clear to those who subsequently review or rely on a record of the care concern that a finding was unable to be made due to evidential limitations.

**OTHER DEFICIENCIES IN THE PROCESS**

**NO CLEAR SCOPE OR PURPOSE**

Stakeholders have described some investigations as ‘a fishing expedition, a trawling exercise, to pull together as much as they can to throw at their defendant in some hope that something would stick’. One experienced practitioner told the Commission the approach can be to look under every rock and explore everything, rather than conducting an investigation with clear scope and purpose if this is the prevailing approach, it may be a consequence of a lack of documented guidance and clarity as to the role and purpose of an investigation. An outdated manual of practice (2010) provides limited direction to investigators, and some aspects of the manual are irrelevant to the current functioning of CCIU. CCIU attempts to fill these deficits through the use of internal guidelines and procedures, but they are not comprehensive, nor endorsed by the Executive.

**PROCEDURAL FAIRNESS**

The Layton Review was clear that investigations must ensure that:

all persons investigated have a right to a high level of procedural fairness, given that one of the potential outcomes of such an investigation may be a person losing their livelihood (in the case of an employee) or having a child in their care removed permanently and, in turn, being deregistered.
Procedural fairness requires the decision maker to use fair and proper procedures when making a decision that affects a person’s rights, interests or legitimate expectations. It has a number of elements including the requirement to inform a person of the case against them and to give them a reasonable opportunity to respond.

Investigators have not been given guidance as to how to afford a person procedural fairness throughout an investigation process. They have been left to develop their own understanding of this indispensable concept. One practitioner with experience in care concern investigations told the Commission that they only became aware of the concept after working in CCIU for a number of years.98

Procedural fairness can be a difficult concept to understand and apply. It should not be left to the responsibility of an individual investigator to determine what it is and its application to investigations.

ASSESSMENT OF THE EVIDENCE
At the conclusion of the investigation, the investigator must decide the outcome on the balance of probabilities.94 However, this is another area in which limited guidance is provided and there is a possibility that this standard of proof is being applied inconsistently.95

Drawing together the available information and assessing the weight to be placed on items of evidence is a difficult task. Unendorsed frameworks may be used to guide this process, but investigators generally approach the task in an individualised manner.91 While the principal investigations officer reads draft investigation reports and consults with investigators about their findings92, the lack of documented guidance raises the potential for the officer to be misinformed during this process. Ensuring that investigators understand how to assess evidence and apply the standard of proof are essential to achieving consistency in decision making.

THE APPLICABLE STANDARDS OF CARE
The standards against which an investigator should assess the level of care provided to the child are not defined.103 The principal reference should be the Standards of Alternative Care in South Australia.104 However, the standards relied on in practice vary between investigators and there is no common understanding as to when a care standard is unmet.105 Service providers also considered there was a lack of clear objective standards of care against which deficits could be measured.106

ACHIEVING THE TWO INVESTIGATORY AIDS
Because an investigator is tasked with examining abuse, neglect and care standards, as well as identifying broader systems issues, the effectiveness of each function can be compromised. The dual purposes of an investigation require distinct approaches. Identifying and analysing systems issues affecting a placement will usually require a more holistic assessment of the child’s care, compared with an incident-focused approach questioning whether a particular episode of abuse has occurred. Achieving these two investigatory aims is challenging in the absence of up-to-date, comprehensive and endorsed policies and procedures.

The outcome of a serious care concern investigation can have far-reaching consequences. The investigator’s decision can have significant repercussions for a child’s placement and for an individual. Guidelines should be developed to address important aspects of an investigator’s role. These should include how to define the scope of an investigation and achieve its dual purposes, how to afford a person procedural fairness, and how to assess evidence and apply the appropriate standard of proof. The standards against which a child’s care is measured should also be defined.

PROTRACTED INVESTIGATIONS
Service providers and carers identified the time investigations took as a significant source of frustration.107 The Commission reviewed all 26 serious care concern investigations that were finalised between 1 July 2013 and 1 December 2014. The average time taken to finalise an investigation was two years and two months. This is obviously substantial, not only for the child but also the person who is the subject of the concern.

THE EFFECT OF DELAYS
Evidence before the Commission suggests CCIU is inadequately staffed, but delays cannot be entirely attributed to resourcing pressures.108 There are a number of factors which may contribute to the length of time investigations take to complete, including:

- initial delays in the determination of a care concern referral and allocation to an investigator109;
- insufficient clarity as to the purpose and scope of an investigation;
- a lack of adequate policies, procedures and guidelines;
- insufficient training provided to investigators110;
- no timeframes for an investigation to be completed111;
- investigations not commencing until after any criminal proceedings have been finalised112;
- attention being diverted from progressing the investigation to keeping stakeholders up to date113;
- the time-consuming process of generating investigation reports. They are often lengthy (about 20–50 pages), digressive and unfocused. This is a likely result of investigations being confused and unconstrained114; and
- the process of giving stakeholders and the subject of concern an opportunity to provide feedback during the finalisation of the report.115
Investigative delays can have an adverse effect on the permanency of placements of children in care and contribute to carers either leaving, or not joining, the out-of-home care system.\textsuperscript{116}

For a child in care, the delay in finalising an investigation may result in the irremediable breakdown of their placement. When responding to a serious care concern, removing the child from the placement will often be in their best interests. However, protracted investigations can effectively end any prospect of the child’s return. In some cases removal may have been the eventual outcome but in others the child may have been reunified with their carers if the investigation had occurred promptly. This has significant consequences for a child in care, particularly given the challenges of finding other suitable out-of-home placements. Delay may also result in a child being asked about an incident long after the event, when they have limited recollection or may be re-traumatised by the questioning process.

A protracted investigation can also be stressful for an individual and have a significant consequence on their livelihood. An employee may be stood down for an extended period or a carer may be unable to obtain a screening clearance to undertake other roles. For example, a foster parent was unable to work in his role as a bus driver pending the outcome of an investigation that took more than two years to be finalised.\textsuperscript{97}

Delays undermine the relevance of CCIU. In many cases, by the time a report is finalised the situation of the child in care is completely different to that which prevailed when the concern was raised. Systems issues that may have been identified may no longer be relevant to the policies or practices of Families SA or the service provider. As a result, Families SA may not draw on the recommendations of an investigation.\textsuperscript{118} For example, a foster parent was unable to work in his role as a bus driver pending the outcome of an investigation that took more than two years to be finalised.\textsuperscript{97}

Delays in investigating serious care concerns are unacceptable. The care concern process should minimise the potential for further harm to children by ensuring responses are timely.\textsuperscript{119} Previous reviews have also highlighted the importance of the prompt resolution of concerns, particularly from a procedural fairness perspective.\textsuperscript{120}

**THE EFFECT OF CRIMINAL PROCEEDINGS**

When a care concern referral contains an allegation that, if proven, would amount to criminal conduct, it is referred to South Australia Police (SAPOL) to consider whether a criminal investigation should be conducted. Until recently, CCIU would defer its own investigation pending the finalisation of any criminal investigation and proceedings. Consequently in some circumstances the care concern investigation would be delayed for more than a year.\textsuperscript{121}

This practice appears to have developed as a result of the recommendation in the CISC Inquiry that the unit’s guidelines include that\textsuperscript{122}:

\begin{quote}
[the unit is to] take no action that would prejudice a police investigation or potential prosecution. In particular, the [unit] must not speak to the child, alleged perpetrator, potential witnesses or other potential complainants without seeking, and then gaining, approval in writing from SA Police.
\end{quote}

However, the Commission has not been able to identify any written policy or guideline that incorporates this recommendation.

The intent of the recommendation was to prevent CCIU from taking action that would prejudice a police investigation or prosecution: it did not require a care concern investigation to be placed completely on hold as has become the practice. In recent times, there appears to have been some progress with respect to this issue. With written permission from SAPOL, limited aspects of a care concern investigation may be undertaken while criminal proceedings are under way. However, there is no clarity as to the circumstances in which this may occur, and the decision appears to be made on an ad hoc basis.\textsuperscript{123}

Complications that may arise if investigations are conducted in parallel can be overcome by staff with specialist investigatory skills, clear lines of communication, and an understanding of the respective roles of CCIU and SAPOL.

An investigation by CCIU into whether or not an incident has occurred, and the apportionment of blame, will usually prejudice criminal proceedings. However, if there is clear communication between the two agencies, the examination of program or system deficits that may have contributed to the incident should be able to be undertaken in parallel with a criminal investigation.

When compared with the interface between law enforcement and child protection agencies in other jurisdictions, the practice in South Australia of delaying the commencement of a care concern investigation is uncommon.\textsuperscript{124}

In Victoria, staff members of the statutory child protection agency, employed as Quality of Care Coordinators, are specifically tasked with coordinating responses to care concerns, including joint responses with the Victoria Police. This enables matters to be more easily progressed without compromising ongoing criminal proceedings.\textsuperscript{125} Similar arrangements would be valuable in South Australia, given the contribution of pending criminal proceedings to the issue of delay. However, it would be important for those coordinating a joint response to have the requisite skills and expertise.
RESPONDING TO A SERIOUS CARE CONCERN
INVESTIGATION

The process that follows the completion of an investigation involves a number of layers of authority. Investigation reports are approved by the manager of CCIU and provided to the Deputy Chief Executive of the Office for Corporate Services, who is required to approve the report. The report is then forwarded to the Chief Executive of the Department for endorsement and final approval. CCIU has no further involvement in the matter.125

The Chief Executive then refers the report to the Deputy Chief Executive of the Office for Child Protection, who is expected to provide the Chief Executive with a response briefing, including an ‘action plan’ responding to the report’s findings, within three months.

The processes followed by the Agency to produce the response briefing are unclear. Documentation outlining inconsistent processes is in circulation in the Agency. It appears the manager of the Families SA office where the child’s case file is held is expected to complete the response briefing and provide it to the manager of the Agency’s adverse events program. The briefing is then provided to the Deputy Chief Executive of the Office for Child Protection who forwards the approved briefing to the Chief Executive of the Department.126

DELAYS AND DEFICITS IN THE AGENCY’S RESPONSE

Between 2013 and 2015 the Agency’s adverse events program lapsed due to a lack of staff. This affected the Agency’s oversight of the completion of response briefings and the attention given to systemic issues raised by CCIU.127

At April 2015, the Commission examined the response of Families SA to 16 of 26 investigation reports finalised between 1 July 2013 and 1 December 2014. The Chief Executive did not receive a response briefing within the designated three-month timeframe in any of the 16 matters. Ten responses had been completed, but the average time taken was five months, with the longest time being just over nine months.128 The Chief Executive was still waiting for responses for six reports that had been approved between May and November 2014. In the case of the report approved in May, 11 months had passed without a written response by the Agency.129

These delays in the Agency’s response time, coupled with protracted investigations, undermine the utility of a process aimed at addressing systems issues and improving practices within Families SA.130

An investigation report does not outline recommendations or actions to be taken by the Agency when addressing issues: that task appears to be left to the local office managers. However, their capacity to consider systems issues and effect change is limited.

Given the resource pressures within Families SA, it is overly optimistic to expect office managers to respond to investigation reports in a considered and strategic manner. It may be difficult for them to detach themselves from their local responsibilities and adopt a more strategic outlook when addressing the findings of a report. In addition, an office manager may not appreciate broader issues affecting the Agency.

Managers do not receive specific guidance or training as to how they should respond to investigation reports, particularly what may be expected of them regarding systems issues that may have been identified.

Even if a manager does complete a response briefing, there is no clear or routine mechanism in place thereafter to identify and act on the lessons learned from the investigation process. This suggests the outcomes of serious care concerns investigations are not used effectively to guide system-wide reform.

COLLABORATION TO INFORM SYSTEM CHANGE

While some responses may need a local focus, senior front-line staff should collaborate with staff who have roles dedicated to the oversight of agency-level responses and the promotion of system change. Such collaboration would allow effective local level responses to inform the Agency’s practices more broadly, with the overall aim of improving the experiences of other children in care who could be adversely affected by similar systems deficits. Local staff should be given clear guidance as to their responsibilities in this collaborative process. They also need to be given time to dedicate to the task.

RESPONDING TO MINOR AND MODERATE CARE CONCERNS

Minor and moderate care concerns are not investigated by CCIU: they are returned to Families SA for response.

There is some documentation that provides limited guidance to Agency front-line staff. However, it is outdated and not disseminated in any systemic way. There is also confusion and a lack of understanding about roles and responsibilities.132 Staff do not receive formal training in responding to care concerns.133 The system relied on experienced staff to provide support and guidance to new staff. However, with the loss of experienced staff, even this informal training mechanism has become difficult to sustain. The knowledge and rigour relating to responding to minor and moderate care concerns have diminished over time. The process is subject to individual interpretation and different approaches across offices.134
MINOR CARE CONCERNS

Minor care concerns should generally be allocated by the relevant office manager to the child’s caseworker to be dealt with as part of their normal case management. It is expected they would work with other agencies if necessary to determine how best to address the concern. Responses are expected to be collaborative and supportive. Case management actions may include:

- more regular contact with the child and carer;
- a review of the child’s care plan;
- clarification of expectations, roles and responsibilities;
- the provision of information or training to carers; and
- development of strategies with carers to address challenging aspects of the placement.

The focus is on supporting and maintaining the placement—it is not about laying blame. Such actions reinforce the inappropriateness of categorising the care concern raised against McCoole as minor. Allegations that are suggestive of sexual abuse, or any incident of abuse or harm, could not be adequately addressed through a case management response.

Care concerns that are suitable for a case management response should genuinely be minor. They should pose very limited risk to the child continuing in the placement, or to other children who may come into contact with the employee or carer.

MODERATE CARE CONCERNS

Although the focus of moderate care concerns is on providing support and maintaining the placement, they call for a more formal response than minor care concerns. An element of the response should be investigatory. However, there is little clarity as to who should be responsible for that aspect of the matter. This can result in an inadequate or delayed response. For example, senior staff in different directorates of the Agency allowed a moderate care concern involving an employee to languish for 20 months as they were confused about who was responsible for responding to the matter.

The prevailing practice appears to be that the office manager who is responsible for the child’s caseworker is the person who is ultimately responsible for responding to the care concern. However, if the person who is the subject of concern is an employee, there is an expectation that their manager will be involved in addressing them, and helping to identify systems issues.

Previously, the response to a moderate care concern was to be completed within 42 days. This included submitting a report to the manager of the investigations unit. Such a report is no longer provided: the outcome is simply recorded on C3MS. The staff member responsible, usually the office manager, is expected to decide whether abuse or neglect, or a deficit in the standard of care, is substantiated. More recent documentation obtained by the Commission indicates there is no set timeframe to complete a response.

COLLABORATION WITH STAKEHOLDERS

The Commission reviewed 100 minor and moderate determinations made between 1 July 2013 and 1 December 2014. Approximately 85 per cent related to a foster parent, a kinship carer or an emergency carer.

If a minor or moderate care concern relates to a foster parent, kinship carer or emergency carer, the responsible section of Families SA (for example, the kinship support program) or the relevant non-government organisation should be informed. It is expected the care concern will be addressed collaboratively by the various stakeholders. However, what is expected of them, and where the division of responsibility lies, are not well defined.

The approach to collaboration is inconsistent across the state. There is a lack of documentation to guide how the Families SA office involved in the response process and the stakeholder should work together. Communication issues are frequently cited. The stakeholder may not be included in the response process at all, or invited to participate as an afterthought.

Excluding stakeholders from the process, regardless of the reason, undermines the effectiveness of the care concern system and in turn jeopardises outcomes for children in care. Decisions may be based on incomplete information. Plans or strategies that are being implemented in an effort to support and maintain a placement may be compromised if the foster care agency is not actively involved. Meaningful collaboration should form part of a functioning and valuable care concern system.

However, there are some cases, such as the care concern raised against McCool, where the seriousness of the allegations and a potential conflict of interest on the part of the service provider, would preclude a collaborative approach during the response to the care concern. In those cases, agencies should be obliged to cooperate rather than collaborate with the investigation.

THE NEED FOR SPECIALIST SKILLS AND OBJECTIVITY

Responding to care concerns can be complex, and the inappropriate determination of serious allegations as minor or moderate unnecessarily contributes to the
challenges that confront Families SA front-line staff. It is a departure from the recommendations of the Layton Review, which contemplated a unit independent from the operations of the Agency to investigate serious allegations of abuse and neglect involving children in care. The system is not designed for the Agency’s front-line staff to deal with serious allegations. They often will lack the necessary skills or independence.

Agency front-line staff have a role to play in responding to care concerns, but only where care concern referrals are properly categorised.

AN EXAMPLE OF AN INADEQUATE RESPONSE

The Commission’s inquiries revealed that the inadequate response to the care concern raised against McCoole was not an isolated occurrence.

For example, a CCR alleged a male foster parent was watching his teenage female foster child dress and undress. This was determined to be a moderate care concern. The determination led to a process that was not in the best interests of the child and did not sufficiently address the concerns.

The allegations were referred to SAPOL but it was not clear from the records obtained by the Commission whether Families SA ascertained if a criminal investigation was to be conducted before it proceeded with the care concern response. A strategy discussion between Families SA and SAPOL should have occurred in this case soon after the allegations were raised in order to plan how the matter should proceed and ensure there was clarity about the responsibilities of each agency.

There is no record on C3MS that this occurred.

Families SA responded to the allegation by arranging for the child’s caseworker to speak with both the child and the foster parents. This occurred in the home of the foster parents. The conversations with the child and the foster parents took place in separate rooms but within about 15 minutes of each other. Having a conversation with the child in the home and with the foster parents nearby was inappropriate. The child may have been reluctant to talk about the allegations in that environment. Given the conversations were conducted so closely in time, it is also unlikely that the caseworker had the opportunity to reflect on the child’s responses before speaking with the foster parents.

Further, the information in the CCR was limited. If the foster parents had been interviewed before the child, they may have been able to provide some context to the allegations being made and the child’s circumstances. The record of the conversation with the child evidenced a lack of preparation. The purpose of speaking with the child and the issues explored were not clear. The record suggests the concerns raised in the CCR were not sufficiently addressed.

A more considered and specialised response was required to this matter than that which occurred. Caseworkers who do not possess the necessary skills to conduct an investigation can undermine the care concern process and threaten the outcome, particularly in circumstances when they are inappropriately tasked to manage serious allegations.

ENGAGING WITH A CHILD DURING AN INVESTIGATION

There is an important difference between talking to, and interviewing, a child. Forensic interviews of children are conducted for a specific purpose, such as investigating an incident of abuse or conducting an assessment of a child and their family.

Caseworkers will often talk to a child about their placement in general terms to find out about their progress and experiences. This is part of standard case management and does not require an in-depth understanding of interviewing techniques. A proper forensic interview is more targeted. The interviewer gains an insight into the child’s world through understanding the way the child’s day is structured and experienced. The interviewer can explore allegations in context and, if necessary, focus the child’s attention on areas of particular importance. An appropriate balance will be reached between the avoidance of leading questions and enabling the child to understand the experiences of interest to the interviewer.

As was highlighted by the McCoole case study, when investigating allegations of abuse, in particular sexual abuse, interviewers need to be aware of a number of factors which may affect whether or not a child discloses their experiences, such as:

- a child may not feel comfortable talking about their experiences when the interview is held in the same environment in which the abuse occurred;
- if a child is not certain whether they will have ongoing contact with the person responsible for the abuse, they may be reluctant to disclose;
- a child is not necessarily more likely to disclose to someone with whom they have an existing relationship; and
- sexual abuse can be particularly difficult for children to disclose as they have a sense of the secrecy surrounding it.

Central to the investigation of an allegation of abuse or neglect is providing the child with sufficient opportunity to disclose their experiences during a properly planned interview. Purposefully providing a child with that opportunity is a complex task. Generally, Families SA caseworkers have very limited, if any, training and expertise in this specialist skill.
THE INFLUENCE OF OTHER FACTORS

Resource limitations and operational pressures within the child protection system can compromise the decision making of practitioners when responding to care concerns. It may be difficult for Families SA staff to detach themselves from these issues. Staff responding to care concerns cannot help but be aware of the ‘very stretched and overburdened’ nature of the system. Factorsthat should not be given precedence over the child’s safety, such as limited alternative placements for the child, may be given too much weight. The staff member may have an established relationship with the carer who is the subject of the concern and find it difficult to set aside their pre-existing views when deciding the outcome. In these circumstances, they may be less likely to make a decision that would require the child to be removed from the placement or make a finding of substantiated abuse against the carer.

Similarly, where the subject of concern is an employee, the conduct of staff may improperly influence the course of the investigation. This was clearly demonstrated in the response to the care concern raised against McCoole. Staff members who knew McCoole made incorrect assertions about him and about the notifier of the care concern. This conduct influenced the staff who were tasked with investigating the allegations.

All of these issues reinforce the need for the investigation of serious allegations to be undertaken independently of Families SA operations.

TRENDS IN CARE CONCERNS

Table 15.3 shows the number, and determined category, of CCRs received by CCIU each financial year from 2011/12 to 2014/15. From 2011/12 to 2013/14, the total number of CCRs declined. This changed in 2014/15, with a four-year peak of 1002 referrals.

For three years until 1 July 2014, the proportions of CCRs determined as minor, moderate and serious were relatively constant. The vast majority of CCRs, on average 78 per cent across three financial years, were determined to be minor care concerns. As shown by Figure 15.1, in 2014/15 there was a dramatic decrease in the number of CCRs determined to be minor. The proportion was less than half of the previous year, falling from 77 per cent in 2013/14 to 37 per cent in 2014/15. There was a corresponding increase in the proportions of CCRs determined to be moderate and no action required.

The trends show that there was a clear change in the work of CCIU in 2014/15. It raises for consideration whether this is a reflection of a change in how care is delivered to children, in reporter behaviour or in the determination practices of CCIU.

THE RELEVANCE OF THE ARREST OF McCOOLE

Before McCoole’s arrest in June 2014, the number of CCRs was steadily declining. Conversely, the number of children in care increased from 2368 at 30 June 2011 to 2631 at 30 June 2014. It is unlikely the decrease in CCRs was due to the growing number of children in care generally being provided with a better standard of care. Rather, a number of deficiencies in the care concern system have likely contributed to the decline in CCRs over this time, including:

- an inadequate understanding of what constitutes a care concern;
- a lack of clarity about when the conduct of a person caring for a child in care should be reported;
- a mistaken belief that because a child is in care a notification is not required; and
- the lack of appropriate response to some CCRs, leading to notifiers believing reporting is futile.

THE INCREASE IN DETERMINATIONS OF ‘NO ACTION REQUIRED’

McCoole’s arrest, and the publicity which ensued, may have had an influence on reporting behaviours. The increase in reports in 2014/15 was accompanied by a ninefold increase in the proportion of CCRs determined to require no action. Given the impact of McCoole’s...
conduct, adults in contact with children in care may have become hyper-vigilant and reported less serious behaviour not previously regarded as warranting notification.

While adults should be observant and attentive at all times to the safety and wellbeing of children in care, better guidance and support following McCoole’s arrest may have helped to limit this reporting of unnecessary concerns.

The Commission was told that many care concerns could be more appropriately responded to in the first instance at the case management level, rather than the matter being reported to CCIU.

**FEWER MINOR DETERMINATIONS**

The steep decline in the proportion of minor care concerns in 2014/15 reflects the shortcomings in the determination process and a risk-averse culture. There is no evidence CCIU purposefully changed the determination thresholds following McCoole’s arrest. However, it is likely greater caution was employed when determining which CCRs required an investigative response, as opposed to a case management response. This seems particularly likely given that the notification in relation to McCoole’s conduct had been erroneously categorised as minor.

**THE PROPORTION OF CARE CONCERNS TO BE RESPONDED TO BY FAMILIES SA**

Families SA is expected to respond to the overwhelming majority of care concerns raised. As shown in Table 15.4, on average from 2011/12 to 2014/15, Families SA was required to respond to 801 care concerns each year. In 2013/14, 96 per cent of CCRs determined by CCIU to require a response were classified as either a minor or moderate care concern. In 2014/15 this proportion fell slightly to 90 per cent. Only a very small proportion of CCRs, on average 7 per cent from 2011/12 to 2014/15, receive an investigation by CCIU independent of Families SA operations.

There is a role for Families SA to play in responding to less serious care concerns, particularly those where there is a real prospect of a case management response improving the outcomes for the child. However, it is questionable whether the present balance whereby CCIU only responds to about one in 10 care concern referrals is appropriate.

Testing of the SDM care concern screening criteria indicated that between 420 and 520 care concerns would be screened in for an investigation and review response each year. However, not all care concerns meeting the threshold of abuse, neglect or significant risk of serious harm would require an investigation independent of Families SA operations. It was determined through applying draft criteria that between 170 and 200 care concerns required an independent investigation by CCIU. This is more than double the number of care concerns that were retained by CCIU for investigation in 2014/15. An increase in the workload of CCIU is not unexpected. The Commission’s inquiries revealed serious allegations of abuse or neglect in out-of-home care were being referred to Families SA offices for response. This practice should cease.

Over an 18-month period to July 2015, CCIU finalised only about one investigation per month. At this rate of finalisation, it would take CCIU a number of years to complete current outstanding matters, not accounting for new investigations. The productivity of the CCIU should increase, to meet the greater workload. In part this would require better resourcing.

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**Table 15.3: The number and determination of care concern referrals, 2011/12 to 2014/15**

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total care concern referrals</td>
<td>975</td>
<td>874</td>
<td>830</td>
<td>1002</td>
</tr>
<tr>
<td>Serious care concerns (percentage of total)</td>
<td>57 (6%)</td>
<td>70 (8%)</td>
<td>33 (4%)</td>
<td>83 (8%)</td>
</tr>
<tr>
<td>Moderate care concerns (percentage of total)</td>
<td>122 (13%)</td>
<td>104 (12%)</td>
<td>143 (17%)</td>
<td>375 (37%)</td>
</tr>
<tr>
<td>Minor care concerns (percentage of total)</td>
<td>780 (80%)</td>
<td>675 (77%)</td>
<td>636 (77%)</td>
<td>368 (37%)</td>
</tr>
<tr>
<td>No action required (percentage of total)</td>
<td>16 (2%)</td>
<td>25 (3%)</td>
<td>18 (2%)</td>
<td>176 (18%)</td>
</tr>
</tbody>
</table>

Source: Data from Care Concern Investigations Unit.
MANAGEMENT OF PRIOR CARE CONCERNS

The Commission reviewed selected documentation relating to more than 300 CCRs received by CCIU between July 2013 and December 2014. The Commission was able to identify clear trends in relation to carers and staff members with histories of prior care concerns and placements with ongoing difficulties.

A significant proportion of CCRs originated within placements in which Families SA was already aware of ongoing problems. For example, in a sample of 50 CCRs which had received a determination of ‘no action required’, approximately 30 per cent related to placements that were the subject of a prior care concern. The rationale for this decision often indicated that Families SA was aware of ongoing issues in the placement and was making efforts to address them through case management. Little consideration appears to have been given to the ineffectiveness of that as a remedial action. Similarly, in a sample of 50 CCRs which had received a determination of ‘moderate’, approximately 42 per cent related to placements in which Families SA was aware that issues existed and again ‘case management’ was being undertaken to address the problems.

Approximately 50 per cent of all care concerns determined to be serious in the review period related to placements in which Families SA was aware of prior or ongoing issues.

Kinship care accounted for 41 per cent of placements with a history of care concerns (across a sample of 200 CCRs relating to subjects who had at least one previous CCR). Sixty-five per cent of these kinship placements involved Aboriginal and Torres Strait Islander children.

In approximately 50 per cent of serious care concern investigation reports reviewed by the Commission, the subject of concern had a history of prior CCRs.

These trends suggest the response of CCIU and the Agency to troubled placements often appears to be ineffective, and decision making often gives insufficient weight to the relevance of a history of care concerns. A history of child maltreatment on the part of a carer or staff member is a useful predictor of future maltreatment. However, the Agency does not make use of the trends that can be identified by analysing the history of prior care concerns to address systems issues.

DEFICITS IN RECORDS MANAGEMENT

Care concern data is recorded on two distinct systems: Objective and C3MS. Objective is the central recording database for care concerns used by CCIU, and C3MS is Families SA’s electronic case management system. Data is not automatically shared across the two systems, and neither system has a complete picture of a care concern. Table 15.5 sets out the data saved on each system.

The paper files used by CCIU prior to Objective have not been completely transferred onto the system due to a lack of resources. In some cases, in order to ascertain a complete picture of a person’s care concern history, four different databases or systems need to be reviewed: Objective, C3MS, CIS (the system predating C3MS) and hard copy files. This is a time-consuming exercise and crucial information could be missed.

C3MS stores care concern information under a child’s name. It is therefore difficult to ascertain through that system alone if the person the subject of concern has a care concern history. To search for their history, the name of any child previously involved must be known. Often it will not be.
Care concern histories can be more easily obtained through searching Objective, as information is stored under the name of the person who is the subject of the concern. However, Families SA staff do not have access to the Objective system.164

Extracting data from both C3MS and Objective is a difficult task, as neither system has adequate reporting capabilities.165 This contributes to care concern data not being used in a strategic way to identify where there may be consistent problems in out-of-home care service delivery.

The Layton Review contemplated that care concern data would be used by Families SA and CCIU to improve systems deficits, assist in the oversight of staff and achieve better outcomes for children in care. This has not occurred.

Currently, CCIU is entirely reactive: it waits to receive allegations before conducting the investigations. However, analysing themes and patterns in care concern referrals and outcomes would be a potent tool for the Agency, enabling them to be more proactive and targeted in addressing abuse and neglect in care. For example, data analysis may reveal that a particular residential care facility or foster care agency is responsible for a disproportionate number of CCRs; clear themes may emerge as to the type of care concerns arising in a particular area, or reveal a troubling pattern of behaviour in an individual. Analyses of this type are not undertaken.

Care concern data should be used in a more proactive way. Data analysis may lead to the early detection of systems issues and assist the Agency to take a strategic approach to the management of their staff and carers. The implementation of a database that permits the tracking of care concerns, critical incidents and other complaints, particularly in residential care, is discussed in Chapter 12.

### Table 15.5: The storage of care concern information on Objective and C3MS

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>C3MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care concern referral</td>
<td>• Care concern referral</td>
</tr>
<tr>
<td>• Determination rationale</td>
<td>• Determination rationale</td>
</tr>
<tr>
<td>• Information gathered and correspondence during a serious care concern investigation</td>
<td>• Details of minor or moderate care concern response</td>
</tr>
<tr>
<td>• Serious care concern investigation report</td>
<td>• Outcome of moderate care concern investigation</td>
</tr>
<tr>
<td></td>
<td>• Serious care concern investigation report</td>
</tr>
<tr>
<td></td>
<td>• Response to serious care concern investigation report including details of actions taken</td>
</tr>
</tbody>
</table>

Source: Witness statements, P Adams; A Dimusevska.

The approach to responding to care concerns in the future should be informed by the discussion throughout this chapter, and the specific features identified below.

### A REFORMED CARE CONCERN SYSTEM

The creation of a new, stand-alone child protection department brings with it an opportunity to reform the approach to investigating abuse and neglect in care and establish an effective care concern system. The following elements will be critical to its success:

- clear policies, procedures and guidelines, accessible to all Agency staff and communicated to all stakeholders;
- specific training for Agency staff and service providers, detailing roles and responsibilities in the care concern system;
- a panel responsible for determining which matters should be investigated independent of the Agency’s operations;
- a unit, independent of the Agency’s operations, responsible for investigating serious allegations (the investigations unit);
- a unit, within a directorate responsible for quality and practice, that has oversight of the care concern system (the response unit);
- integration between the care concern function and the Agency’s human resources unit;
- benchmarks for the completion of investigations and responses to care concerns; and
- an accountability mechanism external to the department.

The approach to responding to care concerns in the future should be informed by the discussion throughout this chapter, and the specific features identified below.

### THE NEED FOR TWO SEPARATE UNITS

The deficits identified in the care concern system prove the need for two separate units to be established in the new department. This is to ensure that sufficient attention and expertise are given to investigating serious allegations (the investigations unit), as well as responding to less serious matters. There is also a need for a dedicated unit to have clear responsibility for oversight of the care concern system (the response unit).
The investigations unit should be independent from the operations arm of the new department. Its focus should be the investigation of all allegations of serious abuse or neglect and significant risk of serious harm. In some circumstances, this unit may also be called upon to investigate serious care standard deficits. The unit would need to be sufficiently resourced to fulfil this mandate, and provide a statewide service. The limited staffing levels that have been in place in CCIU in recent times are unlikely to be adequate. The placement of the investigations unit in the new department should ensure that clear links are established with the human resources unit, and in particular with those staff members responsible for addressing employee misconduct.

The response unit should form part of the new department’s quality and practice directorate. This unit would be an integral part of the reformed care concern system and would have oversight of all care concerns, with particular responsibility for advising and liaising with front-line staff, monitoring care concerns, collating care concern data and informing system change.

Links between both units and the section of the department responsible for the licensing and accountability of service providers would also be essential.

DETERMINING THE INVESTIGATION PATHWAY

Chapter 8 proposes reforms that would give notifiers with concerns about the safety of children (whether mandated to report or not) two options: to report their concerns to the Agency’s Call Centre, or alternatively refer the matter to a child and family assessment and referral network in cases where a notifier believes that a child's circumstances would be adequately addressed by a prevention and early intervention program. However, guidelines and training should make it clear that care concerns should always be reported to the Call Centre. If a care concern notification is made to a referral network in cases where a notifier believes that a child's circumstances would be adequately addressed by a prevention and early intervention program, the notification should promptly relay the information to the Call Centre.

The Agency’s Call Centre should be responsible for assessing care concern notifications using the SDM care concern screening criteria tool. The immediate safety and wellbeing of the child should remain the responsibility of the local office who has case management responsibility for the child.

To fulfil its monitoring and analysis role, the response unit should also be advised of all care concern notifications received.

Care concern notifications assessed by the Call Centre as requiring an investigation and review response should be referred to a three-person panel. This is necessary to guard against the professional judgement of a single decision maker inappropriately determining that front-line staff should respond to serious allegations, as opposed to referring the matter to the investigations unit. The panel should include experienced staff members from the investigations unit and the response unit, and a senior staff member from the quality and practice directorate—either the director or the Agency’s principal practitioner.

The panel would need to meet regularly to ensure investigations start within 48 hours of receiving the notification. Consultation between the panel and operational staff or other stakeholders before determining the investigation pathway should be rare, and if necessary limited to information such as whether the person who is the subject of concern was on shift at the relevant time. The panel should not be responsible for taking any investigative steps.

The panel should be guided by clear criteria when determining whether the care concern is more appropriately investigated by the investigations unit, or front-line staff. Consideration may be given to factors such as:

- the extent and type of alleged harm;
- the number and age of children involved;
- whether a criminal investigation is likely;
- whether the person who is the subject of the concern is a staff member;
- whether there is a history of care concerns; and
- the nature of any systems issues that may be identified.

Given the potential sensitivities and specialist skills required, all allegations that raise the suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) should be investigated by the investigations unit.

The panel should also consider the potential for a child to be forensically interviewed during the investigation, and the likelihood for this interview to be conducted by the Agency, as opposed to SAPOL or Child Protection Services (CPS). It is likely that the investigations unit would conduct the investigation, as front-line staff are unlikely to have the specialist skills required to conduct the interview.

If the panel decides that the allegations can be appropriately investigated by front-line staff, there should be a flexible approach as to who has the responsibility for that investigation. For example, the panel may consider...
some independence from the office responsible for the child’s case management is necessary and allocate the matter to another local office for investigation.

The meeting requirements of the panel should not delay a matter being referred to SAPOL if the allegations are criminal in nature. In the first instance the response unit should be responsible for referring a matter to SAPOL but the panel may also consider the matter if it has not yet been referred.

Figure 15.2 sets out the proposed response pathways of a care concern notification through the reformed system. The reporting function of the response unit (discussed later in this chapter) is also shown.

**STRATEGY DISCUSSIONS**

All investigations undertaken by the investigations unit should start with a strategy discussion, bringing together expertise from the unit and other relevant agencies such as SAPOL and CPS. As part of its monitoring role, the response unit should also be represented. Depending on the nature of the allegations, it may also be appropriate to include human resources expertise, representation from the relevant local office, and the Agency’s licensing and service accountability section.

The strategy discussion should provide an opportunity for agencies to genuinely engage, share information and develop an investigation plan. Each agency needs a clear awareness of the planned activities and responses of all other agencies.167

Chapter 9 acknowledges the importance of inviting other agencies, including non-government agencies, to strategy discussions in appropriate cases. However, inviting a non-government organisation to a care concern strategy discussion requires caution, taking into account different considerations than those when responding to allegations of abuse or neglect in a child’s birth family. This is because in a care concern investigation, the non-government organisation may have a potential conflict of interest. For example, they may be called on to advocate on behalf of an employee or foster carer.

Strategy discussions may also be an important tool for care concerns that the panel has determined appropriate to be investigated by front-line staff.

In some cases, a strategy discussion would need to be held without delay following the care concern notification. It may be necessary, for example, to respond promptly to suspected physical trauma with a forensic medical assessment. Obviously, determining the investigation pathway should not stand in the way of an urgent response, and a further strategy discussion could be convened if appropriate.
SPECIALIST INVESTIGATORS
The investigations unit should be staffed by specialist investigators, in a multidisciplinary team encompassing both child protection and law enforcement expertise. All investigators should be trained in areas such as the Agency’s processes, the purposes of conducting an investigation, investigative techniques, child development, trauma-related behaviours and indicators of abuse and neglect.

Each investigation should be allocated to a primary investigator. However, the combined expertise available in a multidisciplinary team should provide a collaborative environment where investigations and decision making are informed both by child protection principles and the investigative principles used in law enforcement. This should ensure investigations do not become overly incident-focused, without consideration of other contextual factors that may have contributed to the child’s adverse experiences and the carer’s or employee’s conduct.

Investigators should understand the importance of affording procedural fairness to the person under investigation. The investigator should have authority under section 58(3) of the Children’s Protection Act to divulge information so that procedural fairness is not unduly frustrated by a duty to maintain confidentiality. The subject of the concern should be advised in writing of at least the general nature of the allegations within seven days of the notification. However, if a matter has been referred to SAPOL, communication with the subject of concern should not occur without police approval.

Investigators should have authority to gather information under sections 45 and 47 of the Family and Community Services Act and to conduct an investigation under section 19 of the Children’s Protection Act in appropriate circumstances. Contractual arrangements with service providers and conditions of employment should also provide mechanisms through which investigators gather information.

Chapter 21 proposes amendments to the Children’s Protection Act to permit and, in appropriate cases, require the sharing of information between prescribed government and non-government agencies with responsibilities for the health, safety or wellbeing of children, where it would promote those responsibilities. These amendments could be relied on by investigators to gather information during a care concern investigation.

An update to the Interagency Code of Practice was due to be released in July 2016. At the time of writing, it was expected the updated code would make it clear that it applied to the investigation of abuse and neglect of children in care, and this is endorsed by the Commission. There is no reason why inter-agency practices should be less robust because a child is in care.

INTERVIEWING CHILDREN
In many circumstances an investigation of serious allegations will include an interview of the child who is the subject of the concern, and possibly other children in the placement who may be able to provide relevant information. Depending on the nature of the allegations, trained interviewers from CPS or SAPOL may interview the child for the purposes of a criminal investigation, and this can subsequently be relied on for the care concern investigation.

In determining who should conduct an interview with a child, regard should be had to the recent amendments to the Evidence Act 1929 (SA) and the Summary Offences Act 1953 (SA). The legislation now sets out certain preconditions for the admissibility of a recorded interview with a child under the age of 14 years in certain criminal proceedings.

Further, section 104 of the Summary Procedure Act 1921 (SA) requires that an investigating officer, generally a police officer, attend the recorded interview of a child under the age of 14 years, for that interview to be admissible during committal proceedings in the Magistrates Court. (The term ‘investigating officer’ would not include a staff member of the Agency investigating a care concern.) This is because the recording must be accompanied by a transcript verified by the police officer as being a complete record of the interview. This is an important safeguard to ensure the accuracy of documentary evidence.

However, there may be occasions when SAPOL is not involved in a care concern investigation, but CPS considers it appropriate to conduct a forensic interview. The absence of SAPOL should not be viewed as an impediment to CPS conducting a forensic interview. If a child discloses their experiences during that interview, the resulting transcript should be admissible. Section 104 of the Summary Procedure Act should therefore be amended to permit the transcript to be verified by a person in attendance at the interview, other than an investigating officer as defined in the Act. It is not intended that the power to have someone other than a police officer verify the transcript be used in practice except in special circumstances.

Against this background, investigators in the investigations unit need to exercise caution when deciding to interview or re-interview a child. The decision to re-interview a child should always be made in consultation with a senior staff member. If a child has already been interviewed about the allegations by SAPOL or CPS, they should only be re-interviewed if further specific information has been identified as being
necessary for a complete investigation. Any interview needs to have a clear purpose, and should not be approached in an unstructured way.

If an interview is to be conducted, the nature of the allegations investigated by the investigations unit will, in most cases, require the child to be forensically interviewed by an appropriately trained interviewer. There should be investigators in the investigations unit trained in the forensic interviewing of children. The inter-agency training offered through TAFE is not sufficient for this purpose.\(^{[170]}\)

If a child needs to be interviewed during an investigation being conducted by front-line staff, careful consideration should be given to who will conduct that interview, and its purpose, including whether a forensic interview is necessary.

**FLEXIBILITY IN THE APPROACH**

An effective care concern system should provide for both flexibility and review in decision making. The response unit should serve as a liaison point and pivot in the system. When the Agency’s Call Centre assesses a matter as Standard of Care Unmet, it is ordinarily allocated to the local office for review. In some cases, the response unit may regard such a matter as requiring an independent investigation by the investigations unit. In those circumstances, the response unit should refer the matter to the panel for consideration.

There may also be some cases in which the local office considers a matter too serious to be investigated or addressed locally, or that it lacks the necessary expertise to conduct the investigation. In those cases, the office should also have the option of having the response pathway reviewed.

Providing some flexibility in the response pathways will only be beneficial to the care concern system if it is not misused. It should not be viewed as a mechanism to have care concerns reallocated without a genuine reason. It should also not interfere with the timeliness of investigations or responses.

**THE BROADER ROLE OF THE RESPONSE UNIT**

Staff in the response unit should generally have expertise in child protection; experience in conducting investigations would also be desirable.

The response unit should provide an advisory and consultative role for front-line staff who are tasked with responding to care concerns. The unit should also be responsible for ensuring there are clear and up-to-date policies, procedures and guidelines in place covering the various functions of the care concern system. This information should be accessible to staff across the Agency, and disseminated to stakeholders. Documentation relevant to carers should be available online in a clear, accessible format.

The response unit should liaise between the Agency and SAPOL. Matters referred to SAPOL for criminal investigation should generally not be actioned by the investigations unit or front-line staff until the criminal investigation and related proceedings are finalised, to ensure the actions of the Agency do not prejudice any criminal investigation or prosecution. Through liaising with SAPOL, the response unit should advise the investigations unit or front-line staff when an investigation or other review of allegations can begin. In collaboration with SAPOL, the response unit should determine whether there are any aspects of the allegations that may be addressed while the criminal proceedings are still under way without prejudicing the criminal process.

The investigation of care concerns (and standard of care reviews), whether undertaken by the investigations unit or by front-line staff, should be subject to specific timeframes. In Western Australia an investigation is expected to be completed within 30 days\(^{[171]}\); in Victoria, it should be completed within 28 working days of receipt of the care concern.\(^{[172]}\) The Commission considers that in the absence of ongoing criminal proceedings or special circumstances, a period of no more than six weeks should be sufficient to complete the investigation of a care concern.

**COORDINATING RESPONSES TO INVESTIGATIONS**

On completion of an investigation, the investigations unit should produce a report outlining its findings and the rationale for them. The report should then be provided to the Chief Executive of the new child protection department and the response unit.

The response unit would be responsible for notifying other relevant sections of the department of the investigation outcomes, for example the human resources unit, service accountability, carer registration or the local office. The response unit would also be responsible for coordinating their responses. Responses and intended actions of each section should be sought, and reported to the Chief Executive, within four weeks.

During this four-week period, the response unit would play an important role in ensuring the responses of each section were consistent. The unit may also work with the various sections to help develop actions to respond to issues specific to that practice area as well as broader systemic issues.

It is expected the response unit would use effective local level responses to guide broader systems improvements.
THE MONITORING ROLE

Crucial to the effectiveness of the care concern system would be a monitoring and analysis role to be performed by the response unit, including:

• monitoring the timeliness of investigations;
• reviewing systems issues identified during investigations and making recommendations to the Chief Executive in response;
• monitoring the implementation and effectiveness of these recommendations;
• analysing trends in care concerns and systems issues; and
• fulfilling the Agency’s external accountability responsibilities (discussed below).

The response unit would need full access to all records relating to care concerns. As discussed earlier, this information is spread across a number of systems. At present, Objective is likely to be the most useful system but the Agency should consider whether there is a better system that would permit the more effective tracking and analysis of care concern information. The Agency should also dedicate resources to uploading hard copy files of historical care concerns onto an electronic records management system so they are readily searchable and accessible.

A CASE MANAGEMENT RESPONSE

Care concern notifications assessed as Criteria Unmet should be referred to the relevant local office for a case management response, and the child’s caseworker should work collaboratively with the care team to address the concerns. While the response unit should be advised of the notification for the purpose of data analysis, the unit is not expected to have an active consultative role. Senior staff in the local office should be sufficiently equipped to help less experienced staff undertake an appropriate case management response.

EXTERNAL OVERSIGHT AND ACCOUNTABILITY

In 2008, the CISC Inquiry recommended reporting lines be established from the investigations unit (now CCIU) to the Guardian for Children and Young People (GCYP) when allegations of sexual abuse were raised involving children in care. In particular that:175:

• the GCYP be kept informed of the progress of investigations and, on request, be provided with information about an investigation within 24 hours.

It was also recommended that the GCYP have an advocacy role for children in care who had disclosed sexual abuse, and that it be mandatory for the Chief Executive of the Department or Commissioner of Police to notify the GCYP when a child in care made such a disclosure.176

The recommendations were accepted, and agreed practices were put in place between CCIU and GCYP. The extent to which CCIU has complied with this agreement has varied over time and has been dependent on the approach taken by the various managers of CCIU. Trends in the number of matters referred demonstrate that it is likely GCYP has not been advised of all relevant matters as agreed. This has been of particular concern since 2010. From November 2008 to October 2014, only 43 per cent of notifications were referred to GCYP within the timeframe recommended by the CISC Inquiry, and promptness has diminished over the years. In 2013, only five per cent of notifications were received within 24 hours.175

The inconsistencies in CCIU’s reporting practices mean that the intent of the recommendations has not been achieved. The GCYP’s capacity to perform an effective monitoring and advocacy role has been diminished.176

Consistent with recommendations in Chapters 10 and 16 requiring the reporting of key data to the Minister and GCYP, the Chief Executive of the new department should report quarterly to the Minister and GCYP on matters including:

• the number of care concern notifications received and their response pathway;
• how many care concern investigations have been completed;
• whether investigation timeframes were met and the reasons for timeframes not being met;
• the outcomes of investigations; and
• how identified systems issues are being addressed.
This mechanism is not intended to replace the specific reporting structures recommended by the CISC Inquiry in relation to allegations of sexual abuse.

As administrative actions, complaints or concerns that an individual may have regarding the conduct or outcome of an investigation, may be subject to the jurisdiction of the Ombudsman. The role of the Ombudsman is discussed in Chapter 22.
RECOMMENDATIONS

The Commission recommends that the South Australian Government:

172 Provide specialist training and documented guidance to staff within the Agency, as well as home-based carers and carers engaged through commercial agencies, as to their roles and responsibilities with respect to identifying and reporting conduct that may amount to a care concern, and the processes that follow such a report.

173 Consider developing technology to provide children in care with a user-friendly mechanism to engage with caseworkers in the care team and other responsible adults about their experiences and concerns.

174 Review and implement the Structured Decision Making® care concern screening criteria tool for use by Call Centre practitioners.

175 Establish a panel in the Agency to determine the appropriate response pathway with respect to a care concern that is not diverted by the Call Centre to the field, but noting that all allegations that raise a suspicion of sexual abuse (except those which are historical in nature or have otherwise been addressed) must be investigated by the investigations unit.

176 Establish in the Agency an investigations unit independent of the operations of the Agency to investigate matters referred to it by the panel, and staff that unit with a multidisciplinary team of investigators with expertise in child protection and law enforcement, and provide training and guidelines as to the scope of their roles.

177 Ensure that all care concern notifications are investigated in a timely manner:
   a. investigations should commence within 48 hours of the receipt of a notification; and
   b. in the absence of ongoing criminal proceedings or special reasons, investigations should be completed within six weeks from receipt of the notification.

178 Require a strategy meeting to be held at the start of all investigations undertaken by the investigations unit.

179 Define the standards against which deficiencies in the care provided to a child in care should be assessed.

180 Clarify the powers available to investigators, including putting in place appropriate delegations and authorities pursuant to sections 45 and 47 of the Family and Community Services Act 1972 and section 19 of the Children’s Protection Act 1993.

181 Ensure that staff are available in the investigations unit who are trained in forensic interviewing of children when this service is required.

182 Amend section 104 of the Summary Procedure Act 1921 to permit the filing in committal proceedings of a transcript of a recorded interview with a child under the age of 14 years that has been verified by a person in attendance at the interview, other than an investigating officer as defined in the Act.

183 Require investigators to record an outcome as ‘undetermined’ in any case in which there is insufficient evidence to make a definitive finding.

184 Establish a response unit within the directorate responsible for quality and practice to:
   a. provide advice to front-line staff about care concerns;
   b. provide a report to the Chief Executive of the Agency outlining responses and intended actions to issues identified in an investigation report. This should be provided within four weeks of the response unit receiving the investigation report;
   c. undertake a monitoring role in respect of all care concern notifications;
   d. analyse trends in care concern data to proactively address systems issues and inform the management of staff and carers; and
   e. make recommendations to the Chief Executive of the Agency as to proposed improvements in response to identified systems issues.
Establish a liaison function between the response unit and SAPOL, particularly with respect to identification of aspects of a care concern investigation that may be commenced by the Agency while criminal proceedings are pending.

Require the Agency to provide quarterly data to the Minister and the Guardian for Children and Young People about care concerns, including:

a. the number of care concern notifications received and their response pathway;

b. how many care concern investigations have been completed;

c. whether investigation timeframes have been met and the reasons for timeframes not being met;

d. the outcomes of investigations; and

e. how identified systems issues are being addressed.
15 INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CARE

NOTES

1 Office of the Guardian for Children and Young People (GCYP), Preventing sexual abuse of children and young people in state care in South Australia, internal unpublished paper, Government of South Australia, May 2006, p. 3.


8 ibid., p. 36.


11 GCYP, Preventing sexual abuse of children and young people, p. 3.


13 RA Layton (Chair), Our best investment, p. 918.

14 Witness statement: A Dimusevska.


16 The Office for Child Protection is the administrative division of DECD that is responsible for child protection. ‘Families SA’ refers to the office’s service delivery or operational arm, although the name is often used to refer to the office as a whole.

17 DECD, ‘Care Concern Investigations Unit: Reporting relationship and proposed practice model’, minutes, internal unpublished document, no date, p. 1.

18 Oral evidence: C Kelly.

19 Oral evidence: S Macdonald.

20 Witness statement: T Lovegrove.

21 DECD, ‘Care Concern Investigations Unit: Reporting relationship’, minutes, p. 3.

22 Witness statement: A Dimusevska.

23 ibid.


25 C Heinrich, ‘SDM data analysis’.

26 C Kelly, ‘Care Concern Project’, p. 5.

27 Oral evidence: Name withheld (W73).

28 Submission: Name withheld (S113).


30 Oral evidence: C Kelly.

31 Witness statement: P Adams.


33 Oral evidence: P Adams.


35 Witness statement: A Dimusevska.

36 C Kelly, ‘Care Concern Project’, p. 5.

37 Witness statement: A Dimusevska.

38 Data from Families SA.


40 See, for example G Murray, Final report on phase one of the audit of foster carers subject to child protection notifications, Department of Families, Queensland, December 2003, pp. 7, 40, 53, 59, 68.

41 GCYP, Preventing sexual abuse of children and young people, p. 16.

42 ibid., p. 3.

43 Witness statement: A Dimusevska.

44 GCYP, Preventing sexual abuse of children and young people, p. 4.

45 ibid., p. 3.


47 ibid.


50 ibid.

Some oral evidence, witness statements and submissions were received on a confidential basis. The source is known to the Commission, and is identified by a number in the endnotes.
15 INVESTIGATING ABUSE AND NEGLECT IN OUT-OF-HOME CARE

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51 ibid.
53 Witness statement: A Dimusevska.
56 ibid.
57 ibid.
58 Oral evidence: C Kelly.
59 Witness statement: A Dimusevska.
60 ibid.
63 Oral evidence: C Harman.
65 DECD, Care concern documentation, internal unpublished documents.
66 ibid.
67 ibid.
68 Oral evidence: C Kelly.
69 DECD, Care concern documentation.
70 Oral evidence: P Adams.
71 DECD, Care concern documentation.
72 ibid. The documentation refers to 35 child protection notifications being made ‘prior to [the carers’] registration’. It is not clear whether this means before the children were placed with the kinship carers, before the initial registration of the carers was completed or before a full assessment of the carers was completed.
73 Witness statement: P Adams.
74 Oral evidence: P Adams.
75 Oral evidence: Name withheld (W73); K Barry, C Kelly, ‘Care Concern Project’, p. 3.
79 ibid, p. 54.
80 ibid., p. 11.
82 Oral evidence: P Adams; S Macdonald.
84 Witness statement: A Dimusevska.
85 Oral evidence: P Adams.
86 T Harrison, letter re ‘Delegated authority to conduct investigations’, internal unpublished document, DECD, 30 June 2014.
87 T Harrison, response to questions from the Child Protection Systems Royal Commission, 26 November 2015.
89 Government of South Australia, Interagency code of practice, pp. 44-45.
90 Oral evidence: P Adams.
91 ibid.
92 Witness statement: A Dimusevska.
93 DECD, Care concern documentation.
94 Oral evidence: C Kelly.
95 Oral submission: Name withheld (S129).
96 Witness statement: A Dimusevska.
97 RA Layton (Chair), Our best investment, p. 9.18.
98 Oral submission: Name withheld (S129).
99 Witness statement: A Dimusevska.
100 Oral submission: Name withheld (S129).
101 ibid.
102 Witness statement: A Dimusevska.
103 Oral submission: Name withheld (S129).
104 Department for Families and Communities, Standards of alternative care in South Australia, Government of South Australia, revised 2009.
105 Oral submission: Name withheld (S129).
108 Oral evidence: Name withheld (W59).
111 Witness statement: A Dimusevska.
112 ibid.
113 ibid.
115 Witness statement: A Dimusevska.
116 Submission: Connecting Foster Carers.
117 DECD, Care concern documentation.
118 Oral evidence: Name withheld (W59). Oral submission: Name withheld (S129).
121 Witness statement: A Dimusevska.
123 Witness statement: A Dimusevska.

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