



2011

PARLIAMENT OF TASMANIA

**REPORT OF THE  
AUDITOR-GENERAL  
No. 2 of 2011–12**

**Children in out-of-home care**

**September 2011**

*Presented to both Houses of Parliament in accordance with the provisions of Audit Act 2008*

© Crown in Right of the State of Tasmania September 2011

Auditor-General's reports are available from the Tasmanian Audit Office, Hobart, although in limited supply. This report, and other Special Reports, can be accessed via our home page (<http://www.audit.tas.gov.au>).

For further information please contact:

Tasmanian Audit Office

GPO Box 851

Hobart

TASMANIA 7001

Phone: (03) 6226 0100, Fax (03) 6226 0199

Email: [admin@audit.tas.gov.au](mailto:admin@audit.tas.gov.au)

This report is printed on recycled paper.

ISBN 978-0-9808688-9-0



22 September 2011

President  
Legislative Council  
HOBART

Speaker  
House of Assembly  
HOBART

Dear Madam President

Dear Mr Speaker

**REPORT OF THE AUDITOR-GENERAL**

**No. 2 of 2011–12**

**Children in out-of-home care**

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*. The objective of the audit was to express an opinion on the effectiveness of out-of-home care as an element of child protection.

Yours sincerely

H M Blake

**AUDITOR-GENERAL**



## Contents

<b>Foreword</b> .....	<b>i</b>
<b>List of acronyms and abbreviations</b> .....	<b>ii</b>
<b>Executive summary</b> .....	<b>2</b>
Background.....	2
Audit conclusion.....	2
List of recommendations .....	5
<b><i>Audit Act 2008</i> section 30 — Submissions and comments received .....</b>	<b>10</b>
<b>Introduction</b> .....	<b>14</b>
<b>1 Has the Department responded to changing circumstances? .....</b>	<b>18</b>
1.1 Background.....	18
1.2 Were recommendations from previous reports implemented? .....	18
1.3 Did adequate guidelines exist?.....	20
1.4 Was there an adequate information system?.....	21
1.5 Was the Department ready to meet national standards? .....	22
1.6 Conclusion .....	23
<b>2 Were notifications properly actioned? .....</b>	<b>26</b>
2.1 Background.....	26
2.2 Were all notifications promptly triaged? .....	26
2.3 Were investigations timely?.....	29
2.4 Were investigations reliable?.....	30
2.5 Were all substantiations acted on?.....	32
2.6 Conclusion .....	33
<b>3 Were appropriate placement decisions being made?.....</b>	<b>36</b>
3.1 Background.....	36
3.2 Was adequate use made of treatment and support services? .....	37
3.3 Were placement processes compliant with the guidelines?.....	38
3.4 Were placement processes effective? .....	38
3.5 Were placement changes minimised?.....	40
3.6 Conclusion .....	41

<b>4</b>	<b>Were carers well managed?.....</b>	<b>44</b>
4.1	Background.....	44
4.2	Were recruitment and assessment processes effective?.....	44
4.3	Did carers receive necessary training?.....	45
4.4	Did carers receive adequate support? .....	46
4.5	Conclusion .....	49
<b>5</b>	<b>Were placements actively monitored?.....</b>	<b>52</b>
5.1	Background.....	52
5.2	Was the frequency of visits in accordance with guidelines? .....	52
5.3	Was the quality of documentation adequate? .....	52
5.4	Conclusion .....	54
<b>6</b>	<b>Were there adequate processes for transitioning from care? .....</b>	<b>56</b>
6.1	Background.....	56
6.2	Was reunification only recommended after clear evidence of improved circumstances at home? .....	56
6.3	Did young people have adequate support for leaving care? .....	56
6.4	Conclusion .....	57
	<b>Independent auditor’s conclusion .....</b>	<b>60</b>
	<b>Recent reports .....</b>	<b>64</b>
	<b>Current projects.....</b>	<b>66</b>

## List of Figures

Figure 1: Process for a child entering OoHC.....	27
Figure 2: Referrals to Gateway and DHHS .....	28
Figure 3: Compliance with priority timeframes.....	30
Figure 4: Substantiations within 12 months of non-substantiation.....	31
Figure 5: Subsequent actions after substantiation.....	32

## Foreword

A safe and stable environment for children to grow up in, develop and mature is not only essential but expected. It should not be necessary for there to be legislation to ensure this occurs in every circumstance. However, situations do arise where children find themselves at risk. Legislation has been in place since 1997, enabling the Secretary of the Department of Health and Human Services to be appointed as guardian where families cannot meet their responsibilities.

Over the period 2000 to 2006 the number of reports of abuse on children increased from 315 to more than 13 000. A response to this increase was the commissioning of a number of reviews into child protection resulting in the release of 11 reports containing more than 400 recommendations since 2005. Despite these reviews, my Office was requested to conduct a performance audit into aspects of out-of-home care on the basis that, in certain circumstances, systemic break downs may exist.

The Department has taken action on many of the recommendations. This audit examined three of the reports and found there is much yet to do particularly in relation to one of these reports. Findings from this performance audit identified another 21 recommendations essential to ensuring the welfare of children at risk. These recommendations included the need to address documentation deficiencies, better reporting and information sharing, improvement to initial assessments of children at risk and documentation thereof, more accurate details of carers facilitating better placement decisions and achievement of minimum visit frequencies and annual reviews.

Clearly the Department needs to do more if it is to respond promptly to our and other recommendations. It may well be that additional resources need to be allocated to achieve this and it is encouraging that the Department, based on its response to this Report, is committed to actioning recommendations made.

H M Blake

Auditor-General

22 September 2011

## List of acronyms and abbreviations

CCP	Case and Care Plan
CPIS	Child Protection Information Service
CYS	Children and Youth Services
DHHS	Department of Health and Human Services
The Manual	Child Protection Manual
NGO	Non-Government Organisation
Notifications	All reported allegations of child abuse or neglect are recorded as notifications by DHHS
OoHC	Out-of-home care
Substantiation	Where notifications have been further investigated and the child is at risk, the case is said to have been substantiated.



## **Executive summary**

---

## Executive summary

### *Background*

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, as outlined in Chapter 1, 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<sup>1</sup>.

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.

---

<sup>1</sup> Gateway refers to the reception services provided by BaptCare and Mission Australia to process initial enquiries and referrals for children and family services.

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

### *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 this Report.

<b>Rec</b>	<b>Section</b>	<b>We recommend that DHHS ...</b>
1	1.4	<ul style="list-style-type: none"> <li>▪ expedites full implementation of the Child Protection Information System in view of serious identified documentation deficiencies</li> <li>▪ undertakes a comprehensive review of the Child Protection Information System when implementation has been completed.</li> </ul>
2	2.2	... develops improved reporting and information sharing with 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	... investigate 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 the Child Protection Information System is both readily accessible and complete.
11	4.2	... establishes an accurate database in the 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	... explores 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 the 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 the 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.





**Audit Act 2008 section 30 — Submissions and comments received**

## Audit Act 2008 section 30 — Submissions and comments received

### *Introduction*

In accordance with section 30(2) of the *Audit Act 2008*, a copy of this Report was provided to the Department of Health and Human Services. A summary of findings was also provided to the Treasurer, the Minister for Human Services and the Minister for Children with a request for comment or submissions.

The comments and submissions provided are not subject to the audit nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with those who provided a response or comment.

### *Submissions and comments received*

#### Department of Health and Human Services

The Secretary of the Department of Health and Human Services (DHHS) extends appreciation to the Tasmanian Audit Office for accepting the Agency's request to undertake an Audit of Tasmanian children and young people in out-of-home care, and for compiling the subsequent Report. The Agency accepts all the recommendations within the Audit Report and anticipates that their implementation will contribute to better outcomes for children who are placed in out-of-home care.

The Secretary of the DHHS would also like to acknowledge the ongoing dedication of Tasmania's hardworking child protection professionals who protect our most vulnerable children from abuse, neglect and cumulative harm.

In recognition of the importance of Tasmanian children, in April 2011, a dedicated Deputy Secretary for Children was appointed within the Agency, reporting to the Minister for Children through the Secretary. The Deputy Secretary for Children has initiated a systemic review of all Children and Youth Services (CYS) models of care including child protection services and out-of-home care. In addition, the Deputy Secretary has initiated the development and implementation of a dedicated and tailored quality and safety framework within CYS. This framework will provide clear guidance to staff and external stakeholders and incorporate key performance indicators, continuous quality improvement monitoring and reporting processes.

Importantly and consistent with the Auditor-General's Report, and running parallel with the development of the quality and safety framework is the establishment of a dedicated multidisciplinary staff development unit which will be appropriately resourced to provide support, guidance and education and training to all CYS staff. This unit will also establish mechanisms to ensure the recruitment and retention of high quality staff. As a fundamental partner in the delivery of high quality services, CYS through both its quality and safety and staff development programs will improve its support and engagement of carers and non-government agencies.

At the Auditor-General's invitation, the Agency would like to specifically respond to the following findings:

#### Recommendation 4

The Report notes an increase in the percentage of investigations which confirmed the abuse or neglect of a child when an earlier investigation (conducted within the last 12 months) had found that the child was not at immediate risk. The Report notes that the increase commenced in 2008-2009. This coincides with the Agency's evidence-based decision to require workers to place a greater emphasis on the impact of 'cumulative harm' when assessing the level of risk to a child.

Along with other jurisdictions, Tasmania has moved from a position of assessing the level of risk associated with individual notifications to assessing any pattern of notifications (whether or not notifications are substantiated). This approach recognises the negative impact on child development arising from deficiencies in the child's nurturing or physical environment. In these cases the child is not at immediate risk (as is the case with incidents of physical or sexual abuse), although a sustained pattern of neglect represents ongoing cumulated risk for the child. Because of the DHHS policy change (in April 2009) new notifications, where there has been a pattern of concern about the child, became more likely to be substantiated than prior to 2008.

#### Recommendation 5

The Agency accepts its responsibility for ensuring that all children and young people in care receive timely physical, developmental, psychosocial and mental health assessments including the cultural safety of Aboriginal children and those children from culturally diverse communities.

#### Recommendation 11

The Report mentions the need to recruit carers, and any recruitment campaign will include the development of broad retention strategies for carers.

### Recommendation 12

The Agency accepts this recommendation and will consult to establish appropriate reimbursement where volunteer carers have additional qualifications, and are caring for children with complex needs.

### Recommendation 14

In exploring ways to increase the level of support for carers it is important to note that ensuring the cultural safety of Aboriginal children in care is vitally linked to their health and wellbeing outcomes. The National Standards for Out of Home Care require all states and territories to report on the 'proportion of Indigenous children and young people in out-of-home care placed with the child's extended family, with the child's Indigenous community, or with other indigenous people, by carer type' (in accordance with the nationally agreed Aboriginal Child Placement Principle). Work towards meeting the standard has begun.

## **Introduction**

---

## Introduction

### *Background*

Unfortunately, there are situations in which children are suffering or are at risk of abuse, neglect or family violence. The importance of 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. Over the last few years the number of children in out-of-home care (OoHC) in Tasmania has been rising. As at 30 June 2010 there were 893 children in OoHC, compared to 576 in 2005<sup>2</sup>.

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. The responsibility encompasses:

- the decision to intervene to protect a child from harm
- placing a young person in OoHC, following an assessment and court order
- ensuring the OoHC continues to provide a safe and stable environment
- the decision to reunify a child or move them into a permanent care arrangement<sup>3</sup>.

In June 2010, the Auditor-General accepted a request from the Secretary of DHHS to undertake an audit of 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.

---

<sup>2</sup> Australian Institute of Health and Welfare, *Child protection Australia 2009–10*, p.54.

<sup>3</sup> Permanent care options include adoption and transfer of guardianship to carers.

### *Audit objective*

The audit objective was to express an opinion on the effectiveness of out-of-home care as an element of child protection.

### *Audit scope*

The audit scope was concerned with children in OoHC or under State Guardianship, and OoHC-related assessments made in 2009–10. The audit's scope was mainly limited to DHHS although some interviews were held with staff at non-governmental organisations (NGOs).

### *Audit criteria*

The audit criteria we developed were aimed at addressing effectiveness aspects as follows:

- Has the Department responded to changing circumstances?
- Were notifications properly actioned?
- Were appropriate placement decisions being made?
- Were carers well managed?
- Were placements actively monitored?
- Were there adequate processes for transitioning from care?

### *Audit approach*

To conduct the audit, we:

- reviewed OoHC-related documentation
- reviewed previous internal and external reports
- interviewed relevant staff
- tested samples of client and carers' files across the state.

### *Timing*

Audit planning commenced in October 2010. Fieldwork was completed in June 2011 with reporting finalised in September 2011.

### *Resources*

The total cost of the audit was \$230 000.





**1 Has the Department responded to changing circumstances?**

# 1 Has the Department responded to changing circumstances?

## 1.1 *Background*

In Tasmania, the government has a long history in caring for at risk children. However, the role of government as guardian for these vulnerable children has evolved over time. Changes in legislation and rising community expectations resulted in the existing system being subjected to extreme pressure. For instance, notifications (reports of abuse) rose from 315 in 2000–01 to 13 029 by 2005–06<sup>4</sup>. Similar problems have been experienced in other jurisdictions.

In considering the Department's response to these changes, we looked at the following matters:

- Were recommendations of previous reports implemented?
- Did adequate guidelines exist?
- Was there an adequate information system?
- Was the Department ready to meet national standards?

## 1.2 *Were recommendations from previous reports implemented?*

Since 2005, when it became apparent the existing system was struggling to cope with the rapid increase in notifications, a number of reviews involving child protection were conducted. Some were wide ranging, exploring broad structural changes, whilst others were focused on single issues.

This Section examines the extent to which DHHS has implemented the recommendations generated by these reports. In excess of 400 recommendations are contained in the 11 child protection reports released since 2005. Our expectation is that within two years most of the recommendations would have been either implemented or reasons for rejection documented. We selected the following reports for examination:

- *Report on Child Protection Services in Tasmania* (Jacob–Fanning report, 2006)
- *Out of Home Care strategic framework* (KPMG report, 2007)

---

<sup>4</sup> Holzer P. and Bromfield L., Australian Institute of Family Studies, *National Child Protection and Support Services (NCPASS) comparability of child protection data*, 2008.

- *Inquiry into the circumstances of a 12 year old child under Guardianship of the Secretary* (The Mason Report, 2010).

### 1.2.1 *Jacob–Fanning report, 2006 — Report on Child protection Services in Tasmania*

This report was commissioned by the then Minister for DHHS and was written by its then Deputy Secretary, Alison Jacob, and then Commissioner for Children, David Fanning. The Jacob–Fanning report was tasked with looking into the current structure and operating system surrounding child protection. The report found that the system was overwhelmed and struggling to cope and was unable to provide the level of protection expected by government and the wider community.

The report called for structural changes, reform of management practices and giving staff the necessary tools and resources. In all, the report generated 146 recommendations.

We examined the degree of implementation for each recommendation and found that all but five were either being implemented or in the process of implementation.

Despite the high level of implementation, we found the Department did not have a register to ensure recommendations received prompt attention or provide a documentary trail of rejected recommendations. However, we understand that DHHS has since commenced implementation of such a register.

### 1.2.2 *KPMG report, 2007 — Out of Home Care strategic framework*

In 2007, DHHS commissioned a half million dollar report into Child Protection, Family Services and OoHC. The consultants, KPMG, identified that the majority of OoHC services were being provided by DHHS and that the growth in these services had been ‘ad hoc and reactive’. The report called for sweeping changes including:

- OoHC services — home-based and residential care — to be transferred to NGOs over a five-year period
- increased placement options, some incorporating therapeutic foster care
- an OoHC team at DHHS to provide strategic management, quality control and oversight of services
- a more structured approach to matching children to placements.

Following receipt of the KPMG report, DHHS prepared *New Directions for Child Protection in Tasmania: An Integrated Strategic Framework* (New Directions). DHHS advised us that New Directions was the public document supporting the reforms recommended across the system by the internally focused KPMG report. In 2008–09, \$6m in non-recurrent funding was allocated to support those reforms.

We were able to establish that therapeutic residential care had been outsourced to an NGO. We also noted that DHHS had established a panel responsible for the accreditation of carers, which would contribute to implementation of other recommendations. However, we found little evidence that much of the original KPMG report relating to OoHC had otherwise been implemented.

### 1.2.3 *The Mason Report, 2010 — Inquiry into the circumstances of a 12 year old child under Guardianship of the Secretary*

The then Commissioner for Children was requested to examine the circumstances under which a 12-year old girl was prostituted by her mother while under the guardianship of the Secretary. The report generated significant public interest and resulted in 45 recommendations<sup>5</sup>. The report called for the clarification and broadening of powers for the Commissioner for Children in the areas of obtaining documents and conducting audits. The government publicly released its response to the report where:

- 15 recommendations were accepted in full
- 20 recommendations were partially accepted
- the remaining 10 recommendations were not accepted.

We reviewed implementation to date and noted satisfactory progress.

## 1.3 *Did adequate guidelines exist?*

In response to concerns outlined in the Jacob–Fanning report, DHHS developed the online Child Protection Manual (the Manual). A web-based tool accessible to all departmental staff statewide, the Manual provided advice, guidance, legislation and standard forms. It began to be progressively developed during 2009 and had been in use since then.

---

<sup>5</sup> It should be noted that not all of the recommendations related to OoHC, or were within the scope of DHHS.

### *1.3.1 Were the guidelines usable?*

We considered the Manual's content and structure well suited to the needs of Departmental staff and other users. That view was reinforced during the audit, when we were consistently and easily able to access the information we required.

We asked a number of users for their assessments. One senior officer described the Manual as providing only superficial practice frameworks, principles, flow charts and templates. The officer stated that in the larger states dedicated teams continually worked on their manuals.

On the other hand, others commented that they had observed that the Manual was constantly being revised and improved. We noted such an improvement in response to a 2010 criticism of a specific guideline by the then Commissioner for Children.

Generally, we concluded that the Manual was usable and improving, although in Section 3.3 we criticise the lack of guidance in one area.

### *1.3.2 Were the guidelines consistent with other jurisdictions?*

To establish whether the Manual contained guidelines that were consistent with other jurisdictions, we tested an area where there should be some consistency: a charter of rights covering young people in OoHC. We found that guidelines in Tasmania covered similar matters to those in other states, although generally in less detail.

### *1.3.3 Were the guidelines kept up to date?*

Because the Manual was web based it could be centrally updated, allowing for the rapid statewide dissemination of new information.

We found evidence of regular updates based on:

- feedback from users as well as from interstate and New Zealand
- research from Australia and overseas
- results of internal reviews.

Although some reviews were overdue, we were satisfied that DHHS had effective processes to maintain the currency of the Manual.

## *1.4 Was there an adequate information system?*

We did not perform a full review of the Department's information system. Nonetheless, we thought it important to provide context for

the reader about the Department's systems and to provide some preliminary views about the effectiveness of those systems.

Up until September 2010, a manual system was still largely in use. That system was characterised by large and unwieldy paper files that made information retrieval difficult. Summary information across many files was also hard to obtain.

A computerised system called Child Protection Information Services (CPIS), was initially introduced in February 2008 and modified in late August 2010. At the time of the audit, the upload of data from the manual records was still ongoing with many computer records incomplete or containing less information than the paper files. Our initial impression was that the computer structure was an electronic replica of the paper system. On further analysis it appears more likely this impression was created by incompleteness of data. For that reason, we would be unwilling to express an opinion as to how well the system worked.

**Recommendation 1**

**We recommend that DHHS:**

- **expedites full implementation of CPIS in view of serious identified documentation deficiencies**
- **undertakes a comprehensive review of CPIS when implementation has been completed.**

**1.5** *Was the Department ready to meet national standards?*

In late 2010, agreement was reached by all state and territory ministers for the adoption of national standards for OoHC. In all, 13 national standards were adopted, covering areas such as stability and security, indigenous considerations, health needs and education. States and territories were given four years to develop complete, transparent and comparable reporting mechanisms. Initially, states and territories will only be required to report against the standards where nationally consistent measures already exist.

We looked at whether DHHS would be ready to report on the first four standards as at 30 June 2011. We found full compliance with three standards and partial compliance with the remaining one. With regard to the partially completed indicator, DHHS advised of measurement difficulties that were also being experienced by other jurisdictions. DHHS expects it will be able to comply with all future reporting requirements.

## 1.6 Conclusion

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 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.





## **2 Were notifications properly actioned?**

## 2 Were notifications properly actioned?

### 2.1 *Background*

Children requiring protection come to the attention of DHHS through a number of ways. Concerned health professionals, teachers and police officers are required to advise the Department if they have concerns about child welfare. However, anyone including neighbours, relatives and even the parents themselves can notify DHHS. All allegations of child abuse or neglect reported to DHHS are recorded as ‘notifications’. The Department then assesses whether further action is required.

Departmental intake teams carry out initial risk assessments to determine whether additional investigation is warranted. Where notifications have been further investigated and the child is at risk the notification is said to have been ‘substantiated’. In those cases, the expectation was that DHHS would act to protect the child.

See Figure 1 for a summary view of the process that leads to a child being taken into care.

This Chapter examines whether:

- notifications were promptly triaged
- investigations were timely
- investigations were reliable
- substantiations were acted on.

### 2.2 *Were all notifications promptly triaged?*

In 2006, following a steady increase in notifications, problems began to emerge with delays in processing initial notifications and by June 2006, DHHS reported 1452 unallocated notifications.

DHHS responded by commissioning the Jacob–Fanning review, which found that the child protection system was struggling to cope with notification levels. The report recommended responsibility for children’s wellbeing and safety be shared amongst family, community and government service providers.

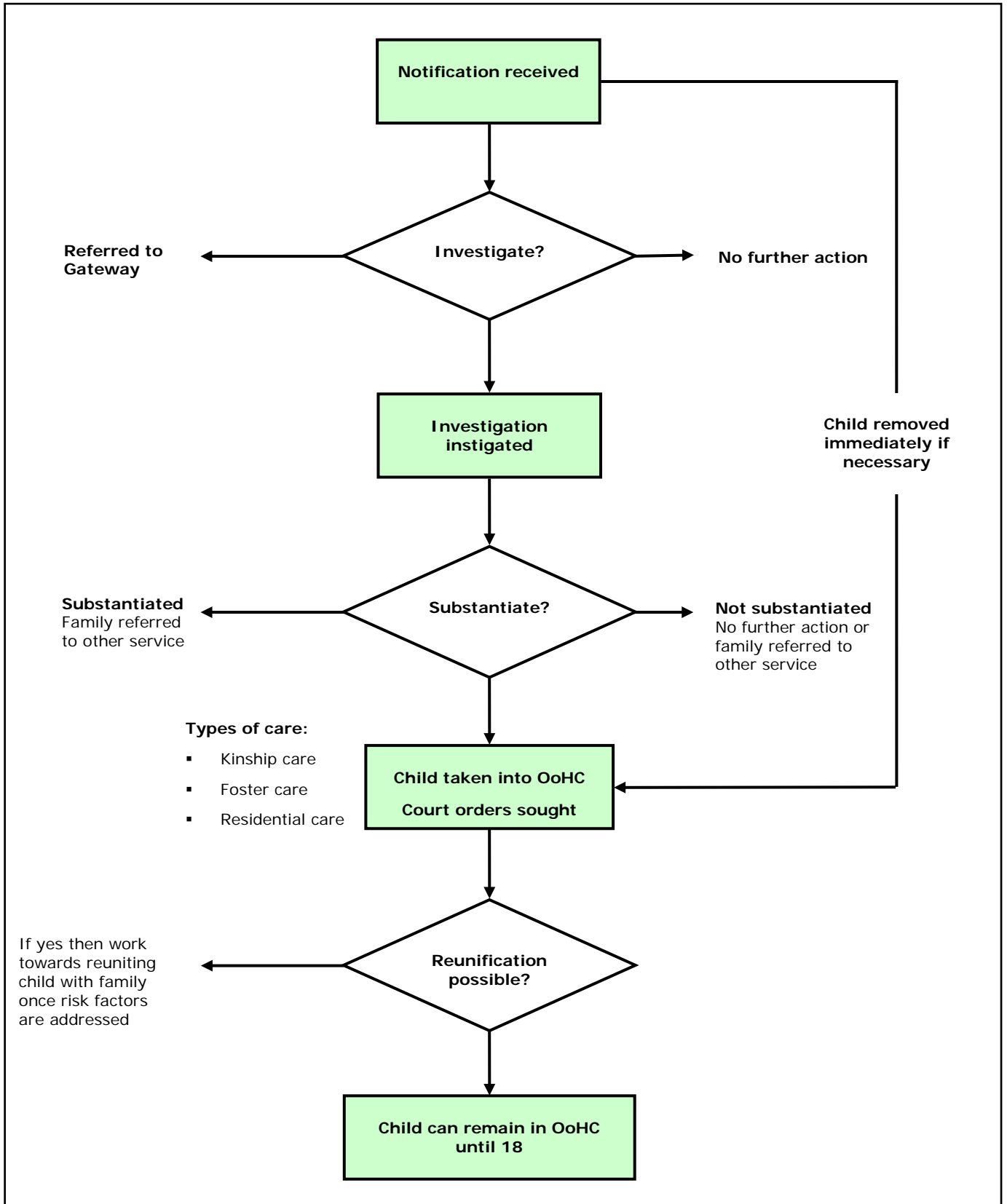
DHHS engaged NGOs to triage initial enquiries through Gateway Services (Gateway)<sup>6</sup>. Gateway provided a diversion from statutory intervention by offering families NGO-based assistance. We noted

---

<sup>6</sup> Gateway refers to the reception services provided by BaptCare and Mission Australia to process initial enquiries and referrals for children and family services. BaptCare and Mission Australia also coordinate an alliance of NGOs providing Family Support Services as diversion or early intervention alternatives to statutory intervention by Child Protection Services.

that DHHS had a senior intake person embedded within each Gateway to ensure any notification was correctly triaged and referred to the Department where necessary.

Figure 1: Process for a child entering OoHC

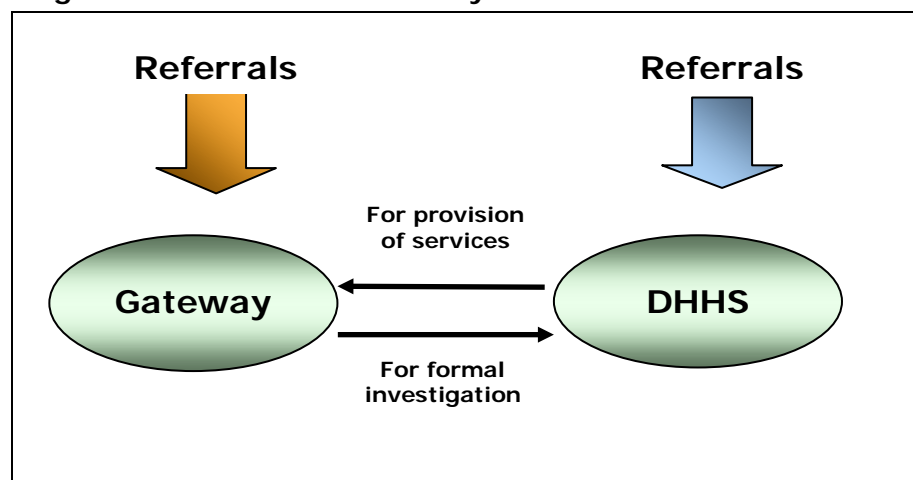


Essentially, DHHS and Gateway offered alternative processing centres for referrals, to determine an appropriate response, which might be:

- no response (e.g. if referral was deemed to be frivolous or malicious)
- referrals to other children and family support services, generally provided by NGOs<sup>7</sup>
- formal investigation of the need for statutory intervention, by DHHS.

Figure 2 shows the system diagrammatically.

**Figure 2: Referrals to Gateway and DHHS**



We were advised that the introduction of Gateway led to a 10 per cent reduction in the number of notifications received by DHHS. This reduction equated to at least 600 children being diverted from DHHS to receive alternative interventions such as family support services through Gateway. Only 10 per cent, or about 60 children of those diverted, were then referred to DHHS for investigation.

From our testing and discussions, we found that:

- All notifications received by DHHS had been promptly assessed.
- Gateway processes included procedures to ensure reliable and consistent processing of notifications such as regular case conferences attended by senior DHHS staff.
- Gateway provided a record of each referral and determination to DHHS as required by the Manual.

---

<sup>7</sup> BaptCare and Mission Australia coordinate an alliance of NGOs providing Family Support Services as diversion or early intervention alternatives to statutory intervention by Child Protection Services

- Between 50 and 65 per cent of OoHC files showed evidence that alternative interventions, such as the provision of family support services, had been attempted before children were placed in OoHC. We saw this as evidence that the system was working as intended and that statutory intervention was being avoided where reasonable alternatives existed.

We were, however, unable to obtain reliable data to measure the effectiveness of Gateway. Although we requested data, we were advised by DHHS that it could not accurately report the number of children and families referred to Gateway.

We noted that the database used by Gateway was not compatible with DHHS's database resulting in double handling of referral information. We were advised that data incompatibility had also hampered information exchange between DHHS and other service providers. DHHS advised remedial action was underway to resolve data mismatches.

Nevertheless, we found the combined DHHS–Gateway structure had been effective in ensuring notifications were promptly, reliably and consistently processed.

#### **Recommendation 2**

**We recommend that DHHS develops improved reporting and information sharing for the Gateway Services.**

### *2.3 Were investigations timely?*

Investigations arise from the triage of referrals and notifications, referred to in Section 2.2. In 2009–10, 19 per cent of notifications (1833) were referred for further investigation.

Notifications referred for investigation were assigned an urgency rating, as follows:

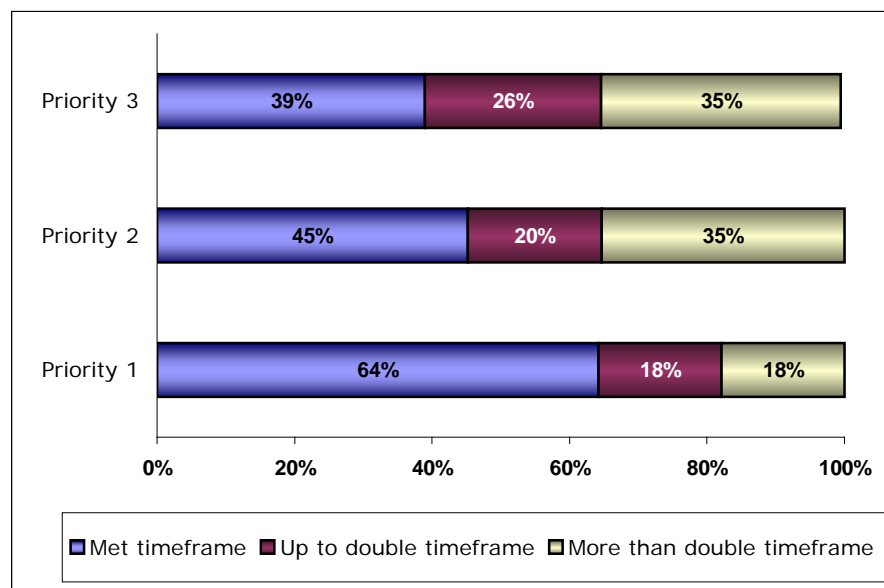
- Priority 1 — response required within half a day<sup>8</sup>
- Priority 2 — response required within 5 days
- Priority 3 — response required within 10 days.

We tested notifications that had been referred for investigation to see whether the above timeframes were met. Figure 3 summarises our findings.

---

<sup>8</sup> Priority 1: a child may be in immediate danger and the Department can remove a child prior to obtaining legal orders.

**Figure 3: Compliance with priority timeframes**



Between 36 to 61 per cent of investigations were not commenced within the Department’s required timeframes. While the best results were for the most urgent cases, 18 per cent of Priority 1 investigations were only commenced two days after notification.

We made further inquiries about a sample of Priority 1 notifications that did not meet the benchmark. We were satisfied the Department had actioned these Priority 1 notifications and found no instances where a child was placed in danger because of delay.

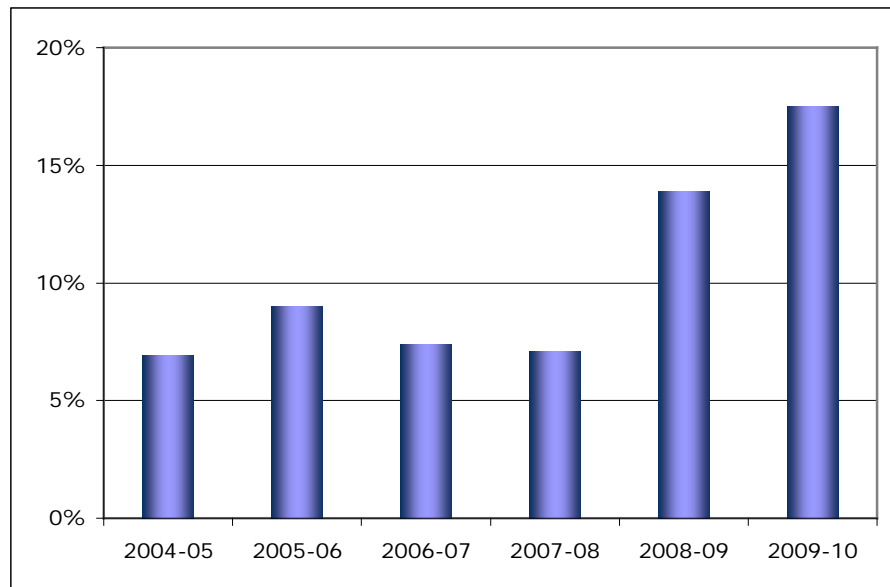
We found that some of the delays were due to documentation deficiencies or changes in circumstances. Overall, we were satisfied that the Department was actively managing the more urgent cases.

**Recommendation 3**

**We recommend that DHHS addresses documentation deficiencies regarding measurement of timeliness of commencement of investigations.**

**2.4** *Were investigations reliable?*

In order to assess reliability of investigations, we used DHHS statistics rather than performing any independent analysis of investigations data. Relevant performance information collected and published by DHHS included the proportion of substantiations following a previous investigation that was not substantiated. The underlying rationale is that the latter decision indicates the earlier one may have been incorrect. Figure 4 shows this indicator over a six-year period.

**Figure 4: Substantiations within 12 months of non-substantiation**

There was a sharp increase in the level of substantiations within 12 months of a non-substantiation from 2008–09 onwards. Before discussing possible explanations for the notable increase we note that the statistic is only a weak measure of the reliability of investigations. There are other reasons why an investigation outcome might vary over time, including:

- an adverse change in a family’s situation
- failure of other reasonable efforts to reduce risk levels, e.g. unsuccessful violence counselling
- failure of the parents to respond to referrals for services, such as drug and alcohol counselling
- policy changes within the Department.

Nonetheless, DHHS used this nationally reported statistic as a reliability indicator and accordingly we sought explanations from the Department for the significant increase. One factor cited was a recent decision to give more weight to multiple referrals.

Other factors which we thought might be relevant were:

- increased attempts at diversionary or early intervention alternatives prior to statutory intervention
- the impact of staff shortages on the capacity to conduct comprehensive investigations (particularly in the North West region where staff shortages and the proportion of substantiations following a non-substantiation were both high).

No quantification of possible factors was provided by the Department. In our view, the severity of the increase was a possible indicator of declining reliability of investigations that merits a more rigorous and quantitative analysis.

**Recommendation 4**

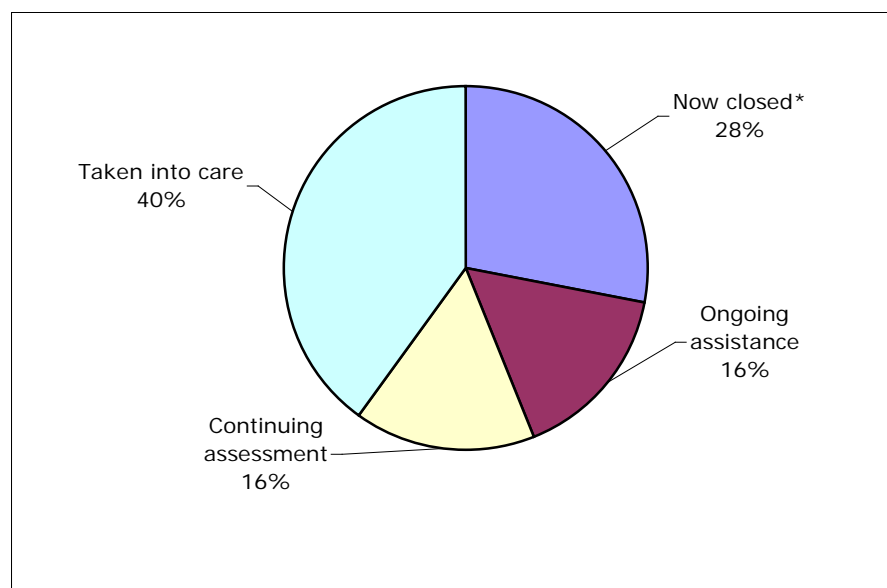
**We recommend that DHHS performs rigorous and quantitative analysis of the reliability of investigations.**

2.5 *Were all substantiations acted on?*

Since a high of 1252 substantiations recorded for 2006–07, there has been a gradual decline in substantiations, so that by 2009–10 the number had dropped to 963<sup>9</sup>.

We found that of those cases substantiated almost half resulted in the children entering OoHC. The balance resulted in referrals to other services or no action due to inadequate or insufficient information being provided. Figure 5 summarises our findings.

**Figure 5: Subsequent actions after substantiation**



\* 'Now closed' relates to notification being closed at response, e.g. family accepts referrals to NGOs or family moves outside Tasmania.

We were satisfied that:

- Children had been taken into care or other satisfactory processes were proceeding.
- DHHS was aware of the status of each case and could explain the actions taken.

<sup>9</sup> Australian Institute of Health and Welfare, *Child protection Australia 2009–10*, p.19.



## 2.6 Conclusion

The combined DHHS and Gateway processes had been effective in ensuring that notifications were promptly, reliably and consistently triaged.

Where notifications had been referred for investigation, 36 to 61 per cent 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 on substantiations.



### **3 Were appropriate placement decisions being made?**

## 3 Were appropriate placement decisions being made?

### 3.1 Background

When a child is taken into OoHC, the Department must carefully choose both the type of care to be provided and the individual carer. There are many practical considerations to be taken into account, such as proximity to family, school and friends, urban or rural alignment, religion, culture, personal habits and background.

The Jacob–Fanning report (2006) noted that a chronic shortage of suitable care options resulted in children being placed in emergency placements rather than as a result of careful planning and matching of children with suitable care models. Subsequently, the 2007 KPMG report recommended five levels of care, including therapeutic foster care.

However, only four types of care available in Tasmania at the time of the audit<sup>10</sup>:

- Kinship care — provided by members of the child’s family in the carer’s own home. This type of care is generally considered to be the best option.
- Foster care — provided by one or more adults in their own home.
- Residential care — children are housed in a Department-owned facility and paid carers provide care on a rostered basis. Rostered care has been phased out by DHHS.
- Therapeutic residential care — where carers employed by NGOs are rostered to provide short-term care (treatment) for children with more complex needs. This form of care was being provided only by NGOs such as the Salvation Army and Anglicare.

This Chapter will examine:

- use of treatment and support services
- whether placement processes complied with guidelines
- effectiveness of placement processes
- minimising placement changes<sup>11</sup>.

---

<sup>10</sup> In addition, NGOs operate rostered care services and provide respite care. The Department has also operated rostered care and group homes, but had ceased placing clients into those forms of care, following recommendations of the 2007 KPMG report. DHHS also provides short-term respite care.

<sup>11</sup> A placement is where a child has been taken into care and placed into some type of OoHC.

### 3.2 *Was adequate use made of treatment and support services?*

Prior to entering OoHC, children have experienced trauma. Additionally, they experience separation from family and being placed with strangers. Left untreated, such trauma can lead to challenging behaviours in later years.

National standards for OoHC require an initial assessment of children's physical, developmental, psychosocial and mental health needs. The requirements include a preliminary health check to provide advice on specialist services and establish time frames for subsequent evaluations and services. There is also the expectation that children and young people will have an ongoing written health record.

Government funding has allowed the Australian Childhood Foundation to deliver counselling and assessment services to children in OoHC. The Foundation is also in partnership with the Salvation Army to provide therapeutic care to four residential units in Hobart.

We looked to see whether early health checks had been undertaken with any identified health issues being suitably addressed. However, we found that there were deficiencies with the currency and adequacy of information, particularly in the South. Case files recorded only basic information such as immunisation details.

In many cases we could not find evidence that a child's physical, developmental, psychosocial or mental health needs had been routinely assessed. While some records included reports from psychologists or alcohol and drug services, we found no evidence of routine assessments or access to therapy or counselling. In particular, we did not find reference to the Australian Childhood Foundation.

We were advised a Community Paediatrician had been appointed and work had begun on a project to coordinate statewide evaluation of children. The project is expected to enable Tasmania to meet applicable national standards from 2012.

#### **Recommendation 5**

**We recommend that DHHS ensures that all children and young people receive timely physical, developmental, psychosocial and mental health assessments in line with national standards.**

### 3.3 *Were placement processes compliant with the guidelines?*

Surprisingly, we found little guidance over what we regarded as the most important elements of the process, such as:

- procedures and forms for assessing the type of care best suited to the child
- procedures and forms for best matching available carers to the needs of the child
- documentation of deliberations and rationale of decisions.

The Manual included a section covering placement decisions but its requirements related to peripheral matters. Notwithstanding the limitations of the Manual, we tested compliance with two provisions.

First, an Essential Information Record should be provided to the child's carer, either at the time of placement, or at worst, within a week<sup>12</sup>. In over 90 per cent of CPIS files, case workers had provided the Essential Information Record. However, we also found that in most cases information provided was minimal and that carers were critical about the sufficiency of information supplied. Secondly, the Manual required that the child's school be informed that a child had been taken into care. We found only one case file where that had not happened.

In summary, we found a lack of guidance over placement processes but reasonable compliance where instructions did exist.

#### **Recommendation 6**

**We recommend DHHS upgrades the Manual to provide guidance on recording the rationale for placement decisions.**

#### **Recommendation 7**

**We recommend DHHS investigates ways to ensure carers receive adequate information at the time children are placed in care, and are kept informed with updated information.**

### 3.4 *Were placement processes effective?*

---

<sup>12</sup> An Essential Information Record contains basic information about a child taken into care including relevant personal, health and education details.

As noted in Section 3.3, we found an absence of guidelines governing placements. Consequently, we reviewed actual practice against our own criterion that each placement should be based on the child's needs, potential carer's attributes and the matching process.

### *Needs assessment*

The Department's placement request process included a needs assessment section, however:

- There were no relevant instructions in the Manual.
- Fifty percent of the sampled client case files did not contain a needs assessment.
- System access to the electronic placement form was unacceptably slow in the South of the State.
- The needs assessment section related more to simple practical needs of the child (such as regular medication) rather than the type of care needed to address the long-term problems and risks facing the child.

### *Carers' attributes*

We noted that none of the CPIS carers' files had been populated with sufficient information to support matching carers' profiles with a child's needs assessment. Desirable information included location, training, skills, experience, religion, culture and background. Instead, placement decisions tended to be based on personal knowledge about the carers.

One reason for the lack of information about carers on the system was that the Department had expected to outsource management of carers and its system was not originally intended to support this information. After implementing the Gateway, sufficient funding was not available to outsource carer management. Instead, the system was expanded to include information about carers. Unfortunately, limitations of the original design and concerns about carers' privacy meant only some information was recorded in CPIS.

In any event, DHHS advised that placement decisions were more likely to be based on availability of carers since there were few options at any point in time. That is, the reality was more akin to finding any available place that could reasonably meet the child's needs rather than selecting the most suitable place.

### *Matching children to carers*

An assessment and matching process was routinely performed prior to placement. However, we found no guidelines, descriptions or checklists regarding the decision-making process.

We also did not find records of deliberations, although in most cases the rationale was attached to the placement request. Some information pertaining to placement was also recorded on individual child and carer files. However, there was no single structured record of the rationale and the specific points considered.

In our opinion, adding rigor to the decision-making process in the form of instructions, guidelines and improved documentation would improve accountability and identification of structural deficiencies.

**Recommendation 8**

**We recommend that DHHS develops guidelines that outline the processes to be followed in making placement decisions.**

**Recommendation 9**

**We recommend that DHHS ensures that a needs assessment is included on case files and that detailed requirements are outlined in the Manual.**

**Recommendation 10**

**We recommend that DHHS ensures that all placement documentation in CPIS is both readily accessible and complete.**

**3.5** *Were placement changes minimised?*

Outcomes from OoHC placements tend to be much better for long-term stable relationships. Accordingly, DHHS aimed to achieve placements with the highest chance of suiting a child's long-term needs.

The proportion of multiple placements was a performance indicator of DHHS's success at achieving long-term placements<sup>13</sup>. A comparison with other jurisdictions suggested that Tasmania had more multiple placements than most other states. Analysis also indicated multiple placements appeared to be falling in the South, but rising in the North West.

---

<sup>13</sup> Multiple placements is a term covering the situation where a child has a succession of different carers over a period of time (DHHS measures the number of multiple placements over a 12-month period).



Unfortunately, due to system limitations, it had not been possible for DHHS to identify and exclude respite placements from its data. The impact had been to overstate the number of multiple placements with non-respite carers and reduced the usefulness of the indicator as measured. DHHS has now advised us that respite placements are to be excluded from the data.

### 3.6 *Conclusion*

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 shortages of carers and therapeutic 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.



## **4 Were carers well managed?**

---

## 4 Were carers well managed?

### 4.1 *Background*

OoHC relies on volunteer carers to provide 24-hour care, usually in their own homes. Carers can come from any background, religion or culture and do not require any previous qualifications or experience. Carers are not paid a salary, but do receive reimbursement for reasonable agreed expenses.

Following the recommendations of the KPMG 2007 report, the Department planned to outsource recruitment, training and assessment of foster carers to external providers, with the Department retaining responsibility for accreditation. However, implementation of this recommendation has been delayed as it requires recurrent funding.

In this Chapter we review the following aspects of carer management:

- recruitment and assessment
- training
- support and reviews.

### 4.2 *Were recruitment and assessment processes effective?*

A crucial requirement for the OoHC system is its ability to recruit new carers to both cope with the increased demand for carers and the need to replace carers leaving the system. In February 2010, an advertising campaign attracted a number of enquiries but it did not result in an increase in the number of available carers. Regional teams reportedly lacked the capacity to process potential carers' applications in addition to their standard duties. A second advertising campaign was undertaken in the early part of 2011, wherein applications were centrally managed. The campaign produced 157 enquiries, which resulted in approximately 50 new households offering foster care.

Data was not available to report whether the recruitment campaign had resulted in an overall increase in foster carers. We were advised that a significant number of carers withdraw from the system due to the demands placed on them. As well as recruiting new carers we expected to find strategies to address the retention of carers such as records of exit interviews. Support to carers is further discussed at Section 4.4.

There was no policy or procedure providing guidance on how to assess potential applicants. Nevertheless, we were satisfied that there were necessary screening processes and that carers received training.

We looked at whether carers' background and home environment checks were current. Most files examined included evidence of both checks. On further examination, we concluded that the deficiencies were checks not recorded rather than checks not actually undertaken.

Overall, we were satisfied with recruitment and assessment processes. We did, however, note the lack of a comprehensive register of approved carers. Such a register would enable the Department to have a better sense of movement in carer numbers over time and the adequacy of those numbers. DHHS advised that a register of carers was being developed.

**Recommendation 11**

**We recommend that DHHS establishes an accurate database in CPIS containing all necessary carer details to facilitate better placement decisions.**

**4.3** *Did carers receive necessary training?*

We looked at whether carers had access to the necessary information, resources and training to provide suitable care to children in OoHC. Prospective foster carers were required to complete eight two-hour training modules which included case studies and behaviour management tools. Kinship carers could elect to undergo the same training.

Additional training for carers was optional with training requests identified during consultation with departmental support staff and commonly arising from behavioural issues that carers had experienced with children in their care.

Some children presented a high level of difficulty and required a higher level of support than general carers could provide. Ideally, those children would have received some form of therapeutic care. However, we found no training or recruitment process to enable carers to become therapeutic foster carers. On the other hand, some training was available to help carers cope with challenging behaviour.

Some specific training difficulties noted included:

- no extra reimbursement for ‘more skilled’ carers (instead, reimbursement was associated with numbers of children in care)
- a lack of information about therapeutic foster care for example identification of skills, qualifications or training requirements
- inadequate provision for respite, or alternative childcare to support carers undertaking training. One possibility is that the Department recruits skilled providers of respite care to better support training.

It was also noted that accredited training was recommended in the 2007 KPMG report. We endorse that recommendation as providing greater encouragement to carers to upgrade their skills.

**Recommendation 12**

**We recommend that DHHS provides additional reimbursement for carers who have undertaken accredited training and are caring for children with complex needs.**

**Recommendation 13**

**We recommend that DHHS 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.**

*4.4 Did carers receive adequate support?*

Support for carers is essential to retaining carers and ensuring the success of placements. The level of support required depends on the difficulties posed by the child and the skills and experience of the carer.

KPMG recommended that this key area be outsourced. It further recommended ratios for carers and children allowing workers to support no more than 12 carers. Similarly, the then Commissioner for Children recommended in 2010 that, ‘urgent attention be given to improving the level of support provided to foster and kinship carers’. The Department advised that it intended to implement the recommendation, but that funding was not yet available.

In this Section, we review some aspects of support for carers, namely:

- visits by departmental officers

- annual reviews of carers
- processes to deal with challenging behaviours.

#### 4.4.1 *Visits by departmental officers*

The Department's KPIs assume that carers would be visited once every four weeks in their first year and six-weekly thereafter. We tested the frequency of visits to carers and found only 16 of the 30 carer's files we tested contained adequate records of visits to carers<sup>14</sup>. In most cases, it was not possible to determine the frequency of visits.

We also reviewed the proportion of carers to departmental support staff to determine whether the Department had sufficient resources to provide the expected frequency of visits. Ratios recommended by KPMG suggested that each worker support no more than 12 carers. We were advised by the Department that other Australian jurisdictions provide approximately that level of support. We found that in Tasmania there were 12 support workers servicing 498 carers, or 1:41.

We were advised that on average each visit, including travel, documentation and follow up action requires approximately a full day. On that basis, a support worker can meet the four or six week visitation KPI for approximately 25 carers if they had no other responsibilities. However, support workers also have a range of responsibilities, for example responding to crises or participating in recruitment and training. It follows that current staff cannot perform the expected number of visits. Our understanding was that OoHC sections are substituting telephone calls and emails for some visits based on informal prioritisation of carer needs.

We concluded that the current level of visits by departmental officers to carers in Tasmania was inadequate.

#### **Recommendation 14**

**We recommend DHHS explores ways to increase the level of support to carers and more accurately record the number and frequency of visits to carers.**

#### 4.4.2 *Annual reviews of carers*

Carers are also expected to have an annual review with a departmental social worker. The annual review is a formal process

---

<sup>14</sup> In the absence of a prescribed record of visit we accepted either an index of visits, or three individual records of visits as evidence that regular visits were occurring.

with specific questions as to whether the carer is addressing the child's emotional, educational and cultural needs. It also seeks to determine how well the carer is coping.

We tested 30 files and found that only eight files contained evidence of a current review. Others had either out-of-date annual reviews or no review at all.

**Recommendation 15**

**We recommend that DHHS ensures annual reviews with carers are undertaken and recorded in CPIS.**

*4.4.3 Were there effective processes to deal with challenging behaviours?*

Some children have complex needs and their challenging behaviours pose additional challenges for carers. When crises occur, the Department uses NGOs to intervene and provide therapeutic residential care. Extra training is also offered to carers (see Section 4.3). It was suggested to us that there was also a need for:

- facilities to allow young people with behavioural issues to cool off
- a therapeutic foster care program to provide long-term care for the most challenging children
- identification of carers that could be accredited as therapeutic foster carers (the Department advised that it was working toward establishing a pilot accreditation panel).

In any event, we accept that it is not always possible to provide a suitable placement. It appeared to us that the Department did not have a solution for such cases. Until recent years, the Department's fallback response to these situations was rostered or residential care. In those situations, young people were housed in a Department-owned facility with rostered carers.

We became aware during the audit of one such house, where neighbours had repeatedly complained of the neighbourhood being 'terrorised' by the behaviour of the residents and that rostered carers appeared unable to control the behaviour or direct the children toward positive outcomes.

As previously discussed, rostered care has been phased out in Tasmania. It seemed unlikely to us that such care represented a reasonable solution and we support the Department's decision to discontinue rostered care.



**Recommendation 16**

**We recommend that DHHS establishes cool-off facilities and a therapeutic foster care program that would enable accreditation of suitably trained foster carers.**

4.5 *Conclusion*

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.



## **5 Were placements actively monitored?**

## 5 Were placements actively monitored?

### 5.1 *Background*

Monitoring plays a significant role in ensuring the safety and wellbeing of children in OoHC. In this Chapter, we examine whether:

- frequency of visits accorded with guidelines
- quality of documentation was adequate.

Case and care plans (CCPs) are key documents for holding summary information about children in OoHC, including placement details and history, identified needs, risk factors, education and health matters. In respect of record keeping, our expectation was that the CCP would provide a structure for interviews and that documentation of visits would be in the form of updates to the CCPs.

### 5.2 *Was the frequency of visits in accordance with guidelines?*

The Manual included the following visiting requirements for a child on:

- an assessment order — weekly
- a twelve-month or interim Care and Protection Order — four-weekly
- a long-term Care and Protection Order — six weekly.

We found that none of the files tested included an up-to-date summary of visits. Less than 50 per cent of the files tested included sufficient records of visits to persuade us that visiting requirements had been met. We could not determine whether the shortcomings were due to a lack of visits or to deficiencies in record keeping.

### 5.3 *Was the quality of documentation adequate?*

Visits need to be documented for many reasons, including demonstration that legal responsibilities were met, to identify required action and to ensure that OoHC staff have up-to-date records.

We found different styles of documentation of visits in the South, North and North West regions.

#### *South*

In the Southern region, CPIS had not yet been well populated as noted in Section 1.4. We noted that access to CPIS in the South was

extremely slow because of the antiquated communication infrastructure on the heritage-listed site. These access limitations had impacted on the quality and quantity of documentation entered. Consequently, details of home visits were located as separate case notes in document listings. We noted that:

- The record structure (a single multi-screen list of unrelated documents) did not facilitate effective use of case notes or support review of the frequency of visits.
- While some case notes recorded detailed observations, others provided only brief summary comments (e.g. ‘all OK’). Where detailed information was provided it consisted of unstructured narratives rather than updates of CCP data.

### *North*

In the North — where implementation of CPIS was more advanced — we noted that the CCP was being used as the primary documentation of the visit and was being promptly updated. Accordingly, visits tended to be better focused on information contained in the CCP and so provided a natural follow up of previous action points. On the other hand, it was rarely possible to determine how often visits had occurred.

### *North West*

In the North West, CPIS files had also been updated. Records of visits to clients were based on paper forms used prior to the introduction of CPIS and stored as case notes attached to the CCP. The case notes were clearly and consistently titled as home visits, e.g., ‘Six-weekly Home Visit’, making them easier to identify and compare with guideline requirements.

#### **Recommendation 17**

**We recommend that DHHS considers upgrading the communication infrastructure available to Child Protection South.**

#### **Recommendation 18**

**We recommend that DHHS uses CCPs to structure visits and that the Plan be promptly updated based on the findings of the visit rather than using an unstructured narrative.**

**Recommendation 19**

**We recommend that DHHS maintains on CPIS a summary of visits to facilitate checking of compliance with prescribed frequency of visits.**

5.4 *Conclusion*

The 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.

**6 Were there adequate processes for transitioning from care?**

## 6 Were there adequate processes for transitioning from care?

### 6.1 *Background*

Children or young people leave OoHC through reunification with their families, moving into permanent care arrangements or independent living<sup>15</sup>. In this Chapter, we look at whether there were adequate processes in place to support reunification or transitioning to independent living. Specifically, this Chapter asks:

- Was reunification only recommended after clear evidence of improved circumstances at home?
- Did young people have adequate support for leaving care?

### 6.2 *Was reunification only recommended after clear evidence of improved circumstances at home?*

Whilst reunification is the first intention of the Department, it should not be attempted without evidence of objective improvement in regard to the risk factors that brought the children into State care. It is also reasonable to expect that wherever possible the views of the child be taken into consideration.

We found that risk documentation was fragmented, brief and lacked identification of the actions required to address those risks. We were also unable to find evidence of any change in circumstances for a sample of children who had been reunified with their families.

#### **Recommendation 20**

**We recommend DHHS 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.**

### 6.3 *Did young people have adequate support for leaving care?*

Whilst children and young people can be reunified with their parents at any time, young people approaching the age of 18, regardless of their current circumstances, should be prepared for adulthood.

---

<sup>15</sup> Permanent care arrangements may also include continuing to live with carers beyond the age of 18 or supported accommodation.



The Manual contained provisions relating to support for young people leaving care and it required preparations to begin from the age of 15. The Department's obligation was to provide information, a personal support team and funding. It was also required development of a leaving care plan that would address:

- access to housing
- further education
- learning to drive
- financial management.

We found that only one of the CCPs for the four applicable children in our sample included a leaving care plan or evidence of discussion of the above matters.

**Recommendation 21**

**We recommend that DHHS ensures that every young person over the age of 15 years has an approved leaving care plan.**

**6.4** *Conclusion*

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.



## **Independent auditor's conclusion**

## Independent auditor's conclusion

This independent conclusion is addressed to the President of the Legislative Council and to the Speaker of the House of Assembly. It relates to my performance audit assessing the effectiveness of out-of-home care (OoHC) as an element of child protection.

In developing the scope of this audit and completing my work, the Department of Health and Human Services (the Department) provided me with all of the information that I requested. There was no effort by any party to the audit to limit the scope of my work. This Report is a public document and its use is not restricted in any way by me or by any other person or party.

### *Responsibility of the Secretary of the Department of Health and Human Services*

The Secretary is responsible for establishing and maintaining effective systems for the care and protection of children placed in his or her care. This includes the establishment of effective systems and processes and allocation of appropriate resources to facilitate effective service delivery.

### *Auditor-General's responsibility*

In the context of this performance audit, my responsibility was to express an opinion on the effectiveness of OoHC as an element of child protection.

I conducted my audit in accordance with Australian Auditing Standard ASAE 3500 *Performance engagements*, which required me to comply with relevant ethical requirements relating to audit engagements. I planned and performed the audit to obtain reasonable assurance whether the Department was maintaining effective systems for the care and protection of children placed in OoHC.

My work involved obtaining evidence based on examining legislation, the Child Protection Manual and case files, for both children and carers that were active during 2009–10.

The audit criteria I applied were aimed at addressing the following effectiveness aspects:

- Has the Department responded to changing circumstances?
- Were notifications properly actioned?
- Were appropriate placement decisions being made?

- Were carers well managed?
- Were placements actively monitored?
- Were there adequate processes for transitioning from care?

To conduct the audit, I:

- reviewed OoHC related documentation
- reviewed previous internal and external reports
- interviewed relevant staff
- tested samples of client and carers' files across the state.

I believe that the evidence I have obtained was sufficient and appropriate to provide a basis for my conclusion.

### *Auditor-General's conclusion*

#### *Inability to form an overall conclusion*

I was unable to form an overall conclusion as to the effectiveness of OoHC as an element of child protection. This was because I was unable to conclude whether identified deficiencies were due to documentation shortcomings or to lack of performance or some combination of both. For that reason some findings refer to 'lack of evidence' or 'not being persuaded' that a criterion was met rather than expressing a definitive conclusion about the criterion.

#### *Conclusions on individual criteria*

Subject to my inability to form an overall conclusion, I was able to form conclusions on each of the six criteria detailed on page 15. These conclusions are recorded at the end of each Chapter and in the Executive Summary.

This Report contains 21 recommendations which are aimed at improving the effectiveness of the provision of OoHC by the Department.

H M Blake

Auditor-General

22 September 2011



## **Recent reports**

---

## Recent reports

	<b>Tabled</b>	<b>Special Report No.</b>	<b>Title</b>
May	2009	80	Hydro hedges
Jun	2009	81	Contract management
Aug	2009	82	Head of Agency contract renewal
Oct	2009	83	Communications by Government and The Tasmanian Brand project
Oct	2009	84	Funding the Tasmanian Education Foundation
Nov	2009	85	Speed-detection devices
Nov	2009	86	Major works procurement: Nation Building projects, Treasurer's Instructions 1299 and 1214
Jun	2010	87	Employment of staff to support MPs
Jun	2010	88	Public Trustee — management of deceased estates
Jun	2010	89	Post-Year 10 enrolments
Jul	2010	90	Science education in public high schools
Sep	2010	91	Follow of special reports: 62–65 and 70
Oct	2010	92	Public sector productivity: a ten-year comparison
Nov	2010	93	Investigations 2004–2010
Nov	2010	94	Election promise: five per cent price cap on electricity prices
Feb	2011	95	Fraud control
Apr	2011	96	Appointment of the Commissioner for Children
May	2011	97	Follow of special reports 69–73
Jun	2011	98	Premier's Sundry Grants Program and Urban Renewal and Heritage Fund
Jun	2011	99	Bushfire management
Jul	2011	100	Financial and economic performance of Forestry Tasmania
Sep	No.1 of 2011–12		Tourism Tasmania: is it effective?



## **Current projects**

## Current projects

Performance and compliance audits that the Auditor-General is currently conducting:

<b>Title</b>	<b>Subject</b>
<b>TasPorts amalgamation</b>	Assesses whether the promised benefits of amalgamation have been achieved.
<b>Planning approval in Tasmania</b>	Examines the planning approval process and will include the role of the Tasmania Planning Commission.
<b>Follow up of special reports</b>	Measures the extent to which audit clients implemented recommendations from Special Reports 75–81, tabled between September 2008 and June 2009.
<b>Project to replace the Motor Registry System</b>	Examines the effectiveness of the project management used to implement the state's new Motor Registry System.
<b>Public Trustee</b>	Reviews management of funds held in trust by the Public Trustee related to Victims of Crime compensation and similar funds.