Tasmanian
Audit Office

Report of the Auditor-General No. 2 of 2011–12

Children in out of home care

September 2011

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INTRODUCTION

Unfortunately, there are situations in which children are suffering or are at risk of abuse, neglect or family violence. The importance of, and need for, child protection is reinforced by evidence that an unsafe or unstable environment increases the risk that a child may go on to experience problems with drugs and alcohol, sexual abuse, mental health and violence.

The *Children, Young Persons and Their Families Act 1997* (the Act) provides for the care and protection of children in a manner that maximises a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential. The Act details a number of principles that broadly favour primary responsibility for care being with families and states that families should be given all possible support and assistance. However, the Act also recognises that some children will not be safe in their family home and provides for the Secretary of the Department of Health and Human Services (DHHS or the Department) to be appointed as guardian where families cannot meet their responsibilities.

In June 2010, the Auditor-General accepted a request from the Secretary of DHHS to undertake an audit of out-of-home care (OoHC) services. The Secretary advised that the Minister for Children had asked the Commissioner for Children to follow up a recent high-profile case, but believed that the specific case may have been symptomatic of some broader issues that warranted a performance audit into OoHC.

Audit Conclusion

The following sub-sections detail the audit findings in respect of individual audit criteria. A frustration that we had in forming some of our conclusions was not being able to determine whether deficiencies were due to documentation shortcomings or to lack of performance or some combination of both. For that reason some of our findings refer to 'lack of evidence' or 'not being persuaded' that a criterion was met rather than expressing a definitive conclusion about the criterion. As a consequence, our intention is to perform a detailed follow up of this audit in 2013, at which point most of the documentation deficiencies should have been resolved.

We also point out that OoHC has been subject to a number of prior reviews. Our perception was that the most costly and substantial recommendations have either not been implemented or have been delayed pending funding. We are usually reluctant to recommend specific funding on the grounds that an increase in one area inevitably results in a decrease in another. Such prioritisation is the province of government, not of auditors-general. Nonetheless, it needs to be recognised that OoHC is an area in which a short-term saving can lead to much greater long-term social, health and financial costs. This is particularly relevant to the need to improve system access and support for carers.

Has the department responded to changing circumstances?

We examined three previous reports:

- Jacob-Fanning, 2006
- KPMG, 2007
- Mason, 2010.

We found reasonable levels of implementation of recommendations for two of the three reports examined. However, there was little progress on implementation of the expensive and substantial KPMG report.

The Department had produced a Child Protection Manual that provided adequate guidance for staff.

A computerised information system was in use but was still being implemented and causing difficulties for departmental staff.

Notwithstanding current difficulties with one of the four national standards, it is likely that the Department will be able to comply with national reporting requirements.

Were notifications properly actioned?

We found the combined DHHS and Gateway processes had been effective in ensuring that referrals to the Child Protection Service (referred to as notifications) were promptly, reliably and consistently triaged[1].

Where notifications had been referred for investigation, 36 to 61 per cent of investigations were not commenced within the Department's required timeframes. However, we were satisfied that the Department was actively managing the urgent cases and there were no indications of children being left in danger because of delays.

There were some indications of a possible decline in reliability of investigations and we recommended this be further investigated.

Nevertheless, the Department had acted where investigations led to notifications being substantiated.

[1] Gateway refers to the reception services provided by BaptCare and Mission Australia to process initial enquiries and referrals for children and family services.

Were appropriate placement decisions being made?

The Department was aware of a lack of resources available to recruit or train therapeutic foster carers.

We were unable to quantify the extent of the shortage of carers and therapeutic foster carers in particular. The difficulty was that the problem was 'invisible' since invariably a placement is found regardless of shortages.

We were advised DHHS often had to look for any available carers rather than matching a child's needs to the attributes of carers. An assessment and matching process was routinely performed prior to placement. However, we noted:

- a lack of guidance over placement processes but reasonable compliance where instructions did exist
- deficiencies in documentation of the decision-making process regarding the actual placement
- a lack of evidence that children's physical, developmental, psychosocial or mental health needs had been routinely assessed in accordance with national standards
- inconsistent identification of child needs on case files that tended to deal with simple, practical matters rather than longer-term problems and risks
- insufficient information to support detailed matching of child needs to carer attributes on carer files.

The percentage of multiple placements was considered by DHHS to be a useful performance indicator of the effectiveness of placement decisions. However, deficiencies in the data made comparative analysis unreliable.

Were carers well managed?

We were satisfied with recruitment and assessment processes. However, we found a number of deficiencies in support for carers, including:

- unavailability of training to enable the provision of therapeutic foster care
- practical difficulties which made it hard for carers to access training in dealing with challenging behaviour
- insufficient ratio of support workers per carer
- insufficient support visits and annual reviews
- lack of mechanisms to help carers deal with challenging behaviours.

Were placements actively monitored?

The Child Protection Manual required children in OoHC to be visited at least six-weekly. None of the files tested included an up-to-date summary of visits and less than 50 per cent of files included sufficient records of visits to persuade us that visit requirements had been met.

Documentation of visits was inconsistent between the regions. In the South, slow computer access had impacted on the quality of documentation, which was characterised by an unhelpful filing structure and unstructured narratives.

Were there adequate processes for transitioning from care?

For a sample of children who had been reunified with their families, we were unable to find documented evidence to confirm there had been objective improvement in regard to the risk factors that brought those children into State care.

We also found that most of a small sample of relevant case files did not include leaving care plans that were expected to address matters such as access to housing and financial management.

LIST OF RECOMMENDATIONS

The following Table reproduces the recommendations contained in the body of the Report.

REC	SECTION	WE RECOMMEND THAT DHHS …
1	1.4	• expedites full implementation of Child Protection Information System in view of serious identified documentation deficiencies • undertakes a comprehensive review of Child Protection Information System when implementation has been completed.
2	2.2	… develops improved reporting and information sharing for Gateway Services.
3	2.3	… addresses documentation deficiencies regarding measurement of timeliness of commencement of investigations.
4	2.4	… performs rigorous and quantitative analysis of the reliability of investigations.
5	3.2	… ensures that all children and young people receive timely physical, developmental, psychosocial and mental health assessments in line with national standards.

6	3.3	… upgrades the Child Protection Manual to provide guidance on recording the rationale for placement decisions.
7	3.3	… investigates ways to ensure carers receive adequate information at the time children are placed in care, and are kept informed with updated information.
8	3.4	… develops guidelines that outline the processes to be followed in making placement decisions.
9	3.4	… ensures that a needs assessment is included on case files and that detailed requirements are outlined in the Child Protection Manual.
10	3.4	… ensures that all placement documentation in Child Protection Information System is both readily accessible and complete.
11	4.2	… establishes an accurate database in Child Protection Information System containing all necessary carer details to facilitate better placement decisions.
12	4.3	… provides additional reimbursement for carers who have undertaken accredited training and are caring for children with complex needs.
13	4.3	… recruits skilled staff or carers to provide respite care to allow carers to attend training. The recruited workers could simultaneously act as 'circuit breakers' to attempt to improve relationships or behaviour of the children.
14	4.4.1	… explore ways to increase the level of support to carers and more accurately record the number and frequency of visits to carers.
15	4.4.2	… ensures annual reviews with carers are undertaken and recorded in Child Protection Information System.
16	4.4.3	… establishes cool-off facilities and a therapeutic foster care program that would enable accreditation of suitably trained foster carers.
17	5.3	… considers upgrading the communication infrastructure available to Child Protection South.
18	5.3	… uses Case and Care Plans to structure visits and that the Plan be promptly updated based on the findings of the visit rather than using an unstructured narrative.
19	5.3	… maintains on Child Protection Information System a summary of visits to facilitate checking of compliance with prescribed frequency of visits.
20	6.2	… ensures reunification plans are completed and include documented evidence that any identified risks have been addressed, the views of the child have been heard and a safe return home is achievable.
21	6.3	… ensures that every young person over the age of 15 years has an approved leaving care plan.

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For the full report go to: http://www.audit.tas.gov.au/publications

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